

Doctorate in  
Clinical Psychology

Lancaster  
University



**Doctoral Thesis**

May 2016

**Quantitative Investigations of Compassion Satisfaction and Challenges to Compassion  
in Mental Health Professionals**

Mirella Hopper

Trainee Clinical Psychologist

School of Health and Medicine

Division of Health Research

Lancaster University

## Thesis Abstract

**Systematic Literature Review:** The first section of the thesis explored ‘compassion satisfaction’ (CS): a positive effect of caregiving where gratification is derived from caring for patients. Stamm’s model of professional quality of life was employed to analyse 16 quantitative studies for evidence of predictors and correlates of CS in mental health professionals (MHPs). CS was associated with increased age and clinical experience, health and wellbeing, therapeutic bond and the MHP’s capacity to maintain a coherent view of their social world, themselves and their clients. Several papers revealed preliminary evidence of a negative relationship between CS and compassionate stress in MHPs.

**Research Paper:** Given the apparent lack of compassion within healthcare services, this quantitative study investigated the impact of individual differences in 104 direct-care staff on the challenges to compassion they experience towards patients who are detained under the Mental Health Act. The Challenges to Compassion Questionnaire was developed for the purposes of this research, and demonstrated good internal reliability and validity. Overall, staff reported minimal challenges to compassion. A multiple regression analysis revealed that intrapersonal emotional intelligence and CS predicted fewer challenges to compassion. Recommendations for promoting compassionate care target individual, interpersonal and organisational factors.

**Critical Appraisal:** The final section adopted a critical and reflective stance to consider the initial decision-making processes regarding the research paper, including the rationale for the study and the chosen data collection methodology, and the practical and procedural challenges encountered during the course of the research, such as ethical approval processes and the impact of software compatibility on survey response rates. The report then explored the primary constructs adopted within the research paper, including compassion and

attachment theory and the implications of their conceptualisations on the research findings, before examining pragmatic applications of the results and offering recommendations for future research.

## **Contents Page**

### **Section 1: Systematic Literature Review**

A Systematic Review of Compassion Satisfaction in Mental Health Professionals

### **Section 2: Research Paper**

Investigating the Relationships between Staff Individual Differences and Challenges to  
Compassion towards Patients who are detained under the Mental Health Act

### **Section 3: Critical Appraisal**

Adjunct Considerations on Conducting Quantitative Research into Compassionate Care  
within Mental Health Services

### **Section 4: Ethics Proposal**

### **Section 5: Appendices**

## **Declaration**

I hereby declare that the research reported is my own original work. This thesis has not been submitted for any other academic award.

*Mirella Hopper, May 2016*

## **Word Count Statement**

The total number of words contained within this thesis, including in-text references, is 43,396. This is comprised of a total text word count of 22,960 and a total appendices word count of 20,434.

*Mirella Hopper, May 2016*

## **Acknowledgements**

I would like to express my sincere gratitude to Dr Ian Fletcher and Kirstie Thompson for their research and academic support until the final hour of this project, and to the local collaborators for their unremitting enthusiasm in recruiting participants to the study.

I am also extremely grateful to my husband Jack, my parents Bridget and Mike and my Grandpa for their unconditional belief in me, and to my friends for their patience in my absence and celebrations in my return.

As compassion starts with the self, I would like to finally acknowledge my own determination, diligence and commitment to this project.

## **Section 1: Systematic Literature Review**

A Systematic Review of Compassion Satisfaction in Mental Health Professionals

Text word count: 7,977

Appendices word count: 8,443

Mirella Hopper

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Mirella Hopper

Doctorate in Clinical Psychology

Furness College

Lancaster University

Lancaster

LA1 4YT

[m.hopper1@lancaster.ac.uk](mailto:m.hopper1@lancaster.ac.uk)

Prepared for submission to: Anxiety, Stress and Coping

## Abstract

**Background and Objectives:** Given the continued popularity of working in the health professions, this systematic literature review investigated the factors associated with ‘compassion satisfaction’ (CS): a positive effect of caregiving where gratification and pleasure are derived from caring for service-users. **Design and Methods:** Stamm’s model of professional quality of life was employed to analyse 16 quantitative studies for evidence of predictors and correlates of CS in mental health professionals (MHPs). Fourteen variables were identified and clustered into professional, client and work-related factors. **Results:** Increased age and clinical experience, health and wellbeing and therapeutic bond were most commonly associated with CS in MHPs. CS was also predicted by the MHP’s sense of coherence regarding their social world, themselves and their clients, which enabled them to preserve their psychological resilience, self-efficacy and compassion and reframe their clients’ distress. **Conclusions:** This review uncovered average to extremely high levels of CS in MHPs across the studies, and preliminary evidence of a negative relationship between CS and compassionate stress in MHPs. Service recommendations to enhance CS include restorative supervision, mentoring and specialised training for younger, ‘front line’ and newly-qualified staff, and the promotion of staff welfare within compassionate and value-based organisations.

## Keywords

- *Compassion Satisfaction* • *Mental Health Professionals* • *Professional Quality of Life*
- *Systematic Literature Review* • *Quantitative* •

## **A Systematic Review of Compassion Satisfaction in Mental Health Professionals**

### **Compassion Satisfaction**

It is not uncommon for clinicians to be confronted by the personal and professional consequences of providing care to individuals who have experienced pain, trauma or distress in relation to a physical or mental health difficulty (Dolan, 2007). Historically, research has focused upon the negative effects of caring for those in need and the impact of this on clinicians' professional quality of life (Stamm, 2009). However, the continued popularity of the caring professions (Office for National Statistics, 2015) suggests that caregiving must offer certain rewards other than financial gain. Consequently, Figley (2002a) began to investigate the positive effects of caring for service-users, from which he identified the construct of 'compassion satisfaction' (CS).

Stamm (2009) described CS as the general gratification and pleasure one derives from working in caregiving systems, together with the sense of achievement, satisfaction and positive affect gained from the ability to help others (Figley, 2002b). This can also encompass positive feelings regarding work colleagues and the experience of making valuable contributions to the work setting and to wider society (Stamm, 2010). CS may be construed as an extension of compassion itself, in which a sense of fulfillment is derived from embodying 'a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it' (Gilbert, 2010; p. xiii). In contrast, should a health professional experience prolonged exposure to a client's distress, difficulties in appropriately distancing themselves from this and/or significant life disruptions as a result of their caregiving duties, the propensity to develop 'compassionate fatigue' (CF) increases (Figley, 2002b). CF is defined as a 'cost of caring' related to caregiver stress from helping, or wanting to help, a client who is suffering or in pain.

**Related constructs.** If CS is the fulfillment derived from caring for others, CF may be assumed to be the opposing dimension in which a lack of satisfaction and pleasure is experienced from caregiving; therefore, is the presence of CS the absence of CF? Some literature describes CS as an ‘inverse’ (LaFauci Schutt & Marotta, 2011) or ‘opposite’ construct to CF (Plante, 2015), suggesting that one can only experience either the positive or negative effects of caregiving at a single time. However, Stamm (2002) hypothesised that CS and CF can co-exist, with those in the helping professions often experiencing both constructs simultaneously. For example, one may experience negative affect associated with CF while still experiencing positive affect and rewards related to caregiving (Kang *et al.*, 2013), suggesting that CS is influenced by the caregiving context itself. CS has also been portrayed as a protective factor against the development of CF (Figley, 2002b; Stamm, 2010), while Mason and Nel’s (2012) study revealed that the discomfort caused by CF in nursing students actually promoted the pursuit of pleasurable workplace experiences, increasing levels of CS. However, Stamm (2002) noted that if ‘burnout’ is experienced concurrently with CF, the caregiver’s over-exhaustion may prevent them from realising the satisfaction or rewards of their task.

The construct of CS also appears to overlap with other concepts, such as ‘job satisfaction’ (Li, Early, Mahrer, Klaristenfeld & Gold, 2014). This is the degree of positive affect experienced towards a job, resulting in positive work behaviours (Adams & Bond, 2000); however, this is a global occupational construct. ‘Altruism’ also has close links to compassion and CS and was first defined by Comte (1858) as the selfless concern for the wellbeing of others in which prosocial actions are performed to directly benefit another. Compassion, it seems, is related to the specific motivation behind altruistic actions; that is, a desire to alleviate another’s suffering. In this sense, CS may encompass a secondary egoistic motivation in which caring behaviours are performed if a reciprocal benefit of doing so is

anticipated, even simply a 'warm glow' experience (Andreoni, 1989). Conversely, the intrapersonal benefits obtained from caregiving may be the unintended consequences of the goal of increasing another's welfare (Batson, 2008). McGaghie, Mytko, Brown and Cameron (2002) reported that health care professionals predominantly possess a 'compassionate core' that is strengthened through a cyclical process in which continued altruistic acts reinforce compassion and maintain work-related satisfaction, both of which appear central to the experience of CS.

### **Psychological Theories of Compassion Satisfaction**

**Attachment theory.** According to Bowlby (1988) a child's attachment bond to their primary caregivers during the first few years of life can have a profound influence on their propensity to provide care and compassion to others during adulthood (Mikulincer, Shaver, Gillath & Nitzberg, 2005). Early experiences of sensitive, responsive and consistent care allow the child to internalise these interactions, forming positive mental representations of themselves and others as worthy of compassion (Silver, 2013). This potentially increases the tendency for satisfaction to be experienced as a result of caregiving. Conversely, those who have experienced unavailable, unattuned or abusive care may encounter difficulties in relating compassionately to themselves and others (Mikulincer & Shaver, 2010). Given this theoretical conceptualisation, researchers have sought to corroborate the relationship between attachment and CS, in which greater CS has been found in attachment security (Collins, 2014; Pardess, Mikulincer, Dekel & Shaver, 2014). However, there are obvious implications should the categorical model of attachment be applied to CS.

**Gilbert's theory.** Gilbert (2010) integrated evolutionary and biopsychosocial theories to hypothesise that human neurophysiology has evolved to respond to kindness and caring from others and ourselves. Gilbert (2010) proposed that humans possess three emotion regulation systems in which the 'drive' and 'threat' systems are frequently activated,

while the ‘soothing’ system, which encompasses compassion and kindness, can become somewhat neglected in modern life due to increased demands. The development of these systems appears to originate in childhood in which individuals who experience little compassion and warmth from their primary caregivers may struggle to activate their soothing systems as adults (Gilbert, 2005).

**Self-compassion.** Self-sacrifice is a common characteristic among caregiving professionals (Saddichha, Kumar & Pradhan, 2012), which is perhaps unsurprising given clinicians’ primary objective of alleviating the distress of others. Consequently, compassion for another is often seen as more salient than self-compassion or self-care (Rose & Glass, 2008). However, Raab (2014) highlighted that one’s capacity for interpersonal compassion increases with self-compassion, as this requires a relational connection, an acknowledgement of the mutual vulnerability of the self and another, and an ability to be sensitive, caring and non-judgemental towards the self (Gustin & Wagner, 2013). Self-compassion may, therefore, also enhance the experience of CS.

**Broaden-and-build theory.** Fredrickson and Fowler’s (2001) broaden-and-build theory proposes that the presence of positive affect facilitates the *broadening* of cognitive, motivational and behavioural processes, therefore increasing reflexivity, creativity and flexibility. Conversely, negative affect narrows thinking and restricts behaviours to survival-focused acts (Fredrickson, 2009). Positive affect also enables the discovery of meaning within experience (Tugade & Fredrickson, 2004), such as reconnecting with personal and professional values (Folkman & Moskowitz, 2000), which in turn reinforces positive emotions (King, Hicks, Krull & Gaiso, 2006). Therefore, the presence of CS - which encompasses positive affect - may reinforce hope, purpose and meaning in providing care to those in distress (Harr, Brice, Riley & Moore, 2014).

Over time, it is thought that broadened thought-action repertoires may lead to the

*building* of intellectual, social and physical resources, such as perspective-taking (Fredrickson & Joiner, 2002), more effective use of social support networks (Cohn & Fredrickson, 2006) and psychological resilience (Fredrickson, 2003). Subsequently, positive affect may be a key factor in successful caregiving, as this can increase a clinician's capacity to provide innovative, reflective and person-centered care, which potentially enhances CS.

### **Benefits of Interpersonal Compassion**

While the majority of studies have explored the psychological, social and physiological benefits of caregiving in volunteers and family carers, this is likely to resemble the experience of professionals. Some researchers suggest that providing compassionate care may be more beneficial than receiving compassion as it can increase positive affect and self-esteem (Mongrain, Chin & Shapira, 2011) and improve mental wellbeing (Yuen *et al.*, 2008). Interpersonal compassion has been found to enhance social connections: a key component of human development and wellbeing (Seppala, Rossomando & Doty, 2013). Reduced blood-pressure and cortisol levels are also highlighted as a consequence of caregiving (Cosley, McCoy, Saslow & Epel, 2010), together with reduced mortality rates (Brown, Nesse, Vinokur & Smith, 2003). In addition to combating compassionate stress (Radey & Figley, 2007), the professional benefits of caregiving include increased work-related motivation (Graber & Mitcham, 2004), sustained professional commitment (Van Hook & Rothenberg, 2009) and enhanced clinical competence (Kim, Han, Kwak, Kim, 2015).

Perhaps most importantly, caregiver CS has the potential to benefit those in receipt of care and support. Larrabee *et al.* (2004) discovered that high levels of compassion in nurses predicted patient satisfaction, while Barsade and O'Neill (2014) found that compassion towards colleagues was related to positive clinical outcomes, including improved mood and better quality of life in patients. Work environment factors have also been studied, revealing that compassionate organisational practices are significantly associated with patient

perceptions of care quality (McClelland & Vogus, 2014).

### **Factors Affecting Compassion Satisfaction**

According to Stamm's (2009) model professional quality of life is influenced by three factors relating to the caregiver's experience: personal, client and work-related environments (Figure 1). If these factors collectively foster feelings of gratification and fulfillment, the likelihood of experiencing CS increases. However, if the experience of caring for patients primarily leads to feelings of exhaustion, stress and frustration, this may result in CF or burnout (Stamm, 2009).

A number of studies have investigated the impact of the three factors on CS in the caring professions. The majority of research in this field relates to the personal characteristics of caregivers, in which increased self-efficacy (Figley, 2002a), self-care practice (Eastwood & Ecklund, 2008) and marital status (Ortega, 2015) have been found to predict CS. While the relationship between client characteristics and CS has received less attention, the prevalence of CF in professionals working with particular clinical populations indicates that specific patient groups may reduce CS in caregivers, such as individuals with a terminal illness (Peters *et al.*, 2012) or those going through pregnancy terminations (Mizuno, Kinefuchi, Kimura & Tsuda, 2013). With regards to specific work-related factors, having a smaller caseload (Byrne, 2006), maintaining positive relations with colleagues (Agcaoili, Mordeno & Decatoria, 2008) and working in rural locations (Crampton, 2014) have been found to enhance CS.

### **Current Study**

Research exploring CS has primarily focused upon specific groups of healthcare professionals, including emergency service workers (Prati, Pietrantonio & Cicognani, 2010), acute care nurses (Kelly, Runge & Spencer, 2015) and aid workers (Musa, Hamid, Amir & Dodeen, 2008). Studies involving mental health professionals (MHPs) have largely

investigated the negative effects of caregiving, such as CF (Collins & Long, 2003; Thompson, Amatea & Thompson, 2014).

Although the core role of all health professions universally is to provide compassionate care (e.g. Department of Health, 2013; Schwartz Centre, 2011), MHPs specifically focus on the interpersonal and affective aspects of patient care in their endeavours to reduce clients' emotional and psychological distress. Therefore, several variables unique to MHPs may affect their professional quality of life and experience of CS. In line with Stamm's (2009) model, this may include personal factors, such as the differing roles of 'front-line' care staff and members of multi-disciplinary teams, client factors, including caring for individuals with childhood trauma histories, and work-related factors, such as providing care within a hospital or community setting.

To date, there are no literature reviews that have examined the construct of CS; however, there are numerous individual studies investigating the presence of CS in MHPs. Given the potential protective role of CS for MHPs who provide care and treatment to patients experiencing psychological distress, the purpose of the current review is to summarise the existing findings in this area and advance the theoretical and pragmatic understandings of CS. The current review aims to identify the common factors that predict, and are associated with, CS in MHPs by reviewing the selected papers via Stamm's (2009) three-factor model of CS.

## **Methodology**

### **Search Strategy**

A systematic literature search was conducted in the following databases to identify papers for inclusion in the review: *PsycInfo*, *PsycArticles*, *Academic Search Complete*,

*Medline, PubMed, Web of Science, Scopus and ProQuest Dissertations & Theses (Global).*

The databases were searched using the major search terms ‘Compassion Satisfaction’ AND ‘Mental Health Professional’, which were also ‘exploded’ to reveal additional search terms (Table 1). Combinations of the search terms were piloted prior to verification of the final search strategy. The subject-specific librarian was also consulted during this process to ensure that the search terms were comprehensive. The inclusivity of the review was enhanced by incorporating relevant ‘grey’ literature.

### **Inclusion Criteria**

The review included quantitative studies written in the English language which explored CS in MHPs and MHPs in training (Table 2) working with adult mental health service-users. The search included studies from 1995 (date of earliest research paper) to 22<sup>nd</sup> October 2015 (date of final search). Articles were included in the review if they reported the use of quantitative measures of CS. Studies which explored a range of other variables, in addition to CS, were also eligible for inclusion in the review.

### **Exclusion Criteria**

The review excluded studies which explored CS in non-MHPs, such as general health care professionals (e.g. physicians), or those which investigated CS in MHPs working with children and young people (<16 years). Studies which included MHPs who did not have regular face-to-face contact with service-users (e.g. online therapy) were also excluded, in addition to prison counsellors, substance abuse therapists and marriage counsellors as the presence of mental health difficulties in their clients was unclear. Professionals providing military or veteran mental health care were also excluded as this was deemed to be a specialist area of mental health in which clinicians encounter specific contextual factors which may influence CS (e.g. physical injury, media influence, socio-political stance). The review did not include studies in which there was ambiguity regarding whether volunteers,

students or trainees had gained clinical experience in caring for individuals with mental health difficulties. Lastly, six intervention studies investigating interventions designed specifically to enhance CS in MHPs (i.e. self-care intervention, mindfulness intervention) were not included in the review.

### **Paper Selection**

In total, 1,526 papers were identified from the initial database searches as potentially appropriate for inclusion in the review. Of these papers, 1,436 were excluded on the basis of the information contained within the title and abstract or due to duplication. Full texts were obtained for the remaining 90 studies. An additional 12 papers were identified through a hand search of the reference lists and a 'cited article search' using Google Scholar, resulting in a total of 102 articles. Following application of the inclusion and exclusion criteria, 86 papers were excluded due to research methodological and data analysis issues, for example Dragu *et al.*'s (2014) paper did not provide sufficient statistical data regarding CS. A final total of 16 papers were included in the review (Figure 2).

### **Quality Appraisal**

The methodological and reporting quality of each study was appraised using the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998) (Appendix A). This was identified as an appropriate measure as the generic nature of the assessment allowed for the appraisal of studies which adopted both cross-sectional and between-subjects research designs. Furthermore, this tool is reported to have moderate content validity and test-retest reliability (Thomas, Ciliska, Dobbins and Miccucci, 2004) and is recommended by the Cochrane public health research group. Table 3 provides a summary of the quality scores for each paper, which overall ranged from 'weak' to 'moderate' according to the scoring criteria. Following discussions with the research supervisor regarding the process of defining the quality ratings, it was agreed collaboratively that only

one of the papers would receive a 'strong' rating. The quality of each study design was evaluated in accordance with the hierarchy of research evidence; therefore, studies adopting randomised control trials receive the highest rating. The blinding component of the tool was omitted due to the exclusion of papers from the review which adopted experimental or intervention designs.

### **Methodological Considerations**

A number of methodological implications may influence the interpretation of findings from the selected studies. Firstly, in addition to the use of standardised outcome measures, study 10 developed a stress exposure survey which did not appear to be validated. Each of the 16 articles also relied on self-report measures which increased the risk of reporter bias. While all studies reported sample sizes of  $n \geq 61$ , the total participant response rates of the studies varied from 84% (study 10) to 17% (study 1). Low response rates have implications for the representativeness and generalisability of findings as this can result in non-response error due to dissimilarities in characteristics and experiences of responders and non-responders (Holbrook, Krosnick & Pfent, 2005).

Potential sampling bias also existed within some papers, such as study 14 which offered participants entry into a raffle to win a \$75 gift certificate. Although this may have increased recruitment, the use of incentives in human research has been recognised as potentially unethical due to the possible 'corruption of judgment' participants may experience when considering whether to take part in research (Grant & Sugarman, 2004). 14 studies employed a convenience sampling technique in which individuals who were available and amenable to sharing their experiences participated in the research. Moreover, study 16 utilised a purposive sampling method whereby the researchers preselected psychiatric wards from which participants were identified; however, the authors recognised this as a study limitation. Conversely, participants with a minimum of six months clinical experience were

recruited to study 7 to ensure sufficient cumulative experience to reliably measure the effects of exposure to patient trauma (Dominguez-Gomez & Rutledge, 2008).

## **Results**

### **General Study Characteristics**

Each of the 16 final papers employed a cross-sectional research design; study nine also adopted a between-subjects design as the author investigated the relationship between meditation and CS. Sampling strategies were predominantly convenience and randomised. The majority of the studies were conducted in North America, two in the United Kingdom and four in Europe and Australia. Participants were recruited from professional registers, community mental health services, public hospitals, psychiatric wards and specialist trauma services. Table 4 presents a summary of each paper.

### **Participant Characteristics**

A total of  $N = 4,320$  MHPs took part in the studies included in the review, with sample sizes ranging from  $n = 61$  (study 11) to  $n = 1,121$  (study 13). Participant ages ranged from 18 to 85 years, with a collective mean age of 45.5 years across 11 papers that reported this variable. Across the review there were consistently higher numbers of female than male participants, ranging from 53% to 84%. In line with the aim of the current review, participant characteristics are reviewed in detail within the following section.

### **Factors Associated with Compassion Satisfaction in Mental Health Professionals**

The findings from each of the 16 studies were reviewed for evidence of personal, client and work-related factors that predict and are associated with CS, based on Stamm's (2009) model of professional quality of life; this was divided into 14 variables in total. Table

5 provides a summary of the main predictors and correlates of increased CS in MHPs identified from the selected studies.

**Personal environment.** Variables relating to the personal characteristics of participants from each study were the most commonly analysed and reported. This included general demographic characteristics, such as age, gender and occupation, in addition to more specific intrapsychic factors, such as coping mechanisms and overall wellbeing. The results were obtained from a combination of the descriptive and inferential statistics available within each paper.

**Age and gender.** Increased age was significantly associated with greater CS in six studies (small-medium effect), three of which identified age as a significant predictor of CS (studies 2, 12, 13). Study 2 did, however, highlight the high mean age of participants within their research which potentially impacted upon the findings. Study 14 discovered a specific small effect of increased age on CS in qualified counsellors working in agency settings. However, in study 10 younger MHPs (aged 18-30 years) experienced higher levels of CS overall, which decreased marginally as age increased.

With regards to participant gender and CS, studies 9 and 14 discovered no significant differences between males and females, while study 16 identified that males experienced higher levels of CS. Female participants in study 5, however, experienced significantly more CS than males, although this finding also encompassed other variables measuring positive wellbeing, such as post-traumatic growth and changes in outlook.

**Length of experience.** Of the seven studies that reported the impact of clinical experience on CS, five highlighted a significant upward trend in the number of years within the field and CS (studies 1, 2, 3, 6, 15). Study 12 reported a small effect of the number of years post-qualification and increased CS, suggesting that this time period may not necessarily have only comprised of clinical experience. Conversely, study 14 found no

significant correlation between years of experience and CS, while study 5 found a significant relationship between CF and length of experience.

**Occupation.** MHPs within 11 studies reported average to extremely high levels of CS (based on Stamm's Professional Quality of Life [ProQOL] scale interpretative categories), which included trauma counsellors (6), therapists (5) and psychologists and social workers (2). While the mental health nurses in study 16 reported a high level of CS, nearly 65% of psychiatric nurses in study 7 reported low CS, with only 49% of participants choosing to re-enter the profession. As both samples were recruited from psychiatric wards, this indicates the presence of confounding variables on CS, such as staff support, incident rates and length of shifts.

Several papers provided descriptive statistics regarding the presence of CS across professionals. Study 10 revealed that social workers and support workers experienced the lowest CS, whereas psychologists reported the highest. Only two of the 16 articles incorporated details of job posts into their analysis. MHPs on fixed-term contracts in study 10 experienced significantly higher CS than those on open-ended contracts, and part-time professionals reported lower levels of burnout than their full-time equivalents in study 8, indicating the role of work-life balance in CS.

**Education, training and clinical practice.** A number of studies investigated the effect of education level, specialist training and therapeutic orientations on CS. While study 14 found no significant correlations between educational level and CS, study 12 found that participants with 'higher' qualifications experienced a significantly greater degree of CS. Studies 12 and 13 identified a relationship between the receipt of specialised trauma training post-qualification and higher CS, while participants who believed in the importance of aggression intervention training in study 16 experienced significantly higher levels of CS. Therapists' use of evidence-based practice (e.g. cognitive behavioural therapy [CBT]) in

study 2 significantly predicted CS; however, these findings were based upon self-reports.

Study 5 also found a small significant effect of the use of humanistic and eclectic approaches on higher levels of CS, while adopting a CBT approach was significantly correlated with burnout.

***Health and wellbeing.*** Five articles explored the relationship between MHPs' health and wellbeing and experiences of CS, in which study 7 discovered significantly greater CS in participants with better mental and physical health. Study 15 also found that personal distress significantly predicted lower CS. A large effect of positive emotionality on CS (mediated by positive reframing) was found in study 11, while study 4 discovered a large significant effect of greater 'total wellness' on CS. Within the latter paper, counsellors who had higher wellbeing rated the importance of career-sustaining behaviours (i.e. personal and professional activities that enhance work-related fulfilment) significantly higher than those with lower scores. Physical exercise in particular revealed a large effect on increased CS.

***Trauma and self-care.*** Details of participants' experiences of personal trauma were collated within five of the studies; however, only study 6 identified this as a significant predictor of increased CS. With regards to self-care practices, study 12 found a small effect of general self-care on CS, while study 14 found a small effect of psychological self-care on higher CS. CS also significantly increased with time spent engaging in self-care per week in study 9. Study 12 identified that participants' beliefs regarding the use of leisure activities as a coping strategy to reduce compassionate stress was significantly associated with CS.

***Intrapsychic constructs.*** A number of intrapsychic processes were also investigated within several studies. Study 15 discovered a small significant effect of increased perspective-taking - a cognitive component of empathy (Decety & Meyer, 2008) - and CS, while study 11 revealed that positive reframing mediated the relationship between positive affect and CS. These findings suggest that cognitive engagement may be a precursor of CS.

The authors of study 16 found a small effect of self-efficacy on CS, together with higher levels of staff confidence in managing patient aggression as a significant predictor of CS. Increased self-compassion in counsellors had a small effect on CS in study 9, in which meditation was significantly associated with higher self-compassion. Study 5 demonstrated that CS was significantly predicted by participants' sense of coherence in life, which refers to one's perception of the world as comprehensible, meaningful and manageable.

**Client environment.** The second environmental component of Stamm's (2009) professional quality of life model refers to the specific characteristics of the clinical populations to whom the MHPs provided care and treatment. The papers included within the review investigated these variables less frequently than the personal characteristics of the professionals themselves, and focused upon three main factors: therapeutic relationships, risk and trauma.

**Therapeutic relationship.** Of the three papers which explored MHPs' therapeutic bonds with clients, studies 1 and 5 discovered that greater perceived working alliance significantly predicted increased CS. However, it is unclear whether a positive therapist-client relationship is the cause or effect of increased CS, or is in fact bi-directional. The remaining study investigated trauma therapists' emotional investment into clients, in which they found that lower emotional involvement with patients' distress predicted CS (6). This suggests that less affective engagement with clients may increase the likelihood of CS.

**Offending and risk.** MHPs who provided therapy to male clients who had committed sexual offences reported average to high levels of CS (1), suggesting that other professional and work environment variables may influence the degree to which MHPs experience compassionate stress within their work. Study 16 found that positive staff attitudes towards patient aggression were significantly related to higher rates of CS. Furthermore, female nurses in this study demonstrated a significantly lower tendency to blame patients for their

aggression, indicating a higher tolerance of this behaviour than males. Within study 4 a small effect of an increased number of 'high-risk' clients (i.e. active harm to self) on counsellors' caseloads on CS was found.

**Trauma.** As research exploring compassionate stress has primarily sampled trauma therapists (Figley, 2002a), several studies explored CS in MHPs who provide treatment to individuals who have experienced trauma. Studies 3 and 12 found that the degree to which clinical practice was devoted to clients who had experienced trauma was unrelated to CS. Moreover, therapists working with victims of sexual violence within study 11 reported average to high levels of CS, and a small significant effect of increased number of years working with trauma survivors and CS was found within study 6.

**Work environment.** Each of the 16 papers were lastly reviewed for work-related factors which may have impacted upon participants' professional quality of life and CS. This section summarises the research findings associated with specific clinical settings, teams, supervision and MHPs' expectations of their job role.

**Service context.** Five papers considered the specific clinical setting on CS, although the country in which the studies were conducted may have impacted upon the findings. While studies 12 and 14 both reported no significant effect of the service context on CS, participants in study 2 who were employed within community mental health centres reported significantly higher CS than those in private non-profit agencies. In contrast, CS was highest for MHPs working within private practices in study 4, possibly due to increased control over workload and service provision, in addition to financial rewards. Those in public agencies reported the lowest levels of CS in study 13, although these findings may represent the impact of specific services on CS rather than that of the particular setting.

**Managerial support and supervision.** Organisational support and CS was investigated by three papers. Study 5 discovered that therapists' perceptions of the practical

and emotional work-related support they received did not predict CS. However, participants' experiences of CS in study 12 were significantly predicted by the perceived supportiveness of management and supervision. The authors of study 12 also found that CF increased as hours of individual supervision per month increased, illustrating that clinicians who experienced more compassionate stress may have actively sought increased supervision. Study 6 revealed that higher perceived control over workplace activities significantly predicted CS. This increased sense of agency, specifically in MHPs who had personal trauma histories, significantly increased CS.

**Staff teams.** The authors of study 6 reported that support from co-workers was not significantly associated with CS. However, study 7 highlighted that 82% of participants who believed that their working environment was 'good-very good', and had positive perceptions of team working, experienced higher levels of CS. These findings demonstrate that a sense of fulfilment from work is dependent on individual differences and can be either an intrapsychic or interpersonal process. A small effect of maintaining regular contact with one's referral network (external to the immediate working environment) on CS was revealed by the authors of study 4.

**Occupational expectations.** Study 8 specifically explored the impact of person-job match on CS: the degree to which the professional's expectations of their occupation, and the actual experience of this, are congruent. The authors discovered a large significant effect of higher overall degree of fit with six areas of work life (i.e. workload, control, reward, community, values and fairness) on CS. Moreover, MHPs based within inpatient settings rated their person-job match significantly lower than those in community teams, indicating that this service context may facilitate less agency in staff members and increase their job demands. Finally, the authors of study 12 discovered that CS was predicted by time spent engaging in research and developmental activities.

In summary, the findings of the reviewed studies indicated that greater CS was associated with personal factors such as increased age, clinical experience, wellbeing and coherence, client factors including positive therapeutic relationship and increased distance from patient distress, and work factors such as managerial support and increased professional agency.

## **Discussion**

This systematic literature review employed Stamm's (2009) model of professional quality of life to analyse 16 studies for evidence of associative and predictive factors of CS in MHPs. While the quality appraisal highlighted several methodological implications, such as potential sampling bias, low response rates and the use of self-report and non-validated measures, analysis of the studies revealed a number of significant, unexpected and at times contradictory findings.

### **Clinical Implications**

Overall, the review discovered that MHPs experienced average to extremely high levels of CS within the majority of studies. However, professionals who experience low rates of CS, or high levels of CF and burnout, within their roles may be less likely to remain in the field of mental health (Figley, 1995). Six studies identified a negative relationship between CS and CF and one paper reported no association. Although CS and CF are potentially separate constructs which occur simultaneously (Stamm, 2002), the presence of CS has also been shown to buffer against the development of CF (Ray, Wong, White & Heaslip, 2013) and burnout (Conrad & Kellar-Guenther, 2006), suggesting that greater CS may mitigate the experience of compassionate stress in MHPs.

The review highlighted preliminary evidence of two primary variables associated with CS: increased age and length of clinical experience. This reflects findings from other research (Ghahramanlou & Brodbeck, 2000) and suggests that older, more experienced clinicians may have developed 'professional maturity' comprised of self-regulation, personal validation, self-care strategies and a moral, ethical and spiritual value-base (Gentry, 2012). Although these two factors are potentially interrelated, some participants reportedly entered the profession at a later age, suggesting that general life experience may also buffer against compassionate stress, possibly through increased resilience and self-awareness. Only one study in the review reported a reverse effect of age and professional experience on CS, indicating that for some the negative effects of caring for individuals in distress are cumulative with chronic exposure (Dominguez-Gomez & Rutledge, 2008). The same study also found a significant increase in burnout and CF with every extra year spent within the community team, indicating potential challenges within this particular service. While previous research has identified that females may be more susceptible to experiencing the negative effects of their caring roles (Meyers & Cornille, 2002), this review highlighted conflicting evidence of the effect of gender on CS. Therefore no conclusive inferences can be made from the findings of the current review.

Psychologists were found to experience the highest levels of CS and the lowest rates of burnout when compared to other disciplines, such as healthcare workers. This may be a result of the disparate level of autonomy experienced within the workplace by these professions, in addition to the protective nature of higher employment grades on health and mental wellbeing (Ferrie, Shipley, Smith, Stansfeld & Marmot, 2002). Furthermore, the emphasis placed on psychologists' use of regular clinical supervision to reflect upon processes elicited within therapy (American Psychological Association, 2010; British Psychological Society [BPS], 2010) may enhance CS by allowing a protected space to 'work

through' any barriers within clinical work, detect compassionate stress and identify opportunities to promote work-related satisfaction.

A relationship between clinicians' engagement in supplementary activities, such as research and training, and increased CS was also found. An early paper by Penn, Romano and Foat (1988) highlighted the role of continued professional development in enhancing job satisfaction due to the human desire for growth. The increasing emphasis on indirect working in psychology (American Board of Professional Psychology, n.d; BPS, 2007), together with a growing focus on social change and community psychology (e.g. Psychologists Against Austerity, 2014), may enhance CS in psychologists by promoting a sense of achievement in making contributions to the field and to societal wellbeing. This demonstrates the importance of fulfilling a range of professional roles in experiencing gratification from working in caregiving systems. As CS appears to centre around the clinician's ability to offer 'managed' emotional investment into patient care (McKim & Smith-Adcock, 2014), and to disengage from an individual's distress (Figley, 2002b), the provision of clinical opportunities away from therapeutic work may also facilitate replenishment of the professional's psycho-emotional resources by offering temporary affective distance from patient distress.

The use of evidence-based practice, such as CBT, also predicted increased CS in MHPs. Evidence-based practice is believed to provide a clinical framework for quality, consistency and accountability (Spring, 2007), which may also prevent professionals becoming enmeshed with their clients' distress. However, one study discovered that the use of CBT increased burnout rates and prevented personal growth for some therapists. One of the underlying theoretical assumptions of CBT is that of 'distorted' cognitions. In addition, high caseloads and manualised, time-limited therapy such as CBT, for example in Increasing Access to Psychological Therapies services, may restrict professional autonomy and limit the

degree to which gratification can be experienced through clinical work (Steel, Macdonald, Schroder & Mellor-Clark, 2015). Employing evidence-based humanistic models within therapy were also related to high levels of CS in MHPs. These approaches adopt a non-pathologising view of human distress (Clay, 2002) and perceive suffering as an opportunity for personal growth (Joseph, 2001).

The common factors model, however, proposes that evidence-based practice shares mutual features that account for the effectiveness of psychological treatment: the therapeutic alliance, co-constructed meanings and the therapy process (Messer & Wampold, 2002). As the current review found that a positive therapeutic relationship between client and therapist predicted CS, it is evident that this alliance plays a key role in promoting professional quality of life, in addition to patient outcomes (Larrabee *et al.*, 2004). According to Linley, Joseph, Cooper, Harris & Meyer (2002) the therapeutic bond becomes an opportunity for the professional to experience positive psychological growth in the midst of the client's emotional distress. Therefore, a positive perception of the therapeutic relationship by both parties may enhance mutual satisfaction, fulfilment and growth, which can then foster a stronger alliance within clinical work.

In support of previous findings (Hatcher & Noakes, 2010), this review revealed high levels of CS in therapists working with sexual offenders. This indicates that clinicians who actively choose to care for a specific cohort of patients could experience more CS as they may encounter less personal and professional barriers in establishing therapeutic relationships. Previous research has shown that clinicians providing sex offender treatment were able to attend to the meaningful and successful elements of their work, enabling a sense of reward to be experienced which then acts as a self-motivator (Kadambi & Truscott, 2006). According to Tugade and Fredrickson's (2004) theory, this experience may also enhance

positive affect, and therefore CS, which further reinforces the meaning and hope found within clinical work.

One of the most unexpected findings of the review was the significantly higher levels of CS found in one study of MHPs who had a personal trauma history. As Yassen (1995) noted: “survivors have something unique to offer this field” (Yassen, 1995; p. 196); this reflects the movement towards peer recovery support (Mind, 2013) and the involvement of experts by experience within service evaluation and delivery (Care Quality Commission, 2015; Together/NSun, 2014). This finding also illustrates that adverse life experiences can promote personal growth in MHPs, together with a sense of purpose and gratification in facilitating the recovery and psychological wellbeing of others. Conversely, individuals with personal experiences of trauma may also be more attracted to trauma work, and therefore perceive their work as satisfying and rewarding (Linley & Joseph, 2007). However, clinicians who are experiencing ‘unresolved trauma’ may encounter more personal distress due to vicarious contact with similar difficulties through therapeutic work. This may activate previously repressed memories of personal adversity (Cerney, 1995), leading to over-identification with a client’s experience and blurring of personal and client healing. Therefore, professionals experiencing high rates of CS may represent a cohort of individuals who have begun to process their trauma.

Although less researched, CS was shown to be influenced by intrapsychic processes, particularly the professional’s sense of coherence and congruence regarding their social context, themselves and their clients. Firstly, MHPs high in CS appeared to hold perceptions of their social world as stable, comprehensible and meaningful. This reflects ‘vicarious resilience’ in an ability to overcome the challenges of caregiving to remain empowered, empathic and optimistic about the world (Hernández, Gangsei & Engstrom, 2007). While previous research has identified that professional social support can buffer the onset of CF

(Ducharme, Knudsen & Roman, 2008) and increase CS (Figley, 2002b), the current review highlighted conflicting findings in which relationships with colleagues and supervisors were not consistently associated with CS. This indicates that it is the professional's perception of the quality of this support, rather than its presence, which contributes to CS. Belonging to a professional network external to the work environment can also offer an independent reflective space and a sense of professional community (Cohen, Levy, Cohen & Karkabi, 2013), both of which may reduce the effects of compassionate stress.

Secondly, the MHP's sense of themselves as a separate, compassionate and effectual agent appeared to enhance CS. Self-compassion is believed to comprise of self-kindness, a sense of common humanity and mindfulness (Neff, 2003), which promotes an acceptance of the self and a more balanced approach to painful emotions (Neff, Kirkpatrick & Rude, 2007). Therefore, self-compassion may enhance the propensity for CS by stimulating sensitivity and care, positive affect and interpersonal connections (Gustin & Wagner, 2013). Germer (2009) proposes that self-compassion can be learnt through mindful meditation – a notion that the findings from the current review also appears to support. Meditation has been shown to allow individuals to actively process their internal states, enhance emotion regulation capacities which counteracts burnout (Hülshager, Alberts, Feinholdt & Lang, 2013) and promote resilience (Hayes, Follette & Linehan 2004), all of which are key to working successfully within caregiving settings.

The review also revealed a relationship between CS and self-efficacy, indicating that MHPs who perceive that they are able to complete their caregiving duties successfully experience satisfaction from doing so (Bandura, 1997); this in turn is likely to enhance self-efficacy. This is in line with Stamm's (2002) definition of CS which encompasses the ability to make positive contributions to care. As participants who experienced a higher degree of control over their workplace, greater management support and congruence between their

actual and expected job roles also reported increased CS, it is apparent that the development and preservation of self-efficacy is dependent upon the interplay between the clinician and their work environment. While previous research found that clinicians' engagement in self-care practices did not strongly influence CF or burnout (Kraus, 2005), the current review identified that self-care strategies, such as exercise and leisure activities, were related to CS. This suggests that CS and CF may sit along two separate continuums and so require specific strategies to address them.

Thirdly, the manner in which clinicians construed their work with clients also predicted CS. For example, positive perceptions of intent and responsibility regarding patient aggression enabled some MHPs to experience their work as more satisfying than others, potentially by holding in mind the functional and protective mechanisms of aggression (Jansen, Middel & Dansen, 2005). Conversely, Barrowclough *et al.* (2001) found that staff who expressed negative attitudes towards patients also attributed their behaviour to being within their control, targeted and internally-motivated; this was also associated with poorer staff-patient relationships and increased behavioural disturbances. This review demonstrated that the clinician's capacity to positively reframe clients' distress and behaviour enhanced CS, which was directly influenced by positive emotion. This provides partial support for the broaden-and-build theory which hypothesises that positive affect obtained through caregiving builds psychological, social and cognitive resources (Fredrickson & Fowler, 2001), such as resilience, perspective-taking and reflection, which may ultimately enhance CS.

**Enhancing compassion satisfaction within mental health contexts.** The findings from the current review indicate that CS in MHPs can be enhanced through several mechanisms. Involving professionals in clinical decision-making, such as inputting into caseload assignments, may increase their sense of agency, self-efficacy and control within the workplace. The psychological resilience and wellbeing of specific professional groups, such

as those processing personal trauma, on the 'front line', younger and newly-qualified staff, may be enhanced through the provision of additional mentoring, reviews and specialised training, in conjunction with daily debriefs to reflect upon distressing aspects of clinical work (Slatten, David & Carson, 2011). Furthermore, service managers should foster compassionate, fair and value-based organisational cultures that specifically aim to enhance mental wellness and satisfaction professionals obtain from their work (Mind, 2011).

In 2007 Wallbank developed 'restorative clinical supervision': an evidence-based model designed in collaboration with professionals to support them in their practice. The model enables clinicians to process emotional responses to therapeutic work to enhance their capacity to make effective clinical decisions. Individual and group restorative supervision is shown to be highly effective in enhancing CS, reducing staff sickness and improving team dynamics (Wallbank, 2014). As highlighted by this review, supervision should also focus on the quality of this support in promoting a protected space for discussions regarding case management and mentoring ('normative'), identification of signs of compassionate stress and enhancement of self-care strategies ('restorative') and supporting CPD and professional networking ('formative') (Proctor, 2011).

Specialist roles have also been developed within this area. For example, the Green Cross 'compassion fatigue educator and therapist' aims to enhance psychological resilience and CS in MHPs by providing psychoeducation regarding CF, facilitating the development of self-care and recovery plans and teaching coping skills (Figley Institute, 2013). The 'compassion fatigue specialist training' has also demonstrated statistically and clinically significant increases in MHPs' rates of CS and reductions in CF and burnout (Gentry, Baggerly & Baranowsky, 2004). These training programs may wish to include findings from contemporary research, such as the current review, to incorporate new understandings regarding the personal, client and work-related factors that may increase CS in MHPs.

## **Limitations and Future Research**

The current review has several limitations which should be taken into account when considering the findings. Firstly, in addition to exploring predictor variables, the review also investigated a number of correlations; therefore, no causations can be deduced from these particular findings. The review also did not explicitly investigate the relationship between CF and CS. Consequently, future literature reviews could further explore the presence of these constructs within MHPs to determine whether they can co-exist, and to identify if CS increases over time as CF decreases. The quality ratings of the individual papers were not inter-rated due to time limitations; therefore, reliability may be further enhanced via this process within future reviews.

The cross-sectional design of the studies provided data from a single point in time. Therefore, future empirical studies and reviews should encompass longitudinal designs in order to determine whether the experience of CS fluctuates (Michalec, Diefenbeck & Mahoney, 2013), or is maintained over time, and the specific temporal predictors of CS. As the current quantitative review investigated CS as measured by the ProQOL, other reviews may wish to appraise qualitative research, such as Hunter's (2012) study which explored therapists' perceptions of the influence of the therapeutic bond on CS. This will also provide 'thicker' understandings of MHPs' perspectives regarding the factors they believe to contribute to obtaining CS from their caregiving roles, and how this impacts upon them professionally and personally.

Stamm's (2009) model, which provided a framework for the current review, appears to lack acknowledgement of the impact of wider cultural, social or political influences on professional quality of life. Although the review included studies conducted within several countries, the influence of specific sociocultural factors on CS was not explored due to the absence of quantitative research investigating these aspects. This highlights limitations in the

cross-cultural generalisability of the findings. Furthermore, studies which explored the presence of CS in clinicians who work indirectly with patients, via telephone therapy for example (Bickford, 2012), were not included. Future research may wish to investigate the presence of CS, CF and burnout in professionals in ever-increasing indirect clinical roles, in addition to those who provide non-clinical input to service-users, such as interpreters (Shlesinger, 2005).

Given the increasing evidence of the relationship between caregiver CS and clinical outcomes (Barsade & O'Neill, 2014; Larrabee *et al.*, 2004), future reviews could explore the effect of CS on patient satisfaction and outcomes through direct involvement of service-users (National Institute for Health Research, 2015). None of the studies including in this review explored professionals' attachment and CS, despite the apparent link between early interpersonal bonds and later patterns of relating (Mikulincer, Shaver, Gillath & Nitzberg, 2005). Consequently, future research should explore the impact of early attachment experiences on the capacity for compassion towards others.

## **Conclusions**

This quantitative literature review investigated the predictors and correlates of CS in MHPs using Stamm's model of professional quality of life. The findings suggest that older, more experienced clinicians who have developed self-care strategies to enhance their physical and mental wellbeing, and who are able to preserve a coherent view of their social world, themselves and their clients, experience higher levels of satisfaction from caregiving. Furthermore, professionals who are able to develop positive therapeutic relationships with patients in the face of their psychological distress and risk presentations also experience greater CS. Future research should attempt to build on the preliminary evidence that CS may

provide physical, psychological, social and occupational benefits to MHPs, while also protecting against compassionate stress and improving service-user satisfaction and outcomes. This will promote awareness within caregiving organisations of the importance of shaping services that enhance CS in staff.

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79

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Figure 1

## Stamm's Model of Compassion Satisfaction and Compassion Fatigue

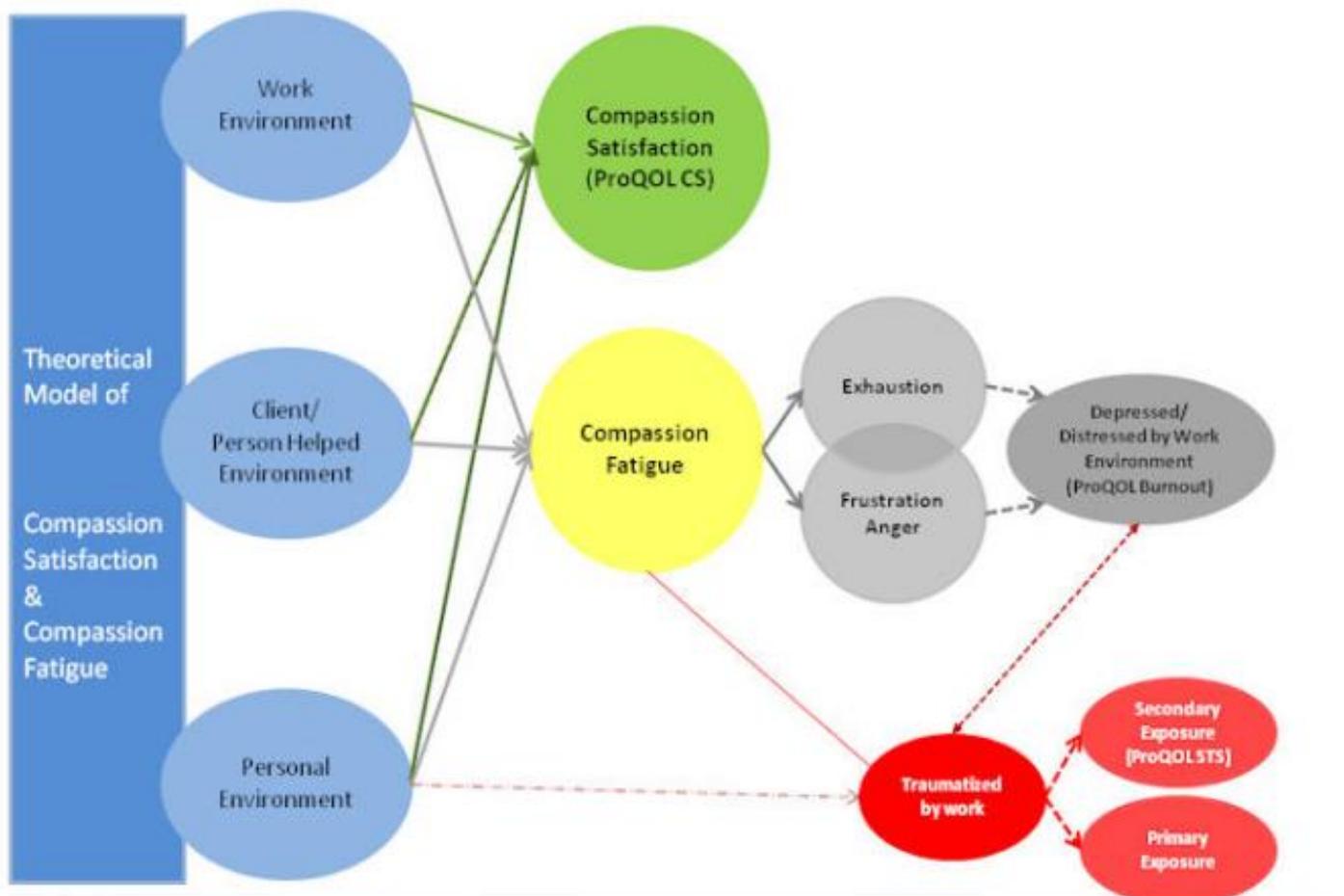
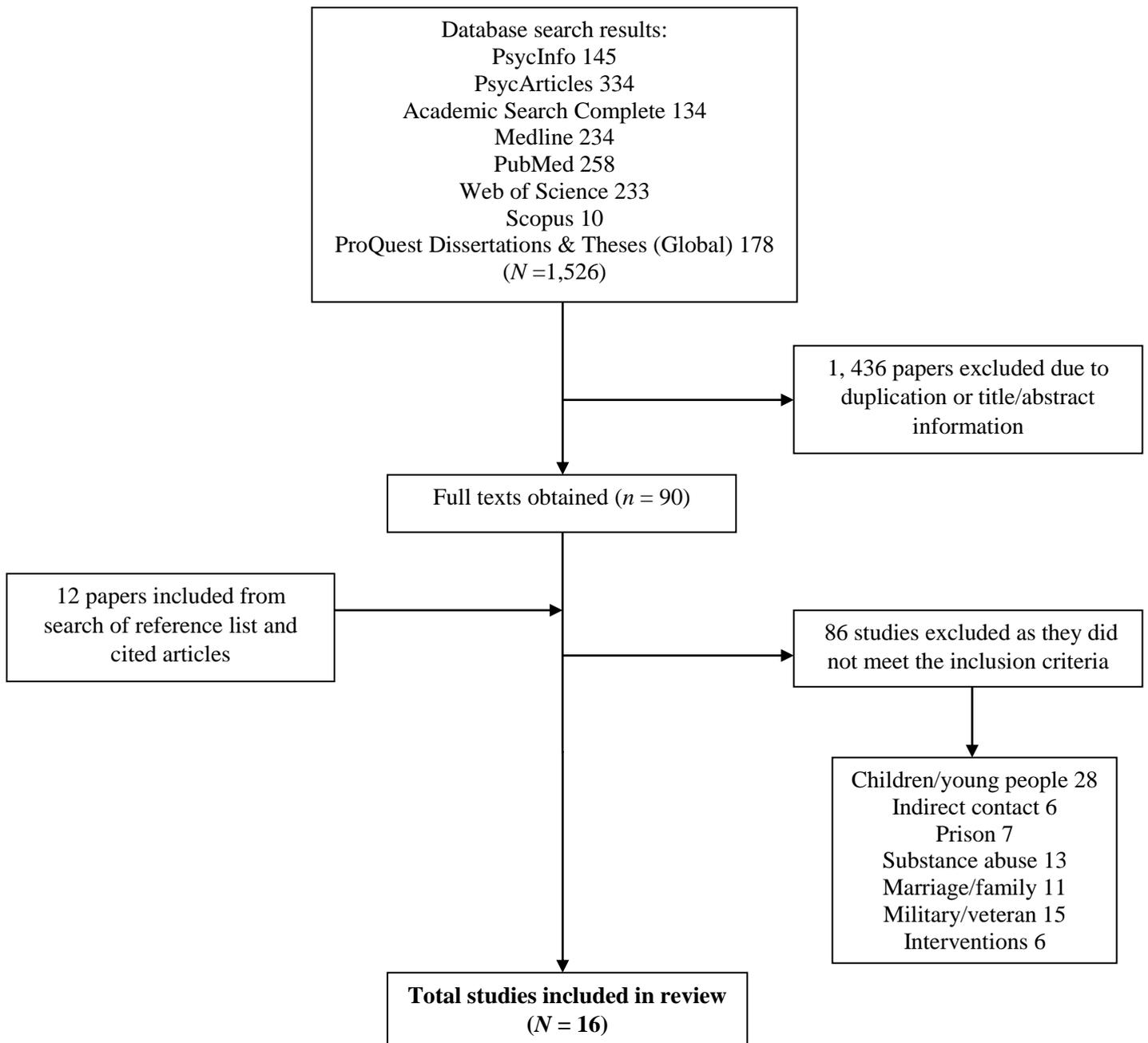


Figure 2

## Flow Diagram for Studies included in the Review



**Table 1**  
**Search Terms**

	<b>Major Search Terms</b>	
	<b>Compassion Satisfaction</b>	<b>Mental Health Professional</b>
<b>Exploded Search Terms</b>	Compass*  Satisfaction  Quality of Work Life  Life Satisfaction  Well Being  Job Satisfaction	Clinic*  Psychologists  Nurses  Social Workers  Psychiatrists  Psychotherapists  Therap*  Counsel*  Volunteers  Students  Advoca*  Doctors

\* Search wildcard

**Table 2****Sample of Mental Health Professionals included in the Review**

<b>Sample of Mental Health Professionals</b>	<b>Study Number</b>
Clinical Psychologists	2
Psychiatric nurses	7
Mental health nurses	16
Social workers	2
Clinical social workers	15
Counsellors	3, 4, 9, 14
Counsellors-in-training	14
Trauma therapists	6, 12
Sexual violence survivor therapists	11
Therapists	1, 5
Community mental health professionals	10
Generic mental health professionals	8, 13

**Table 3. Quality Assessment Tool for Quantitative Studies Scores**

<b>Study</b>	<b>A. Selection Bias</b>	<b>B. Study Design</b>	<b>C. Confounders</b>	<b>D. Data Collection Method</b>	<b>E. Withdrawals and Dropouts</b>	<b>Final Quality Rating</b>
1. Carmel & Friedlander (2009)	Weak	Weak	N/A	Strong	Strong	<b>Weak</b>
2. Craig & Sprang (2010)	Moderate	Weak	N/A	Strong	Strong	<b>Moderate</b>
3. Dean (2014)	Weak	Weak	N/A	Strong	Strong	<b>Weak</b>
4. Lawson & Myers (2011)	Moderate	Weak	N/A	Strong	Strong	<b>Moderate</b>
5. Linley & Joseph (2007)	Moderate	Weak	N/A	Strong	Strong	<b>Moderate</b>
6. McKim & Smith-Adcock (2014)	Weak	Weak	N/A	Strong	Strong	<b>Weak</b>
7. Mangoulia <i>et al.</i> (2015)	Weak	Weak	N/A	Strong	Moderate	<b>Weak</b>
8. Ray, Wong, White & Heaslip (2013)	Moderate	Weak	N/A	Strong	Strong	<b>Moderate</b>
9. Ringenbach (2009)	Weak	Moderate	Moderate	Strong	Strong	<b>Moderate</b>
10. Rossi <i>et al.</i> (2012)	Moderate	Weak	N/A	Moderate	Strong	<b>Moderate</b>
11. Samios, Abel & Rodzik (2013)	Weak	Weak	N/A	Strong	Strong	<b>Weak</b>

<b>Study</b>	<b>A. Selection Bias</b>	<b>B. Study Design</b>	<b>C. Confounders</b>	<b>D. Data Collection Method</b>	<b>E. Withdrawals and Dropouts</b>	<b>Final Quality Rating</b>
12. Sodeke-Gregson <i>et al.</i> (2013)	Moderate	Weak	N/A	Strong	Strong	<b>Moderate</b>
13. Sprang <i>et al.</i> (2007)	Weak	Weak	N/A	Strong	Strong	<b>Weak</b>
14. Star (2013)	Weak	Weak	N/A	Strong	Moderate	<b>Weak</b>
15. Thomas (2013)	Moderate	Weak	N/A	Strong	Strong	<b>Moderate</b>
16. Verhaeghe <i>et al.</i> (2014)	Weak	Weak	N/A	Strong	Strong	<b>Weak</b>

**Table 4. Summary of Studies included in the Review**

Study	Research aims, questions and hypotheses	Research design	Participants and sample size	*Measures	Main results
1. Carmel & Friedlander (2009)	1) Therapists' general responses to working with clients who have sexually offended would be inversely associated with the strength of the working alliance. 2) Therapists reporting higher levels of CS would experience stronger working alliances with clients.	Cross-sectional, cohort design.	Convenience and snowball sample of therapists (n=106) working in any therapeutic setting with male clients who had committed sexual offence from a national organisation in USA.	Demographic questionnaire, WAI-S, ProQOL-IV-R, IES-R.	Small significant effect of age and years of experience on CS; medium significant effect of years working with sexual offenders on CS; stronger working alliance significantly predicted CS.
2. Craig & Sprang (2010)	1) Does increased use of evidence-based practices predict CS, burnout and CF?	Cross-sectional, cohort design.	Random sample of clinical psychologists and social workers (n=532) selected from national professionals registers in USA.	ProQOL-III, TPQ.	Age, years of experience and use of evidence-based practice significantly predicted CS.
3. Dean (2014)	1) Investigate the possible correlations between CF, CS and burnout in licensed professional counsellors 2) Does the percentage of practice devoted to treating PTSD clients relate to a change in CF, CS and burnout?	Non-experimental, correlation, cohort design.	Convenience sample of licensed professional counsellors (n=77) from national professionals register in state of North Carolina, USA.	Demographic survey, ProQOL.	Medium significant effect of age and years licensed on CS; percentage of practice devoted to clients with a diagnosis of PTSD not related to CS.
4. Lawson & Myers (2011)	1) What are the levels of (and relationships between) wellness, professional quality of life factors (CF, CS, burnout) and career sustaining behaviours (CSB) among counsellors? 2) Are there differences in CF, CS and burnout in counsellors when compared to allied professionals?	Cross-sectional, cohort design.	Random and convenience sample of professional counsellors (n=506) from national counselling association in USA.	5F-WEL, CSBQ, ProQOL.	Large significant effect of wellbeing on CS which also significantly increased professionals' engagement in career-sustaining behaviours; small significant negative effect of increased high-risk clients on caseload and CS.

Study	Research aims, questions and hypotheses	Research design	Participants and sample size	*Measures	Main results
5. Linley & Joseph (2007)	1) Investigate salient factors that may be associated with positive (CS) and negative (CF, burnout) aspects of therapist wellbeing.	Cross-sectional, cohort design.	Random and convenience sample of therapists (n=156) from two national professionals registers in UK.	Occupational questionnaire, CSS, JSPE, WAI-Bond, ProQOL, SOC-13, PTGI, CiOQ.	Therapeutic bond and sense of coherence predicted CS; small significant effect of transpersonal and eclectic therapeutic training/practice on CS; length of time working as a therapist significantly correlated to CF.
6. McKim & Smith-Adcock (2014)	1) What is the relationship between workplace and individual-level variables and counsellors' CF and CS? 2) What predictor variables explain the most variance in CF and CS?	Non-experimental, correlation, cohort design.	Convenience sample of trauma therapists (n=98) from two multi-disciplinary international trauma societies (one with focus on practice, one with focus on research) in USA.	Demographic questionnaire, ProQOL, PBI, SLE-SF.	Medium effect of higher perceived control over workplace on CS; small effect of years of clinical experience on CS; less involvement with clients' distress and experience of personal trauma predicted CS.
7. Mangoulia, Koukia, Alevizopoulos, Fildissis & Katostaras (2015)	1) Investigate the prevalence of CF, burnout and CS in psychiatric nurses and their risk factors 2) Examine possible effects of personal and work-related characteristics on nurses' levels of CF, burnout and CS.	Cross-sectional, cohort design.	Convenience sample of psychiatric nurses (n=174) from 12 public hospitals in Greece who had a minimum of six months' experience.	Demographic and work-related characteristic questionnaire, ProQOL-IV-R	Positive relationships with colleagues, excellent physical and mental health and positive perceptions of team work significantly associated with CS.
8. Ray, Wong, White & Heaslip (2013)	1) Higher CS, lower CF and positive work environment or person-job match will predict lower burnout.	Non-experimental, cross-sectional, cohort design.	Convenience sample of MHPs (n=169) from one community mental health site in Ontario, USA.	ProQOL-IV-R, AWS, MBI-GS, demographic questionnaire.	Large significant effect of higher overall degree of fit with six areas of work life on CS.

Study	Research aims, questions and hypotheses	Research design	Participants and sample size	*Measures	Main results
9. Ringenbach (2009)	1) To what extent does a professional counsellor's reported meditation practice relate to self-compassion, CF, CS and burnout? 2) Does a professional counsellor's reported level of self-compassion relate to CF?	Between-subjects, comparative design.	Convenience sample of professional counsellors (n=164) from professional membership register in USA, divided into meditation group (n=62) and non-meditation group (n=102).	Demographic questionnaire, ProQOL, SCS, MCSDS.	Small significant effect of self-compassion on CS; significant effect of self-care time on CS.
10. Rossi <i>et al.</i> (2012)	1) Negative and traumatic life events increase the risk of CF and burnout 2) Teaching/training events protect from CF and burnout 3) To examine the relationship among burnout, CF, CS and psychological distress	Cross-sectional, cohort design.	Convenience sample of MHPs (n=260) from four community-based mental health services in Verona, Italy.	Socio-demographic and occupational characteristics, ProQOL-III, GHQ-12, stress exposures questionnaire (developed by authors).	Psychological distress significantly associated with lower CS; fixed-term contract significantly associated with increased CS.
11. Samios, Abel & Rodzik (2013)	1) CS will buffer against CF, depression and anxiety 2) Positive reframing will mediate the relationship between positive emotionality and CS in trauma therapists.	Cross-sectional, cohort design.	Convenience sample of therapists (n=61) working with sexual violence survivors from national register for psychologists and other community health care services in Australia.	ProQOL, DASS (depression and anxiety subscales), BABS, BC (positive reframing subscale).	Large significant effect of positive emotionality on CS; partially mediated by positive reframing.
12. Sodeke-Gregson, Holttum & Billings (2013)	1) Investigate CS and CF in a sample of UK therapists working with trauma clients 2) Examine which variables strongly predict CS and CF.	Cross-sectional, cohort design.	Convenience sample of trauma therapists (n=253) from specialist trauma and secondary-care services in UK.	Demographic and background information questionnaire, CSI, ProQOL-V5.	Small significant effect of number of years post qualification and self-care time on CS; age, perceived management and supervision support and time spent engaging in research activities significantly predicted CS.

Study	Research aims, questions and hypotheses	Research design	Participants and sample size	*Measures	Main results
13. Sprang, Clark & Whitt-Woosley (2007)	1) Explore the degree to which CS, CF and burnout vary as a function of provider characteristics.	Cross-sectional, cohort design. Part of a larger study by some of same authors.	Convenience sample of licensed/certified MHPs (n=1,121) in a rural Southern State, USA.	ProQOL, survey exploring personal and professional characteristics.	Increased age significantly predicted CS; specialist training associated with greater CS.
14. Star (2013)	1) Is there a relationship between CF, burnout, CS, self-care and recent life changes among professional counsellors and counsellors-in-training? 2) Do individual differences relate to CF, burnout, CS and self-care in these populations?	Cross-sectional, cohort design (not between-groups, comparative design).	Convenience sample of licensed professional counsellors and counsellors-in-training (n=253) (at masters or doctoral level) from counsellors' conference, graduate programs and listservs in USA.	Demographic questionnaire, ProQOL-V5, RLCQ, SCAW.	Small effect of psychological self-care and increased age on CS in counsellors working in agency setting.
15. Thomas (2013)	1) Examine associations between personal distress and professional quality of life.	Correlation, cross-sectional, cohort design.	Random sample of clinical social workers (n=171) from all licensed clinical social workers in state of Louisiana, USA.	Demographic questionnaire, ProQOL-IV-R, IRI.	Personal distress significantly predicted CS; small significant effect of age, years of experience and perspective-taking on CS.
16. Verhaeghe <i>et al.</i> (2014)	1) Explore nurses' attitudes and perceived self-efficacy toward inpatient aggression 2) Explore the associations between attitudes and perceived self-efficacy and nurse-related characteristics.	Cross-sectional, cohort design.	Convenience and purposive sample of mental health nurses (n=219) from nine psychiatric wards in Belgium.	ATABQ, CCPAI, ProQOL.	Staff confidence in managing patient aggression predicted CS; small significant effect of positive staff attitude towards aggression, desire for aggression intervention training and self-efficacy on CS.

\*5F-WEL - Five Factor Wellness Inventory; ATABQ - Attitudes Towards Aggressive Behaviour Questionnaire; AWS - Areas of Work Life Scale; BABS - Bradburn Affect Balance Scale; BC - Brief Cope; CCPAI - Confidence in Coping with Patient Aggression Instrument; CiOQ - Changes in Outlook Questionnaire; CSBQ - Career-Sustaining Behaviours Questionnaire; CSI - Coping Strategies Inventory; CSS - Crisis Support Scale; DASS - Depression, Anxiety and Stress Scale; GHQ-12 - General Health Questionnaire-12; IES-R - Impact of Events Scale-Revised; IRI - Interpersonal Reactivity Index; JSPE - Jefferson Scale of Physician Empathy; MBI-GS - Maslach Burnout Inventory-General Survey; MCSDS - Marlowe-Crowne Social Desirability Scale; PBI - Psychologist's Burnout Inventory; ProQOL - Professional Quality of Life Scale; ProQOL-III - Professional Quality of Life-III; ProQOL-IV-R - Professional Quality of Life-IV-Revision; ProQOL-V5 - Professional Quality of Life-Version 5; PTGI - Posttraumatic Growth Inventory; RLCQ - Recent Life Changes Questionnaire; SCAW - Self-Care Assessment Worksheet; SCS - Self-Compassion Scale; SLE-SF - Stressful Life Experiences-Short Form; SOC-13 - Sense of Coherence-Short Form; TPQ - Trauma Practices Questionnaire; WAI-Bond - Working Alliance Inventory Form T-Bond subscale; WAI-S - Working Alliance Inventory-Short Form.

**Table 5**

**Predictors and Correlates of Increased Compassion Satisfaction in Mental Health Professionals**

	<b>Professional Quality of Life Factors</b>		
	<b>Personal Environment</b>	<b>Client Environment</b>	<b>Work Environment</b>
<b>Predictors/Correlates of Compassion Satisfaction</b>	Age		
	Years of clinical experience	Positive therapeutic relationship	Management and supervision support
	Completion of specialist training	Lower involvement in clients' distress	Agency within the workplace
	Use of evidence-based practice	Positive attitudes towards risk behaviour	Contact with referral network
	Health and wellbeing		Job expectations-reality congruence
	Positive affect		
	Self-care		Engagement in research and development activities
	Self-efficacy and confidence		
	Self-compassion		
	Sense of coherence		

## Appendix A

### Quality Assessment Tool for Quantitative Studies Guidance

#### COMPONENT RATINGS

##### A) SELECTION BIAS

**(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?**

1. Very likely
2. Somewhat likely
3. Not likely
4. Can't tell

**(Q2) What percentage of selected individuals agreed to participate?**

1. 80 - 100% agreement
2. 60 – 79% agreement
3. Less than 60% agreement
4. Not applicable
5. Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
	1	2	3

##### B) STUDY DESIGN

**Indicate the study design**

1. Randomized controlled trial
2. Controlled clinical trial
3. Cohort analytic (two group pre + post)
4. Case-control
5. Cohort (one group pre + post (before and after))
6. Interrupted time series
7. Other specify \_\_\_\_\_
8. Can't tell

**Was the study described as randomized? If NO, go to Component C.**

No                      Yes

**If Yes, was the method of randomization described?**

No                      Yes

**If Yes, was the method appropriate?**

No                      Yes

<b>RATE THIS SECTION</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
	1	2	3

### **C) CONFOUNDERS**

**(Q1) Were there important differences between groups prior to the intervention?**

1. Yes
2. No
3. Can't tell

**The following are examples of confounders:**

Race  
Sex  
Marital status/family  
Age  
SES (income or class)  
Education  
Health status  
Pre-intervention score on outcome measure

**(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis).**

1. 80 – 100% (most)
2. 60 – 79% (some)
3. Less than 60% (few or none)
4. Can't tell

<b>RATE THIS SECTION</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
	1	2	3

**D) DATA COLLECTION METHODS****(Q1) Were data collection tools shown to be valid?**

1. Yes
2. No
3. Can't tell

**(Q2) Were data collection tools shown to be reliable?**

1. Yes
2. No
3. Can't tell

<b>RATE THIS SECTION</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
	1	2	3

**E) WITHDRAWALS AND DROP-OUTS****(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?**

1. Yes
2. No
3. Can't tell
4. Not Applicable (i.e. one time surveys or interviews)

**(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest.)**

1. 80 -100%
2. 60 - 79%
3. Less than 60%
4. Can't tell
5. Not Applicable (i.e. Retrospective case-control)

<b>RATE THIS SECTION</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
	1	2	3

**GLOBAL RATING**

<b>A</b>	<b>SELECTION BIAS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
<b>B</b>	<b>STUDY DESIGN</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>C</b>	<b>CONFOUNDERS</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>D</b>	<b>DATA COLLECTION METHOD</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>E</b>	<b>WITHDRAWALS AND DROPOUTS</b>	<b>1</b>	<b>2</b>	<b>3</b>

**GLOBAL RATING FOR THIS PAPER:**

1 STRONG (no WEAK ratings)

2 MODERATE (one WEAK rating)

3 WEAK (two or more WEAK ratings)

## Appendix B

### Anxiety, Stress, & Coping: Notes for Contributors

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1. General guidelines
2. Style guidelines
3. Figures
4. Publication charges
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## **Section 2: Research Paper**

Investigating the Relationships between Staff Individual Differences and Challenges to  
Compassion towards Patients who are detained under the Mental Health Act

Text word count: 8,177

Appendices word count: 9,790

Mirella Hopper

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Mirella Hopper

Doctorate in Clinical Psychology

Furness College

Lancaster University

Lancaster

LA1 4YT

[m.hopper1@lancaster.ac.uk](mailto:m.hopper1@lancaster.ac.uk)

Prepared for submission to: Psychology and Psychotherapy: Theory, Research and Practice

## Abstract

**Objectives:** The apparent lack of compassion within the healthcare system over recent years has received mounting academic, clinical and legislative consideration. An existing measure, the Fears of Compassion Scale, was judged to have shortcomings in clinical relationship contexts. Consequently, the Challenges to Compassion Questionnaire (CCQ) was developed to identify the individual, interpersonal and organisational barriers that mental health professionals (MHPs) experience in displaying compassion towards patients. **Design:** A quantitative methodology was employed to investigate the relationships between individual differences in direct-care staff and the challenges they encounter in providing compassionate care to patients who are detained under the Mental Health Act. **Methods:** 104 participants completed an online questionnaire, comprised of the CCQ and measures of attachment, emotional intelligence, professional quality of life and explicit attitudes. A sub-sample of participants completed an online test of implicit attitudes. **Results:** The CCQ demonstrated good internal reliability and validity. A multiple regression analysis revealed that intrapersonal emotional intelligence and compassion satisfaction predicted fewer challenges to compassion. Variables associated with increased challenges to compassion included attachment-related anxiety, having a support worker role and compassion fatigue. **Conclusions:** This study discovered minimal challenges to compassion in direct-care staff. The key role of MHPs' connection with their emotional selves in increasing compassion for patients was highlighted, in addition to the gratification obtained from caregiving. As compassion can provide a 'corrective' emotional and interpersonal experience for patients, recommendations include enhancing staff wellbeing, self-compassion and mentalising capacities, promoting kinship within teams and developing psychologically-informed services that also provide secure attachments.

### **Practitioner Points**

1. Direct-care staff reported minimal challenges to compassion towards detained patients, but burnout scores suggested experiences of work-related stress due to environmental and organisational factors.
2. The age, gender and length of clinical experience of mental health professionals were unrelated to challenges to interpersonal compassion.
3. Services are able to enhance the provision of compassionate care by promoting staff wellbeing, self-compassion, intrapersonal emotional intelligence and mentalising capacities.
4. The Challenges to Compassion Questionnaire (CCQ), developed for the specific purposes of this study, demonstrated good internal reliability and validity.

### **Keywords**

- *Challenges to Compassion* • *Mental Health Professionals* • *Mental Health Act* • *Attachment*
- *Emotional Intelligence* • *Attitudes* • *Quantitative* •

## **Investigating the Relationships between Staff Individual Differences and Challenges to Compassion towards Patients who are detained under the Mental Health Act**

### **Compassion in Healthcare**

Grave malpractice and care failings within both the National Health Service (NHS) and private sector have been exposed over recent years (Department of Health [DOH], 2012a; Francis, 2013), jeopardising the lives and integrity of patients and staff, and the reputation of healthcare organisations. Subsequently, the construct of ‘compassion’ and the apparent lack of kindness within the healthcare system has received mounting academic, clinical and legislative consideration (Cole-King & Gilbert, 2011; DOH, 2012b; Shea, Wynyard & Lionis, 2014). Compassion is described as ‘a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it’ (Gilbert, 2010; p. xiii). Singer and Klimecki (2014) also note that compassion activates the orbitofrontal cortex and striatum within the brain which stimulates positive other-oriented emotion and motivates prosocial decision-making and behaviour.

Campling (2015) identified four interrelated levels at which challenges to the provision of compassionate care may arise: societal, organisational, interpersonal and individual. Firstly, Long (2008) argues that the prevalence of consumerism and individualism within modern society may cultivate clinicians who are competitive and egoistic. However, the last decade has also seen a rise in charity (Charities Aid Foundation, 2015) and social change aimed at reducing inequalities (Public Health England, 2015), suggesting that other factors may impact upon compassionate healthcare. Secondly, frequent exposure to clients’ pain and distress arouses primitive emotions for staff, such as anxiety. Although this may be contained through organisational structures (Menzie Lyth, 1959), services subject to restructuring due to austerity measures, within a growing culture of

defensible practice (O'Neill, 2002) and protocol-driven care (Beck, 2013), may exacerbate stress and dissipate compassion. Healthcare staff are also often rewarded for 'non-caring tasks', such as compliance with key performance indicators (Whitby & Gracias, 2013), completion of 'bureaucratic paperwork' (Thompson & Ciechanowski, 2003) and adherence to targets (Wallbank & Beales, 2014), all of which may detract from providing compassionate services.

A lack of compassion may also flow through teams. Conflicting roles and objectives, and attempts to shift responsibility between professionals, can create dysfunctional 'pseudo-teams' (Campling, 2015). Poor team communication, staffing shortages and limited group reflection (Wallbank & Beales, 2014) are also interpersonal barriers to compassionate care, in addition to a lack of clinical supervision (Francis, 2013), and a disconnection between managers and clinicians (Whomsley, 2014). Lastly, professionals frequently detach from patients' distress as a protective mechanism (Skogstad, 2000). However, should this defence become entrenched, the capacity to remain compassionate is suppressed (Shapiro, 2008). Boundaries, professional titles and risk assessments may also offer clinicians means of 'hiding' from the humanity of patients (Momori, 2014).

### **Costs of Compassion**

Repeated exposure to the suffering of others and attempts to alleviate their distress can have two primary repercussions over time for the professional: 'compassion fatigue' (CF) and 'burnout' (Stamm, 2009a) (Figure A); this is influenced by personal, patient and work-related environments. Figley (1995) first used the term CF to refer to secondary traumatic stress in mental health professionals (MHPs) who worked with traumatised patients. For some, hearing stories about clients' suffering coupled with heightened stress from wanting to alleviate their pain can lead to vicarious absorption of distress and adverse psychosocial consequences (Sabo, 2011), such as neurobiological and psychological changes (Tyler, 2012). MHPs with

CF may experience feelings of guilt, hopelessness and anxiety which they respond to by increasing their attempts to meet patients' needs. The professional costs of CF include poor concentration, absenteeism, and poor record keeping (Johns, 2006), in addition to personal costs such as substance abuse, somatic complaints and changes in intrapsychic beliefs (Wentzel & Brysiewicz, 2014). Burnout is described as a reactional trigger to chronic workplace stress which gradually develops over time (Abendroth, 2011); this may be associated with an unsupportive organisational environment or high workload (Stamm, 2015). Burnout often results in depersonalisation, emotional exhaustion and reduced personal accomplishments (Sabo, 2011).

### **Fears of Compassion**

CF and burnout in MHPs are well-documented within the literature (Agcaoili, Mordeno & Decatoria, 2008; Figley, 2002; Kraus, 2005). However, unlike the inadvertent loss of compassion over time characterised by CF and burnout, *fears of compassion* refers to an individual's active conflict in receiving and expressing affiliative emotions (Gilbert, McEwan, Matos & Ravis, 2011). While studies have explored individuals' fears of directing compassion towards the self (Pauley & McPherson, 2010), and receiving compassion from others (Rockcliff, Gilbert, McEwan, Lightman & Glover, 2008), there is a dearth of investigations into fears of compassion *for others*. Despite acknowledgement of the increasing barriers to the provision of compassionate care, research has yet to explore the challenges that MHPs encounter in displaying compassion to patients. Furthermore, the existing Fears of Compassion Scale (FCS) - developed to assess patient difficulties in expressing compassion for others within general relationships (Gilbert, McEwan, Matos & Ravis, 2011) - has limited use in determining MHPs' challenges to compassion within the context of clinical or therapeutic relationships with patients. Several psychological theories will now be drawn upon to further understand challenges to compassion, which are

potentially shaped by individual, interpersonal and organisational factors (Gilbert, McEwan, Matos & Rivis, 2011; Jazaieri *et al.*, 2013). The term *challenges to compassion* will now be used in place of *fears of compassion*.

### **Psychological Theories of Compassion**

**Evolutionary theory.** Compassion from an evolutionary perspective is recognised as a physiological, affective and behavioural state which is orientated towards enhancing the welfare of another who is suffering (Goetz, Keltner & Simon-Thomas, 2010). The origins of compassion were thought to relate to ‘kin selection’ and so were naturally confined to family members (Wright, 2009). However, the evolution of ‘reciprocal altruism’ enabled the development of mutual non-kin relationships (Keltner, 2009). According to evolutionary theory, a MHP will display compassion towards a patient if three interpersonal objectives are met: if alleviation of an individual’s distress is perceived as relevant to the professional, if the distress is attributed as undeserved or uncontrollable, and if the professional’s resources are sufficient to allow relief of the patient’s distress.

**Attachment theory.** Bowlby’s (1988) theory proposes that a child’s attachment to their primary caregivers serves to protect them and enhance their chances of survival. The ‘caregiving behavioural system’ of the carer responds to the child’s needs through protection and compassion. This complements the child’s ‘attachment behavioural system’ which motivates their proximity and emotional attachment to the caregiver. A child whose attachment behavioural system has been nourished through experiences of optimal care will develop their own secure caregiving system and a positive internal working model of themselves and others (Silver, 2013); this provides a foundation for care-orientated feelings (Mikulincer, Shaver, Gillath & Nitzberg, 2005). Evidence suggests that MHPs with attachment security are more responsive to clients’ needs, foster stronger therapeutic

relationships and provide more effective therapy (Zegers, Schuengel, van Ijzendoorn & Janssens, 2006).

In contrast, children who have experienced inconsistent or unavailable care may develop attachment-related avoidance or anxiety (Fraley, 2002). It is believed that these relational patterns continue to influence interpersonal functioning, self-identity and emotion regulation capacities across the lifespan (Chopik, Edelstein & Fraley, 2013). Limited attachment security may mean that the individual is biased towards self-preservation which can restrict their capacity to focus on the emotional needs of patients (Wang, 2005), subsequently increasing their challenges to interpersonal compassion (Gilbert, McEwan, Matos & Ravis, 2011).

**Gilbert's theory.** Gilbert's (2010) integration of evolutionary and attachment theories postulates that humans have evolved to respond to kindness and caring. During early interactions with key attachment figures, three affect regulation systems within the child (i.e. 'drive', 'threat' and 'soothing') are nurtured or inhibited (Gilbert, 2005). The soothing system is related to affiliation, safety and kindness, and so appears to play a key role in the propensity for compassion (Gilbert, 2005). However, individuals who have experienced limited warmth and affection during childhood may have underdeveloped soothing systems, and therefore may experience increased challenges to compassion for the self and others (Depue & Morrone-Strupinsky, 2005). Mental health contexts themselves also appear to influence activation of the MHP's soothing system. For example, fear and shame are occasionally spread within services to motivate change within staff teams (Cole-King & Gilbert, 2011), resulting in over-stimulated threat and drive systems.

### **Compassion in Secure Mental Health Settings**

Due to the circumstances surrounding an individual's admission to a secure inpatient mental health service, it is hypothesised that MHPs working in these contexts may experience

greater challenges to providing compassionate care. In addition to complex psychological, interpersonal and emotional difficulties, patients who are detained under the Mental Health Act (DOH, 1983/2007) are deemed to pose a risk to themselves and/or others as a result of their mental distress. This may present as violence to others, harm to self, offending, health and safety risks and exploitation by others (Mind, 2013).

**Organisational barriers.** Specific organisational factors, such as reduced bed numbers but increased occupancy demand, staff shortages and high client caseloads, appear to influence the challenges to compassion that MHPs experience towards detained patients by reducing staff empathy and tolerance of patients' difficulties (King's Fund, 2015). Emotional strain has also been found among acute inpatient staff, together with low autonomy, high job demands and limited support from managers (Johnson *et al.*, 2012). The intensive nature of inpatient contexts also limits the space that staff have available to reflect upon the interpersonal content of their practice and minimises respite from behaviours that can be extremely challenging (Whitby & Gracias, 2013).

**Interpersonal barriers.** Gilbert's conceptualisation of compassion hypothesises that the heightened sense of vigilance and apprehension present when caring for individuals with risk presentations (Jacob & Holmes, 2011) would hyperactivate the MHP's threat system and reduce access to the compassion system. The power inequality between professionals and patients is also exacerbated within a secure inpatient context due the disparity in liberty, autonomy and agency, in addition to the stigma and social isolation often experienced by inpatients and offenders (Rao *et al.*, 2009). This inherent power held by MHPs can also increase egocentrism and reduce empathy for patients, often leading to 'ethical blind spots' (Bazerman & Tenbrunsel, 2011) in which clients are seen as 'less than human' (Robertson, 2014). Consequently, inpatients are reportedly more at risk of receiving poor healthcare than other client groups (Wainwright, 2014).

**Individual barriers.** According to evolutionary theory, compassion towards detained patients is affected by the MHP's appraisal of their capacity to alleviate the client's distress. This is supported by Maben, Adams, Peccei, Murrells and Robert's (2012) research in which mental health workers experienced greater compassion towards patients for whom they felt able to affect positive change. Staff self-efficacy beliefs can also be influenced by organisational factors, such as low degree of agency and poor managerial support (McKim & Smith-Adcock, 2014). Compassion also acts as a 'moral barometer', guiding MHPs' judgements and actions to alleviate undeserved harm (McCullough *et al.*, 2001); therefore, compassion may only be provided to inpatients if the clinician believes this is 'deserved' (Jazaieri *et al.* 2013). Moreover, compassion may be 'withheld' if a client is perceived to have committed a moral wrong-doing (Batson, Klen, Highberger & Shaw, 1995).

MHPs' attitudes towards detained patients may also influence their capacity for compassion (Lammie, Harrison, Macmahon & Knifton, 2010), in addition to their attitudes towards caregiving itself (De Carli, Tagini, Sarracino, Santona & Parolin, 2015). Moreover, mental health workers' implicit attitudes towards patients were identified as more negative than their explicit attitudes and more predictive of caregiving behaviour (Brenner, Rose, von Hippel & Wilson, 2013). The role of intrapersonal ('self') and interpersonal ('other') emotional intelligence (EI) can also have implications for compassionate caregiving. Mayer, Salovey and Caruso (2004) proposed that global EI is composed of five dimensions: identifying, understanding, attending to and expressing, regulating and using emotions to guide actions. Each of these facets, particularly emotional regulation (Martos, Lopez-Zafra, Pulido-Martos & Augusto, 2013), appear to be fundamental in sustaining positive social relationships which are key to compassion. Carmona-Navarro and Pichardo-Martínez's (2012) study revealed a positive relationship between greater EI in nurses and more positive

attitudes towards suicidal behaviour in patients, suggesting a relationship between these intrapsychic variables.

### **Benefits of Compassionate Care**

While there are many challenges to compassion within secure inpatient settings, in addition to the potential costs of kindness to MHPs themselves, the delivery of compassionate care can provide a corrective emotional and interpersonal experience for patients (Bridges, 2006), improve their psychological wellbeing and contribute to their personal recovery journeys (Spandler & Stickley, 2011). Compassionate services and staff teams can promote patient safety, provide high quality care, support clinical outcomes and increase adherence to treatment recommendations (Lown, Rosen & Marttila, 2011; Schwartz Centre, 2011).

Compassionate care has also been shown to benefit the caregiver (Yuen *et al.*, 2008). This may impact vicariously on patient wellbeing, for example through a more accurate understanding of patient difficulties (Epstein *et al.*, 2005). Stamm's (2009a) professional quality of life model also incorporates the positive aspect of caring - 'compassion satisfaction' (CS) - which is the gratification and pleasure professionals derive from caring for patients. MHPs working within inpatient services have reported high rates of CS (Verhaeghe *et al.*, 2014), which has been linked to patient satisfaction (Larrabee *et al.*, 2004) and improved quality of life in clients within other settings (Barsade & O'Neill, 2014). This indicates that a genuine person-centred connection between professionals and patients may facilitate staff wellbeing, together with positive clinical outcomes for clients.

### **Current Study**

Although there are clear benefits to delivering compassionate care within mental health settings, contemporary literature is increasingly acknowledging challenges to this in practice (e.g. Campling, 2015). However, research has yet to explore the individual, interpersonal and organisational challenges to compassion that MHPs encounter towards

patients. Current research does indeed recommend investigations of compassion predictors within healthcare professionals (Whomsley, 2014), yet the existing fears of compassion measure has limitations in assessing challenges to compassion within the context of clinical relationships with service-users (Gilbert, McEwan, Matos & Ravis, 2011). Moreover, despite the current evidence that compassionate caregiving may relate to adult attachment (Mikulincer, Shaver, Gillath & Nitzberg, 2005), implicit attitudes (Brener, Rose, von Hippel & Wilson, 2013) or EI (Martos, Lopez-Zafra, Pulido-Martos & Augusto, 2013), studies have not yet examined the impact of these factors on MHPs' challenges to compassion towards patients.

Direct-care staff are more exposed to detained patients' distress and risk behaviours due to their predominantly ward-based duties. Subsequently, it is anticipated that this cohort will have different professional experiences, interpersonal relationships, behaviours and attitudes towards detained patients than other clinicians (e.g. members of a multi-disciplinary team); therefore, potentially increasing their challenges to compassion.

**Research objective (1):** To examine whether there is a relationship between individual differences in direct-care staff (i.e. adult attachment, EI, implicit attitudes, age, gender, occupation, time working in secure settings) and challenges to compassion they experience towards patients who are detained under the Mental Health Act.

**Research objective (2):** To develop a more appropriate measure of the challenges MHPs experience in displaying compassionate care to patients, incorporating client, team and service-level challenges that may be encountered.

## Methodology

### Design

The current study adopted a quantitative methodology to investigate the relationships between several variables relating to individual differences in direct-care staff who work with detained patients, and the challenges to compassion they experience. A two-part survey, comprised of an online questionnaire and an online test of implicit attitudes, was administered to participants. A new measure of challenges to compassion was also developed for the specific purposes of this study.

### Participants

Direct-care staff who had worked with patients detained under the Mental Health Act within secure inpatient mental health services were recruited to participate in the study. Participants were included if they had worked with detained patients for more than one month to ensure attainment of sufficient exposure to secure inpatient services to reliably measure challenges to compassion. Professionals who formed a part of multi-disciplinary teams, such as psychologists and psychiatrists, and non-clinical managers were excluded from the study.

In total,  $N = 104$  participants completed the online questionnaire (Figure B). Participants were recruited from a range of settings including acute services, psychiatric intensive care units, locked rehabilitation services, and low secure and medium secure hospitals. Seventy-six percent of participants were female and 24% were male, with a mean age of 38.6, ranging between 20-67 years. According to the demographic data provided, 39.4% participants were support workers, 38.4% were nurses and 22.1% were clinical managers. Participants reported working within secure mental health services for a mean length of 9.4 years, ranging from 1 month-48years; nine participants had less than six months experience. Of this sample, 21 participants completed the online test component of the survey.

## Measures

**Demographics.** Participants completed a demographic questionnaire which was developed using Qualtrics survey software (Appendix A). This provided a measure of each participant's age, gender, occupation and length of time working in inpatient settings.

**Attachment.** Participant attachment was measured using the Experiences in Close Relationships Scale-Short Form (ECR-S) (Wei, Russell, Mallinckrodt & Vogel, 2007) (Appendix B). The ECR-S is a 12-item self-report measure which adopts a 7-point Likert scale to assess interactions within emotionally-intimate relationships, based on the dimensions of 'anxiety' and 'avoidance' (Fraley, 2002). The dimensional model of attachment adopted by the ECR-S allows detection of attachment patterns within specific interpersonal contexts, such as romantic relationships, while also providing an understanding of attachment traits that are associated with various relational outcomes. According to the developers, the ECR-S has adequate internal consistency (alpha coefficients from .77 to .86 for anxiety; .77 to .88 for avoidance), test-retest reliability ( $r = .82$  for anxiety;  $r = .89$  for avoidance) and construct validity.

**Emotional intelligence.** The Short Profile of Emotional Competence (S-PEC) (Mikolajczak, Brasseur & Fantini-Hauwel, 2014) was used to measure participants' EI (Appendix C). The S-PEC is a 20-item self-report tool which measures EI (self) and EI (other) along a 5-point Likert scale, based on the five dimensions of EI (Mayer, Salovey & Caruso, 2004). Although other measures of EI exist, these were deemed either too lengthy for the purposes of this study (e.g. Emotional Quotient Inventory), or limited in their ability to detect differences in interpersonal and intrapersonal EI (e.g. Mayer-Salovey-Caruso Emotional Intelligence Test). According to the S-PEC, a higher score indicates higher levels of EI. Analysis of the S-PEC by the developers revealed good concurrent validity ( $p < .001$ ), and the global score demonstrated high internal consistencies in addition to composite

reliability.

**Challenges to compassion.** A Challenges to Compassion Questionnaire (CCQ) was developed by the principal investigator and field supervisor for the purposes of this study (Appendix D). The measure is an extension to the FCS (Gilbert, McEwan, Matos & Ravis, 2011), due to its focus on challenges to compassion within clinical relationships, and is grounded within theories of compassion described above. As the CCQ is not a validated measure, the Professional Quality of Life Scale was used to assess the validity of the CCQ. The CCQ contains 10 items and is rated along a 7-point Likert scale; a higher score suggests increased challenges to compassion.

**Professional quality of life.** The Professional Quality of Life Scale (ProQOL) (Stamm, 2009b) was used to assess the validity of the CCQ, as this is the most widely-used standardised measure of the positive and negative consequences of working as a caregiving professional and was developed from international data of over 3000 participants (Appendix E). Version five of the ProQOL contains 30 items and measures three constructs (i.e. CF, burnout, CS), each comprised of 10 items which are rated using a 5-point Likert scale. A higher score on each of the scales indicates a greater level of CS, CF and burnout. According to Stamm (2010), the ProQOL has good reliability ratings for each scale (CF =.81, burnout =.75, CS =.88) and adequate construct validity across 200 research papers.

**Implicit attitudes.** Participants' implicit attitudes towards detained patients were measured using the Implicit Association Test (IAT). The IAT is a widely employed paradigm in social psychology research (Project Implicit, 2011; von Hippel, Brener & von Hippel, 2008) and was originally developed by Greenwald, McGhee and Schwartz (1998) who hypothesised that unconscious mental representations of concepts can influence attitudes and behaviour. The IAT has shown more predictive validity in social contexts than explicit self-report methods (Greenwald, Poehlman, Uhlmann & Banaji, 2009), is resistant to social

desirability bias (Egloff & Schmukle, 2002), and is one of the few measures that compares implicit preferences between pairs of concepts or categories. The IAT used within the current study was developed using the research supervisor's knowledge of the instrument, and experience of the specific clinical context by the principal investigator and field supervisor.

The IAT consisted of a target group ('detained patients') and a comparison group (general 'hospital patients'). Eight positive and negative attribute words for each group were identified based on their emotional valence ratings from the ANEW list of over 13,000 words (Warriner, Kuperman & Brysbaert, 2013), and by drawing upon related IAT studies (Kampfe, Penzhorn, Schikora, Dunzl & Schneidenbach, 2009). Three stimuli were identified to represent the target and comparison groups (Nosek, Greenwald & Banaji, 2005) (Table A). The IAT is scored from -2 (strong preference towards displaying compassion for detained patients) to +2 (strong preference for displaying compassion to hospital patients); a score of 0 indicates no preference for either group. Participants also completed an additional question regarding their explicit preference towards the target and comparison group (Appendix F).

### **Ethical Procedure**

The study received ethical approval from the Lancaster University Faculty of Health and Medicine Research Ethics Committee in July 2015 (reference: RS2014/128). As the target sites for recruitment of participants included both NHS and private sector services, ethical approval was also obtained from five NHS Research and Development committees across England between October 2015 and January 2016. *Section 4* contains details of the ethical approval processes.

### **Research Procedure**

The research was publicised to relevant clinicians by the principal investigator through attendance at a forensic special interest group. The principal investigator then sent

each local collaborator an email invitation which was distributed to all potential participants within their services (Appendix G). The email contained a link to the online survey which, when followed by participants, presented an information sheet (Appendix H) and a consent form (Appendix I). All participants were also provided with a random number, automatically generated by the Qualtrics software, to ensure anonymity from the outset. Participants were asked to re-enter this number when completing the online test to allow the two data sets to be linked during analysis.

Participants were firstly asked to complete the demographic questionnaire and then the measures in the following order: CCQ, ECR-S, ProQOL, S-PEC, explicit attitudes question. Each participant was provided with feedback regarding their individual responses, in line with the standardised scoring system for each measure. Participants were then asked to follow a second online link to the IAT. On completing the IAT, participants received automatic feedback regarding their individual implicit attitudes. An IAT debrief statement, together with a general study debrief, was presented at this time (Appendix J).

### **Data Analysis**

IBM SPSS Statistics 21 was used to analyse the data (IBM Corp., 2012). Significant and borderline significant results (i.e. <10%) will be reported. Independent *t*-tests were used to explore gender differences across each measure, analyses of variance (ANOVA) examined differences in participant occupation across the measures, correlations were employed to determine relationships among the variables and a multiple regression analysis was used to identify any significant predictors of challenges to compassion in MHPs.

## Results

### Descriptive Statistics

**Challenges to compassion.** An exploratory factor analysis was firstly conducted to investigate the construct validity and factor structure of the CCQ measure that was specifically developed for the current study. This revealed sampling adequacy according to the Kaiser-Meyer-Olkin measure (.792), and a significant Bartlett's test of sphericity ( $p < .001$ ). The one-factor structure indicated that the CCQ scale is a valid measure of challenges to compassion in MHPs, distinguishing this as a unidimensional construct. Table 1 illustrates that item 5 of the CCQ (i.e. *'being compassionate towards patients who have done bad things is letting them off the hook'*) has the strongest effect on challenges to compassion. The Cronbach's alpha also demonstrated that the CCQ has good internal reliability ( $\alpha = .857$ ) (Tavakol & Dennick, 2011). CS and EI (self) were found to be negatively associated with challenges to compassion, while attachment-related anxiety was related to increased CCQ scores. The relationships between the CCQ and other variables will be examined in depth within the subsequent sections. Overall, the current sample reported low challenges to compassion with 96.2% of participants scoring less than half on the measure. Female participants reported fewer challenges than males, with male nurses reporting the most challenges.

**Table 1. CCQ Factor Loadings**

<b>CCQ Item</b>	<b>Factor Loading</b>
1	.662
2	.583
3	.492
4	.740
5	.844
6	.650
7	.759
8	.437
9	.431
10	.668

**Individual differences.** When examined in relation to Stamm's (2010) cut scores, burnout and CF levels within the current population fell below average, while 95.2% of participants scored over 50% on the CS ProQOL subscale. Females demonstrated greater levels of CS than their male counterparts, but also slightly higher rates of burnout. Nurses reported the most CF, while clinical managers demonstrated the greatest levels of burnout and CS. Higher rates of attachment-related avoidance were discovered in the current sample than attachment-related anxiety, with more females reporting attachment-related anxiety than males. Support workers reported the highest attachment-related anxiety, while nurses demonstrated the greatest rates of attachment-related avoidance. Descriptive analysis also revealed higher EI (self) mean scores than EI (other) within the current sample, in which

females and nurses reported the highest levels, while support workers reported the lowest. Overall, the current population demonstrated a slight explicit preference in demonstrating compassion to detained patients over hospital patients. Descriptive statistics by total population, gender and occupation can be found in Tables 2-5 below.

**Table 2. Descriptive Statistics by Total Population**

Measure	M (SD)	N
ECR-S (anxiety)	17.80 (7.26)	104
ECR-S (avoidance)	22.61 (4.77)	104
S-PEC (self)	33.05 (5.59)	104
S-PEC (other)	30.53 (4.55)	104
CCQ total	18.24 (7.91)	104
ProQOL (CF)	18.79 (5.10)	104
ProQOL (burnout)	31.27 (4.26)	104
ProQOL (CS)	39.35 (7.14)	104

CCQ – Challenges to Compassion Questionnaire; ECR-S – Experiences in Close Relationships Scale-Short Form; ProQOL - Professional Quality of Life Scale; S-PEC - Short Profile of Emotional Competence.

### Inferential Statistics

**Independent *t*-test.** Independent samples *t*-tests were conducted to investigate gender differences across each measure (Tables 3 and 4). Females were found to experience significantly greater CS than males,  $t(102) = 2.953, p < .05$ , Cohen's  $d = 0.63$ , while males reported significantly greater length of experience than females,  $t(102) = -2.264, p < .05$ , Cohen's  $d = 0.47$ . With regards to specific dimensions of the S-PEC and gender, males identified significantly greater use of their own emotion to guide action,  $t(102) = -2.025, p < .05$ , Cohen's  $d = 0.51$ , whereas females reported significantly greater use of others' affect to guide their actions,  $t(102) = 2.171, p < .05$ , Cohen's  $d = 0.51$  (see Figure C for Cohen's  $d$  effect sizes).

**Table 3. Descriptive and *t*-test Statistics by Gender**

Measure	Males		Females		<i>t</i> -test
	M (SD)	N	M (SD)	N	
ECR-S (anxiety)	16.48 (7.46)	25	18.22 (7.20)	79	1.042
ECR-S (avoidance)	22.12 (4.09)	25	22.76 (4.98)	79	.582
S-PEC (self)	31.80 (5.42)	25	33.44 (5.42)	79	1.286
S-PEC (other)	30.20 (4.57)	25	30.63 (4.56)	79	.413
CCQ total	19.76 (8.98)	25	17.76 (7.54)	79	-1.104
ProQOL (CF)	18.64 (6.99)	25	18.84 (5.70)	79	.141
ProQOL (burnout)	30.20 (4.53)	25	31.61 (4.14)	79	1.449
ProQOL (CS)	35.80 (8.28)	25	40.47 (6.40)	79	<b>*2.953</b>

\**p* < .05

**Table 4. S-PEC Descriptive and *t*-test Statistics by Gender**

<b>S-PEC Dimensions</b>	<b>Total Population</b>		<b>Males</b>		<b>Females</b>		<b><i>t</i>-test</b>
	<b>M (SD)</b>	<b>N</b>	<b>M (SD)</b>	<b>N</b>	<b>M (SD)</b>	<b>N</b>	
<b>(Self)</b> Identification	8.29 (1.68)	104	8.24 (1.48)	25	8.30 (1.75)	79	.165
Understanding	6.35 (1.63)	104	6.28 (1.14)	25	6.37 (1.75)	79	.232
Expression	6.38 (1.56)	104	6.56 (1.16)	25	6.32 (1.67)	79	-.679
Regulation	5.71 (1.40)	104	5.68 (1.07)	25	5.72 (1.49)	79	.129
Use	6.66 (1.54)	104	7.20 (1.04)	25	6.49 (1.64)	79	<b>*-2.025</b>
<b>(Other)</b> Identification	5.88 (1.48)	104	6.04 (1.57)	25	5.82 (1.46)	79	-.638
Understanding	6.50 (1.48)	104	6.36 (1.44)	25	6.54 (1.49)	79	.543
Listening	6.51 (1.49)	104	6.12 (1.27)	25	6.63 (1.54)	79	1.512
Regulation	6.05 (1.38)	104	6.16 (1.46)	25	6.01 (1.35)	79	-.465
Use	5.55 (1.91)	104	4.84 (1.72)	25	5.77 (1.92)	79	<b>*2.171</b>

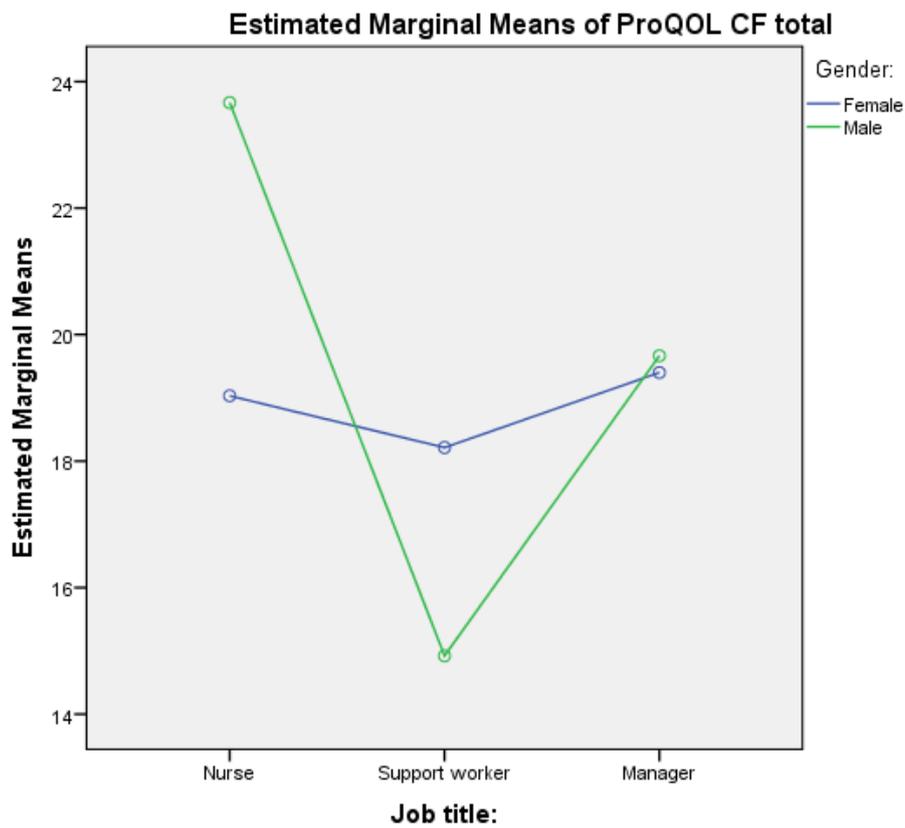
\*  $p < .05$

**ANOVAs.** One-way ANOVAs were conducted to examine differences within participant occupation across the measures (Table 5). A significant difference was found between challenges to compassion and occupation, with support workers experiencing significantly greater challenges,  $F(2, 101) = 3.426, p < .05$ . Managers demonstrated significantly higher levels of both CS,  $F(2, 101) = 3.364, p < .05$ , and burnout,  $F(2, 101) = 4.030, p < .05$ , and also reported a significantly greater length of time working in secure services  $F(2, 101) = 3.540, p < .05$ . A significant difference was discovered for EI (other),  $F(2, 101) = 3.212, p < .05$ , in which support workers demonstrated the highest rates. Two-way ANOVAs revealed significant interactions between occupation x gender on CF,  $F(2, 98) = 3.672, p < .05$ , in which male nurses experienced the highest CF (Figure 1), and gender x age,  $F(3,96) = 2.905, p < .05$  on CS, whereby younger males experienced the most fulfilment from caregiving (Figure 2).

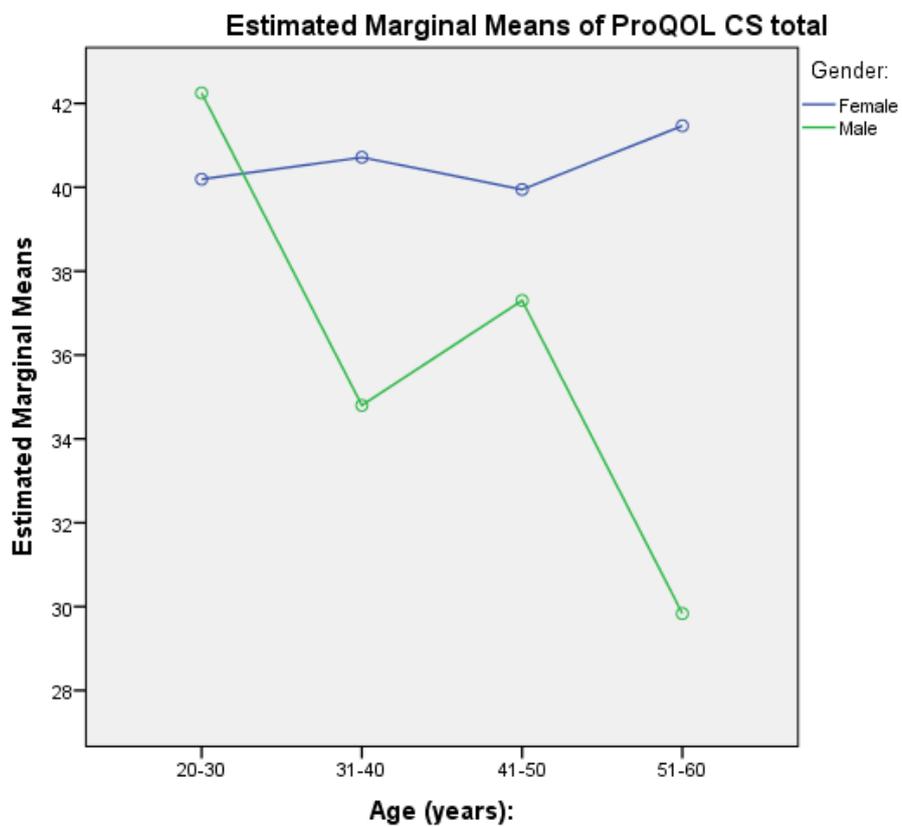
**Table 5. Descriptive and ANOVA Statistics by Occupation**

Measure	Support Workers		Nurses		Clinical Managers		<i>F</i>
	M (SD)	N	M (SD)	N	M (SD)	N	
ECR-S (anxiety)	18.34 (7.20)	41	18.28 (7.06)	40	16.00 (7.75)	23	.904
ECR-S (avoidance)	22.95 (4.07)	41	23.05 (4.80)	40	21.22 (5.74)	23	1.262
S-PEC (self)	32.34 (6.53)	41	34.05 (4.43)	40	32.57 (5.55)	23	1.059
S-PEC (other)	31.41 (4.01)	41	30.78 (3.48)	40	28.52 (6.34)	23	<b>*3.212</b>
CCQ total	19.63 (7.75)	41	18.93 (8.94)	40	14.57 (4.83)	23	<b>*3.426</b>
ProQOL (CF)	17.17 (5.61)	41	20.08 (6.05)	40	19.43 (6.15)	23	2.627
ProQOL (burnout)	29.85 (3.95)	41	32.05 (3.80)	40	32.43 (4.95)	23	<b>*4.030</b>
ProQOL (CS)	39.05 (7.95)	41	37.83 (6.91)	40	42.52 (4.92)	23	<b>*3.364</b>

\* $p < .05$



**Figure 1. Interaction effects between occupation x gender on CF**



**Figure 2. Interaction effects between age x gender on CS**

**Pearson product-moment correlations.** Table 6 displays the intercorrelations for each variable using Pearson correlations.

**Challenges to compassion.** A positive correlation was found between challenges to compassion and attachment-related anxiety,  $r = .20, p < .05$ , indicating that these participants experienced greater challenges to displaying compassion to others than those who identified themselves as experiencing attachment-related avoidance,  $r = .16, p > .05$ . Challenges to compassion were also negatively correlated with EI (self),  $r = -.22, p < .05$ , but not EI (other),  $r = .098, p > .05$ . Neither age,  $r = .048, p > .05$ , or clinical experience,  $r = -.042, p > .05$ , were found to be related to challenges to compassion.

**Professional quality of life.** The CCQ was positively correlated to participant responses on the CF subscale of the ProQOL,  $r = .20, p < .05$ , and negatively correlated to the CS subscale,  $r = -.44, p < .01$ , indicating that the CCQ is able to identify difficulties relating to interpersonal compassion. A negative correlation was discovered between CF and CS,  $r = -.28, p < .01$ , which highlights that these may indeed exist along one dimension, while there was also a significant relationship between CF and burnout,  $r = .29, p < .01$ .

**Attachment.** The analyses revealed that attachment-related anxiety was positively correlated with CF,  $r = .34, p < .01$ , and had a negative relationship with CS,  $r = -.21, p < .05$ , which proposes that this pattern increases the likelihood of experiencing compassionate stress within a caregiving role. Both attachment-related anxiety, and particularly avoidance, demonstrated a positive association with EI (other),  $r = .21, p < .05$ ;  $r = .32, p < .01$ , which indicates that overall these individuals have the capacity to make sense of others' emotions. Attachment-related anxiety and avoidance were positively correlated within the current study,  $r = .58, p < .01$ .

**Emotional intelligence.** Only the 'listening' dimension of EI (other) was significantly related to challenges to compassion,  $r = -.217, p < .05$ , demonstrating that staff who have a

greater capacity to attend to emotions in others experience fewer challenges to compassion. Furthermore, the results highlighted an increased use of one's own emotions with age,  $r = .202, p < .05$ , in conjunction with an increased expression of one's own emotions with increased clinical experience,  $r = .221, p < .05$ . EI (self) and EI (other) were found to be significantly related,  $r = .36, p < .01$ . The intercorrelations between the measures and S-PEC dimensions can be found in *Section 5*.

**Attitudes.** Finally, analysis revealed a significant positive correlation between explicit and implicit attitudes,  $r = .436, p < .05$ , suggesting that as staff explicit preferences for detained or hospital patients strengthened, so did their implicit preferences towards the same population. Furthermore, a negative effect of length of experience on implicit attitudes was discovered,  $r = -.537, p < .05$ , which indicates that an increased length of time working with detained patients also increased participants' implicit preference for this client group.

**Table 6. Variable Intercorrelations**

	<b>M</b>	<b>SD</b>	<b>ECR-S (anx)</b>	<b>ECR-S (avoid)</b>	<b>S-PEC (self)</b>	<b>S-PEC (other)</b>	<b>CCQ total</b>	<b>ProQOL (CF)</b>	<b>ProQOL (burnout)</b>	<b>ProQOL (CS)</b>	<b>Age (years)</b>
<b>ECR-S (anx)</b>	16.48	7.263	-								
<b>ECR-S (avoid)</b>	22.12	4.769	** <i>.576</i>	-							
<b>S-PEC (self)</b>	33.05	5.585	-.003	.056	-						
<b>S-PEC (other)</b>	30.53	4.545	* <i>.213</i>	** <i>.322</i>	** <i>.355</i>	-					
<b>CCQ total</b>	18.24	7.907	* <b>.200</b>	<b>.162</b>	* <b>-.216</b>	.097	-				
<b>ProQOL (CF)</b>	18.79	5.996	** <i>.338</i>	.028	.037	-.008	* <b>.200</b>	-			
<b>ProQOL (burnout)</b>	31.27	4.255	.035	-.137	.082	.015	.019	** <i>.286</i>	-		
<b>ProQOL (CS)</b>	39.35	7.142	* <i>-.209</i>	-.064	.126	-.004	** <b>-.443</b>	** <i>-.277</i>	.061	-	
<b>Age (years)</b>	38.60	11.508	-.130	-.162	-.030	-.013	.048	.045	.092	-.123	-

\*  $p < .05$ ; \*\*  $p < .01$

**Multiple regression.** A linear regression analysis was conducted to regress challenges to compassion on seven variables ( $p < .1$ ): occupation, attachment-related anxiety and avoidance, EI (self), EI (other - listening), CF and CS. All variables entered into the analyses correlated at  $r \leq .44$ , meeting the assumption of little multicollinearity. The analysis revealed that the model was statistically significant,  $F(7, 96) = 5.463, p < .00, R^2 = .233$ , adj., in which 23.3% of the total variability in challenges to compassion was explained by the model. Two variables significantly accounted for the unique variance in challenges to compassion, namely CS,  $\beta = -.363, t(96) = -3.411, p < .01$ , and EI (self),  $\beta = -.277, t(96) = -2.209, p < .05$  (Table 7). This indicates that, as CS and the capacity to reflect upon one's own emotional states increases, challenges to compassion decreases. The multiple regression model was re-run with only the significant variables entered, revealing CS as the most parsimonious predictor of challenges to compassion,  $\beta = -.468, t(101) = -4.776, p < .001$ . The full regression analysis can be found in *Section 5*.

**Table 7. Multiple Regression Analysis**

Variable	B	SE	$\beta$
*S-PEC (self)	-.277	.125	-.195
**CS	-.363	.106	-.328

\* $p < .05$ ; \*\* $p < .01$

## Discussion

Given recent reports highlighting the fundamental lack of compassion within mental health services (Care Quality Commission, 2015), this study was the first to investigate the impact of individual differences in direct-care staff on the challenges to compassion they experience for patients who are detained under the Mental Health Act. Challenges to compassion were measured using the CCQ: an original scale which demonstrated good internal reliability and validity. The CCQ negatively correlated with CS and positively correlated with CF, providing preliminary evidence that the CCQ assesses difficulties in expressing compassion for others. However, unlike the depletion of compassion over time characterised by CF, the CCQ taps into active conflicts in displaying compassion to others. The CCQ also expands upon the existing FCS by investigating caregiving within the context of clinical relationships with patients and exploring the influence of client, team and service-level on MHPs' challenges to compassion.

A multiple regression analysis revealed that EI (self) and CS significantly predicted fewer challenges to compassion. Other variables associated with challenges to compassionate care included attachment-related anxiety, having a support worker role, CF and listening to others' emotions. Age, gender and length of time working within secure mental health services were unrelated to challenges to compassion. A positive relationship was also discovered between explicit and implicit attitudes towards detained patients. Overall, the current population reported minimal challenges to the provision of compassionate care to detained patients, indicating the presence of protective factors against the individual, interpersonal and organisational challenges to compassion.

## **Clinical Implications**

In contrast, a recent study conducted by Matthews and Williamson (2016) highlighted support workers' tension between compassion versus the emotional detachment 'expected' by the organisation, resulting in 'moral distress'. Support workers within the current study also experienced significantly greater challenges to compassion than other roles. This cohort is potentially more likely to use physical interventions to manage patient risk. Staff who engage in frequent physical restraint have described becoming emotionally 'hardened' to the experience (Sequeira & Halstead, 2004), implying a degree of affective detachment from highly distressed patients. Support workers also have minimal professional autonomy which can influence self-efficacy of improving patient wellbeing (Manojlovich, 2005), and impact on caregiving behaviour (Maben, Adams, Peccei, Murrells & Robert, 2012). This study also revealed that support workers reported the highest rates of attachment-related anxiety and the lowest EI (self), both of which were associated with increased challenges to compassion.

Challenges to compassion for others have previously been associated with attachment-related anxiety and avoidance (Gilbert, McEwan, Matos & Ravis, 2011). The current study discovered that only attachment anxiety significantly increased MHPs' challenges to compassion. Comparable to Kafetsios' (2004) findings, this study discovered a significant relationship between attachment-related avoidance and greater EI (other); however, these individuals often evade emotional closeness in interpersonal contexts (Shaver, Mikulincer & Pereg, 2003). Therefore, it is possible that this emotional disconnection serves as a protective factor from encountering the conflicting relational motives evident in attachment-related anxiety.

Participants who experienced attachment-related anxiety may present with a hyperactivation of the attachment behavioural system in which the intensity of their emotional expression is heightened to elicit care from another (Mikulincer & Shaver, 2007). As the

caregiving system is formed from the attachment system, staff with attachment-related anxiety may become excessively concerned with caring for patients due to preoccupation with interpersonal relationships, but with the underlying goal of self-preservation. This may explain the significant relationship found between attachment-related anxiety and CF within this study, demonstrating that extensive attempts to meet patients' needs can lead to compassionate stress. However, these individuals also experience ambivalence to caregiving due to hypervigilance to rejection, therefore, increasing challenges to compassion. Conversely, Braun (2011) noted that organisational change and complex systems can increase anxiety and insecurity, indicating that attachment security may also be inhibited by wider service factors.

Higher EI (self) predicted fewer challenges to compassion within the current study, illustrating the key influence of the MHP's connection with, and regulation of, their emotional states on their capacity for compassion (Martos, Lopez-Zafra, Pulido-Martos & Augusto, 2013). Compassion has been described as 'feeling with' another, leading to positive affect and the provision of care, unlike the affective component of empathy which involves 'feeling for' another, which can increase negative emotionality and interpersonal withdrawal (Singer & Klimecki, 2014). Therefore, the propensity to display compassion to others appears to also require a cognitive process, similar to the perspective-taking component of empathy (Reniers, Corcoran, Drake, Shryane & Völlm, 2011), in acknowledging the intersubjectivity of their affect which is connected to, but distinct from, a patient's distress. However, previous research has revealed that challenges to compassion for others are also related to challenges to compassion for the self (Gilbert, McEwan, Matos & Ravis, 2011).

'For someone to develop genuine compassion towards others, first he or she must have...the ability to connect to one's own feelings and to care for one's own welfare' (Dalai

Lama, 2003; p. 125). This appears to reference EI (self) and self-compassion, which are known to be related constructs (Senyuva, Kaya, Isik & Bodur, 2014). Neff's (2003) depiction of self-compassion encompasses self-kindness during times of hardship, a willingness to experience distress and a sense of common humanity. The latter component reflects the mutual vulnerability that is required to truly connect with a patient's distress. Although self-compassion was not measured within the current study, Gustin and Wagner (2013) described this as the 'butterfly effect' of caring, in which self-compassion cultivates interpersonal compassion (Mills, Wand & Faser, 2015). Moreover, fostering compassionate attitudes towards others can also enable internalised self-kindness (Bates, 2005).

While Mikolajczak, Brasseur and Fantini-Hauwel (2014) describe that the ability to reflect upon others' emotional states is predictive of the quality of social relationships, the current study did not find a relationship between EI (other) and challenges to compassion. However, staff who reported an ability to listen to patients' emotions experienced fewer challenges. Active-empathic listening has been identified as a form of non-verbal affection within relationships (Floyd, 2014), giving it a fundamental role within interpersonal compassion. It is possible that staff who demonstrated active listening during patient interactions were reinforced for doing so through improved self-efficacy (Levitt, 2002) and therapeutic alliances (Sexton, Littauer, Sexton, & Tommeras, 2005), and reductions in patient distress (Price & Baker, 2012).

Unsurprisingly, CS significantly predicted fewer challenges to compassion for patients within this sample. This is indicative of a cyclical process in which MHPs who alleviate patient suffering through compassion are more fulfilled within their roles, which perpetuates further engagement in compassionate acts (McGaghie, Mytko, Brown & Cameron, 2002). The positive emotionality associated with displaying compassion for another in distress (Klimecki, Leiberg, Lamm & Singer, 2013) may also be a precursor for

the positive affect related to CS (Samios, Abel & Rodzik, 2013). Campling's (2015) notion that leadership compassion filters down to staff was partly supported by the current finding of high rates of CS in managers. Leaders who demonstrate compassion have been shown to prompt similar responses in their staff by creating 'elevation' (Vianello, Galliani & Haidt, 2010). However, an increased sense of social power has also been shown to decrease compassion for individuals in distress (van Kleef *et al.*, 2008). It is also likely that managers have the greatest affective distance from patient distress which may protect them from challenges to compassion (Figley, 2002).

Higher rates of CS were also found in staff who perceived that showing compassion to patients was the 'norm' within their team, highlighting a relational influence on compassion. Having a strong attachment to a team is described as the 'emotional bedrock' on which therapeutic environments are created (Haigh, 2004), and has been shown to reduce stress and improve patient care (Borrill, West, Shapiro & Rees, 2000). However, the inherent need for inclusion within a team can lead to intergroup bias which challenges the delivery of compassionate care (Whitby & Gracias, 2013), including 'exclusionary othering' (Canales, 2000) that can result in dehumanising, stereotyping and oppression within secure settings (Paternelj-Taylor, 2004). Furthermore, Hinshelwood (2001) identified that if the 'unbearable suffering' of patients is not processed by staff due to the intolerable emotions this elicits, unconscious defence mechanisms, such as projection, may be developed to allow continued functioning (Campling, 2004). The consequence of this is a distorted reality in which unrealistic treatment solutions are created, patients are depersonalised and teams become distracted from the core task of compassionate care (Campling, 2015).

In contrast to other literature (Kopera *et al.*, 2015), this study revealed a positive relationship between MHPs' implicit and explicit attitudes towards detained patients. Furthermore, the longer participants reported working with this client group, the more they

demonstrated an implicit preference in displaying compassion for them, suggesting an increasing positive attitude over time. This is encouraging given that implicit attitudes are potentially predictive of caregiving behaviours (Brenner, Rose, von Hippel & Wilson, 2013). Despite this, an implicit preference for hospital patients was uncovered when staff expressed challenges in displaying compassion for patients who harm themselves. Previous research has found that staff attitudes towards self-harm can be linked to the propensity to provide care (Wheatley & Austin-Payne, 2009). While the attitude data from the current research could not be analysed due to low response rates, previous studies have explored the predictive validity of attitudes on behaviour (Fazio & Olson, 2003). Strack and Deutsch's (2004) 'reflective-impulsive' model theorises that staff perceptions of their capacity to provide compassion are processed by the implicit-impulsive system, then the explicit-reflective system if reflective space is available, and are united to stimulate caregiving. It is possible that features of the inpatient environment may influence the degree to which staff are able to respond in a reflective manner due to a reduced capacity to access higher-order cognitive processes under stress (Reising, 2013).

This study discovered below average levels of CF and burnout, in which nurses reported the highest CF rates. This may reflect the interpersonal and affective nature of their clinical work; similar findings have been reported internationally (Mangoulia, Koukia, Alevizopoulos, Fildissis & Katostaras, 2015). Previous research has suggested that greater emotional distance from patients may protect against CF (Lauvrud, Nonstad & Palmstierna, 2009). However, the current study discovered that staff who perceived compassion as a drain on emotional resources experienced greater CF, indicating that withholding compassion as a protective mechanism may heighten compassionate stress. A negative relationship between CS and CF was found within this and other papers (Plante, 2015). This suggests that prolonged contact with individuals experiencing psychological distress may increase the

propensity to develop compassionate stress and reduce the satisfaction clinicians attain from their caregiving duties (Dominguez-Gomez & Rutledge, 2008).

Burnout scores for the current sample were double those of CF, suggesting that a number of staff, particularly clinical managers, experienced work-related stress. Previous studies have linked staff burnout in inpatient settings to job characteristics (Cahill *et al.*, 2004), low personal accomplishment (Johnson *et al.*, 2011) and poor relationships with colleagues (Johnson, Worthington, Gredecki & Wilks-Riley, 2016). According to Gilbert's (2010) theory, burnout may also impede the MHP's access to caring mental states and increase their challenges to compassion due to an over-activation of the threat system.

Although no significant differences were found between challenges to compassion and gender, male participants reported more challenges than females. Evolutionary theory hypothesises that compassion is an innate human response (Keltner, Marsh & Smith, 2010); however, gender differences in how compassion is learned and communicated exist (Mercadillo, Diaz, Pasaye & Barrios, 2011). Seppala (2013) described that women primarily express compassion through nurturing and emotional warmth, while men display this through protection and safety. In parallel, early critics of attachment theory differentiated between an attachment system that is protection and security-based and one that is grounded in warmth and affection (MacDonald, 1992). Consequently, female MHPs may perceive their primary role to provide warmth and kindness, whereas male staff may be inherently motivated towards maintaining safety and security, both of which are necessities within inpatient services. Fulfilment from this role may explain the high rates of CS found in younger males.

**Promoting compassion within inpatient mental health contexts.** As compassion may be alien to many detained patients (Swinton, 2013), but can contribute greatly to their wellbeing and recovery (Spandler & Stickley, 2011), recommendations for promoting compassionate care on an individual, interpersonal and organisational level are made. Firstly,

an abundance of literature has highlighted the impact of staff wellbeing on the quality of care provision (e.g. DoH, 2014; Royal College of Physicians, 2015). In response, NHS Employers (2015) published an ‘emotional wellbeing toolkit’ to promote staff mental health. Clinical psychologists are also uniquely placed to nurture staff psychological wellbeing by modelling EI (Freshwater, 2008), enhancing CS through restorative supervision (Wallbank, 2014), and providing emotional support (Whitby & Gracias, 2013). Cree and Rodgers (2013) argue that a compassionate culture within mental health systems begins with self-compassion, which is related to psychological functioning (Neff, Kirkpatrick & Rude, 2007), life satisfaction and social connectedness (Neff & Pommier, 2013); these are staff characteristics that patients would greatly benefit from.

Interpersonal interventions aimed at enhancing compassion for others can reduce stress (Inagaki & Eisenberger, 2015) but also increase mentalising capacities (Lutz, Brefczynski-Lewis, Johnstone & Davidson, 2008): a social-cognitive ability to hold both the self and others in mind (Bateman & Fonagy, 2013). Being able to ‘tune in’ to a patient’s world is a fundamental skill of MHPs and can enhance affiliations (Gilbert, 2005) and improve patient satisfaction (MacInnes, Courtney, Flanagan, Bressington & Beer, 2014). However, compromised mentalisation (due to early attachments or stressful environments) can lead to a ‘misreading of minds’ (Rossouw, 2013), increasing challenges to compassion. Clinical psychologists can stimulate mentalising and psychological mindedness in staff by drawing on their specialist skills in formulation, training and consultation (British Psychological Society, 2007). Finally, Ballatt and Campling’s (2011) model of compassion originates in ‘kinship’ between colleagues (Figure D), demonstrating the importance of developing a culture of belonging and sharing within teams.

Inpatient services are themselves attachment figures that can ‘transmit security and stability to service-users’ (Seager, 2013; p. 222-223). Subsequently, organisations can

enhance the wellbeing and relationships of staff and patients by promoting a secure, nurturing and affiliative milieu (Seager, 2007), for example through psychologically-informed environments (PIEs) (Haigh, Harrison, Johnson, Paget & Williams, 2012), or compassion-focused and contextual behavioural environments (Veale, Gilbert, Wheatley & Naismith, 2015). Some organisations have also introduced Schwartz rounds which focus on the psychological impact of service-related challenges through group reflection (Schwartz Centre, 2011), allowing staff to remain connected to the emotional content of their roles while also uncovering mechanisms they have developed to manage anxiety (Wren, 2014).

### **Limitations and Future Research**

Although this study is innovative in exploring challenges to compassion in MHPs, there are several limitations to consider. Firstly, due to the anonymous nature of participation, monitoring of adherence to the inclusion/exclusion criteria was not possible. The results also represent a voluntary sample which assumes that staff had motivating factors for participating in the research, such as minimal challenges to compassion or greater difficulties relating to their professional quality of life. Furthermore, it is possible that some participants also cared for informal patients (i.e. not detained), which may have influenced the findings.

The implications of utilising self-report measures on demand characteristics and awareness of defence mechanisms (Davidson & MacGregor, 1998) should also be considered, in conjunction with adopting abbreviated scales in which constructs were at times measured by two items only. While the ‘forced response’ option within the Qualtrics survey ensured a complete data set, this prevented analysis of partially completed responses which may have enhanced the richness of the data. Moreover, the study was unable to determine whether attitudes impacted upon challenges to compassion due to the low IAT response rate.

Therefore, future studies should explore explicit and implicit attitudes towards mental health patients and challenges to compassion to determine predictive validity.

Due to anonymity, details of service contexts in which participants were recruited from are unknown. As particular clinical populations may influence MHPs' compassion (Ferguson & Ireland, 2006), future research should expand on the current study by administering the CCQ within a range of settings to ascertain specific patient and service challenges to compassion faced by staff. In addition, research exploring challenges to compassion within members of multi-disciplinary teams may reveal distinct challenges and protective factors. Consistent with previous research comparing staff and patients perceptions (Schalast, Redies, Collins, Stacey & Howells, 2008), future studies may wish to investigate patient views of the impact of staff compassion on client satisfaction and clinical outcomes, and their recommendations of how to improve compassionate care (Gilbert, 2006). Lastly, ongoing evaluation of programmes, such as Schwartz rounds (Schwartz Centre, 2011) and mentalisation-based interventions (Bleiberg, 2003), will provide vital insights into the effectiveness of strategies that could reduce MHPs' challenges to compassion towards patients.

## **Conclusions**

This quantitative study revealed minimal challenges to compassion towards detained patients in 104 direct-care staff. Furthermore, increased length of clinical experience with detained patients increased MHPs' implicit preference for this population. Intrapersonal emotional intelligence and CS predicted fewer challenges to compassion in staff, while this was increased by attachment-related anxiety, having a support worker role and CF. Age, gender and length of time working in secure mental health settings were unrelated to

challenges to compassion. An original measure of challenges to compassion developed for this study demonstrated good internal reliability and validity. As compassion is an intersubjective experience of kindness and affiliation between professional and client, the cultivation of staff wellbeing and kinship among teams within secure, containing and nurturing organisations are fundamental to this process. This is of increased importance when considering how compassion can contribute to patient satisfaction, psychological wellbeing and recovery.

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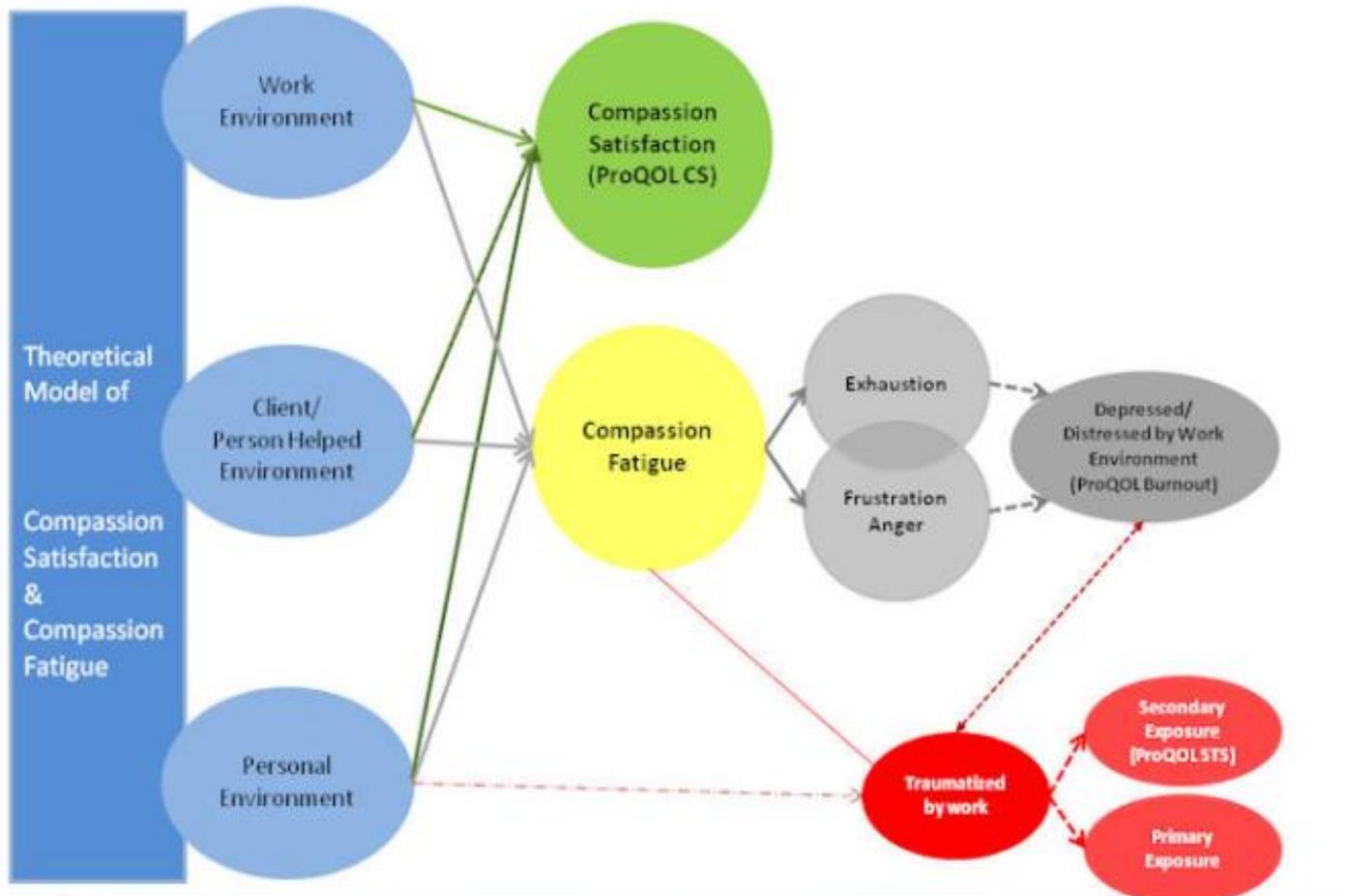
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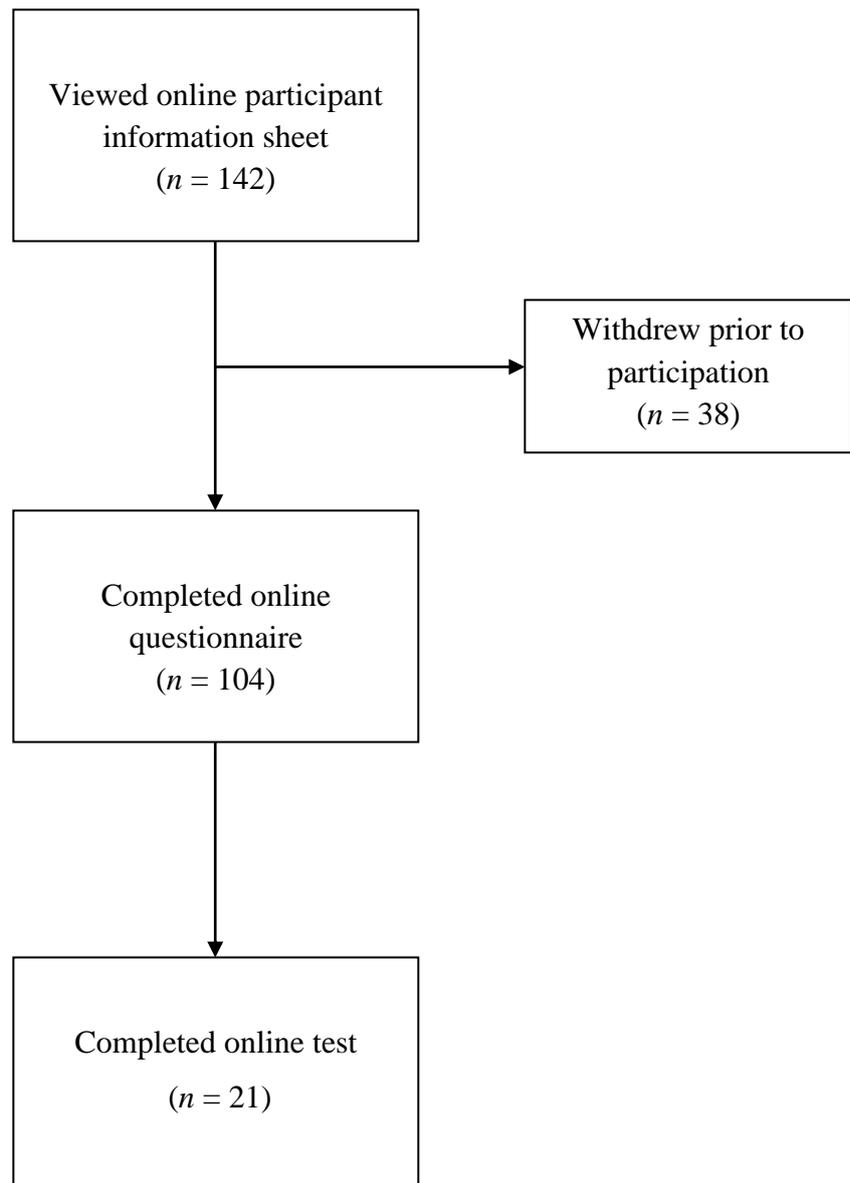
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Figure A

## Stamm's Model of Compassion Satisfaction and Compassion Fatigue



**Figure B**  
**Recruitment and Participation Flowchart**

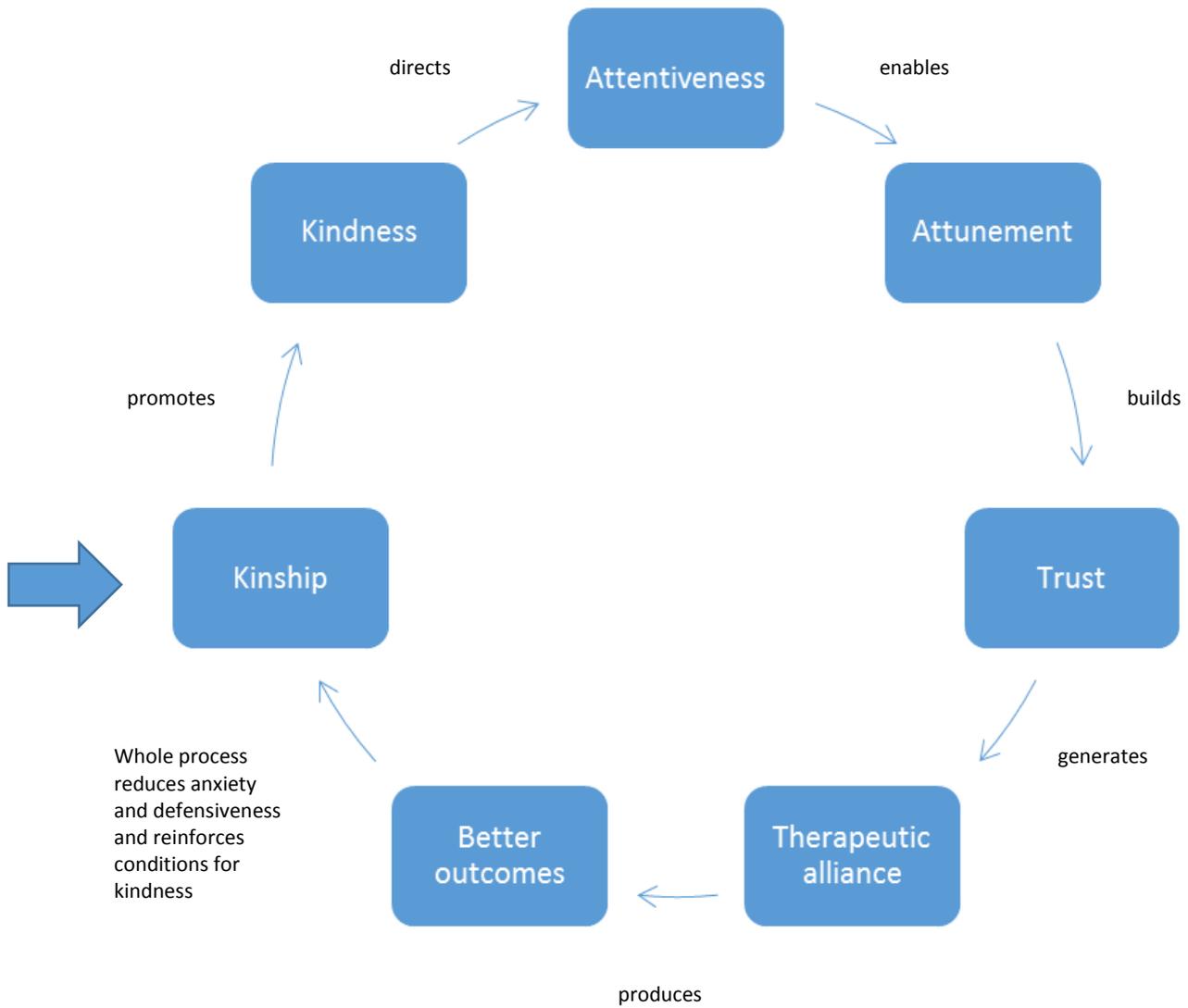


**Figure C**  
**Cohen's *d* Effect Sizes**

<b>Cohen's <i>d</i></b>	<b>Effect Size</b>
0.2	Small
0.5	Medium
0.8	Large

Figure D

## Ballatt and Campling's Model of Intelligent Kindness



**Table A**  
**Implicit Associations Test Stimuli**

<b>Positive Attributes</b>	<b>Negative Attributes</b>	<b>Target group stimuli (‘detained patients’)</b>	<b>Comparison group stimuli (‘hospital patients’)</b>
Affection	Challenging	PICU	A&E
Care	Difficult	Locked	Cardiac
Healing	Selfish	Sectioned	Diabetic
Warmth	Weak		
Hopeful	Ungrateful		
Considerate	Stressful		
Understanding	Unpleasant		
Protective	Irresponsible		

## Appendix A

### Participant Demographic Questionnaire

#### Personal Details

**1. Age:**

---

**2. Gender:**

---

**3. Total length of time working in secure services/with patients who are detained under the Mental Health Act (1983/2007):**

---

**4. Job title:**

- Nurse
- Support worker
- Clinical Manager
- Other

**5. Please provide an email address if you would like to receive a summary of the overall findings of the research:**

---

## Appendix B

### Experiences in Close Relationships Scale-Short Form (ECR-S)

#### Experiences in Close Relationships

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Using the 1 to 7 scale, after each statement write a number to indicate how much you agree or disagree with the statement.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
strongly disagree			neutral/mixed			strongly agree

1.	It helps to turn to my romantic partner in times of need	
2.	I need a lot of reassurance that I am loved by my partner	
3.	I want to get close to my partner, but I keep pulling back	
4.	I find that my partner(s) don't want to get as close as I would like	
5.	I turn to my partner for many things, including comfort and reassurance	
6.	My desire to be very close sometimes scares people away	
7.	I try to avoid getting too close to my partner	
8.	I try not to worry about being abandoned	
9.	I usually discuss my problems and concerns with my partner	
10.	I get frustrated if romantic partners are not available when I need them	
11.	I am nervous when partners get too close to me	
12.	I worry that romantic partners won't care about me as much as I care about them	

## Appendix C

### Short Profile of Emotional Competence (S-PEC)

#### Emotional Experiences

The questions below are designed to provide a better understanding of how you deal with your emotions in daily life. Please answer each question spontaneously, taking into account the way you would normally respond. There are no right or wrong answers as we are all different. For each question please give a score from 1 to 5.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Does not describe me at all		Unsure	Often	Describes me very well

	1	2	3	4	5
1. I don't always understand why I respond in the way I do.					
2. When I feel good, I can easily tell whether it is due to being proud of myself, happy or relaxed.					
3. I am good at describing my feelings.					
4. I never base my personal life choices on my emotions.					
5. When I am feeling low, I easily make a link between my feelings and a situation that affected me.					
6. I can easily get what I want from others.					
7. Most of the time I understand why people feel the way they do.					
8. When I am touched by something, I immediately know what I feel.					
9. I do not understand why the people around me respond the way they do.					
10. When I see someone who is stressed or anxious, I can easily calm them down.					
11. Other people tend to confide in me about personal issues.					
12. My emotions inform me about changes I should make in my life.					
13. I find it difficult to explain my feelings to others even if I want to.					
14. If someone came to me in tears, I would not know what to do.					
15. I find it difficult to listen to people who are complaining.					
16. I am good at sensing what others are feeling.					
17. If I wanted, I could easily make someone feel uneasy.					
18. I find it difficult to handle my emotions.					
19. When I am angry, I find it easy to calm myself down.					
20. Quite often I am not aware of people's emotional state.					

## Appendix D

### Challenges to Compassion Questionnaire (CCQ)

#### Challenges to Compassion

Everyone has different beliefs about being kind and compassionate towards others. While sometimes we might feel it is important to show compassion, certain situations and groups of people may make this more challenging. I am interested in your beliefs about this. Please think about the statements below and use the scale to rate the extent to which you agree with each of them.

**1                      2                      3                      4                      5                      6                      7**

Completely disagree

Neither agree  
or disagree

Completely agree

1.	Being compassionate to patients is a sign of weakness and they may take advantage of you	
2.	It is hard to be compassionate towards patients who cause harm to themselves	
3.	It is the 'norm' in my team not to show compassion to patients, it's just how things are	
4.	If I am compassionate towards patients, I worry that this will drain my emotional resources and I won't be able to cope	
5.	Being compassionate towards patients who have done bad things is letting them off the hook	
6.	I'm not compassionate towards patients because they cannot return this	
7.	I cannot be compassionate towards people who are so dissimilar to me	
8.	The service I work in favours punishment over compassion	
9.	I am compassionate to others so that they will like me	
10.	I distance myself from patients who are distressed as this feels too uncomfortable for me	

## Appendix E

### Professional Quality of Life Scale (ProQOL)

#### Professional Quality of Life

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1	2	3	4	5
Never	Rarely	Sometimes	Often	Very often

1.	I am happy.	
2.	I am preoccupied with more than one person I help.	
3.	I get satisfaction from being able to help people.	
4.	I feel connected to others.	
5.	I jump or am startled by unexpected sounds.	
6.	I feel invigorated after working with those I help.	
7.	I find it difficult to separate my personal life from my life as a helper.	
8.	I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.	
9.	I think that I might have been affected by the traumatic stress of those I help.	
10.	I feel trapped by my job as a helper.	
11.	Because of my helping, I have felt "on edge" about various things.	
12.	I like my work as a helper.	
13.	I feel depressed because of the traumatic experiences of the people I help.	
14.	I feel as though I am experiencing the trauma of someone I have helped.	
15.	I have beliefs that sustain me.	
16.	I am pleased with how I am able to keep up with helping techniques and protocols.	
17.	I am the person I always wanted to be.	
18.	My work makes me feel satisfied.	
19.	I feel worn out because of my work as a helper.	
20.	I have happy thoughts and feelings about those I help and how I could help them.	
21.	I feel overwhelmed because my case [work] load seems endless.	
22.	I believe I can make a difference through my work.	
23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I help.	
24.	I am proud of what I can do to help.	
25.	As a result of my helping, I have intrusive, frightening thoughts.	
26.	I feel "bogged down" by the system.	
27.	I have thoughts that I am a "success" as a helper.	
28.	I can't recall important parts of my work with trauma victims.	
29.	I am a very caring person.	
30.	I am happy that I chose to do this work.	

**Appendix F**  
**Explicit Attitudes Question**

**Patient Attitudes**

Please tick one box beside the statement which best describes how you feel:

	I strongly prefer detained patient to hospital patient
	I moderately prefer detained patient to hospital patient
	I slightly prefer detained patient to hospital patient
	I equally prefer detained patient and hospital patient
	I slightly prefer hospital patient to detained patient
	I moderately prefer hospital patient to detained patient
	I strongly prefer hospital patient to detained patient

## Appendix G

### Research Participation Email Invitation

Hello,

My name is Mirella and I am conducting a research project as part of my doctorate in clinical psychology at Lancaster University.

My research aims to find out more about some of the challenges you may have experienced when working with detained patients.

I would like to recruit as many direct-care staff (i.e. support workers, nurses and ward/clinical managers) as possible, as the information you provide will help to understand more about how you may be best supported when working with detained patients.

Your participation in the study and the information you provide will be anonymous from the outset. You can withdraw from the study at any time, up until the point in which you have submitted your responses to the online questionnaires. The whole process should take around 15 minutes in total and your time would be greatly appreciated. Your service has approved the study and is therefore supportive of your participation.

If you choose to participate, you will receive immediate personalised feedback regarding your survey responses, which can be useful for self-reflection and personal/professional development.

If you are happy to take part in the study, *please follow the link below to complete the online questionnaire and test:*

.....

Warmest regards,

Mirella Hopper  
Trainee Clinical Psychologist  
Lancaster University

## Appendix H

### Participant Information Sheet

**Study title:** *Investigating the relationships between staff individual differences and challenges to compassion towards patients detained under the Mental Health Act.*

**Background information:** My name is Mirella and I am conducting a research project as part of my clinical psychology training at Lancaster University.

**What is the study about?** The purpose of the study is to find out more about some of the challenges you have experienced when working with detained patients, particularly around maintaining compassion. I am interested in the relationships between individual differences (e.g. general relationships with others etc.) and compassion towards patients. The information you provide will help to understand more about how services can consider the role of individual differences to facilitate compassionate care in secure services.

**Why have I been approached?** As a direct-care professional working with detained patients, I am very interested in your experiences and some of the challenges you may have encountered as a result of working with this population.

**Do I have to take part?** No you do not have to take part in the study – it's completely up to you. If you do decide to participate you are free to withdraw at any time without giving reason, up until the point in which you have submitted your responses to the online questionnaire or test.

**What will I be asked to do if I decide to take part?** If you would like to take part in the study *please proceed to the next screen and complete the consent form.* Following this you will be taken to a two part online survey: part one asks about general relationships and the challenges to compassion you may experience in the workplace; part two assesses attitudes towards detained patients. The whole process should take around 15 minutes in total; your time would be greatly appreciated.

**Will my information be confidential?** You will not be asked to provide your name at any point during the study. Instead, you will be provided with a random number to link your online survey and online test. The information you provide will be kept confidential and only the researchers involved in the study will have access to it. Your questionnaire and test results will be stored electronically on the University network in a password protected file.

**What will happen to the results?** The results of the study will be summarised and reported and may be submitted for publication in an academic journal. You will be provided with feedback on your individual results and can receive a summary of the overall findings if you choose to leave a contact email. Please note that only you will be provided with your individual results; it is not possible for the research team, or anyone else to link your individual results with any identifying information.

**Are there any risks involved?** There are no risks anticipated with participating in this study. However, if you have any concerns after taking part you are encouraged to inform the principal investigator and use the resources provided at the end of this information sheet.

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

**Where can I get further information about the study if I need it?** If you have any questions about the study please contact the principal investigator or any of the researchers involved.

**Who is involved in the study?**

Research Role	Name	Address	Contact
Principal Investigator	Mirella Hopper	Clinical Psychology - Division of Health Research, Faculty of Health & Medicine, Furness College, Lancaster University, Lancaster, LA1 4YG	<a href="mailto:m.hopper1@lancaster.ac.uk">m.hopper1@lancaster.ac.uk</a>
Field Supervisor	Kirstie Thompson	Cygnets Hospital Wyke Blankney Grange, Huddersfield Road, Wyke, Bradford, West Yorkshire BD12 8LR	<a href="mailto:kirstiethompson@cygnethealth.co.uk">kirstiethompson@cygnethealth.co.uk</a>
Research Supervisor	Ian Fletcher	Clinical Psychology - Division of Health Research, Faculty of Health & Medicine, Furness College, Lancaster University, Lancaster, LA1 4YG	<a href="mailto:i.j.fletcher@lancaster.ac.uk">i.j.fletcher@lancaster.ac.uk</a>

**What do I do if I have a complaint?** If you wish to make a complaint or raise concerns about any aspect of the study and do not want to speak to the researchers, you can contact Jane Simpson within the Clinical Psychology department or Roger Pickup outside of the Clinical Psychology Doctorate Programme:

Research Director for Clinical Psychology  
Division of Health Research,  
Faculty of Health & Medicine,  
Furness College,  
Lancaster University,  
Lancaster,  
LA1 4YG

Associate Dean for Research  
Division of Biomedical and Life Sciences,  
Faculty of Health & Medicine,  
Furness College,  
Lancaster University,  
Lancaster,  
LA1 4YG

**Where do I go if I feel upset after taking part in the study?** Should you feel concerned as a result of taking part in the research, the following resources may be useful:

1. Contact your GP
2. Contact your employee support service
3. NHS Direct - Tel: 0845 4647; Email: [nhsdirect.nhs.uk](mailto:nhsdirect.nhs.uk)
4. Samaritans - Tel: 08457 9090900; Email: [jo@samaritans.org](mailto:jo@samaritans.org)

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

**If you are interested in taking part in this study please follow the online link in the email you were sent. This link will allow you to complete the questionnaire and online test.**

## Appendix I

### Consent Form

**Study title:** *Investigating the relationships between staff individual differences and challenges to compassion towards patients detained under the Mental Health Act.*

If you are interested in taking part in this research project, please read the information sheet and tick each box below to give your consent to participate in the study. The researchers' contact details are available on the information sheet should you have any questions prior to taking part.

**Please tick each box to provide your consent:**

- I confirm that I have read the information sheet and understand what is expected of me during the study
- I am happy to answer questions about my general relationships, the challenges to compassion I may experience in the workplace and my attitudes towards detained patients
- I understand that my participation in the research and the data I provide will be anonymous from the outset
- I understand that my anonymous questionnaire and test responses will be stored securely in a password protected file on the Lancaster University Network
- I understand that the data I provide will be shared and discussed with the field and research supervisors of the project
- I understand that my participation is voluntary and that I am free to withdraw from the study at any time, up until the point in which I have submitted my responses to the online questionnaires
- I consent to the University keeping documents from the research in a secure location for 10 years after the study
- I consent to take part in the study.

## Appendix J

### Participant Debriefs

#### IAT Debrief Information

Thank you for completing the online test which explored your attitudes towards detained patients.

Please note that the results of the test provide only *an indication of your attitudes*. The results can also vary depending on a variety of factors, such as how you were feeling when you completed the test. Therefore, the results of the test should be used with caution.

#### General Debrief Information

Thank you again for taking part in this research, entitled:

*Investigating the relationships between staff individual differences and challenges to compassion towards patients detained under the Mental Health Act*

This study explored how your relationship experiences, your attitudes towards detained patients and your awareness of your own and others' emotions related to any challenges you may face in demonstrating compassion towards detained patients.

The responses you have provided will help to further understand how services may be able to provide optimum support for employees working in secure mental health settings.

Should you feel concerned as a result of taking part in the research, the following resources may be useful:

1. Contact your GP
2. Contact your employee support service
3. NHS Direct - Tel: 0845 4647; Email: [nhsdirect.nhs.uk](mailto:nhsdirect.nhs.uk)
4. Samaritans - Tel: 08457 9090900; Email: [jo@samaritans.org](mailto:jo@samaritans.org)
5. For further information and support regarding 'burnout', please contact any of the above or in addition you can contact:
  - Fit for Work - Tel: 0800 032 6235
  - Royal College of Nursing information and advice service - Tel: 0845 7726100 or counseling service - Tel: 0845 7697064

## Appendix K

### **Psychology and Psychotherapy: Theory, Research and Practice: Notes for Contributors**

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) 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. 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.

#### 1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

#### 2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

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

### 3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

### 4. Submission and reviewing

All manuscripts must be submitted via <http://www.editorialmanager.com/paptrap/>. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

### 5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded [here](#).
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.
- All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
- Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (<http://www.consort-statement.org>).
- Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (<http://www.prisma-statement.org>).

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

## 6. Multiple or Linked submissions

Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

## 7. Supporting Information

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### **Section 3: Critical Appraisal**

Adjunct Considerations on Conducting Quantitative Research into Compassionate Care  
within Mental Health Services

Text word count: 4,113

Appendices word count: 2,035

Mirella Hopper

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Mirella Hopper

Doctorate in Clinical Psychology

Furness College

Lancaster University

Lancaster

LA1 4YT

[m.hopper1@lancaster.ac.uk](mailto:m.hopper1@lancaster.ac.uk)

## **Adjunct Considerations on Conducting Quantitative Research into Compassionate Care within Mental Health Services**

This report will review the main findings from the research paper, before adopting a critical and reflective stance to consider initial decision-making processes regarding the study, the practical and procedural challenges encountered during the course of the research, the theoretical constructs adopted throughout and the pragmatic application of the findings.

### **Main Research Findings**

The main research paper discovered that intrapersonal emotional intelligence (EI) and compassion satisfaction (CS) significantly predicted fewer challenges to compassion in 104 direct-care staff who work with patients detained under the Mental Health Act. The Challenges to Compassion Questionnaire (CCQ), developed for the specific purposes of the study, demonstrated good internal reliability and validity. Challenges to displaying compassion for this patient group were also associated with attachment-related anxiety, the support worker role, compassion fatigue (CF) and listening to others' emotions. Age, gender and length of time working in inpatient mental health services were unrelated to challenges to compassion. A negative relationship between CS and CF was also identified. Overall, the sample of mental health professionals (MHPs) recruited to take part in the study reported minimal challenges to the provision of compassionate care in secure mental health contexts.

## Research Decision-Making Processes

When considering potential research areas in 2014, I was struck by the extensive media, clinical and academic attention given to the seeming lack of compassion that had been exposed within healthcare services, most notably by Sir Robert Francis (2013). These growing concerns brought about the development of new legislation, including ‘*Compassionate care in the [National Health Service] NHS*’ (Department of Health [DoH], 2013), and the implementation of national proficiency strategies, such as ‘*Compassion in Practice*’ (DoH, 2012). In response, however, critics asserted that implementing compassion systematically could become just another ‘programme of activity’: a tick-box exercise which does not fully address the wider factors that contribute to diminishing compassion within services (Campling, 2015). Moreover, in line with Gilbert’s (2010) philosophy that all humans have evolved with the capacity for kindness and caring, I perceived that the vast majority of healthcare staff entered the profession with a pre-existing aptitude for compassion, but believed that there were increasing obstructions to this in practice.

While research had drawn upon Gilbert, McEwan, Matos and Ravis’ (2011) original construct of *fears of compassion* to explore the challenges that individuals experience in directing compassion towards the self (Pauley & McPherson, 2010), and in receiving compassion from others (Rockcliff, Gilbert, McEwan, Lightman & Glover, 2008), there was a dearth of research into fears of compassion *for others*. More explicitly, research was yet to explore professionals’ active conflict in providing compassion to mental health patients. There are many possible reasons for the dearth of research in this area until now; however, this potentially reflected the lack of recognition of the specific challenges to compassion within healthcare organisations. Instead, ‘the contemporary narrative is to blame uncaring individuals’ (Sawbridge & Hewison, 2014; p. 1).

In my previous role as a therapy assistant in 2009 within a low secure hospital for individuals with learning disabilities, I myself experienced and witnessed challenges to compassion, but also encountered a wide range of protective mechanisms that were implemented by the service to explicitly address these barriers. This included employing a therapeutic community framework, reflective groups, team formulation meetings, twice-daily community meetings, weekly group supervision, regular needs-led training, key worker systems and support worker contributions to ward round and care programme approach meetings. By openly acknowledging the existence of the challenges to compassionate care, I feel we that were more equipped to deliver this.

Consequently, I felt driven to conduct a research project which investigated MHPs' perceptions of the challenges they encountered in displaying compassion for their patients, with a specific focus on individual, interpersonal and organisational variables. I initially considered a qualitative study given my personal alignment with phenomenology, constructivism and social constructionism which assumes that individuals construct their own subjective truths from their experiences in the world and with others; therefore, there is no single 'truth' to be discovered. However, due to the practical, ethical and political challenges often involved in obtaining idiosyncratic reflections of a contentious issue (such as challenges to compassion) through qualitative methods (Liamputtong, 2007), a quantitative study was deemed more appropriate for the initial investigations into this research area. Yet rather than exclusively representing scientific realism which attempts to discover one objective truth or reality, this study adopted a position of pragmatism in order to discover practical solutions to the issues surrounding the challenges MHPs face in upholding compassion for their patients. Follow-up qualitative research in this area would of course add richness and depth to the preliminary understandings gained from the current study.

As the existing Fears of Compassion Scale assessed challenges to compassion within global relationships (Gilbert, McEwan, Matos & Rivis, 2011), I initiated the development of a new measure of challenges to compassion which explores caregiving within the context of clinical relationships. The new CCQ is primarily underpinned by evolutionary and attachment theories of compassion and examines the functions and perceived consequences of displaying interpersonal compassion. Specialist knowledge and clinical experience within secure inpatient mental services also allowed my field supervisor and myself to incorporate items into the measure which highlighted the potential individual, interpersonal and service-level barriers staff may have encountered within their practice. Other key decisions involved selecting item numbers and features of the Likert scale (Boynton & Greenhalgh, 2004).

Potential limitations of the CCQ include a risk of response set due to non-reversed items, extreme and neutral responding using the Likert scale, minimal items measuring interpersonal and organisational barriers and the cross-cultural implications of developing an English language measure, as unfortunately no translations were available for the study. However, as the CCQ is not specific to secure mental health settings, it can be utilised across contexts to enable services to identify specific challenges to compassion that require attention, either through formal administration of the measure or as a framework to guide reflective discussions with mental health staff. Furthermore, this tool may prove valuable during staff recruitment procedures in order to explicitly identify MHPs who experience challenges to compassion and the specific nature of those fears. Responses may indicate particular training or continuing professional development needs of new staff, for example in relation to understanding the functions of self-harming behaviour (CCQ item 2) or enhancing personal self-care resources and professional resilience (CCQ item 4).

When setting up the study, significant consideration was also given to the research design, specifically the data collection methodology which was to be via an online survey.

For example, would participants have computer and internet access on the inpatient wards and allocated time to complete the measures during their shifts, or would it be more practicable to do so on a home computer during their personal time? To address these issues, I sought permission from each organisation to allow staff time to complete the measures during their shift should they wish to, while also providing the link to the online survey in the email invitation to enable participants to forward this to a personal email account to be completed at home. The local collaborator within each service also received an electronic copy of the measures, allowing staff to complete these by hand should they prefer, although this was not opted for by any participants. A final decision was to include automated feedback following responses to the questionnaire, which provided an interpretation of participants' scores and signposting to related resources. This feature can improve response rates by providing an incentive to proceed (van Selm & Jankowski, 2006); in this case this facilitated self-reflection in participants and contributed to their personal and professional development.

### **Practical and Procedural Challenges**

In order to broaden recruitment opportunities and to include a range of inpatient staff in the study, I sought ethical approval for the research from both the private and public sector. This included two private research ethics boards and five NHS Research and Development (R&D) committees across England, in addition to the Lancaster University Faculty of Health and Medicine Research Ethics Committee (REC). I received ethical approval for the study from the private organisations within two weeks of submitting a short application, demonstrating lean and efficient systems that support staff participation in research. In contrast, approval from the NHS R&D departments ranged from one to four months, with a

number of procedural disparities evident across each committee. For example, one Trust requested my attendance at a quality and safety meeting to discuss practical application of the research findings, three NHS Trusts allowed me to sign the Integrated Research Application System form as the principal investigator, and my attendance at another Trust R&D meeting was excused to relieve practical pressures in attending several panels across the county.

REC procedures serve to protect the safety and wellbeing of patients and staff involved in research (Health Research Authority, 2014). However, I feel that the pragmatic complexities in obtaining ethical approval for low-risk academic research could create barriers in contributing to the evidence-base of clinical psychology and the wider psychological practice of others (British Psychological Society [BPS], 2014). Similar experiences portrayed in the literature illustrate the inconsistent and lengthy ethical processes that exist, together with the potential for delayed research projects and dissuasion from conducting future research (Gill & Burnard, 2009; Jonker, Cox & Marshall, 2011). Furthermore, Davies (2015) expressed concerns that, as projects are already under time constraints, the current ethics approval systems may jeopardise the 'deliverability' of research within the NHS, hindering the involvement and representation of staff and patient views within research.

Although the majority of local collaborators for the study were clinical and forensic psychologists, two psychiatrists also adopted this role. This is indicative of interprofessional collaboration within psychological research and multi-disciplinary efforts to enhance the provision of compassionate care across inpatient mental health services. As interdisciplinary research can offer individual and organisational solutions to multifaceted issues in clinical practice (Green & Johnson, 2015), this is something I will continue to advocate for in the future, in addition to building partnerships with other professions to facilitate shared learning in overcoming challenges to compassion (NHS Change Day, 2016).

With regards to practical challenges encountered during the research process, only 20% of the total sample went on to complete the second part of the survey: the implicit associations test (IAT). On completion of the questionnaires, participants were asked to follow a second link which led them to the online test. It is possible that some staff did not read this information or did not have time to complete the second survey component due to the busy ward environment. Moreover, one information technology department reported that the IAT software could not be installed on to that Trust's computer system due to administration rights and firewall blocks. Therefore, participants were asked to complete this element of the survey on non-Trust or personal computers, which had obvious implications for the test response rates. Although this was not found to be an issue within the other Trusts, on reflection it is important to give greater consideration to the potential practical obstacles that may arise following activation of an online survey, such as software compatibility (Reynolds, 2007).

## **Exploration of Theoretical Constructs**

### **Compassion**

Arguably the most recognisable psychological definition of compassion is 'a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it' (Gilbert, 2010; p. xiii). However, compassion has also been studied by spiritual leaders (Dalai Lama, 2003), evolutionary theorists (Goetz, Keltner & Simon-Thomas, 2010), philosophers (Hume, 1978) and neuroscientists (Singer & Klimecki, 2014), leading to tensions as to whether this construct represents the technical or humanism paradigm (Spandler & Stickler, 2011). This illustrates the complexities in conceptualising the development, process and expression of compassion, in addition to the impact of

challenges on these processes.

Klimecki, Leiberg, Lamm and Singer (2013) reported that compassion activates neural networks associated with positive emotionality. However, other research has identified that the affective experience of compassion may in fact be unpleasant (Condon & Barrett, 2013). For some individuals compassion may signal danger from past experiences of vulnerability (Shaver & Mikulincer, 2002). Gilbert, McEwan, Matos and Rivis (2011) discovered a significant relationship between fears of compassion *from others* and *for others*, indicating the pervasive impact of affiliative experiences on not only the willingness to provide compassion to others, but also the developmental capacity to do so (Mikulincer, Shaver, Gillath & Nitzberg, 2005). Furthermore, clinicians who have experienced personal trauma themselves may be more likely to share in their clients' suffering (Baird & Kracen, 2006), potentially reducing their propensity for compassionate caregiving (Singer & Klimecki, 2014).

Previous research into gender differences and compassion has shown that females are more likely to anticipate positive self-rewards from caregiving than males (Sprecher, Fehr & Zimmerman, 2007); this may reflect differing reinforcement histories as a result of sex-role socialisation (Nordmeyer, 2002). MacGeorge (2003) also discovered that male participants were less sympathetic towards help-seekers than females, particularly when perceiving them as responsible for their difficulties. Gilligan's (1982) early 'ethics of justice' theory proposed that men are more likely to evaluate moral issues, such as compassion (McCullough et al., 2001), from a rational and justice standpoint, whereas women will adopt principles of care and mercy. In addition, Gilligan (1982) hypothesised that the most 'morally-mature' individuals have the capacity to balance care for the self with care for others. Although a recent meta-analysis revealed that males reported greater levels of self-compassion than females (Yarnell et al., 2015), women are often socialised to prioritise others' needs over

their own (Raffaelli & Ontai, 2004). Consequently, it is important to consider the implications of the 'feminisation' of compassion on participants' responses to the CCQ measure within the research paper (Seppala, 2013).

Participants' social and cultural contexts also potentially influenced their conceptualisations of compassion. For example, lower socioeconomic status has been associated with increased compassion for others (Stellar, Manzo, Kraus & Keltner, 2012) and prosocial behaviour (Piff, Kraus, Cote, Cheng & Keltner, 2010), possibly due to a greater commitment to egalitarian values. In contrast, 'superior' social power is related to disrupted executive functioning, moral exceptionalism and egocentricity (Robertson, 2014), with obvious implications for the capacity to provide compassionate care.

Although similarities in compassion have been identified across cultures (Trommsdorff, Friedlmeier & Mayer, 2007), it is apparent that interpersonal compassion may be more valued within interdependent/collectivist cultures than those which endorse independent/individualist values (Lopez, 2009). However, de Greck et al. (2012) identified that Chinese participants reported higher personal distress and lower perspective-taking than German subjects. This is indicative of a diminished distinction between the self and others in participants from an interdependent culture: a differentiation which is seemingly required for compassion to occur (Singer & Klimecki, 2014). Furthermore, cultural differences were found within Koopmann-Holm and Tsai's (2014) study in which Americans demonstrated an increased avoidance of negative affect within expressions of sympathy than German participants. However the authors of this paper adopted a model which assumes that compassion is motivated by a desire to reduce negative affect caused by witnessing another's suffering.

## **Compassion Fatigue and Compassion Satisfaction**

There continue to be conflicting reports within the literature regarding the relationship between CF and CS. CF occurs when a caregiver becomes vicariously enmeshed with the distress of their clients (Figley, 2002), whereas CS is the general gratification and pleasure derived from caring for others (Stamm, 2009). Subsequently, conclusions remain tentative as to whether these constructs are unidimensional (LaFauci Schutt & Marotta, 2011), or if they are separate and can be experienced simultaneously (Stamm, 2002). If CF and CS are indeed unrelated (Samios, Abel & Rodzik, 2013), in conjunction with findings that CF is predictive of psychological distress (Adams, Boscarino & Figley, 2006) and CS is related to greater wellbeing (Mangoulia, Koukia, Alevizopoulos, Fildissis & Katostaras, 2015), it is perhaps appropriate to compare these findings to the dual continuum model of mental health. This proposes that mental distress and mental wellbeing fall along two distinct paradigms, in which one does not signify the absence of the other (Keyes, 2002). In this sense, CS is not necessarily the absence of CF, and vice versa. As a result, it may be possible for MHPs to encounter compassionate stress while also experiencing fulfilment from caregiving; in turn, the presence of CS was shown in the research paper to reduce challenges to compassion.

## **Attachment Theory**

Participant attachment was examined in the research paper by the Experiences in Close Relationships Scale-Short Form (Wei, Russell, Mallinckrodt & Vogel, 2007): a dimensional measure of attachment rather than that of a categorical approach such as the Attachment Style Prototype (Hazan & Shaver, 1987). The dimensional model (Figure 1) assumes that individuals vary continuously in their attachment organisation according to new developmental and interpersonal experiences (Fraley, 2002). In contrast, the categorical model (Figure 2) adopts an attachment classification system, which Shi, Wampler and Wampler (2013) claim loses information regarding individual differences and assumes that

each category is mutually-exclusive. While the same authors have also argued for a co-existence of categorical and dimensional measures of attachment, a recent review of each model identified that individual differences in attachment are continuously distributed across global attachments and specific relationship contexts (Fraley, Hudson, Heffernan & Segal, 2015).

Analogous to the dimensional model of attachment is the concept of ‘earned’ security. This refers to an individual who has experienced negative early relationships, but has since developed a secure internal working model of attachment through emotional support from alternative caregivers (Saunders, Jacobvitz, Zaccagnino, Beverung & Hazen, 2011). Given the significant relationship between attachment-related anxiety and challenges to compassion discovered within the research paper, it is perhaps important to consider strategies that promote attachment security in MHPs. The use of validated experimental techniques to prime mental representations of attachment security have been shown to improve perceptions of the self and others (Carnelley & Rowe, 2007), foster compassion for those in distress (Mikulincer, Shaver, Gillath & Nitzberg, 2005), improve emotion regulation and mental health (Mikulincer & Shaver, 2015) and reduce hostility towards ‘outgroups’ (Mikulincer & Shaver, 2001). Mikulincer, Shaver, Gillath and Nitzberg (2005) regard attachment security priming as an opportunity to redirect personal resources and attention away from self-protective functions which are triggered under threat towards the caregiving behavioural system. However, individuals with attachment-related anxiety ‘may experience an adverse reaction to the secure attachment primes’ (Mallinckrodt, 2007; p. 171), such as distress when visualising a secure caregiver.

Attachment security in MHPs has been associated with better therapeutic alliances and clinical outcomes (Schauenburg et al., 2010). However, there is evidence to suggest that successful treatment may also result from greater differences in patient-professional

attachment patterns (Bruck, Winston, Aderholt & Muran, 2006). Mallinckrodt (2010) reported that ‘mismatching’ patients’ attachment patterns can prevent inadvertent reinforcement of their current interpersonal orientation, therefore providing a ‘corrective interpersonal experience’. Furthermore, professionals with their own ‘earned’ security may provide more successful interventions as they have also overcome personal challenges (Dozier, Cue & Barnett, 1994). The literature recommends that MHPs should become aware of their personal attachment to determine how this may interact with their patients’ (Bucci, Seymour-Hyde, Harris & Berry, 2016) and allow them to develop targeted self-care strategies (Collins, 2014). Subsequently, it may be beneficial for inpatient mental health services to employ staff with a range of attachments to suit the divergent needs of the clinical population, in conjunction with promoting an awareness of each professional’s attachment patterns and any associated challenges to compassion. However, I feel that it is imperative that this should occur within a secure, nurturing and compassionate organisational environment which recognises the potential for staff and patients to move towards ‘earned’ security.

### **Application of the Research Findings**

Conducting a research project which investigated challenges to compassion in MHPs has prompted me to reflect upon my professional responsibility in implementing the findings with pragmatism, innovation and of course compassion. As Beard & Barter (2014) emphasised, clinical psychologists (CP) regardless of grade have much to offer the compassion agenda, and can therefore influence change at micro, meso and macro levels. As part of this, I will enter into my role as a newly-qualified CP within a recovery-orientated community psychology service not only with a greater awareness of the complex interplay of

challenges to compassion, but also with knowledge of practical interventions I can facilitate to address them.

The '*Wellbeing and Performance Agenda*' encourages all professionals to take 'psychological responsibility' for themselves and others within organisations by being accountable for their own welfare and the impact of their behaviour on those around them (WellBeing and Performance Group, 2014). In adopting a 'bottom up' approach, I have given greater consideration to my own professional wellbeing and the personal resources I have developed that enable me to remain resilient, reflective, compassionate and attentive within my clinical work. Strategies that allow me to do this include self-compassion training, holistic therapy, mindfulness, cognitive defusion and personal reformulation. Modelling psychological responsibility and mindedness within teams can also engender a culture of creativity, openness, adaptability and commitment (Mowbray, 2014), qualities which may serve to cultivate compassion towards clients and improve their experience of services (NHS, 2014a).

Given CPs' leadership qualities (BPS, 2010) and specialist clinical skills (BPS, 2007), I also feel that we are uniquely-placed to provide direct interventions to staff teams that promote psychological wellbeing, EI, CS and intra and interpersonal compassion. For example, within my new post I have been given the opportunity to co-facilitate staff compassion-focused and reflective groups. Furthermore, CPs are able to contribute to the evidence-base, commissioning of services and development of policies by evaluating the clinical effectiveness of interventions such as these (BPS, 2011), for example on patient satisfaction and outcomes, in addition to staff wellbeing, performance and retention.

With regards to a 'top down' approach, I believe that recovery-orientated services are aptly positioned to promote compassion by cultivating hope, acceptance, social connections and human values (Roberts & Wolfson, 2003). Services based on principles of personal recovery also emphasise equal partnerships between MHPs and patients and value the

personal narrative of each client (NHS, 2010). These organisational features may redistribute existing power differences between staff and patients and provide clinicians with a more intimate understanding of their patients' personal histories and resultant psychological distress. I feel I am able to contribute to recovery-orientated service provision by facilitating these processes through team formulation sessions, adopting a person-centered and relational approach to risk assessment and management, and advocating for service-user collaboration in the development and delivery of mental health services, for example through peer professional roles and service-user led programmes (Shepherd, Boardman, Rinaldi & Roberts, 2014; Together/NSun, 2014).

Although the research paper was innovative in investigating MHPs' challenges to compassion towards their patients, the findings also highlight several potential areas for further research. Most notably, the study discovered minimal challenges to compassion in direct-care staff. While ever more literature within this field continues to focus on examples of poor care and malpractice, the dominant narrative that 'uncaring' individuals are to blame is perpetuated (Sawbridge & Hewison, 2014). Therefore, future projects may wish to explore the influence of wider organisational and social pressures on compassion, for example by reviewing how compassion is embedded into professional training programmes (Firth-Cozens & Cornwell, 2009), and investigating the effects of austerity measures on MHPs and service delivery (Mitchell, Beninger, Rahim & Arthur, 2013). Examination of how the processes of social power and exclusion contribute to diminishing compassion and stigmatising attitudes towards individuals with mental health difficulties (Mental Health Foundation, 2016) may also provide valuable insights into socially-constructed challenges to compassion. Finally, future research could aim to identify evidence of existing compassionate practice within mental health services (NHS, 2014b), understand how staff negotiate the challenges to

compassion they do encounter, and study the protective factors that maintain CS, psychological wellbeing and interpersonal compassion in MHPs.

### **Conclusions**

This report adopted a critical and reflective stance to consider issues that had arisen from conducting research which investigated challenges to the delivery of compassionate care within mental health services. Strengths of the project included its attempts to address the contemporary individualised narrative around challenges to compassion, the development of a valid and reliable Challenges to Compassion Questionnaire, and the dimensional model of attachment that was adopted. However, limitations consisted of software incompatibility, low test response rates, and the implications of complexities in conceptualising compassion on the research findings. Consideration was given to my professional responsibility in applying the research findings across micro, meso and macro levels, using both ‘bottom up’ and ‘top down’ approaches. Future research may wish to explore the influence of wider organisational and social pressures on the provision of compassionate care within mental health services, in addition to recognising examples of current good practice.

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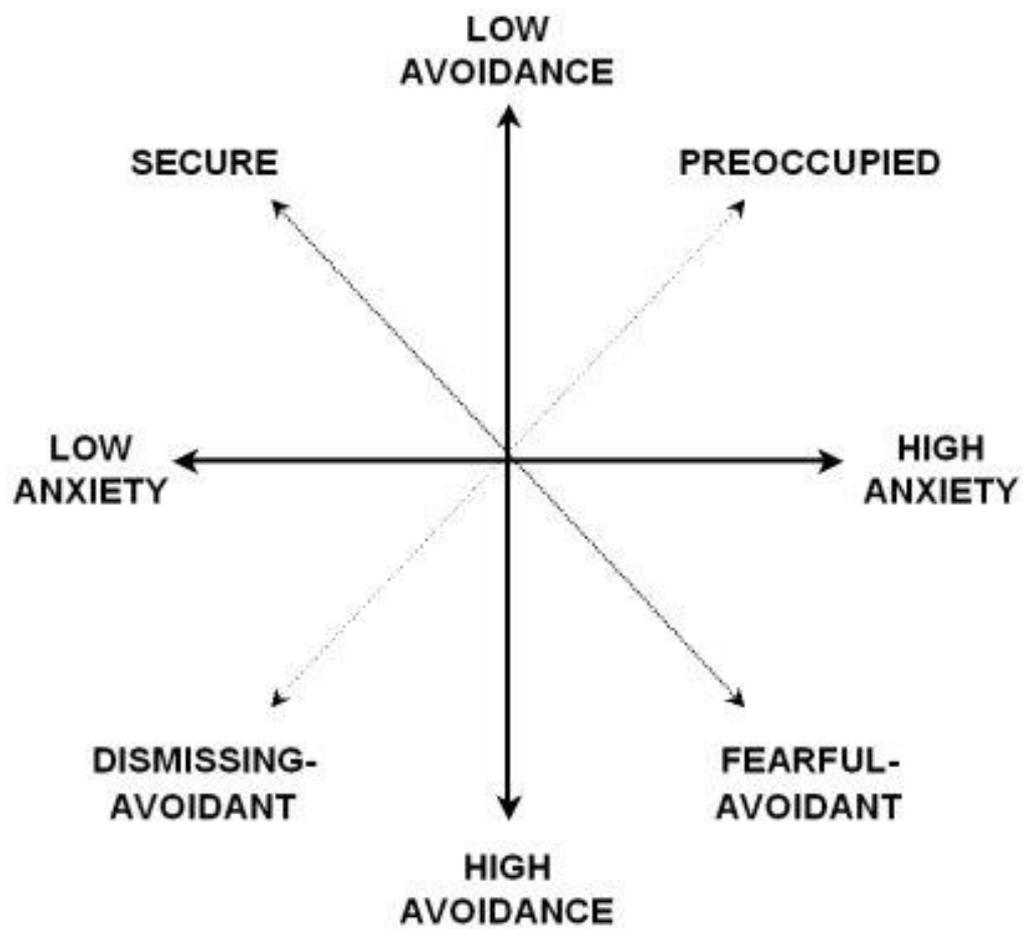
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Figure 1

## Dimensional Model of Attachment



**Figure 2**  
**Categorical Model of Attachment**

		<i>Internal Working Model of Self</i>	
		Positive	Negative
<i>Internal Working Model of Other</i>	Positive	<b>Secure</b>	<b>Dismissing</b>
	Negative	<b>Preoccupied</b>	<b>Fearful</b>

## **Section 4: Ethics Proposal**

Word count: 2,693

Mirella Hopper

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Mirella Hopper

Doctorate in Clinical Psychology

Furness College

Lancaster University

Lancaster

LA1 4YT

[m.hopper1@lancaster.ac.uk](mailto:m.hopper1@lancaster.ac.uk)

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

**1. Title of Project:** Investigating the relationships between staff individual differences and challenges to compassion towards patients detained under the Mental Health Act

**2. Name of applicant/researcher:** Mirella Hopper

**3. Type of study**

Includes *direct* involvement by human subjects.

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. Please complete the University Stage 1 Self Assessment part B. This is available on the Research Support Office website: LU Ethics. Submit this, along with all project documentation, to Diane Hopkins.

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

PG Diploma     Masters dissertation     DClinPsy SRP     PhD Thesis   
PhD Pall. Care

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

DClinPsy Thesis

**Applicant Information**

**5. Appointment/position held by applicant and Division within FHM:** Trainee Clinical Psychologist

**6. Contact information for applicant:**

**E-mail:** m.hopper1@lancaster.ac.uk

**Telephone:** 07970258313

**Address:** 4 Hawthorn Grove, Rothwell, Leeds, West Yorkshire, LS26 0AJ

**7. Project supervisor(s), if different from applicant:** Ian Fletcher & Kirstie Thompson

**8. Appointment held by supervisor(s) and institution(s) where based (if applicable):**

Ian Fletcher, Senior Lecturer in Research Methods, Division of Health Research, Furness College, Lancaster University, Lancaster LA1 4YW

Kirstie Thompson, Clinical and Forensic Psychologist, Cygnet Hospital Wyke, Blankney Grange, Huddersfield Road, Wyke, Bradford, West Yorkshire, BD12 8LR

Both supervisors have approved the proposed project.

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

Principal investigator - Mirella Hopper

Research Supervisor - Ian Fletcher

Field Supervisor – Kirstie Thompson

## **The Project**

**NOTE:** In addition to completing this form you must submit a detailed research protocol and all supporting materials.

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

Recent studies have investigated the challenges people experience in demonstrating compassion for others. While research has yet to explore this within secure services, it is hypothesised that mental health professionals working with patients detained under the MHA may experience greater challenges to compassion towards patients. Studies suggest that professionals' attachment, attitudes and emotional intelligence influence compassionate behaviour. It is hoped that this study will provide a greater understanding of the factors which increase the challenges to compassion in order to reduce these challenges. Clinical psychologists are uniquely placed to address this through promoting self-awareness and personal reflection in other professionals. This quantitative study will explore the relationships between several variables relating to individual differences in staff on challenges to compassion. A sample of between 110-125 direct-care staff will be recruited to take part and will complete an online questionnaire and an online test of implicit attitudes.

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

Start date: September 2015 End date: May 2016

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

This study will aim to recruit between 110-125 participants who are direct-care (nursing) staff working with patients who are detained under the Mental Health Act as a main part of their role. They will be recruited from both NHS and private sector secure hospitals. There is no age cut-off or gender exclusion.

*Inclusion criteria:* All direct-care staff who are largely based on the ward (e.g. support workers, nurses, clinical managers) and who have worked directly, with patients detained under the MHA for more than one month will be included in the study. The age range for participation is 18 years and over and there is no age cut-off. All participants must be able to understand and respond to English language questionnaires, as no translations are available. As this is an online study, it will only be possible to access the Implicit Association Test (IAT) via the internet.

*Exclusion criteria:* Professionals included in the multi-disciplinary team (MDT) (e.g. psychologists, psychiatrists, social workers, occupational therapists, physiotherapists) and non-clinical managers (e.g. hospital managers) will not be included in the study. It is anticipated that direct-care staff will have differing experiences, attitudes and behaviours than other professionals as a result of being based on the ward when working with detained patients. Direct-care staff who have worked with patients detained under the MHA for less than one month will be excluded from participation. This will ensure that all participants have acquired sufficient experience of working with this population in order to complete measures regarding their attitudes towards detained patients. As the questionnaires and computerised test are formatted in English, any participant who is unable to understand and respond using the English language will not be included in the research.

**13. How will participants be recruited and from where? Be as specific as possible.**

The principal investigator will attend a forensic special interest group (FSIG) with the field supervisor in order to make links with other professionals working within secure services for detained patients and to publicise the study. The service links (FSIG attendees) will advertise the study to all potential participants. The principal investigator will also email information regarding the study and an online link to each local collaborator, which will then be forwarded to all direct-care staff. If participants are happy to take part in the research they will follow the online link which will take them to a participant information sheet. If participants are happy to proceed at this point, they will have consented to enter the study and the next screen will be the questionnaires. On completion of the questionnaires participants will be asked to follow an online link to the test. All participants who meet the inclusion criteria will be included in the study.

**14. What procedure is proposed for obtaining consent?**

On following the online link provided to participants within the email, they will be presented with the participant information sheet. This clearly states that if participants are happy to proceed to the next screen, they will have consented to enter the study. They will also be reminded that they may still withdraw from the study at any time, up until the point in which they have submitted their responses to the online questionnaire and online implicit attitudes test.

**15. 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.**

During the study participants will be asked to share personal information regarding their past and current relationships. Therefore, participants will be informed of this within the information sheet prior to taking part in the study. Participants will be provided with the contact details of the principal investigator and research and field supervisors to respond to any queries regarding the study. The information sheet will also contain useful resources for all participants to access should they feel concerned during or following participation in the study, although this is not anticipated. Debrief information will be provided on completion of the online measures.

**16. 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 researchers identified within this study. However, a research contract has been completed and agreed by the field and research supervisors and principal investigator. This will be used to guide the level of input and support received by the principal investigator throughout the study. This can be reviewed should any risks to the researchers occur. The principal investigator (who will be responsible for collecting the data) will also receive regular supervision from the field and research supervisors via telephone and face-to-face meetings. The field supervision will also provide input should any concerns be highlighted by the participants regarding the secure services.

**17. 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 may not be any direct benefits for participants who take part in this study. However, participants will receive automated feedback on their individual results from the measures to facilitate self-reflection and personal/professional development, and can also receive a summary of the overall findings if they choose to leave a contact email.

**18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:**

Participants will not receive any payments for taking part in the study.

**19. Briefly describe your data collection and analysis methods, and the rationale for their use. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.**

The principal investigator will email information regarding the study and an online link to each local collaborator, which will then be forwarded to all direct-care staff. If participants are happy to take part in the research they will follow the online link which will take them to a participant information sheet. If they are happy to proceed to the next screen at this point, they will have consented to enter the study. All participants will be asked to complete a short questionnaire regarding their demographic details (including age, gender and length of time working in secure settings). Challenges to compassion will then be measured using the Challenges to Compassion Questionnaire(CCQ), staff attachment will be measured using the Experiences in Close Relationships Scale-Short Form (ECR-S) and emotional intelligence will be measured by the Short Profile of Emotional Competence (S-PEC). As the CCQ is a non-standardised measure, the validity of the CCQ will be measured using the Professional Quality of Life Scale (ProQOL). On completion of the questionnaires, participants will be provided with feedback on their individual results.

Participants will then be asked to follow an online link which will take them to the IAT. This will measure direct-care staffs' implicit attitudes towards detained patients. On completion of the IAT participants will automatically receive feedback regarding their implicit preferences towards the target or comparison group. At this time they will also be presented with a standard debrief statement from the IAT website explaining that this test provides an indication of tendencies only, together with a more general debrief regarding their participation in the study. It is anticipated that completion of all outcome measures will take approximately 15 minutes in total. Data from both the online questionnaires and the IAT will be anonymised through the use of a four number and/or letter sequence of the participant's choice. Throughout the research the field supervisor and all other service links will not have access to participants' raw data to uphold confidentiality, only the researchers involved in the study will have access to the anonymised data.

The data will be statistically analysed using correlation and multiple regression analysis to investigate the hypotheses and relationships between individual differences and the dependent variable (CCQ). Multiple regression analysis is reported to provide a more comprehensive understanding of a particular issue or construct within behavioural sciences due to the multiple explanations or causal factors involved.

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

The field supervisor provided service expertise in order to develop the CCQ; this measure contains items which address the specific challenges encountered by direct-care staff working within a secure setting with detained patients.

**21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.**

All data files from the study will be anonymous from the outset. The raw data from the measures will be stored securely by the principal investigator on the University network in a password protected file on their personal H: drive. The data analysis will be conducted via the virtual private network facility (VPN) to access files on the principal investigator's H: drive. At no time will any data files be downloaded onto a personal or University PC hard drive. On completion of the study, the anonymous data will be securely transferred by the principal investigator to the Research Coordinator for the Lancaster University Clinical Psychology Doctorate Programme. This data will be destroyed by the Research Coordinator ten years following submission of the research.

22. Will audio or video recording take place?     no                       audio                       video

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

N/A

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

The findings from this research will have clinical and organisational implications for enhancing compassionate care in staff working with detained patients in secure settings, but also for those who work with patients who present with similar risk or offending behaviours within the community. A summary of the results of this study will be disseminated to participating services and to interested participants if they express a wish to receive summary findings and they supply a contact email. This study will also be submitted to the British Psychology Society's international journal 'Psychology and Psychotherapy: Theory, Research and Practice' for dissemination of the findings to other mental health professionals and services, both nationally and internationally. The research will also be disseminated as part of the principal investigator's thesis and will be presented to trainees and staff on the Lancaster University Clinical Psychology Doctorate to develop the knowledge base of current and future clinicians and researchers in the field of compassion.

**24. 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?**

Due to the purpose of the IAT, which assesses implicit attitudes that participants may not be consciously aware of, it is possible that the results may reveal that some direct-care staff have an implicit preference for the target or comparison group. In order to address this, the IAT standard debrief information will be presented to participants on completion of the study, explaining that the IAT provides an indication of attitude tendencies only. The IAT has been completed by thousands of research participants online

(<http://www.projectimplicit.net/index.html>) and has been published within peer-reviewed studies (Brenner, Rose, von Hippel & Wilson, 2013; von Hippel, Brenner & von Hippel, 2008). Participants will also be provided with a description of the purpose of the study within the information sheet, in order to promote informed consent to participate in the research.

The purpose of the research is not to expose negative implicit attitudes towards detained patients, but to explore the variables which potentially affect challenges to compassion in order to facilitate the development of self-knowledge and awareness, psychological mindedness and personal reflection to increase compassionate behaviour in direct-care staff.

Signatures:

Applicant:

.....

Date:

.....

\*Project Supervisor (if applicable):

.....

Date:

.....

\*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

### Research Project Timetable

- *April 2015* - Finalise research contract between research and field supervisors, develop research protocol and ethics application (draft-read)
- *May* - Develop materials (e.g. CCQ, IAT), submit final ethics application
- *June* - Decide on journal, collate relevant literature
- *July-August* - Attend Forensic Special Interest Group to develop contacts within other secure services, contact relevant R&D departments and complete forms, finalise measures/method, write introduction and method
- *September-October* - Draft-read of introduction and method, data collection
- *November-December* - Data analysis, write results
- *January 2016* - Write abstract and discussion, draft-read of full paper
- *February* - Make amendments
- *March* - Final draft-read of full paper
- *April* - Make final amendments
- *May* - Submit final report
- *June* - Attend viva, thesis presentation
- *August 2016* - Submit paper for publication



## Example NHS Research and Development Ethical Approval Letter

5<sup>th</sup> February 2016

Mrs Mirella Hopper  
Lancaster University  
Furness College  
Lancaster  
LA1 4YT

Dear Mrs Hopper

**Re: Investigating the Relationships between Staff Individual Differences and Challenges to Compassion towards Patients Detained under the Mental Health Act**

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol	1	11.09.2015
Email Invitation to Administration Teams	1	11.09.2015
Debrief Information	1	11.09.2015
Experiences in Close Relationships Scale (ECR)	1	11.09.2015
Challenges to Compassion (CCQ)	1	11.09.2015
Participant Demographics	1	11.09.2015
Professional Quality of Life Scale (ProQOL)	1	11.09.2015
Short Profile of Emotional Competence (S-PEC)	1	11.09.2015
Participant Information Sheet	1	11.09.2015
Consent Form	1	11.09.2015
Evidence of insurance - Zurich Municipal		31.08.2015
CVs of Researcher and Academic Supervisor		

This approval is granted subject to the following conditions:

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time.

May I take this opportunity to wish you well with the project.

Yours sincerely

## **Section 5: Appendices**

Word count: 167

Mirella Hopper

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Mirella Hopper

Doctorate in Clinical Psychology

Furness College

Lancaster University

Lancaster

LA1 4YT

[m.hopper1@lancaster.ac.uk](mailto:m.hopper1@lancaster.ac.uk)

**Appendix I**  
**S-PEC Dimension Intercorrelations**

Measure	S-PEC Self					S-PEC Other				
	Identif.	Underst.	Expression	Regulation	Use	Identif.	Underst.	Listening	Regulation	Use
<b>ECR-S (anx)</b>	.092	.148	-.024	.166	-.031	.074	<b>*-.194</b>	.084	-.062	-.015
<b>ECR-S (avoid)</b>	.120	.165	.047	-.043	-.026	-.013	-.081	.015	-.136	-.016
<b>CCQ total</b>	.022	-.044	-.141	-.017	.014	-.028	-.035	<b>*-.217</b>	.049	-.018
<b>ProQOL (CF)</b>	.051	.048	.062	-.013	-.056	.052	-.053	.070	.121	.173
<b>ProQOL (burnout)</b>	.076	.030	.103	-.018	.137	.078	.192	-.028	.051	<b>*.195</b>
<b>ProQOL (CS)</b>	-.105	-.023	.104	.027	-.008	.054	.101	.171	.026	.066
<b>Age (years)</b>	-.048	-.036	.131	.013	<b>*.202</b>	.081	.050	.026	-.057	-.170
<b>Length of experience</b>	-.068	.012	<b>*.221</b>	.011	.076	.147	.071	.074	-.027	-.051

\* $p < .05$

**Appendix II**  
**Multiple Regression Analysis**

<b>Variable</b>	<b>B</b>	<b>SE</b>	<b>β</b>
Occupation	-.813	.938	-.079
ECR-S (anxiety)	.029	.127	.027
ECR-S (avoidance)	.209	.181	.126
<b>*S-PEC (self)</b>	-.277	.125	-.195
S-PEC (other – ‘listening’)	-.878	.473	-.165
CF	.144	.128	.109
<b>**CS</b>	-.363	.106	-.328

\* $p < .05$ ; \*\* $p < .01$