Full title: Engaging with Distress: Training in the Compassionate Approach

Running title: Training in the Compassionate Approach

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Authorship

McEwan designed the study, collected the focus group data, analysed the qualitative data, wrote the first draft of the manuscript and edited the final version of the paper; Minou independently analysed the qualitative data and assisted with agreement of themes and contributed to the writing of the first draft and final version of the paper; Moore contributed to the first draft of the paper; Gilbert delivered the Compassion training and contributed to the design of the study.

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Abstract

Introduction: Compassionate care involves providing a welcoming environment, promoting bidirectional compassion, providing training in compassion and creating supportive organisations. To date there has not been a study evaluating Compassion interventions for the high-threat profession of mental health nursing. Neither has there been a study providing an in-depth qualitative evaluation of training and implementation. The current study aims to address these gaps in the literature. Aim: The aims were to evaluate Compassionate Mind Training-CMT for mental health nurses and to assess implementation. Method: Focus groups were conducted (N=28) one year later to evaluate CMT and implementation. Results: Content analysis revealed four training themes: i) Useful framework; ii) Thought-provoking and exciting; iii) Appreciation of person-centred approach; iv) Need for ongoing training and supervision. Three implementation themes emerged: i) Applied approach with patients and staff themselves; ii) Environmental challenges to implementation; iii) Attitudinal challenges to implementation. Discussion: Consistent with previous studies, professionals experienced reduced self-criticism and an increased self-compassion, which extended to increased compassion and reduced criticism of colleagues and patients; and professionals applying training directly to reduce patient self-criticism. Implications: For successful implementation formal adoption of Compassion-approaches are needed with strategic integration at all levels.

Accessible Summary

What is known on the subject:

- Mental health nurses provide care within an environment that is often threatening.

- The environment is often threatening because: 1) patients' needs are complex and highly emotional, 2) nurses often do not have the time and resources they would wish for, 3) caring for patients can be emotionally exhausting and distressing.
- Compassionate care involves providing a welcoming environment, promoting bidirectional compassion, providing training in compassion and creating supportive organisations.
- To date there is no study evaluating compassion interventions for the high-threat profession of mental health nursing and no study qualitatively evaluating compassion training and implementation

What the paper adds to existing knowledge:

- This study looked at what happens if compassion training delivered by the originator of Gilbert's model of compassion is given to mental health nurses.
- Nurses were interviewed one year later to see how relevant and useful the training was, and whether they had been able to use it in their daily work.
- Consistent with previous studies, the study found a reduction in professionals self-criticism and an increase in self-compassion, which in this study extended to increased compassion and reduced criticism of colleagues and patients; and professionals applying the training directly to reduce patient self-criticism.

What are the implications for practice:

- Nurses felt that more training and supervision was needed to build the confidence to use the training regularly at work.
- They felt it had been difficult to use the training because of the threatening environment in which they worked.
- Nurses recommended that the whole organisation would need the training to make it part of their everyday work.

Description

This paper outlines original primary research assessing the usefulness and relevance of delivering a wellbeing intervention (Compassionate Mind Training) to mental health

professionals and details perceived barriers and facilitators to implementing compassionate approaches in a mental health setting.

Relevance Statement

Compassionate care is an established concept in healthcare with calls to apply compassion in practice but few discussions outline clearly what compassion and compassion training should look like and how to implement it. In mental health contexts, the discussion of compassion has not had the same prominence, but this is beginning to change with calls for the creation of therapeutic environments in which compassionate care can be fostered. This paper offers a unique study where compassion training was delivered to mental health nurses by the originator of the approach and assessed the barriers and facilitators to implementation. The study offers insights from mental health nurses into a trainable model of compassion in healthcare and how it can be successfully implemented into practice.

Key words: Burnout; Compassion; Healthcare; Training; Wellbeing

Introduction

Healthcare provision is recognised as a particularly stressful profession (Hall et al., 2016) which demands care and compassion in a high-threat environment. Mental health professionals in particular, face highly emotional situations, such as supporting people who are suicidal, hearing about traumatic events, and being subject to patient violence and threats (Rössler, 2012). Hence, burnout and poor wellbeing in mental healthcare professionals is common. A review by Johnson et al. (2017) found that professionals in mental healthcare settings reported poorer wellbeing than staff in other healthcare settings. In turn, this is associated with reduced quality of patient care, staff sickness, higher turnover rates (Johnson et al., 2017) and barriers to compassionate care (Dev et al., 2018).

Compassion fatigue (distress and secondary trauma resulting from providing care to others who are suffering or distressed) and burnout (being overwhelmed and exhausted by constant demands) are not the only factors that diminish the capacity to provide compassionate care (Fernando & Consedine, 2014; Rossi et al., 2012). In a review, Sinclair et al. (2016) found professionals' capacity to provide compassionate care was limited by: i) educational deficiencies, such as suboptimal training environments with few mentoring, group or self-reflective opportunities (Curtis, 2013); ii) practice-setting hindrances, such as paperwork, lack of time, support, staffing and resources (Crawford et al., 2014); iii) and a workplace culture with entrenched views and negative attitudes (Horsburgh & Ross, 2013).

Yet, compassion is ranked by patients and their families as being among their greatest healthcare needs (Heyland et al., 2010). A study of patients' perceptions of compassion in healthcare showed that patients consider it closely aligned to conveying care within nursing practice (Bramley & Matiti, 2014). Patients also felt strongly that compassionate care entails an understanding of their particular situation and how it feels to be them (Bramley & Matiti, 2014).

Although valued, there has been a debate about whether compassion is a dispositional quality or something that can be nurtured through training (Lown et al., 2015). Chadwick argued that compassion is an untrainable quality, occurring in a spontaneous manner (Chadwick 2015). However, evidence suggests that compassion can be nurtured (Vivino et al., 2009) or diminished (Hojat et al., 2009). This is consistent with research noting a decrease in medical trainees' empathy and caring behaviours towards the end of their education, thought to be due to the thwarting of ideals (Murphy et al., 2009; Neumann et al., 2011). The debate around the

trainability of compassion in healthcare is long ongoing (Pence, 1983). However, recently the interest in the role of compassion in healthcare re-emerged mainly due to the public perception and concern over the lack of it (Mannion, 2014; Shea & Lionis 2017). There is evidence of a lack of compassion in healthcare becoming an international concern, with reports in the UK (Francis, 2013), Greece (Shea & Lionis 2017) and the USA (Nauert, 2011).

To address the lack of compassion in healthcare, there has been a call for training in compassion, mindfulness and emotional intelligence (Şenyuva et al., 2014). A recent literature review showed that person-centred interventions– such as counselling, relaxation exercises, mindfulness or cognitive-behavioural training and compassion-based training – led to significant reductions in burnout and stress (Fortney et al., 2013; van Mol et al., 2015) an increase in self-compassion (Beaumont et al., 2016; Finlay-Jones et al., 2016; Raab et al., 2015) and reductions in self-criticism (Beaumont et al., 2016), depression and stress (Finlay-Jones et al., 2016). Mindfulness has been a popular intervention to improve staff wellbeing and increase self-compassion (e.g. Duarte et al., 2016; Erogul et al., 2014; Raab et al., 2015). However, mindfulness interventions do not directly teach compassion. Rather the self-awareness, non-judgement and emotional acceptance taught through mindfulness has a secondary effect on self-compassion (Neff & Dahm, 2015). By contrast, in the present study mental health professionals were directly taught compassion as defined within the Compassionate Mind Training (CMT) framework originated by Gilbert (2005) and delivered by him.

CMT is a person-centred approach that aims to empower the individual and, in this sense, it bears some similarity to other recovery-based approaches such as the Tidal model (Barker et al. 2001). However, CMT is unique in that it is based on a biopsychosocial empirical model, rooted in attachment theory, evolutionary theory and social mentality theory. Significantly, this model of compassion targets transdiagnostic characteristics of mental health difficulties such as shame and self-criticism and is thus helpful to both clinical (as Compassion Focused Therapy) and non-clinical populations (as Compassionate Mind Training). CMT is an emotion-regulation intervention and for this reason hypothesized to be particularly useful within high-stress work environments such as mental healthcare settings. Indicatively, a recent study (Oostvogels et al. 2018) showed that emotion-focused coping and emotion-regulation influenced the interaction between staff and patients with a personality disorder diagnosis, helping them to offer compassionate care and to avoid burnout. In a discussion of the design of compassionate care, Crawford et al (2014) suggest that providing a welcoming

environment, promoting bidirectional compassion, providing training in compassion to healthcare professionals and involving service users, practitioners and leaders in creating supportive organisational structures might engender more compassionate and ethical working environments.

To date, only two studies have reported on similar compassion-based interventions: a 6 week online self-compassion cultivation training for psychology trainees (Finlay-Jones et al., 2016) finding improvements in self-compassion, happiness, emotion-regulation, depression and stress; and a 3 day Introduction to CFT workshop with healthcare providers and educators (Beaumont et al., 2016) finding improvements in self-compassion and self-criticism. However, these studies did not include any qualitative data or enquire about the training experience and what might be improved to aid implementation of training into practice. These studies also did not revisit staff to enquire about their experience of implementing training. Hence, this study is unique in these respects: i) that the compassion training was delivered by the originator of the training (Gilbert, 2005) and therefore has strong fidelity and adheres to a biopsychosocial theoretical model which is supported by an evidence-base through research; ii) the training was evaluated in-depth through focus groups; and iii) staff were revisited at one-year follow-up to assess whether professionals were able to implement the training and iv) the study was conducted with a unique sample within the high-threat profession of front-line mental health professionals working on in-patient wards and in crisis intervention.

Study Aim

The aims were to evaluate a brief intervention (Compassionate Mind Training-CMT) for mental health professionals and to assess to what degree staff were able to implement this training using qualitative methods (focus group).

Compassion in CMT

Gilbert (2013) defines compassion as "sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it". He identifies key competencies of compassion such as the motivation to engage with distress, to care and be moved by it and to be able to tolerate it (Gilbert, 2005, 2010). The CMT model makes clear that humans are

profoundly social beings and roots compassion in the evolution of mammalian caring and attachment (Gilbert, 2014). According to the model, compassion evolved because human beings depend on others for survival, support, safety and the conditions that enable them to thrive. Compassion was originally targeted at kin and allies rather than strangers. This is an exception in the healthcare professions (Gilbert, 2019). Since compassion operates through and depends on social bonds and relationships, it is also context-dependent. This means that different systems of organisation can either facilitate or inhibit it. Thus, compassion in mental health, as conceptualized by CMT, means the creation of those contexts within which compassion competencies can flourish and also the empowerment of people living with mental distress through knowledge about the function of emotion.

Specifically, CMT psychoeducation uses accessible language around our evolutionary roots: our 'old brain' and 'new brain' capacities, attachment relationships, and our threat, drive and soothing systems. Specifically, it explains that our 'old brain' shares motivations common to most mammals such as avoiding harm, seeking resources and allies, and caring for kin. 'New brain' refers to competencies that have evolved more recently such as complex reasoning capacities, creative thinking, capacity for anticipating the future and reflecting upon the past (Gilbert, 2017; Dunbar, 2016; Sudderhorf, 2018). This particular biological make-up can lead to distress. For example, our capacity to imagine the likely future outcomes of our actions can also lead to rumination and worry.

Furthermore, psychoeducation clarifies how complex our emotions are and that they can be difficult to regulate. Taking a function-analytical approach to emotion, CMT notes that all emotions have a function and usefulness. It thus de-stigmatizes 'negative' emotions by explaining their role in keeping us safe by detecting threat and preparing us for action. The function of our emotions is elucidated via the three-circle model (Gilbert et al., 2008). The model maps our emotions onto three systems: the threat system is about protection and safety and the main emotions attached to it are anger, anxiety and sadness; the drive system is incentive and resource-focused; and the soothing system is about settling, non-wanting, and safeness. Mental distress can arise from the mis-balance of those systems, for instance from an overactive threat system.

Methods

We followed a qualitative design, as we aimed to capture the subjective experience of professional individuals training in CMT. Specifically, focus group interviews were used due

to their capacity to yield rich experiential data and to bring the researcher in direct contact with key individuals (Clarke, 1999). Focus groups meant that participants could explore this matter not individually but as a unit (Kitzinger, 1995). In this way, any suggestions for implementation resulting from this project communicate the ideas and opinions emerging from a group of professionals reflecting on their common experience and shared understanding.

To address the potential drawbacks of focus groups (Barbour & Kitzinger 1999; Webb & Kevern 2001) such as losing control over the interaction, a structured interview schedule was followed closely. Moreover, as per the Côté-Arsenault and Morrison-Beedy (2005) recommendation, the purpose of the interaction was well defined, groups were led by a trained facilitator, and the environment was familiar to the participants.

Ethical Considerations

Approval was obtained to run the focus groups by R&D Derbyshire NHS Foundation Trust on the following basis 'Excluded from REC review as with professionals.' All participants gave informed consent to participate in the groups (none withdrew their consent), and to their anonymized data being used in publication. All quotes presented here are given under the pseudonyms created by the participants during the focus groups.

Participants

We used a purposive sample of mental health professionals working at an NHS Trust local to the trainer and researchers. The team managers approached the trainer, and the researcher sought the team managers' permission to approach professionals involved in the training via email. Three NHS teams (2 in-patient teams & 1 Crisis Intervention team) of front-line mental health nurses (n=28) took part in standardised two-day CMT training. In total 17 mental health professionals comprising 15 mental health nurses and one team manager (12 females, 5 males) attended a focus 1 year later, with 7 participants from a community team, 5 from an inpatient team and 5 from a further inpatient team. At the request of participants, the focus groups took place at their workplace and lasted between 30-40 minutes. On the days of the focus groups, 11 staff members who had wanted to attend had either needed to stay on shift, had been delayed in traffic returning from visiting patients in the community, or were away on annual leave or sick leave.

Training

Two-days of CMT were delivered by the originator of CMT (Gilbert, 2005), therefore fidelity to the model was high. Training entailed: defining compassion; psychoeducation, including the three circle model (a model outlining our threat, drive and soothing systems), old and new brain competencies (and how these conflict), and the concept of multiple selves (how our angry, sad and anxious selves all respond to stress); and practices, such as soothing rhythm breathing and three flows of compassion imagery (imagining having compassion for oneself, giving compassion to others and receiving compassion from others).

Data collection

One year after training, a female Research Psychologist (KM, PhD) – who had no prior relationship with participants, but was experienced in compassion research – approached the team managers to invite staff to participate in a focus group. KM conducted the three focus groups with participants which were audio recorded.

At the beginning of each focus group, the researcher introduced themselves, informed them of her research background in CMT and the goals of the study, and then asked participants to create a pseudonym to ensure anonymity in the data recorded. The researcher followed an interview schedule consisting of nine questions which were adhered to in all three occasions: 1) What was your overall impression of the compassion training?; 2) How understandable was the training?; 3) What aspects of the training have you used?; 4) What would help you to work in a more compassionate way?; 5) What could be improved to enable you to provide higher quality compassionate care, what would facilitate compassion?; 6) Have there been any changes in your service as a result of compassion training?; 7) How have you found implementing the training?; 8) What are the issues when trying to implement compassion training?; 9) Is there anything you feel we haven't talked about today that you would like to add?

Analysis

The focus groups were transcribed verbatim by a professional transcriber. The dataset was already anonymised as participants created and used their own pseudonyms. Pseudonyms were used throughout the transcripts to allow identification of quotes from individuals without the use of personal names. The transcripts were checked for other identifying details and, if found, were removed from the dataset. The resulting transcriptions were analysed using Qualitative Content Analysis (CA) in NVIVO software. CA involves in-depth exploration of specified content (usually written text) in search of meaning units that will, in

turn, provide the categories which will help describe the phenomenon under examination. The method is extensively used in psychiatric nursing research and is particularly suited to the examination of phenomena where little prior knowledge exists (Elo & Kyngäs 2008). As such it is suitable to our aim of enquiring about a novel experience, the introduction of mental health practitioners to the framework of CMT training, and how this was experienced by them. CA is designed to mainly identify manifest content and this was our main interest as we sought to reach a direct representation of participants responses to the research question (Crowe at al. 2015). The coding was conducted by two independent researchers (KM & LM) who subsequently met to determine extent of agreement. Themes were derived from the data using the three-step process proposed by Elo & Kyngäs (2008): Preparation (identifying meaning units and recording representative instances); Organising (coding process and identification of categories); and Reporting (presenting findings and interpreting them in the context of existing knowledge).

Results

Our research question defined a framework of analysis according to training and implementation. Four main categories were subsequently defined with regard to training. These were: i) Useful framework; ii) Thought-provoking and exciting; iii) Appreciation of person-centred approach; iv) Need for ongoing training and supervision. In terms of implementation there categories were identified: i) Applied approach with patients and staff themselves; ii) Environmental challenges to implementation; iii) Attitudinal challenges to implementation.

Training experience

Overall, the course was positively evaluated by staff, characterizing it as ‘useful’, ‘helpful’, and ‘beneficial’. In terms of delivery format, staff appreciated the use of multi-media, participatory elements and humour, which made the course engaging and enjoyable. Most staff understood CMT as more than professional development and saw it as self-development. The concept of being kind towards oneself was identified as an ‘enlightening’ aspect that could be transferable both to professional and personal contexts.

Useful framework

The insights into human behaviour through the framework of evolutionary psychology were seen as especially helpful. Staff found that explanations of how our 'old' and 'new' brain interact and affect our emotions led to a better understanding of threatening behaviour. Another significant point was how CMT helped people recognise the ways multiple emotions, that are connected to the multiple aspects of the self (e.g. angry self, anxious self), can dominate and overwhelm the individual.

[John] The evolutionary stuff about acknowledging that we're human and this is the way the mind develops with its own flaws…it gets people thinking.

[Dave] I do think it helps as a model to understand people, to understand people's distress and work with it.

Staff noted that despite its scientific foundation in evolutionary theory and the relatively short time of delivery, the content of the course was 'easily graspable', easy to relate to one's own experiences and applicable to practice. It was acknowledged that the language used to describe the approach was layperson-friendly and provided common examples that were easy to relate to.

[Janet] I've had some kinds of trainings, like CBT, where you have to learn the language that is used before you get to an understanding of the concepts and approach the intervention, whereas CMT talks in everyday language, and I think that allows you to get an understanding early on.

Thought-provoking and exciting

Some staff felt positive and excited to have a new framework within which they could work. They used words such as 'thought-provoking' and went away from the training enthused and keen to begin using the framework.

[Jane] It felt very new and exciting, it was a lovely kind of feeling to add some tools to my toolbox.

Appreciation of person-centred approach

Staff appreciated the person-centred nature of the approach and the value it places on people. Staff felt that this could have a significant impact on working culture.

> **[Emily]** …that kind of understanding and that kind of basic grasp and what the approach is, I think people value that, because it is about people it's about being valued it's about being kind and all that stuff to yourself and others.

This aspect was linked to the high adaptability of CMT, with one participant commenting that it is not tied to specific professional backgrounds or patient groups.

> **[Jane]** CMT is about people and person, rather than disorder, so it doesn't necessarily matter what background ether the professional or the service group they work with is from.

Need for ongoing training/supervision

There was some concern over the specialized content of the course with some of the staff finding it 'theory heavy'; that the course was a lot to take in and could be spread over a longer period. Some suggested that the training be mandatory to allow consistency across the organisation and that a good place for implementation might be at shift handover.

> **[Darren]** It's something that needs to be implied to keep it going, keep it rolling and kept in focus. But it can quite easily be put on a backburner and it shouldn't be because it's useful.

Implementation experience

Staff felt that the training had to some extent become embedded in their team's practice, in terms of it being mentioned and utilised on a daily basis. They agreed there had been personal changes, that they were more open-minded and less critical of themselves and their patients. In one team it was noted that their manager's enthusiastic support for the approach was highly influential in allowing staff the time to implement it. However, they also felt that a lack of follow-up training or supervision meant that they could only take the approach so far with patients and that they lacked the knowledge or confidence to take it further.

Applied approach with patients and self

Many examples were given about how staff had used the approach with patients and patients' relatives. Staff appeared surprised at how beneficial sharing the approach with patients was, how it helped provide context and normalisation to patients' distress, and the shifts they had seen in patients thinking and behaviour. These interactions involved talking with patients about the framework, but also giving them leaflets to read and guiding them in a CMT exercise to write self-compassionate letters.

> **[Jane]** I felt quite comfortable to go and talk through the evolution with other people, helping people to put some context into the difficulties they were experiencing was helpful and helped me understand too.
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> **[Tom]** For people who are struggling with self-criticism, I really like using this…trying to emphasise that their self-talk is not very compassionate and would they talk to someone else in that way and most people find that enlightening, it's very powerful.
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> **[Tom]** I try to help them understand why they might feel emotionally overwhelmed; and how to someone who isn't in that crisis situation, maybe the relatives, don't understand why the person is thinking and feeling the way they are at the time, but to use that as a basic explanation I find very helpful.

Staff also talked about how they had used the approach on themselves at work and at home and that CMT allowed for the chance to 'slow down' and build on relationships with patients, in what are usually fast-paced working environments. This slowing down allowed for building awareness of the demands on one's time and allowed for refocusing of attention.

> **[Jason]** As a nurse, we're trained to rush in, and get stuck in and just do stuff, that's how we evolved… CMT felt very much like putting the brakes on and taking time to breathe.

Staff talked about reframing scenarios in which they would normally engage in self-criticism.

[Ben] When things go wrong, it's sort of sitting back instead of blaming yourself, you're thinking 'well I can't change that but I did the best I could'. Things that normally get me down I've thought, 'stop, be kind to yourself'.

Environmental challenges

Staff identified lack of time as one of the most significant challenges to implementation. Additional pressures derived from the insufficient staff -to -patient ratio which increased their workload. There was a lack of contact time and continuity with patients. Staff noted that the physical environment of the wards is unfavourable for CMT. 'Noise', 'heat', and, 'harsh lighting' were emerging key words as was the characterization of the environment as 'chaotic'.

> **[Ben]** Sometimes I've seen patients and thought I could have done or said more but because I'm thinking I've got to go there, here, there, you've not got yourself prepared and your head's racing.

> **[Jason]** One of the biggest challenges is finding time and space in a day to realise the moment…the pace triggers all your own threat systems, your anxiety, your anger and combating those and then finding the time and space to demonstrate compassion…there's always the phone ringing the pressure to be somewhere else to do something else.

Staff noted the need for this training to become common among all the staff to support implementation. They noted that non-homogeneous training could create a sense of isolation in non-trained staff and hinder implementation.

> **[Tom]** CMT is mentioned on a daily basis, and so the other part of the team who hadn't done the training felt isolated in those conversations.

> **[Rachel]** Some of our team haven't done the training and that can create a bad feeling. People make comments like "I'm not worthy of that" and that makes you feel guilty for investing time in it.

> [**Dave**] Although I might have sounded quite negative there, but it's impossible for us to adopt this approach because of the environment etc. The training and the fact that it makes you aware of those distractions and the other million things that are going on, that detract and take you away from where you want to be with that person and with yourself, that training and that acknowledgment brings that to the attention, if you're aware of it you can do something about it. So from that point of view, it is quite a positive thing.

Indeed, the most difficult obstacle appeared to be organisational culture. Examples included: lack of support for staff training; the 'target-driven' culture that was perceived as non-conducive to a compassionate working; the individualistic culture of their organisation; and the lack of emphasis on staff wellbeing. They also noted a lack of strategy for implementation and a lack of motivated individuals to lead on dissemination and implementation.

> **[Emily]** Yep, this compassion is kind of like great, but until we get ourselves as an organisation, to promote those values as a culture…on a mass and as a whole, then we are not really embedding it really.

> **[Emily**] I think the Trust sends out mixed signals to a certain degree – yep, this is compassion, about looking after ourselves, looking after each other, being kind – but at the same time, you have other side of the organisation, which we need, in terms of disciplinary action, targets, performance, all those kind of things, but I think there's a feeling that things don't marry up that well really, and until we start showing compassion for the staff …

Attitudinal challenges

Attitudinal barriers were identified in terms of a resistance to engage with some aspects of the training. Staff noted that some people might take more 'naturally' to it while others can find it more difficult.

> **[Claire]** I am not saying that people don't do it but some people find it embarrassing. It's not what they've been used to. Some people probably don't want to do it

> **[Ben]** I think a couple of people that were in our group, had never really been to that kind of thing before. It felt that perhaps a little bit self-conscious – got quite giggly and that was quite distracting really.

Finally, it is worth noting that some staff felt that the approach was only just beginning to become embedded within their teams and that more time and investment was needed for the approach to move from awareness and occasional practice, to being fully embedded.

> **[Ben]** It's like an oil tanker that you're trying to turn really. We've only just turned to port really.

Discussion

The current study provided a unique in-depth qualitative assessment of how CMT (as delivered by its originator-author PG) was experienced by mental health professionals in in-patient and crisis intervention care settings, and assessed the implementation into daily practice at one-follow-up. The practices used in CMT aim to restore balance by stimulating the soothing system, using mental imagery which assists in calming the threat system. This emotion-regulation was hypothesised to be particularly helpful in a high-demand, high-threat healthcare setting, where professionals are required to manage their patients' and their own, threat systems.

The study showed that CMT was positively experienced in terms of its contents and the fact that it provides a useful framework and knowledge on the way emotion systems function. This led to a better understanding of the way emotions can overwhelm individuals and resulted in more open-minded and less critical ways of relating to oneself and patients. Crucially, staff found CMT to be transferable to their work and home environment, recognising the benefits for their self-development and personal wellbeing. Consistent with previous quantitative studies assessing self-compassion and self-criticism (Beaumont et al., 2016; Finlay-Jones et al., 2016), the current study found qualitative evidence that professionals experienced a reduction in self-criticism and an increase in self-compassion. In an extension of these specific outcomes from previous research, the current study also found increased compassion and reduced criticism of colleagues and patients, and professionals applying the training directly with patients to reduce the patient's self-criticism.

In terms of implementation, staff found it easy and beneficial to discuss the framework with patients and noted a shift in patients' thinking and behaviour. However, there were also barriers to implementation. These mostly concerned environmental factors such as the lack of time to implement CMT and lack of formal, organisational support. This is consistent with previous literature reporting that often the working environment poses challenges to compassionate care (Crawford et al., 2014; Mannion, 2014). Modern healthcare environments can create obstacles to compassionate care such as, staffing levels, targets and efficiencies (e.g. shorter lengths of hospital stays and shift change-over), and demands for paperwork and audit (Mannion et al., 2005).

Most attitudinal barriers – such as lack of confidence in practicing CMT, or the practices feeling unnatural and embarrassing to some individuals – were seen as potentially overcome by applying CMT consistently and uniformly across the organisation. It is not unusual for

individuals undergoing compassionate-based interventions to initially experience fears, blocks, and resistances to compassion (Cole-King & Gilbert, 2014). This can be in part due to fears of letting go of self-criticism as this is seen as a driving force to avoiding inferiority/or obtaining success and status; or fears that compassion opens up vulnerability and encourages others to take advantage. This was noted by one participant who did not want to be seen as inappropriate/too familiar for using the approach with community patients. Despite these challenges, at follow-up staff had made progress in implementing the approach, both with themselves and their patients.

Overall, this study iterates three important points with regard to delivering and implementing training for mental health professionals in compassionate care. Firstly, it highlights the significance of organisational context. Compassionate care does not 'occur in a vacuum' (Mannion 2014: 116). Organisational context always affects how compassionate care is defined and delivered. Participants here assert this strongly in noting that the approach must be uniformly and formally adopted at the organisational level for them to be able to implement the training effectively. Secondly, as Mannion (2014) concluded, in enabling compassionate care 'no single approach is likely to be a panacea' and that different approaches may work in different healthcare contexts. Our study showed the usefulness and relevance of CMT to mental health professionals in acute settings (in-patient wards and crisis teams) This suggests that CMT may be particularly suited to designs of compassionate care in mental health contexts due to providing increased understanding of the underlying causes of patients' distress and challenging behaviour. As noted above, greater understanding of patients' distress and greater awareness of their own threat systems, allowed the staff in our study to be more open-minded and less critical of themselves and their patients. This is especially significant in light of patients' perception of compassion as entailing 'understanding' of their particular situation (Bramley & Matiti, 2014). Thirdly, the study highlights the capacity for training mental health professionals in compassion, as part of the aspiration for compassionate care, and significantly as an emotion-regulation method for themselves.

Limitations

Generalizing from qualitative research rests on the re-emergence of similar themes under similar conditions (Polit & Beck, 2010). A replication study in different mental health settings is recommended for the future. At present, results from this evaluation study are not

generalizable. Although 28 professionals received training, only 17 were available to attend the focus groups on the day.

A hypothesised outcome from compassion training is that it should result in improved patient care. In a review of 36 studies focusing on compassion in healthcare staff (Sinclair et al., 2017), none of these studies measured patient experience. The current evaluation study is also limited in this regard. In future research it will be important to assess patient experience, potentially through routine data.

Implications for Practice

This study contributes to the debate on the spontaneity versus trainability of compassion in healthcare, providing evidence that compassion – when defined within a specified model, such as CMT – can be understood as a set of competencies and can be trained. Our analysis suggests that it is a systematic adoption of compassionate care as a service aspiration and a strategic goal that would enable the benefits of compassion to materialize.

This evaluation study only serves to highlight the potential of CMT as a useful framework for mental health professionals. For future studies to validate the effects and benefits of compassion training on staff and patient care, formal adoption of it at a systematic level should take place. This was reflected by staff stating that continued supervision and/or follow-up training would be helpful in developing their knowledge and confidence of using the model. They also felt that training would need to be delivered to the whole team and adopted as part of the organisational culture for CMT to be truly embedded within the organisation. One possible way of strategically integrating compassion at all levels of an organisation, where it might have the potential to influence staff retention, cost and patient care level. It will also be important to monitor its usefulness by reporting on patient care outcomes where CMT or similar interventions have been introduced.

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