The Acceptability of a Newly Developed Brief Compassion-Focused Intervention for Trainee Psychological Wellbeing Practitioners: A Qualitative Study.

Chloe Gibbons

D.Clin.Psy Thesis (Volume 1), 2021

University College London
I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Chloe Gibbons

Date: 1st July 2021
Overview

Compassion is central to the work of mental health professionals (MHPs), however research indicates that there is a systemic lack of compassionate care within mental health services. Both compassion fatigue and a lack of self-compassion have been implicated in reducing one’s compassionate capacity and therefore form the focus for this thesis, which is presented in three parts.

Part one is a systematic literature review exploring MHPs’ perceptions of the factors influencing their experiences of compassion fatigue. Twenty qualitative studies were reviewed and synthesised, with findings indicating that MHPs risk of experiencing compassion fatigue is influenced by a variety of personal and contextual factors. Factors influencing compassion satisfaction were also identified by the review. Limitations of the review are identified and discussed, as are clinical recommendations based upon the findings and potential areas for future research.

Part two presents a pilot study evaluating the acceptability of a newly developed brief compassion-focused intervention for trainee MHPs. Qualitative methods were used, including open-ended questions sent to participants via online surveys and further in-depth semi-structured interviews carried out with 10 participants. The intervention was largely perceived to be acceptable and helpful. However, some aspects of the intervention and the context in which it was delivered were discussed as creating barriers to engagement and implementation, thereby reducing its acceptability. Challenges encountered and limitations of the study are discussed, before clinical implications and areas for further research are suggested.

Part three is a reflective and critical discussion of carrying out the empirical study described in part two. Epistemological and personal reflexivity are explored, before discussing reflections on the research process, key learning points, and areas for further development and evaluation of the intervention.
This was a joint research project with another trainee clinical psychologist at University College London (Silan Antwi Gyane-Akinola [SAG-A]; see Appendix A).
Impact Statement

This thesis has addressed gaps in the literature and has several research and clinical implications.

The literature review described in part one identified a range of factors influencing mental health professionals (MHPs) experiences of compassion fatigue (CF). Clinical recommendations may be made, based upon insights gained from this review, to prevent and/or reduce CF in MHPs, thereby mitigating the potentially deleterious impact of CF on their ability to be empathic and compassionate with patients (Mathieu, 2007; Elwood et al., 2011) and the negative impact of this on both staff wellbeing and patient outcomes (Negash & Sahin, 2011; Bride et al., 2007).

In particular, the literature review highlights the protective role compassion satisfaction (CS; Figley & Stamm, 1996) may play in reducing the risk of MHPs experiencing CF and identifies ways in which mental health services could cultivate CS in their employees, thereby mitigating the risk of CF. For example, by acknowledging and celebrating successes in MHPs work, reducing non-clinical demands/barriers, and providing opportunities for continued learning and development. Furthermore, identification of factors more directly influencing the risk of MHPs experiencing CF facilitates recommendations for both MHPs and the services they work within, such as increasing supervision and support for MHPs; reducing stigma around MHPs discussing the challenges of their work; training to raise awareness and understanding of CF; and interventions to increase self-compassion in MHPs (Deighton et al., 2007; Potter et al., 2015; Beaumont et al., 2016b).

Areas for further research are also highlighted from this review, which identified a possible association between empathy, CF and CS. Whilst quantitative research indicates an association between these three constructs (Turgoose & Maddox, 2017; Bush, 2009),
qualitative exploration may facilitate greater understanding of the interplay between them that may ultimately improve the provision of compassionate care in mental health services.

The empirical paper presented in part two described an evaluation of the acceptability of a newly developed brief compassion-focused intervention for trainee MHPs. Consistent with previous research exploring the impact of lengthier interventions (Beaumont et al., 2017), this study demonstrated that the brief compassion-focused intervention was acceptable and valued by participants. Discussion of factors that enhanced participants experiences of the intervention and facilitated the beneficial changes they subsequently noticed, coupled with barriers to implementation of the intervention that reduced its acceptability, indicate the potential value of further developing and evaluating the intervention. Through this process, it is hoped that the intervention could be refined and improved upon so that it may be helpfully incorporated into teaching programmes for MHPs. Research indicates that successfully doing so may enhance students wellbeing and engagement with their training, protect them from symptoms associated with burnout and CF later in their careers, and have wider benefits for healthcare provision (e.g. through improving the delivery of compassionate care; Beaumont & Martin, 2016).
Table of Contents

Overview ......................................................................................................................... 3
Impact statement .............................................................................................................. 5
Table of Contents ............................................................................................................ 7
Tables and Figures .......................................................................................................... 8
Acknowledgements ......................................................................................................... 9

Part 1: Literature Review ............................................................................................... 10
  Abstract .......................................................................................................................... 11
  Introduction ...................................................................................................................... 12
  Method ............................................................................................................................ 17
  Results ............................................................................................................................ 26
  Discussion ....................................................................................................................... 73
  References ...................................................................................................................... 80

Part 2: Empirical Paper ................................................................................................. 94
  Abstract .......................................................................................................................... 95
  Introduction ...................................................................................................................... 96
  Method ........................................................................................................................... 103
  Results ........................................................................................................................... 115
  Discussion ...................................................................................................................... 143
  References ...................................................................................................................... 152

Part 3: Critical Appraisal ............................................................................................... 165
  Overview ......................................................................................................................... 166
  Self-reflexivity ............................................................................................................... 166
  Reflections on the research process ............................................................................... 169
  Learning ......................................................................................................................... 173
  Closing summary ............................................................................................................ 175
  References ...................................................................................................................... 177

Appendices ..................................................................................................................... 181
  Appendix A: Joint Research Project Declaration ......................................................... 182
  Appendix B: Initial Thematic Map/Hierarchy - Systematic Review ................................. 185
  Appendix C: CASP Qualitative Research Checklist ...................................................... 187
  Appendix D: Confirmation of Ethical Approval .............................................................. 191
  Appendix E: Acceptability-related Questions Distributed via Online Surveys ............... 195
  Appendix F: Full Battery of Outcome Measures Administered .................................... 197
  Appendix G: Interview Topic Guide .............................................................................. 205
  Appendix H: Research Study Information Sheet and Consent Form .............................. 208
  Appendix I: Interview Information Sheet and Consent Form .......................................... 214
  Appendix J: Mapping the Relationship between Codes - Empirical Paper ................. 220
  Appendix K: Frequency of Themes Described by Participants – Empirical Paper ......... 227
Tables and Figures

List of Tables

Part 1: Literature Review

Table 1: Search Terms ................................................................. 20
Table 2: Study Characteristics ......................................................... 28
Table 3: Quality Assessment using the CASP Qualitative Research Checklist ........ 39
Table 4: Contribution of Each Study to the Findings ................................. 44
Table 5: Overarching Analytic Themes and Subthemes ............................... 48

Part 2: Empirical Paper

Table 1: Participant Demographics .................................................. 108
Table 2: Survey Questionnaire Response Rates ....................................... 115
Table 3: Content Analysis of Survey Responses: Themes and Subthemes ........... 118
Table 4: Thematic Analysis of Interviews: Themes and Subthemes .................. 120

List of Figures

Part 1: Literature Review

Figure 1: PRISMA Flow Diagram of the Study Selection Process .................... 22
Acknowledgments

First and foremost I would like to thank Dr Michelle Wilson for being a more supportive and dedicated research supervisor than I could ever have hoped for. I am incredibly grateful for your guidance and kind words of encouragement throughout the ups and downs of this process. You never made me feel as though any question was too small or too silly, even though I’m sure plenty were! Thank you.

I would also like to thank the other members of the research team, stakeholders and participants who generously gave their time and energy to our research study, and without whom the project would not have been possible. Thank you to Dr Chris Irons for generously and patiently sharing your expertise with us, and to Priya, Jack and Jayde for helping me to explore and reflect upon the influence of my own experiences on the research. To Silan, thank you for being an amazing research partner and sharing the struggles and successes of this project with me.

Finally, I would like to thank my incredibly supportive family and friends. I feel very lucky to have you all. Thank you for your endless cheerleading, packages of sweets and chocolates, fun-filled distractions from thesis, and mostly for your unwavering faith in me. To Lucy, my partner in procrastination, I feel so lucky to have had you by my side throughout this journey and I wouldn’t/couldn’t have done it any other way. And to my lovely mum, thank you for always being there for me and making me feel as though I can do anything I set my mind to.
Part 1: Literature Review

Risk and Protective Factors for Mental Health Professionals Experiencing Compassion Fatigue: A Systematic Review and Thematic Synthesis of Qualitative Studies.
Abstract

Aims: This review synthesised qualitative research exploring mental health professionals’ perceptions of the factors influencing their experiences of compassion fatigue and compassion satisfaction.

Methods: A systematic review of qualitative research was completed using the PsychINFO, CINAHL, EMBASE, Medline, Pubmed, Scopus, Web of Science, ASSIA, IBSS and Emcare databases. The Critical Appraisal Skills Programme research checklist was used for quality appraisal, and a sensitivity analysis assessed the contributions made by studies appraised as of lower quality. A thematic synthesis approach was used for the analysis.

Results: The meta-synthesis yielded eight overarching analytic themes across 20 qualitative studies. The research findings suggest that mental health professionals’ risk of experiencing compassion fatigue is influenced by: workplace factors; levels of compassion satisfaction; the nature of the work; understanding and awareness of compassion fatigue; therapist factors; strategies employed; self-compassion; and life factors. Factors influencing compassion satisfaction were also explored and identified, such as the extent to which they feel they are contributing to changes in their patients’ lives; ethical stress; patient factors; and opportunities for professional development.

Conclusions: The results of this review offer insights into the factors influencing compassion fatigue and compassion satisfaction in MHPs. Limitations of the current review are identified and discussed, as are clinical recommendations based upon the findings and potential areas for future research.
Introduction

Empathy, the ability to understand the private world of others as if it were one’s own (Rogers, 1957), and compassion, awareness of suffering coupled with a wish and effort to relieve it (Gilbert, 2009), are considered necessary skills for mental health professionals (MHPs) working therapeutically. Both have consistently been associated with the development of effective therapeutic alliances (Rogers, 1957; Kohut, 2010; Beck, 1979) and improved treatment outcomes (Flückiger et al., 2012; Brill & Nahmani, 2017). However maintaining an empathic and compassionate stance can put MHPs at risk of developing compassion fatigue (CF) as a result of their work (Figley, 1995).

CF is one of several interrelated constructs describing the potential costs to professionals of working within helping professions. First coined by Joinson in 1992 after observing nurses “seemingly absorbing the traumatic stress” of those they helped, the term CF was initially used to refer to “a unique form of burnout that affects people in caregiving professions” (Joinson, 1992, p.116). Over time, CF has become better-defined as the empathic strain and exhaustion arising from persistently engaging with other people’s distress and suffering (Figley, 2002; Turgoose & Maddox, 2017). It is characterised by a reduced ability to empathise with and feel compassionate towards others, as well as physical and emotional fatigue (Mathieu, 2007; Elwood et al., 2011).

The evolution of a less ambiguous definition of CF has enabled it to be more easily distinguished from the similar constructs of ‘burnout’, ‘vicarious trauma’ and ‘secondary traumatic stress’ (Sorenson et al., 2017). Whilst alike in concept and symptomology, CF is differentiated from ‘burnout’ as CF is considered a “product” of the empathic relationship between professional and patient (Hill et al., 2015), whereas burnout describes difficulties arising from organisational and environmental stressors (Stamm, 2009). CF is also distinguishable from ‘vicarious trauma’, the “negative transformation” of professionals’ inner
experiences and cognitions resulting from empathic engagement with trauma (Pearlman et al., 1990), and ‘secondary traumatic stress’, which refers to “a syndrome of symptoms” mirroring those of post-traumatic stress disorder (Bride, 2004). Whilst there is overlap between these three constructs, CF is distinct in that it is not specific to trauma-related work.

CF is prevalent across a range of helping professionals, including doctors (Gleichgerrcht & Decety, 2014), nurses (Yang & Kim, 2012), social workers (Simon et al., 2005), MHPs (Ray et al., 2013; Zeidner et al., 2013), and emergency services workers (Cicognani et al., 2009). Previous research has consistently demonstrated the deleterious impact of CF on these professionals’ wellbeing (Negash & Sahin, 2011; Mathieu, 2007; Singh et al, 2020), as well as their ability to carry out their work with compassion and empathy (Bride et al., 2007; Turgoose & Maddox, 2017).

The association between CF and empathic patient-professional relationships has led to speculation in the literature that MHPs may be especially vulnerable to CF, and indeed it is prevalent in psychologists (Craig & Sprang, 2010), mental health nurses (Bell et al., 2019), counsellors (Thompson et al., 2014), psychotherapists (Figley, 2002), and clinical social workers working therapeutically (Thomas & Otis, 2010). Engaging empathically with patients is considered desirable and beneficial across most helping professions, but it is deemed “essential” for MHPs working therapeutically with clients (Rogers, 1957; Williams et al., 2015). Within the context of therapy, empathy is described as one of the “necessary and sufficient” conditions for psychotherapeutic change (Rogers, 1957), and is regarded as integral to developing strong therapeutic relationships (Kohut, 2010; Beck, 1979) and delivering effective therapy (Clark, 2010; Elliott et al., 2011; O’Brien & Haaga, 2015).

Aiding understanding of this phenomenon, Figley’s (2002) etiological model of CF proposes that, whilst necessary for effective therapy, actively and persistently engaging empathically with patients and their distress places MHPs at greater risk of CF. Within this
model Figley proposes eleven variables that, together, comprise a causal model for CF in MHPs. According to Figley (2002), ‘empathic ability’ enables MHPs to notice and engage with the suffering of their patients, which they are motivated to alleviate due to ‘empathic concern’. Upon exposure to patients in distress, these variables create an ‘empathic response’, whereby MHPs attempt to reduce their patients’ suffering through ‘empathic understanding’. Engaging with patients’ distress in this way exposes them to experiencing the emotions of their patients and, if unable to disengage from their patients’ suffering or help to relieve their patients’ distress, Figley (2002) proposes that MHPs experience ‘compassion stress’. This ongoing unfulfilled wish to relieve the suffering of the patient reduces therapists quality of life and, if permitted to build, places them at greater risk of CF. This risk is exacerbated by prolonged ‘exposure to patients’ suffering’, provocation of ‘traumatic memories’ of the therapist or patient, and ‘disruptions to the psychotherapists’ life’ outside of work.

Figley’s (2002) model also describes factors mitigating the risk of experiencing CF. ‘Disengagement from patients and their distress’, as well as deriving a ‘sense of achievement from one’s work’, are proposed to reduce ‘compassion stress’ and thereby the risk of CF. Throughout the literature the latter of these concepts, the sense of achievement and pleasure derived from being able to help others and make meaningful contributions through one’s work, is more commonly referred to as ‘compassion satisfaction’ (CS; Figley & Stamm, 1996). Research has consistently shown CS to be an important factor both reducing the risk of professionals experiencing CF (Sprang et al., 2007) and mitigating its impact (Harr et al., 2014; Figley, 2002).

Given the importance of empathy in mental health work, coupled with consistent findings that MHPs’ necessary empathy may increase their vulnerability to CF rendering them less able to carry out their work empathically and compassionately (Turgoose & Maddox, 2017), it is important to understand the factors that both contribute to and mitigate against CF.
Aims of the Current Review

Whilst previous reviews have been carried out regarding CF in other healthcare professionals, including nurses (Yang & Kim, 2012) and professionals working with traumatised patients (Collins & Long, 2003), Turgoose and Maddox (2017) carried out the first systematic review of CF in MHPs. They reviewed 32 quantitative studies exploring factors associated with CF in MHPs, finding that professionals’ own trauma history, mindfulness, empathy, caseload, levels of burnout, and CS were commonly related to their experiences of CF. When discussing their findings, Turgoose and Maddox (2017) described the scope of their review as limited due to its focus on quantitative research, noting that further important insights could be gained from broadening the scope to consider qualitative research exploring MHPs experiences of CF.

Salmond et al (2019) carried out a qualitative review of CF in direct care nurses, including psychiatric nurses, finding that constant stress, feeling powerless and overwhelmed, lack of awareness of CF, and not knowing how to manage CF increased nurses risk of experiencing CF. Acceptance, teamwork, distraction and disengagement from patients, awareness of CF, work-life balance, and active self-care strategies were found to protect nurses against CF. Another qualitative synthesis reviewed research exploring experiences of CF, alongside interrelated constructs such as vicarious trauma and burnout, specifically in MHPs working in substance misuse services (Thompson, 2018). This review included 11 studies and found that feeling undervalued and a lack of resources contributed to CF, secondary traumatic stress and/or burnout, whilst CS, professional growth, feeling supported, and self-care maintained compassion.

Whilst the above insights are valuable, neither review focused on studies exploring the experiences of MHPs working therapeutically across a range of contexts. The potentially deleterious impact of CF on professionals’ ability to be empathetic and compassionate, coupled
with the vital role of these qualities in effective therapy, highlights the importance of understanding the factors that influence MHPs' experiences of CF. Given that CF and CS are emotional experiences linked to professionals’ roles, qualitative research may offer new insights and understandings of these concepts and the factors influencing them (Thompson, 2018). The current review therefore makes use of a qualitative synthesis approach, described as useful in attempting to understand and synthesise lived experiences (Walsh & Downe, 2005), instead of using a quantitative synthesis approach, which is typically adopted when seeking to quantify cause and effect (McEvoy & Richards, 2006).

This research aims to systematically review qualitative research exploring CF and CS in MHPs, in order to better understand the factors associated with increasing and decreasing the risk of CF. Studies exploring MHPs experiences of CS will be included in the current review, as previous research has consistently found CS to be an important factor in preventing and mitigating CF.
Method

Methodological Approach and Epistemological Position

This review adopts a thematic synthesis methodology (Thomas & Harden, 2008); which provides a structured, systematic framework for collating and integrating the findings of multiple qualitative studies. This inductive approach reflects a ‘critical realist’ position, proposing that reality exists and that our knowledge of it is mediated by our perceptions and beliefs (Barnett-Page & Thomas, 2009). Underpinned by this epistemological position, it provides a methodology for extracting and integrating findings from original studies that are considered to reflect a truth about the external world, whilst also recognising that these findings are filtered through the researchers’ own experiences and assumptions (Barnett-Page & Thomas, 2009; Noyes et al., 2018).

This methodological approach was chosen as it was both appropriate for the purpose of this review and consistent with the researcher’s own epistemological position.

Data Collection

Research Question.

Specific and well-defined research questions form the basis of any review, heavily guide the search strategy, and are more likely to result in a manageable number of appropriate citations being identified as relevant to answer the review question (Rojon & Saunders, 2012). The PICOD (Population, phenomena of Interest, Context, Outcome of interest and Design) mnemonic is therefore recommended to develop a specific, meaningful question for qualitative synthesis (Soilemezi & Linceviciute, 2018).

This review aimed to synthesise qualitative research exploring MHPs’ perceptions of the factors influencing their experiences of CF and CS. The following PICOD was developed
to define the research question for this review, in consultation with the review team and a specialist librarian:

- Population: Paid MHPs providing therapy to patients
- Interest (phenomena of): MHPs experiences of CF and/or CS
- Context: Public-sector and/or private mental health services
- Outcome of interest: Factors that contribute to and/or protect against MHPs experiencing CF and/or CS
- Design: Qualitative research

**Inclusion and Exclusion Criteria.**

Research studies meeting the following criteria were included in the review:

1) Participants were paid MHPs providing therapy to patients
2) Exploration of factors that contributed to and/or protected against MHPs experiencing CF and/or CS
3) A qualitative method of data collection, such as interviews or focus groups
4) Disseminated in English before September, 2020

Research studies were excluded if:

1) The research was not specifically focused on CF and/or CS, e.g. studies with a primary focus on related phenomena such as burnout or secondary traumatic stress
2) Participants working in mental health contexts but who were not delivering therapy to patients

**Protocol.**

PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses; Moher et al., 2015) guidelines were used to develop a protocol informing the search and selection strategy, quality appraisal process, and synthesis of the included studies.
Search Strategy.

In keeping with the ‘critical realist’ approach underpinning thematic synthesis, this review employed a comprehensive search strategy to identify as many relevant papers as possible (Barnett-Page & Thomas, 2009).

Systematic searches were carried out across 10 databases representing the fields of psychology, nursing and allied health, biomedicine, social sciences, and medicine: PsychINFO; CINAHL; EMBASE; Medline; Pubmed; Scopus; Web of Science; ASSIA; IBSS; and Emcare. Databases were searched to include papers published up to and including September 2020. The last searches were performed on 8th October, 2020.

As recommended, the search terms used were guided by the aforementioned research question and mapped onto the different aspects of the PICOD (Soilemezi & Linceviciute, 2018); i.e. MHPs, CF and/or CS, and risk/protective factors (see Table 1).

Both the databases searched and the search terms used were chosen in consultation with the review team and a specialist librarian. Research designs are often unspecified or incorrectly indexed. As such, the specialist librarian consulted advised against search terms specifying a qualitative design. The search was limited to research studies disseminated in English.

Additional relevant studies were also identified through hand-searching the reference lists and citations of the included papers.
Table 1. *Search terms.*

<table>
<thead>
<tr>
<th>Population</th>
<th>AND</th>
<th>Phenomena of Interest</th>
<th>AND</th>
<th>Outcome of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health nurse</td>
<td></td>
<td>Compassion fatigue</td>
<td></td>
<td>Predict</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>Psychiatric nurse</td>
<td>OR</td>
<td>Empathy fatigue</td>
<td></td>
<td>Risk factor</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>Mental health professional</td>
<td>OR</td>
<td>Compassion satisfaction</td>
<td></td>
<td>Risk*</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td>Caus*</td>
</tr>
<tr>
<td>Therapist</td>
<td></td>
<td></td>
<td></td>
<td>Susceptible</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td>Susceptibility</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td>Protect</td>
</tr>
<tr>
<td>Mental health physician</td>
<td>OR</td>
<td></td>
<td></td>
<td>Prevent*</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td>Resilience</td>
</tr>
<tr>
<td>Psychiatr*</td>
<td></td>
<td></td>
<td></td>
<td>Vulnerable</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td>Vulnerability</td>
</tr>
<tr>
<td>Social worker</td>
<td>OR</td>
<td></td>
<td></td>
<td>Experience*</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td>Assiciat*</td>
</tr>
</tbody>
</table>
**Study Selection.**

The combined search results identified 8824 articles in total. Duplicates were first removed, leaving 3473 articles. Titles and abstracts were then screened and articles not meeting the inclusion criteria were removed, leaving 51 articles. Full-texts were retrieved and carefully considered against the inclusion and exclusion criteria. Seventeen articles were eligible to include in the review. A further three studies were identified through hand searching the references and citations of the eligible articles, resulting in a total of 20 articles (see Figure 1 for PRISMA flow diagram of the study selection process; Moher et al., 2015).

To monitor adherence to the inclusion and exclusion criteria, a second researcher independently reviewed a random selection of 25% of the full text articles (n = 5). There was strong inter-rater agreement, Cohen’s kappa = .833 (95% CI .683 to .983). Any and all disagreements between the raters were discussed until consensus was achieved.
**Figure 1.** PRISMA flow diagram of the study selection process.

- Articles identified through the electronic database search \( n = 8824 \)
- Duplicate references removed \( n = 5351 \)
- Titles and abstracts reviewed \( n = 3473 \)
- Articles excluded based on titles and abstracts \( n = 3419 \)
- Full-text articles retrieved for detailed review against inclusion and exclusion criteria \( n = 51 \)
- Full text articles excluded \( n = 34 \)
  - Exclusion reasons:
    - Not primarily focused on exploring risk and/or protective factors for CF and/or CS \( n = 24 \)
    - Not paid MHPs delivering therapy \( n = 5 \)
    - Quantitative method \( n = 2 \)
    - Conference abstract/poster \( n = 3 \)
- Articles included from the initial search \( n = 17 \)
- Articles included from reference lists and citations of papers found to meet the inclusion criteria \( n = 3 \)
- Articles included in the qualitative synthesis \( n = 20 \)
Data Extraction.

There is debate in the literature regarding what constitutes data to be extracted when synthesising qualitative studies (Noyes et al., 2018). As varied reporting styles within qualitative research can make it difficult to distinguish and identify key concepts or findings (Sandelowski & Barroso, 2002), this review followed recommendations set out by Thomas and Harden (2008) for the thematic synthesis of qualitative research in systematic reviews. As such, all text, tables and figures under the headings of ‘results’ or ‘findings’ were considered data and were extracted electronically before being imported verbatim into NVivo (NVivo Qualitative Data Analysis Software, 2020). All of the data relevant to the review questions was analysed and synthesised, regardless of how it was labelled or described within the original studies.

Analysis

Meta-Synthesis Approach.

Thomas and Harden’s (2008) guidelines for thematic synthesis state that one should initially develop descriptive themes, summarising and grouping the original findings of the studies reviewed. The researcher then aims to “move beyond” the content of the original studies in an interpretative process, developing “analytic themes” aiming to respond to the review question (Thomas & Harden, 2008; Britten et al., 2002).

In the descriptive phase, data from each study was coded line-by-line, with the bank of existing codes being added to and new codes being created as necessary. Once all of the data had had at least one code applied, all of the data relevant to each code was examined to check the consistency of interpretation and coding. Following this, each study was re-read to ensure that all relevant data had been appropriately coded and to identify any data contradicting the preliminary codes, indicating that additional levels of coding would be required. Similarities
and differences between the initial codes were then considered, so they could be arranged into a hierarchy demonstrating the relationships between them (see Appendix B).

The analytic stage of the analysis involved reviewing the data coded under each theme to infer factors described as increasing and decreasing the likelihood of MHPs experiencing CF and/or CS. This process was carried out by the researcher independently, before being shared and discussed with the wider research team to prevent researcher bias influencing the themes identified and to allow for more abstract or analytic themes to be developed. Data regarding risk and protective factors for CF and CS was re-examined to allow for any changes to be made. This cyclical process was repeated until the researcher and the research team agreed that the analytic themes identified (presented in Table 5) sufficiently explained all of the initial descriptive themes and inferred factors influencing MHPs experiences of CS and CF.

Associated recommendations for clinical practice and policies related to each analytic theme were also considered to increase the applicability to practice of this review.

**Methodological Credibility Checks.**

Throughout the analysis, reflective notes were kept by the researcher in an attempt to ‘bracket’ and remain mindful of the influence of their existing assumptions, ideas and preconceptions (Timulak, 2009; Fisher, 2009). Themes identified were considered and revised with the guidance of the research supervisor and wider research team in a cyclical process until consensus was reached (Thomas & Harden, 2008; Levitt et al., 2017). Triangulation of the resultant themes was carried out by consulting the existing qualitative and quantitative literature regarding risk and protective factors for CF and CS (Timulak, 2009). The relationship between the themes identified in this review and existing research are described in the discussion below.
Confidence in Meta-Synthesis Findings.

Following GRADE-CERQual guidance (Confidence in the Evidence from Reviews of Qualitative Research; Lewin et al., 2015), measures were taken throughout the review to facilitate methodological transparency and increase confidence in the findings. Each study included was appraised using the CASP Qualitative Research Checklist (CASP, 2018; see Table 3). The contribution of each study to the frequency of the final analytic themes is displayed in Table 4, facilitating transparency as to the adequacy of data supporting each theme.
Results

Study Characteristics

Relevant characteristics of the 20 qualitative research studies included are summarised in Table 2.

Aims of included studies.

The studies included in this review qualitatively explored MHPs experiences of CF and/or CS. Ten of the studies aimed to explore factors protecting participants against CF (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; DeLange & Chigega, 2015; Gallagher, 2015; Hunter, 2012; Jorgensen, 2012; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Udipli et al., 2008), eight considered factors increasing the risk of CF (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Gallagher, 2015; Hunter, 2012; Moffatt, 2018; Norrman Harling et al., 2020; Udipli et al., 2008), and two addressed factors increasing MHPs experiences of CS (Gallagher, 2015; Hunter, 2012). Nine studies aimed to more broadly explore MHPs experiences of working in mental health services, describing risk and protective factors for CS and CF as emergent themes (Cramond et al., 2020; Cunningham, 2015; Holstein, 2011; Johnson, 2016; Killian, 2016; McCoy, 2019; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000).

Participants.

There were 512 participants across all of the studies. Sample sizes ranged from 3 to 222. Across the studies stating participant gender, 15% were male and 85% were female. Where reported, participants’ ages ranged from 25 to 74, and years of experience providing therapy ranged from 1 to 40 years. Averaged across studies reporting participants’ ethnicities, 89% of participants were described as ‘Caucasian’, 3% ‘African-American’, 2% ‘Latin American’, 0.5% ‘Hispanic’, 3% ‘Asian’, and 2.5% were reported as ‘other’ or ‘unspecified’.
Averaged across the studies, the profession of 57% of the participants was described as ‘Counsellor’, 6% ‘Psychologist’, 23% ‘Psychotherapist’, and 57% otherwise unspecified ‘MHP’.

Setting.

The included studies were predominantly carried out in English speaking Western countries. Fourteen were conducted in the United States of America, and one in each of the following: the United Kingdom, Ireland, South Africa, Australia, Canada and Sweden. All took place in private and/or public mental health services. Seven of the studies looked at the experiences of MHPs working with specific client groups, as potentially increasing or decreasing their likelihood of experiencing CF and/or CS. These studies took place in settings involving therapeutic work with trauma survivors (Adams, 2020; Killian, 2016; Michalchuk & Martin, 2018), substance misusers (Nurse, 2020; Perkins & Sprang, 2013), perpetrators of violence (Roman, 2000), and work in palliative care (Cramond et al., 2020) and forensic settings (Johnson, 2016).

Data Collection and Analysis.

Five studies employed mixed methodologies; the quantitative aspects of their research were not included in this review (Cunningham, 2015; Gallagher, 2015; Holstein, 2011; Johnson, 2016; Udipi et al., 2008). Sixteen studies collected data through individual interviews, one used focus groups, and one used a combination of the two. Two of the studies collected data through use of open-ended questions on surveys.

The studies employed a range of methodologies for analysis of their findings, including: Interpretative Phenomenological Analysis, Grounded Theory Approach, Thematic Analysis, Narrative Analysis, and Interpretative Content Analysis.
Table 2. Study characteristics.

<table>
<thead>
<tr>
<th>Study</th>
<th>Research Aims</th>
<th>Sample Characteristics</th>
<th>Setting and Recruitment Method</th>
<th>Data Collection Method</th>
<th>Data Analysis Method</th>
<th>Research Implications and Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams (2020)</td>
<td>To explore how male MHPs treating trauma survivors describe managing and/or preventing CF</td>
<td>N = 16 USA</td>
<td>Qualitative design.</td>
<td>Thematic Analysis</td>
<td>Recommendations: • Additional support for male MHPs • Encourage use of practical strategies and practices associated with a positive change in mental health • Increasing CS in male MHPs • Awareness training of how male MHPs manage/prevent CF to be provided to organisations, professionals and their families</td>
<td></td>
</tr>
<tr>
<td>Benoit, McCarthy, Veach &amp; LeRoy (2007)</td>
<td>To explore genetic counsellors experiences of CF, including: whether genetic counsellors experience CF, how CF affects genetic counsellors, how aware genetic counsellors are of CF, and what training regarding CF may be most helpful for genetic counsellors.</td>
<td>N = 12 USA</td>
<td>Qualitative design.</td>
<td>Consensual Qualitative Research Method</td>
<td>Recommendations: • Developing a repertoire of strategies for managing CF • Graduate and post-graduate training on CF • Peer supervision groups for genetic counsellors • Balancing delivery of bad news with delivery of good news • Acknowledging the reality of genetic counsellors’ work • Guidance/supervision to help professionals reframe their views and celebrate successes</td>
<td></td>
</tr>
<tr>
<td>Bowen &amp; Moore (2014)</td>
<td>To explore perceptions and concepts related to compassion in mental health counselling, how</td>
<td>N = 16 USA</td>
<td>Qualitative design.</td>
<td>Grounded Theory Approach – Constant Comparative method.</td>
<td>Recommendations: • Supervision from peers and supervisors for counsellors experiencing CF</td>
<td></td>
</tr>
</tbody>
</table>
mental health counsellors perceived CF and CS, and what factors positively and negatively shape their perceptions of these concepts.

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Recruitment</th>
<th>Design</th>
<th>Themes</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cramond, Fletcher &amp; Rehan (2020)</td>
<td>UK</td>
<td>Purposive</td>
<td>Qualitative</td>
<td>Client population, Work environment, Coping mechanisms</td>
<td>• Encourage counsellors practicing self-care</td>
</tr>
<tr>
<td></td>
<td>N = 12</td>
<td>sampling</td>
<td>design</td>
<td></td>
<td>• Supervisors normalising CF for trainee/newly qualified counsellors</td>
</tr>
<tr>
<td></td>
<td>Profession: Clinical Psychologists</td>
<td></td>
<td></td>
<td></td>
<td>• Supervisors to be cognizant of signs of distress and burnout,</td>
</tr>
<tr>
<td></td>
<td>Gender: 9 female, 3 male</td>
<td></td>
<td></td>
<td></td>
<td>• Training for supervisors on CF and satisfaction</td>
</tr>
<tr>
<td></td>
<td>Age range: not reported</td>
<td></td>
<td></td>
<td></td>
<td>• Educators to incorporate curriculum and experiential activities that address affective development for counsellors</td>
</tr>
<tr>
<td></td>
<td>Experience: 3-26 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ethnicity: not reported</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cunningham (2015)*</td>
<td>USA</td>
<td>Purposive</td>
<td>Mixed methods</td>
<td>Main themes: Client population,</td>
<td>Recommendations:</td>
</tr>
<tr>
<td></td>
<td>N = 3 (qualitative only)</td>
<td>sampling</td>
<td>design</td>
<td>Work environment, Coping mechanisms</td>
<td>• Training for psychologists working in palliative care around reflecting on their work, the containing of emotions and recognising their own limitations</td>
</tr>
<tr>
<td></td>
<td>Profession: Counselling Clinicians</td>
<td></td>
<td></td>
<td></td>
<td>• Creating systems to encourage practitioners to seek support around experiences of CF</td>
</tr>
<tr>
<td></td>
<td>Gender: 3 female, 0 male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age range: 27-56</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experience: not reported</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ethnicity: Caucasian (n = 3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Purpose</td>
<td>Participants</td>
<td>Setting</td>
<td>Research Design</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------------------------</td>
<td>----------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>DeLange &amp; Chigeza (2015)</td>
<td>To explore the fortigenic qualities of South African psychotherapists in private practice, and how these may buffer psychotherapists from CF and stress of conscience, allowing them to maintain full time private practice for longer than 10 years.</td>
<td>N = 7</td>
<td>South Africa</td>
<td>Qualitative design.</td>
<td>Narrative analysis.</td>
</tr>
<tr>
<td>Holstein (2011)*</td>
<td>To explore the levels of CF, secondary traumatic stress, burnout and CS experienced by psychotherapists working</td>
<td>N = 102</td>
<td>USA</td>
<td>Mixed methods design.</td>
<td>Phenomenological Data Analysis.</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Methodology</td>
<td>Themes</td>
<td>Recommendations</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>--------------</td>
<td>-------------</td>
<td>--------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Hunter (2012)</td>
<td>N = 8 Counselling therapists, 7 female, 1 male</td>
<td>Qualitative design. Grounded Theory Approach.</td>
<td>Main themes: The empathic resonance of the therapist, The role investment by the patient, The sense of mutual affirmation between them, The satisfaction and risks of working with trauma.</td>
<td>• Encouraging therapists to make use of personal and professional coping&lt;br&gt;• Organisational support for therapists&lt;br&gt;• Highlighting the possible risks and benefits of therapeutic work for therapists during their training&lt;br&gt;• Supportive and reflexive supervision&lt;br&gt;• Informal debriefing with trusted colleagues&lt;br&gt;• Peer supervision groups&lt;br&gt;</td>
<td></td>
</tr>
<tr>
<td>Johnson (2016)*</td>
<td>N = 8 MHPs delivering therapy, Psychiatrist, Clinical Psychologist</td>
<td>Mixed methods design.</td>
<td>The qualitative portion of the study involved individual semi-structured interviews.</td>
<td>• Continuing education courses and additional training to be offered to correctional MHPs&lt;br&gt;• Develop official forums and policies pertaining to secondary traumatic stress and self-care&lt;br&gt;• Increased awareness of prevention and treatment for secondary traumatic stress&lt;br&gt;</td>
<td></td>
</tr>
</tbody>
</table>

In community behavioural health settings, as well as factors correlating with CF in this population.

- Age range: 23-74<br>- Experience: 1-40 years<br>- Ethnicity: Caucasian 89%, African American 5.5%, Hispanic 4.4%, Other 1.1%

Recruitment: Purposive sampling the study involved a single open-ended question in the self-constructed questionnaire exploring how organisational cultures contribute to or mitigate CF.

Main themes: Support, Mitigates/Contributes, Work demands, Organisational culture, Supervision, Training, Communication, Time off, Respect, Personal therapy, Agency size, Gossip.

Recruitment: Purposive sampling workplaces as accepting, safe and trustworthy

- Honesty being encouraged within the workplace<br>- Differences being tolerated well<br>- Positive team environments,<br>- Fostering good relationships between colleagues,<br>- Discouraging workplace gossip<br>- Enhancing physical comfort of employees

Recruitment: Snowball sampling

- Most common diagnoses, Changes in worldview, Challenges of working in corrections, Secondary trauma and CF,
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Participants</th>
<th>Setting</th>
<th>Recruitment</th>
<th>Data Collection</th>
<th>Analysis</th>
<th>Findings</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jorgensen (2012)</td>
<td>Exploring the experiences of licensed MHPs who have encountered and navigated through CF, in order to increase understanding of how CF is experienced by MHPs across a variety of disciplines.</td>
<td>N = 9</td>
<td>USA</td>
<td>Qualitative design.</td>
<td>Grounded Theory Approach – Constant Comparative method.</td>
<td>Recommendations:</td>
<td>- Building rapport between MHPs and correctional staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Profession: Clinical mental health counsellors, Clinical social workers, Marriage and family therapists, and Psychologists.</td>
<td></td>
<td>Three rounds of Individual semi-structured interviews with each participant (n = 9)</td>
<td></td>
<td>- Highlighting the importance of supervisory support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gender: 6 female, 3 male</td>
<td></td>
<td></td>
<td></td>
<td>- Fostering dialogue and share narratives between MHPs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age range: not reported</td>
<td></td>
<td></td>
<td></td>
<td>- Education to increase awareness of CF at the point of training</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experience: 2-30+ years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethnicity: Caucasian (n = 6), Hispanic (n = 1), African American (n = 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Killian (2016)</td>
<td>To explore emergent themes, including stress symptoms and coping strategies of helping professionals who specialize in the treatment of trauma survivors.</td>
<td>N = 20</td>
<td>USA</td>
<td>Qualitative design.</td>
<td>Grounded Theory Approach – Constant Comparative method.</td>
<td>Recommendations:</td>
<td>- Therapists prioritising time for socialising, leisure and/or hobbies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Profession: Clinical social workers, Marriage and family therapists, Counselling psychologists, Professional counsellors.</td>
<td></td>
<td>Individual semi-structured interviews (n = 20)</td>
<td></td>
<td>- Protecting and maintaining work/life balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gender: 16 female, 4 male</td>
<td></td>
<td></td>
<td></td>
<td>- Maintaining peer contact and consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age range: 28-57 years</td>
<td></td>
<td></td>
<td></td>
<td>- Setting limits to avoid overworking and role strain,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experience: 2-16 years</td>
<td></td>
<td></td>
<td></td>
<td>- Fostering therapists sense of agency and control at work</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethnicity: Caucasian (n = 15), African American (n = 2), Latina (n = 2), Asian (n = 1)</td>
<td></td>
<td></td>
<td></td>
<td>- Employee assistance programmes for helping professionals to process personal traumas</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Study Title</td>
<td>Participants</td>
<td>Methods</td>
<td>Findings</td>
<td>Recommendations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| McCoy (2019)           | To explore the process of self-care in MHPs who provide services to post-incarcerated men with elevated mental illness, in order to better understand how these practitioners manage self-care whilst providing therapeutic services. | N = 20<br>Profession: MHPs working with post-incarcerated men<br>Gender: 15 female, 5 male<br>Age range: 29-72 years<br>Experience: 3-40 years<br>Ethnicity: not reported | USA<br>Setting: Mental health services - Private practice, Community mental health, Non-profit organisations, Hospitals.<br>Recruitment: Theoretical sampling | Qualitative design. Individual semi-structured interviews (n = 20) | Grounded Theory Approach – Constant Comparative method. 4 main themes and 18 sub-themes emerged. Main themes: Meaning and importance of self-care, Job-related barriers, Self-care strategies, The role of support at work. Recommendations:  
• Creation of guidelines and training material related to clinician self-care and self-awareness |
| Michalchuk & Martin (2018) | To explore the lived experiences and meaning of resiliency and growth in psychologists. It sought to explore how psychologists experience resiliency, satisfaction, and personal growth despite the challenges of working with trauma survivors. | N = 6<br>Profession: Licenced Psychologists working with trauma survivors<br>Gender: 5 female, 1 male<br>Age range: not reported<br>Experience: 2-25 years<br>Ethnicity: not reported | Canada<br>Setting: Mental health services for trauma survivors<br>Recruitment: Not reported | Qualitative design. Individual semi-structured interviews (n = 6) | Interprettative Phenomenological Analysis. 1 Superordinate theme and 4 subordinate themes emerged. Superordinate theme: Maintaining resiliency. Recommendations:  
• Positively oriented training in relation to preventing burnout, vicarious trauma and CF  
• Using the shared journey with patients to develop strength, growth and resiliency  
• Focusing on positive aspects of trauma work such as vicarious growth and resiliency |
| Moffatt (2018)          | To explore the pattern of innate and external qualities that aid MHPs in their everyday work with those categorised as “severely mentally ill”, and the strengths and self-care strategies that enable MHPs to continue their work. This study also aimed to explore the symptoms related to | N = 3<br>Profession: Psychologists - Clinical Psychologist (n = 1), Counselling Psychologist (n = 1), Forensic Psychologist (n = 1).<br>Gender: 1 female, 2 male<br>Age range: 40-70 years<br>Ethnicity: not reported | USA<br>Setting: Mental health services<br>Recruitment: Snowball sampling | Qualitative design. Individual semi-structured interviews (n = 3) | Appreciative Inquiry. 5 themes identified. Main themes: Expression of wisdom, Opportunities, Assets, Strengths, Stories. Recommendations:  
• Promoting putting self-care first and foremost in psychological training  
• Encourage regular self-care practice  
• Increasing self-awareness |
<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Setting</th>
<th>Recruitment</th>
<th>Methodology</th>
<th>Main Themes</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Norrman Harling, Hörgman & Schad (2020) | N = 8 | Sweden | Purposive sampling | Qualitative design | 5 main themes and 17 sub-themes identified. | • Organisational changes to alleviate work burdens on psychologists  
• Clear decisions regarding treatment pathways to reduce administrative burden  
• Promoting clinician agency and sense of control  
• Encouraging clinicians to use self-care strategies and maintain healthy work/life boundaries  
• Ongoing professional development and education opportunities for clinicians |
| Nurse (2020) | N = 10 | USA | Purposive sampling | Qualitative design | 5 main themes and 11 sub-themes identified. | • Development of wellbeing plans for professionals  
• Training for professionals about demands/difficulties they may encounter at work |
<p>| Perkins &amp; Sprang (2013) | N = 20 | USA | Purposive sampling | Qualitative design | 2 main themes identified. | • Organisational awareness of increased risk of CF for MHPs |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Sample</th>
<th>Recruitment</th>
<th>Themes</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Roman (2000) | To explore the experiences of female psychotherapists counselling men who batter their female partners, specifically looking at the clinician’s affect, attitudes, beliefs, CF, countertransference and dreams. | N = 7 | Setting: Mental health services providing treatment to male perpetrators of domestic violence | Working with male patients who abuse their female partners, Feelings and attitudes about the patients, Thoughts about the nature of the clinical work, Dreams while treating men who batter their female partner, Countertransference while treating men who batter their female partner, CF while treating men who batter their female partner. | Recommendations:  
- Supervision and support groups  
- Working through countertransference  
- Raise awareness of “pull” for female psychotherapists to want to nurture/mother male patients  
- Implement new criminal justice policy and procedures for perpetrators of violence  
- Consider which psychological interventions are offered and how they are offered  
- Increase training and preparation for therapists of the emotional toll of psychotherapeutic work. |
| N = 222 | USA | Mixed methods design. | 7 main themes and 16 subthemes identified. | Main themes: Exposure to patients, Empathy and residual compassion stress, Sense of achievement/satisfaction, Disengagement/detachment, |
| Udipi et al. (2008)* | To examine the relationships among CF, CS, burnout, coping, and genetic counsellor demographic characteristics. | N = 222 | Setting: Counselling services in physical health settings across America | Interpretative Content Analysis. |
| Profession: Genetic Counsellors | | Sampling: Purposive | | |
| Gender: 213 female, 9 male | | | | |
| Age range: 23-65 years | | | | |
| USA | | | | |
| Setting: Purposive sampling | | | | |
| Gender: 7 female, 0 male | | | | |
| Age range: Not reported | | | | |
| Experience: 1-8 years | | | | |
| Ethnicity: Caucasian (n = 5), African American (n = 1), Asian American (n = 1). | | | | |
Experience: 4 months-33 years
Ethnicity: Caucasian ($n=205$), African American ($n=1$), Asian ($n=8$), Latino ($n=3$), International ($n=1$), Other ($n=4$).

126 participants responded to this question and provided answers for qualitative analysis.

Prolonged exposure to suffering, Traumatic recollections and memories, Other life demands.

- Engaging counsellors in professional conversations about the realities of clinical practice.

*Note: Studies marked with an asterisk (*) used mixed methods designs. As the focus of this review is qualitative in nature, only the qualitative aspects of these studies are summarised and reported here.*
Quality Appraisal and Sensitivity Analysis

Quality Appraisal.

Despite debate and lack of consensus in the literature regarding what constitutes “quality” in qualitative research, and whether it is therefore appropriate to assess the quality of qualitative research (Long et al., 2020), this review used ‘sensitivity analyses’ to assess the possible impact of study quality on the review’s findings, in line with Thomas and Harden’s (2008) guidelines.

Each of the included studies were first systematically appraised using the 10-item CASP (CASP, 2018; see Appendix C). The CASP appraises the strengths and limitations of qualitative research methodology, including: research aims; appropriateness of using a qualitative methodology; research design; recruitment; data collection; and data analysis. It also guides consideration of whether the findings are well-presented and contribute meaningfully to the literature.

Despite being endorsed by the Cochrane Qualitative and Implementation Methods Group (Noyes et al., 2018) and the World Health Organisation (WHO; Hannes & Macaitis, 2012) for use in qualitative synthesis as an easy-to-use measure of “transparency, research practice and reporting standards” (Long et al., 2020), the reliability and validity of the CASP has not been thoroughly assessed (Ma et al., 2020).

As such, in accordance with established methodological guidance, studies were not excluded from this review based on their appraised quality (Centre for Reviews and Dissemination, 2009; Noyes et al., 2018). Instead, the CASP was used to consider the quality of each of the studies, so that a sensitivity analysis may be carried out to explore the impact of studies identified as lower quality on the results of the thematic synthesis (Centre for Reviews and Dissemination, 2009; Thomas & Harden, 2008).
The quality appraisal of the included studies is summarised in Table 3. A second researcher independently appraised the quality of a random selection of 25% of the included studies \((n = 5)\) to check reliability. There was substantial inter-rater agreement, Cohen’s kappa = .642 (95% CI .522 to .762). Any and all disagreements between the raters were discussed until consensus was achieved.
Table 3. Quality assessment of included studies using the CASP Qualitative Research Checklist (Critical Appraisal Skills Programme, 2018).

<table>
<thead>
<tr>
<th>Study</th>
<th>CASP Research Checklist Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Adams (2020)</td>
<td>✔️</td>
</tr>
<tr>
<td>Benoit, McCarthy Veach &amp; LeRoy (2007)</td>
<td>✔️</td>
</tr>
<tr>
<td>Bowen &amp; Moore (2014)</td>
<td>✔️</td>
</tr>
<tr>
<td>Cramond, Fletcher &amp; Rehan (2020)</td>
<td>✔️</td>
</tr>
<tr>
<td>Cunningham (2015)</td>
<td>✔️</td>
</tr>
<tr>
<td>DeLange &amp; Chigeza (2015)</td>
<td>✔️</td>
</tr>
<tr>
<td>Gallagher (2015)</td>
<td>✔️</td>
</tr>
<tr>
<td>Holstein (2011)</td>
<td>✔️</td>
</tr>
<tr>
<td>Hunter (2012)</td>
<td>✔️</td>
</tr>
<tr>
<td>Johnson (2016)</td>
<td>✔️</td>
</tr>
<tr>
<td>Jorgensen (2012)</td>
<td>✔️</td>
</tr>
<tr>
<td>Killian (2016)</td>
<td>✔️</td>
</tr>
<tr>
<td>McCoy (2019)</td>
<td>✔️</td>
</tr>
<tr>
<td>Michalchuk &amp; Martin (2018)</td>
<td>✔️</td>
</tr>
<tr>
<td>Moffatt (2018)</td>
<td>✔️</td>
</tr>
<tr>
<td>Norrman Harling, Hörgman &amp; Schad (2020)</td>
<td>✔️</td>
</tr>
<tr>
<td>Nurse (2020)</td>
<td>✔️</td>
</tr>
<tr>
<td>Perkins &amp; Sprang (2013)</td>
<td>✔️</td>
</tr>
<tr>
<td>Udipi et al. (2008)</td>
<td>✔️</td>
</tr>
</tbody>
</table>

Note: Please see Appendix C for the CASP and its criterion.
Research Aims and Design.

All of the studies complied with the criterion of describing clear research aims for which a qualitative methodology was appropriate and providing adequate justification for the research design chosen.

Recruitment.

Studies were appraised as having a recruitment strategy appropriate to the aims of the research if they justified their sampling decisions and explained their recruitment strategy. Eighteen studies were assessed as meeting this criteria. Two studies were marked as “can’t tell” as, whilst they both described the rationale behind their participant inclusion and exclusion criteria, neither reported the recruitment strategy used (Killian, 2016; Michalchuk & Martin, 2018).

Data Collection.

All of the studies met the criterion of collecting data in a way that addresses the research issue, as they explicitly described and justified the methods, form and setting of the data collection.

Researchers’ Reflections on their Role in the Research.

Thirteen of the studies met criterion involving researchers critically examining their role in the research, relationship to the participants, and the possible bias or influence this may have had on the research design or process. Reflexive practices, such as bracketing interviews and reflective journals, and adaptations made to the research methodology or analysis where potential areas of bias were identified, were used in these studies.

Seven studies made no explicit reference to consideration of the possible relationship between the researcher and the research carried out. Six were therefore assessed as not being able to tell from the research papers whether the researchers had taken these into consideration.
when designing and carrying out the research (Adams, 2020; Holstein, 2011; Michalchuk & Martin, 2018; Killian, 2016; Perkins & Sprang, 2013; Udipi et al., 2008) and one was appraised as not meeting this criterion as it described use of a snowball sampling method, whereby the researcher knew the first participant who then recruited additional participants to the study, with no explicit exploration of the possible impact this may have had (DeLange & Chigeza, 2015).

**Ethical Issues.**

Seventeen studies were appraised as having met the seventh criterion, as they adequately described ethical issues being taken into consideration throughout the research process. This involved explaining processes of seeking ethical approval, gaining consent from participants, and issues pertaining to the secure handling of data.

It was not possible to identify whether three of the studies met the seventh criterion, as there was no explicit discussion of ethical issues being taken into consideration throughout the research process (Benoit et al., 2007; Hunter, 2012; Udipi et al., 2008).

**Analysis and Description of Findings.**

The final three items on the CASP involve assessing whether the analysis was sufficiently rigorous, the findings are presented clearly, and the research is of value.

Eighteen studies were appraised as having adequately analysed the data as they described the analysis process, explained the process of identifying themes, provided sufficient data to support their findings, referred to any contradictory data, and described credibility checks within the analysis process. There was, however, variation in the quality and quantity of information provided. Two studies were assessed as not meeting the CASP criterion regarding sufficiently rigorous data analysis. One of these described the researcher undertaking the analysis on their own, with no credibility checks or member-checking of the findings,
provided limited explanation of the analysis process, and gave minimal evidence to support each of the themes identified (Holstein, 2011). The other provided no description of the data analysis processes undertaken, other than stating that a “qualitative case study methodology approach” had been used (Johnson, 2016).

All of the studies were assessed as meeting the ninth criterion, in that they provided a clear statement of findings. Each of the twenty studies described their findings, moving beyond descriptive analysis to more interpretative discussion of themes identified, and linking them back to the research question. Several of the studies provided tables and hierarchies to clearly demonstrate the relationship between the themes and subthemes.

All twenty studies also provided valuable contributions to the existing literature and discussed their findings in relation to implications for clinical practice, policies, and previous research. In some of the studies, the researchers also described the limitations of their own research and possible areas for further exploration.

**Sensitivity Analysis**

The sensitivity analysis involved removing data originating from the studies identified as weakest during the quality appraisal process and subsequently comparing the results to the original themes. This was done in order to explore the relative contributions of the studies of lower quality and whether inclusion of these studies altered the structure or content of the themes.

Using the CASP, and in discussion with the wider research team, it was agreed that studies appraised as failing to meet any one of the criteria and studies assessed as “can’t tell” for two or more of the criteria were classified as weaker (Holstein, 2011; DeLange & Chigeza, 2015; Johnson, 2016; Killian, 2016; Michalchuk & Martin, 2018; Udipi et al., 2008). After removing these studies one of the sub-themes, ‘Therapist factors: Humour’, was supported by
three studies as opposed to being supported by five when all of the studies are included. This theme should therefore be interpreted with caution. Significant support for the other themes remained, suggesting that inclusion of the six studies identified as weaker did not significantly alter the findings of this review.

Table 4 provides a summary of the contribution of each of the included studies to the themes and sub-themes identified as a result of this review. The study making the smallest overall contribution to the themes and sub-themes described in the results section of this review, evidenced in only five, used a mixed methods design (Holstein, 2011). Data collection using open-ended questionnaire items, in comparison to other studies using semi-structured interviews, may at least in part account for the smaller contribution of the Holstein (2011) study to the overall findings of this review.
### Themes and Sub-themes

<table>
<thead>
<tr>
<th>Study</th>
<th>1</th>
<th>1.1</th>
<th>1.2</th>
<th>1.3</th>
<th>2</th>
<th>2.1</th>
<th>2.2</th>
<th>2.3</th>
<th>2.4</th>
<th>3</th>
<th>3.1</th>
<th>3.2</th>
<th>4</th>
<th>5</th>
<th>5.1</th>
<th>5.2</th>
<th>5.3</th>
<th>5.4</th>
<th>5.5</th>
<th>6</th>
<th>6.1</th>
<th>6.2</th>
<th>6.3</th>
<th>7</th>
<th>8</th>
<th>8.1</th>
<th>8.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams (2020)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Benoit, McCarthy Veach &amp; LeRoy (2007)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Bowen &amp; Moore (2014)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cramond, Fletcher &amp; Rehan (2020)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cunningham (2015)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>DeLange &amp; Chigeza (2015)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gallagher (2015)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Holstein (2011)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hunter (2012)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Johnson (2016)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Jorgensen (2012)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Study</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Killian (2016)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>McCoy (2019)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michalchuk &amp; Martin (2018)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moffatt (2018)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norrman Harling, Hörgman &amp; Schad (2020)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse (2020)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perkins &amp; Sprang (2013)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roman (2000)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Udipi et al. (2008)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: A tick indicates that the theme/sub-theme was described by the study. Please see Table 5 for a summary of the findings (themes and sub-themes).
Meta-Synthesis

The findings of the included studies were synthesised and eight overarching themes emerged (see Table 5 for a summary of themes and subthemes). When analysing and synthesising data relating to risk and protective factors for both CF and CS, it became apparent that CS and its influencing factors were predominantly discussed in relation to their subsequent influence on levels of CF. CS, and factors contributing to or reducing it, are therefore presented as a theme within the broader factors influencing MHPs experiences of CF.

The first theme describes workplace factors influencing MHPs experiences of CF, with subthemes of: support from colleagues and supervisors, workplace cultures, and the sustainability of frameworks within the workplace.

The second theme, relating to factors increasing or decreasing CS, has four subthemes: contributing to changes in patients’ lives, experiences of ethical stress arising when feeling unable to help patients, patient factors, and opportunities for professional development.

The third theme, the influence of the nature of the work on experiences of CF, has two subthemes: the extent to which MHPs become desensitised to their patients suffering, and experiences of vicarious trauma.

The fourth theme discusses therapist factors, described as either contributing to or protecting against CF. This theme has five subthemes relating to the influence of levels of self-confidence in their skills and abilities, hopefulness, affinity for people and a desire to form meaningful relationships, sense of humour, and MHPs identity outside of their role as a therapist.

The fifth theme relates to understanding and awareness of CF, and how this can help MHPs to notice and respond to CF in ways that mitigate its impact.
The sixth theme, strategies employed to alleviate and protect MHPs against CF, includes three subthemes relating to boundary setting, identifying and responding to their own needs, and detaching from the distress of their patients.

The seventh theme describes how use of self-compassion, both as a way of being with oneself and as an active practice, can help to prevent and mitigate experiences of CF.

The eighth, and final, theme describes life factors outside of work that influence experiences of CF. This theme has two subthemes relating to how supported the participants felt by their family and friends, and how fulfilled they felt by their lives outside of work.

The frequency with which each theme occurred across the 20 included studies is presented in Table 4.
Table 5. *Overarching analytic themes and subthemes.*

<table>
<thead>
<tr>
<th>Analytic Theme</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Workplace Factors</td>
<td>1.1. Support</td>
</tr>
<tr>
<td></td>
<td>1.2. Culture of the workplace</td>
</tr>
<tr>
<td></td>
<td>1.3. Structures and frameworks</td>
</tr>
<tr>
<td>2. Compassion Satisfaction</td>
<td>2.1. Contributing to changes in patients’ lives</td>
</tr>
<tr>
<td></td>
<td>2.2. Ethical stress</td>
</tr>
<tr>
<td></td>
<td>2.3. Patient factors</td>
</tr>
<tr>
<td></td>
<td>2.4. Professional development</td>
</tr>
<tr>
<td>3. The Nature of the Work/Trauma</td>
<td>3.1. Becoming desensitised to suffering</td>
</tr>
<tr>
<td></td>
<td>3.2. Vicarious trauma</td>
</tr>
<tr>
<td>4. Understanding and</td>
<td></td>
</tr>
<tr>
<td>Awareness of Compassion Fatigue</td>
<td></td>
</tr>
<tr>
<td>5. Therapist Factors</td>
<td>5.1. Self-confidence</td>
</tr>
<tr>
<td></td>
<td>5.2. Hope</td>
</tr>
<tr>
<td></td>
<td>5.3. Affinity for people and relationships</td>
</tr>
<tr>
<td></td>
<td>5.4. Humour</td>
</tr>
<tr>
<td></td>
<td>5.5. Sense of self outside of being a therapist</td>
</tr>
<tr>
<td></td>
<td>6.2. Recognising and responding to their own needs</td>
</tr>
<tr>
<td></td>
<td>6.3. Detachment</td>
</tr>
<tr>
<td>7. Self-Compassion</td>
<td></td>
</tr>
<tr>
<td>8. Life Factors</td>
<td>8.1. Feeling supported</td>
</tr>
<tr>
<td></td>
<td>8.2. A life outside of work</td>
</tr>
</tbody>
</table>
1. Workplace Factors

Seventeen studies described how workplace factors influenced the risk of participants experiencing CF, both positively and negatively (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, 2015; Gallagher, Holstein, 2011; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008). The participants descriptions fell into three sub-themes: support from their colleagues, the culture of the workplace, and the sustainability of the frameworks/structures they were working within.

1.1. Support.

“The theme with the highest response rate (n=38) had to do with support, whether from peers, co-workers, or management. Seven responded that lack of support contributes to compassion fatigue while 31 responded that support given mitigates compassion fatigue.” (Holstein, 2011)

“Sharing with other clinicians... And watching other clinicians be vulnerable and say, you know, I didn’t like him or I couldn’t stand that person or it hurt me or any of that stuff. To hear other clinicians own those feelings made it a lot safer and easier for me to own my own.” (Roman, 2000)

Participants across seventeen studies spoke about how support from colleagues, or a lack thereof, could contribute to or mitigate the risk of them experiencing CF (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, 2015; Gallagher, 2015; Holstein, 2011; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008).

In sixteen studies, therapists described how supportive colleagues and supervisors played an important role in helping them to manage or prevent CF (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Gallagher, 2015; Holstein, 2011; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008).
Through the support of colleagues and supervisors, therapists described being able to notice, process and therefore mitigate experiences of CF.

Participants in seven studies emphasised the normalising impact of “shared vulnerability” between co-workers, in which they were able to share their difficulties with colleagues who understood what they were going through as they had experienced similar difficulties themselves (Roman, 2000; Jorgensen, 2012; Cramond et al., 2020; Bowen & Moore, 2014; Adams, 2020; Gallagher, 2015; Johnson, 2016).

Working within a team and having colleagues to “bounce ideas off of” was discussed as protecting against CF, through helping therapists to feel less alone in their work (Jorgenson, Nurse, 2020; Bowen & Moore, 2014; Michalchuk & Martin, 2018; Adams, 2020). Further to support from peers and colleagues, clinical supervision was described as helping to protect against CF (Bowen & Moore, 2014; Adams, 2020; Benoit et al., 2007; Gallagher, 2015; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Norrman Harling et al., 2020; Cramond et al., 2020). Supervision was considered helpful when supervisors were caring, made the therapists feel safe, and supported therapists to make sense of and navigate through experiences of CF.

In comparison, unsupportive colleagues and supervisors contributed to experiences of CF (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cunningham, 2015; Gallagher, 2015; Holstein, 2011; Johnson, 2016; Kililan, McCoy, 2019; Norrman Harling et al., 2020; Perkins & Sprang, 2013; Roman, 2000), as participants felt ashamed of themselves and their practice, unheard, and misunderstood after unhelpful experiences of sharing with colleagues who were deemed untrustworthy and responded judgmentally (Adams, 2020; Cunningham, 2015; Holstein, 2011; Johnson, 2016; McCoy, 2019; Norrman Harling et al., 2020). Further, therapists felt unsupported by supervisors when supervision was held infrequently, seen as a “box ticking” exercise, and when it felt as though their practice was under scrutiny (Adams, 2020; Bowen & Moore, 2014; Cunningham, 2015; Gallagher, 2015; Johnson, 2016; Norrman
Harling et al., 2020; Perkins & Sprang, 2013; Roman, 2000). In these instances, with colleagues and supervisors, participants described feeling isolated and unsupported, thereby increasing the risk of them experiencing CF (Benoit et al., 2007; Bowen & Moore, 2014; Cunningham, 2015; Johnson, 2016; Killian, 2016).

1.2. Culture of the workplace.

“Clinical psychologist off sick with exhaustion, depression, really? You know it was a bit of an extra stigma… it’s something that you know a lot about and therefore ergo shouldn’t suffer from but of course we’re human, aren’t we?” (Cramond et al., 2020)

“There’s a kind of safety net… That when we’re in a bad place we can say, this is not good at the moment, rather than having to toughen up.” (Gallagher, 2015)

The impact of workplace cultures on experiences of CF were discussed in seven studies (Jorgensen, 2012; Gallagher, 2015; McCoy, 2019; Bowen & Moore, 2014; Holstein, 2011; Michalchuk & Martin, 2018; Nurse, 2020).

Participants described either an explicit or unsaid expectation that they should be “infallible” and able to manage their work without complaint as it is “their job” (Cramond et al., 2020; Norrman Harling et al., 2020; Udipi et al., 2008; Benoit et al., 2007; Bowen & Moore, 2014). They described shame and stigma around MHPs experiencing difficulties with their own mental health, which prevented them from seeking help and increased their risk of experiencing CF. A pressure felt to minimise their own difficulties and “put on a performance” was also described, the effort of which participants said exacerbated experiences of CF (Benoit et al., 2007; Cramond et al., 2020; Norrman Harling et al., 2020).

At the other end of the spectrum, working in person-centred services with humanistic cultures helped to protect against and mitigate experiences of CF (Jorgensen, 2012; Gallagher, 2015; McCoy, 2019; Bowen & Moore, 2014; Holstein, 2011; Moffatt, 2018; Nurse, 2020; Michalchuk & Martin, 2018). Being treated as “human” normalised difficulties participants experienced and facilitated help-seeking (Jorgensen, 2012; Gallagher, 2015; McCoy, 2019;
Participants also valued working in services in which there was an appreciation of their wider needs and flexibility in helping them to meet these needs (Jorgensen, 2012; Gallagher, 2015; McCoy, 2019; Moffatt, 2018; Nurse, 2020). This fostered job satisfaction, which participants said mitigated CF.

1.3. Structures and Frameworks.

“Too much work (too many patients) and too much stress from administrative tasks lead to burnout which then may render practitioners more vulnerable to and/or less able to manage compassion fatigue” (Benoit et al., 2007)

Fifteen studies described how workplace structures and frameworks influenced therapists experiences of CF (Adams, 2020; Michalchuk & Martin, 2018; Roman, 2000; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Gallagher, 2015; Holstein, 2011; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Norrman Harling et al., 2020; Nurse, 2020; Udipi et al., 2008).

Working within unsustainable frameworks contributed to and exacerbated experiences of CF (Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Gallagher, 2015; Holstein, 2011; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Norrman Harling et al., 2020; Nurse, 2020; Udipi et al., 2008). Participants reported large, unmanageable caseloads as draining and stressful, with constant change, increasing demands and a pressure to “do more with less” increasing the risk of CF (Cramond et al., 2020; Nurse, 2020; Johnson, 2016; Norrman Harling et al., 2020; Gallagher, 2015; Holstein, 2011; McCoy, 2019). In particular, participants expressed frustration with administration tasks and “bureaucratic red tape”, as they found these tasks meaningless and derived little pleasure from them (Benoit et al., 2007; Norrman Harling et al., 2020; Nurse, 2020; Holstein, 2011; McCoy, 2019).

In comparison, sustainable frameworks helped prevent and mitigate experiences of CF (Norrman Harling et al., 2020; Adams, 2020; Moffatt, 2018; Jorgensen, 2012). Sustainable frameworks involved caseloads and demands that felt interesting, manageable, and relevant to
MHPs roles. Having strong leadership that set clear expectations was said to mitigate CF by reducing uncertainty about the remit of participants’ roles (Norrman Harling et al., 2020; Roman, 2000).

2. Compassion Satisfaction

Participants in nineteen studies described experiences of CS, both as a phenomenon in itself and as a protective factor preventing and mitigating therapists’ experiences of CF (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, 2015; DeLange & Chigeza, 2015; Gallagher, 2015; Hunter, 2012; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Moffatt, 2018; Norrman Harling et al., 2020; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008). The factors influencing experiences of CS, and therefore CF, across these studies fell into four sub-themes: Contributing to change in patients’ lives, Ethical stress, Patient factors, and Professional development.

2.1. Contributing to change in patients’ lives.

“I’m surprised to see that the same areas that fatigue some [people] provide satisfaction for others. However, I guess that makes sense as I figure that the fatigue is created when the counselor is struggling and not seeing progress with these clients, whereas the satisfaction comes from when success with these clients does occur.” (Bowen & Moore, 2014)

Making a difference.

The sense of making a difference through their work was the predominant factor that influenced therapists experiences of CS (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; DeLange & Chigeza, 2015; Gallagher, 2015; Hunter, 2012; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, 2020; Roman, 2000; Udipi et al., 2008).
Feeling as though they had not helped their patients acted as a barrier to MHPs experiencing CS, with not seeing patients progressing towards their goals being described as particularly frustrating and disheartening (Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Gallagher, 2015; Hunter, 2012; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018).

On the other hand, therapists described the satisfaction they derived from feeling as though they had contributed to positive changes in their patients’ lives (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; DeLange & Chigeza, 2015; Gallagher, 2015; Hunter, 2012; Johnson, 2016; Jorgensen, 2012; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, 2020; Roman, 2000). Seeing patients make changes and noticing areas of improvements resulting from their work, particularly in areas where patients had previously experienced significant difficulties, was associated with therapists feeling as though they had done their job well and that their work was meaningful. This was described as the main source of CS for therapists in eight of the studies (Adams, 2020; Bowen & Moore, 2014; Cramond et al., 2020; Gallagher, 2015; Hunter, 2012; Jorgensen, 2012; Norrman Harling et al., 2020; Roman, 2000). Further, two studies spoke about the buoying and re-energising impact of therapists being able to experience their patients joy with them (Adams, 2020; Jorgensen, 2012). Participants in all twelve of the aforementioned studies described how CS acted as a buffer, protecting them from experiencing CF.

*Feeling valued.*

Whilst feeling unappreciated by their patients prevented MHPs from experiencing CS and increased their risk of CF (Benoit et al., 2007; Johnson, 2016; McCoy, 2019; Udipi et al., 2008), feeling as though their work was valued increased CS, which in turn protected them against CF (Michalchuk & Martin, 2018; Nurse, 2020; Udipi et al., 2008, Jorgensen, 2012; Adams, 2020; Bowen & Moore, 2014; Benoit et al., 2007; DeLange & Chigeza, 2015; Johnson,
2016; Norrman Harling et al., 2020; Roman, 2000; Cramond et al., 2020). Furthermore, feeling appreciated by both their colleagues (by being treated respectfully and being turned to for help) and their patients (through expressions of gratitude) created a sense of CS for therapists (Michalchuk & Martin, 2018; Nurse, 2020; Udipi et al., 2008, Adams, 2020; Bowen & Moore, 2014; De Lange & Chigeza, 2015; Johnson, 2016; Norrman Harling et al., 2020; Roman, 2000).

2.2. Ethical stress.

“Participants described their frustration when a patient wants something they cannot provide, or when they know what is best and the patient wants something else. Inability to help is very distressing: ‘I really wish I could have helped you, and I am devastated personally because I couldn’t.’“ (Benoit et al., 2007)

Ethical stress is defined as the emotional, physical and psychosocial consequences arising from the moral distress of knowing the right course of action but being unable to carry it out (Figley, 2002; Ulrich et al., 2007). Participants in thirteen studies described how ethical stress influenced their experiences of CS and CF (Adams, 2020; Bowen & Moore, 2014; Benoit et al., 2007; Cramond et al., 2020; Gallagher, 2015; Hunter, 2012; Jorgensen, 2012; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008). Ethical stress resulted from barriers preventing therapists from being able to help their patients, despite knowing what they could do to help them. The presence of ethical stress was repeatedly linked with reductions in CS and increases in CF, whereas it’s absence was associated with therapists feeling a greater sense of CS, which in turn helped to mitigate or protect against CF.

The impact of ethical stress on the participants experiences of CS and CF was influenced by their perceptions of their work. Participants spoke about the heaviness of feeling responsible to their patients and as though their work will have direct consequences as increasing ethical stress when they are unable to help (Benoit et al., 2007; Bowen & Moore, 2014; Hunter, 2012; Jorgensen, 2012; Michalchuk & Martin, 2018; Nurse, 2020; Perkins &
Sprang, 2013; Roman, 2000; Udipi et al., 2008). Further, high levels of risk and uncertainty in relation to patient outcomes was described as a barrier to CS for therapists who felt a strong sense of responsibility for the wellbeing of their patients (Benoit et al., 2007; Bowen & Moore, 2014; Roman, 2000; Udipi et al., 2008, Cramond et al., 2020; Nurse, 2020; McCoy, 2019).

2.3. Patient factors.

“All but one of the participants reported experiencing a deep sense of satisfaction from the work, particularly when working with those clients who were invested in the process of therapy and with whom they felt a natural empathy” (Hunter, 2012)

Sixteen studies described patient factors that therapists felt influenced the levels of CS that they experienced in their work (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, 2015; Hunter, 2012; Johnson, 2016; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008).

Participants spoke about qualities that made specific patients easier or more rewarding to work with, which facilitated the development of CS (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cunningham, 2015; DeLange & Chigeza, 2015; Hunter, 2012; Johnson, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Nurse, 2020; Perkins & Sprang, 2013; Udipi et al., 2008). These included patients who were invested in therapy, motivated to make changes and receptive to guidance of the therapists (Hunter, 2012; Cunningham, 2015; Bowen & Moore, 2014; McCoy, 2019), as well as patients who openly expressed pleasure or gratitude for the support they had received (Adams, 2020; Bowen & Moore, 2014; Michalchuk & Martin, 2018; Nurse, 2020; Udipi et al., 2008, Benoit et al., 2007; DeLange & Chigeza, 2015; Johnson, 2016). Furthermore, working with client groups they felt passionate about helping was particularly rewarding and satisfying for therapists (DeLange & Chigeza, 2015; Michalchuk & Martin, 2018; Hunter, 2012; Bowen & Moore, 2014; Nurse, 2020; Perkins & Sprang, 2013).
In thirteen studies, participants also discussed patient factors that prevented them from experiencing CS in their work (Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Hunter, 2012; Johnson, 2016; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008). Patients who were reluctant to engage with therapy and resistant to change were identified as the most challenging and unsatisfying to work with (Bowen & Moore, 2014; Hunter, 2012; Killian, 2016; McCoy, 2019; Roman, 2000; Udipi et al., 2008, Nurse, 2020; Cramond et al., 2020). Those with greater levels of complexity (such as chronic difficulties or comorbid presentations) were similarly less satisfying to work with, however to a lesser extent as these patients were perceived as less purposively obstructive in the lack of progress being made (Benoit et al., 2007; Norrman Harling et al., 2020; Nurse, 2020; Perkins & Sprang, 2013; Michalchuk & Martin, 2018). Therapists also described experiencing less satisfaction in their work with patients who were unlikeable or difficult to empathise with, such as perpetrators of abuse or patients who displayed aggression towards them (Benoit et al., 2007; Johnson, 2016; McCoy, 2019; Perkins & Sprang, 2013; Roman, 2000; Nurse, 2020; Bowen & Moore, 2014). Further, working with patients with interpersonal difficulties, where therapists felt the need to constantly monitor and maintain the boundaries of the patient/therapist relationship, was described as mentally demanding and therefore contributed to experiences of CF (Bowen & Moore, 2014; Johnson, 2016; McCoy, 2019; Nurse, 2020).

2.4. Professional development.

“I think new professional learning is very helpful to deal with my compassion fatigue because I think, at least for me part of compassion fatigue is feeling like I don’t know what to do... The trainings I go to are very invigorating and revitalizing and give me new ideas and refresh my memory about things I already knew... I can’t think of a training where I didn’t come out feeling vitalized and like ‘I want to try this, you know use this to help people’.” (Jorgensen, 2012)
Seven studies described the importance of continued professional development in increasing therapists’ CS (Benoit et al., 2007; Jorgensen, 2012; Moffatt, 2018; Norrman Harling et al., 2020; Nurse, 2020; Roman, 2000; Gallagher, 2015). Whilst some participants spoke about feeling unsatisfied in their work as they felt they were not learning anything new or progressing their development (Benoit et al., 2007; Gallagher, 2015; Jorgensen, 2012), others described the revitalising impact of continued learning and the positive impact of this on their levels of CS (Jorgensen, 2012; Moffatt, 2018; Norrman Harling et al., 2020; Nurse, 2020; Roman, 2000).

3. The Nature of the Work

Participants across sixteen studies described ways in which the emotionally intense nature of their work increased the likelihood of them experiencing CF (Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, 2015; DeLange & Chigeza, 2015; Gallagher, 2015; Hunter, 2012; Johnson, 2016; Jorgensen, 2012; Killian, 2016; Michalchuk & Martin, 2018; McCoy, 2019; Nurse, 2020; Roman, 2000; Perkins & Sprang, 2013; Udipi et al., 2008).

3.1. Becoming desensitised to suffering.

“There appears to be a price to facing this trauma closely every day. The price is compassion fatigue”. (Roman, 2000)

Therapists in eleven studies spoke about becoming desensitised to the suffering of their patients over time, which they felt increased their risk of experiencing CF (Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Johnson, 2016; McCoy, 2019; Norrman Harling et al., 2020; Nurse, 2020; Michalchuk & Martin, 2018; Killian, 2016; Perkins & Sprang, 2013; Udipi et al., 2008). This desensitisation was associated with both the frequency and intensity of patients stories that therapists heard. Therapists described becoming increasingly
desensitised after hearing large volumes of patients difficulties (Benoit et al., 2007; Cramond et al., 2020; Johnson, 2016; McCoy, 2019; Killian, 2016; Nurse, 2020; Udipi et al., 2008), particularly when these were similar in nature or repetitive (McCoy, 2019; Nurse, 2020). Similarly, higher levels of desensitisation, and subsequently CF, were reported as resulting from “bearing witness” to highly emotive, painful and traumatic stories from their patients (Benoit et al., 2007; Johnson, 2016; McCoy, 2019; Norrman Harling et al., 2020; Nurse, 2020; Hunter, 2012; Cramond et al., 2020; Michalchuk & Martin, 2018; Bowen & Moore, 2014).

Having balanced and varied caseloads, as well as “unique” patients, was described as preventing therapists from becoming desensitised to their patients trauma, thereby reducing the risk of them experiencing CF (DeLange & Chigeza, 2015; Jorgensen, 2012; Cunningham, 2015; Gallagher, 2015).

3.2. Vicarious trauma.

“For some participants... Their traumatic memories of past clinical events (some of which occurred quite a while ago) still elicit an emotional response, and sometimes, other patients evoke memories of the traumatic event. Participants also described how being overwhelmed with emotions from work hampered their ability to deal with emotional demands in their home life and vice versa.” (Benoit et al., 2007)

Participants in three studies spoke about experiencing vicarious trauma symptoms following work with perpetrators and victims of traumatic events (Benoit et al., 2007; Cunningham, 2015; Roman, 2000). Participants described difficulties sleeping (Benoit et al., 2007; Cunningham, 2015; Roman, 2000), hypervigilance (Cunningham, 2015) and intrusive memories (Benoit et al., 2007; Cunningham, 2015; Roman, 2000) relating to their work, which increased their risk of CF by evoking unsustainably strong emotional responses and preventing them from detaching from their patients’ traumas.
4. Awareness and Understanding of Compassion Fatigue

“This process of becoming aware of the personal and professional effects of compassion fatigue included making initial connections between their distress and its contributory factors. This process continued as participants engaged in internal examination while continuing to make connections between what they were experiencing and the contributory factors which needed to be changed in order to navigate through the distress of the compassion fatigue they were experiencing.” (Jorgensen, 2012)

Participants across fifteen studies described their awareness and understanding, or lack thereof, of CF as influencing their vulnerability to experiencing it (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Gallagher, 2015; Hunter, 2012; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Moffatt, 2018; Norrman Harling et al., 2020; Nurse, 2020; Roman, 2000; Udipi et al., 2008).

Having little knowledge or awareness of CF was described as a risk factor (Benoit et al., 2007; Bowen & Moore, 2014; Gallagher, 2015; Adams, 2020; Jorgensen, 2012; McCoy, 2019). Participants spoke about being more vulnerable to experiencing CF when they were newly qualified (Benoit et al., 2007; Bowen & Moore, 2014; Gallagher, 2015; Adams, 2020; Jorgensen, 2012; McCoy, 2019) or when they had received no training on the phenomenon (Benoit et al., 2007; Bowen & Moore, 2014) as they were unable to notice the symptoms of CF, felt shame about their experiences, and were unsure of how to mitigate it.

On the other hand, developing an awareness and understanding of CF helped prevent and mitigate it (Udipi et al., 2008, Jorgensen, 2012; Killian, 2016; Gallagher, 2015; Nurse, 2020). Learning about CF through their own personal experiences (Adams, 2020; Roman, 2000; Jorgensen, 2012; McCoy, 2019; Moffatt, 2018; Hunter, 2012; Bowen & Moore, 2014; Cramond et al., 2020; Gallagher, 2015), the support of their colleagues (Cramond et al., 2020; Bowen & Moore, 2014; Adams, 2020; McCoy, 2019; Jorgensen, 2012), and training programmes (Adams, 2020; Jorgensen, 2012; McCoy, 2019; Norrman Harling et al., 2020; Nurse, 2020; Benoit et al., 2007) helped develop therapists understanding and awareness of the
phenomenon. Having experienced CF, participants described feeling motivated to mitigate its impact and prevent themselves from experiencing it again (Jorgensen, 2012; McCoy, 2019; Johnson, 2016; Adams, 2020), as well as being better able to notice and alleviate it (Jorgensen, 2012; Cramond et al., 2020; Norrman Harling et al., 2020; McCoy, 2019).

5. Therapist Factors

Seventeen studies described qualities, attitudes and values of the therapists themselves that either protected them against or contributed to their risk of experiencing CF (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cuningham, DeLange & Chigeza, 2015; Gallagher, 2015; Holstein, 2011; Hunter, 2012; Johnson, 2016; Killian, 2016; McCoy, 2019; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Nurse, 2020; Roman, 2000; Udipi et al., 2008).

5.1. Self-confidence.

“Participants also speculated that counselors have personality characteristics that may increase their risk for compassion fatigue, for instance, a desire to be in control, wanting to be liked, and perfectionism.” (Benoit et al., 2007)

“Experience, self-belief, process and self-development... These factors are seen as being a source of resilience against stress and compassion fatigue”. (Gallagher, 2015)

Eleven studies discussed participants confidence in their own skills and ability, as well as their propensity for self-criticism and self-doubt, as influential in the likelihood of them experiencing CF (Adams, 2020; Benoit et al., 2007; Cramond et al., 2020; Gallagher, 2015; Jorgensen, 2012; Michalchuk & Martin, 2018; Moffatt, 2018; Norrman Harling et al., 2020; Nurse, 2020; Roman, 2000; Udipi et al., 2008).

Perfectionism amongst the therapists, associated with high expectations of themselves and a desire to be in control of patient progress, was described as a risk factor for CF (Benoit et al., 2007; Norrman Harling et al., 2020). Linked to this, self-criticism (Benoit et al., 2007;
Norrman Harling et al., 2020; Nurse, 2020; Udipi et al., 2008, Jorgensen, 2012) and tendencies to doubt their own skill or abilities (Benoit et al., 2007; Jorgensen, 2012) were also spoken about as increasing therapists’ vulnerability. In addition to making the therapists feel inferior and incapable of doing their work, perfectionism, self-criticism and self-doubt were described as “demanding a lot of emotional and mental energy”, which the participants associated with an increased risk of CF (Norrman Harling et al., 2020).

Comparatively, having confidence in their skills and abilities as therapists protected MHPs against CF (Jorgensen, 2012; Benoit et al., 2007; Udipi et al., 2008, Gallagher, 2015; Cramond et al., 2020; Adams, 2020; Roman, 2000; Nurse, 2020; Michalchuk & Martin, 2018). Self-belief, internal validation, and assuredness in their experience were discussed as sources of resilience for therapists, buffering them against CF (Gallagher, 2015; Adams, 2020).

5.2. Hope.

“Hope is like a breath of fresh air... It’s the client’s gift back to the clinician” (Adams, 2020)

Eleven studies discussed how, where therapists sat on the continuum from hopefulness to hopelessness, played a significant role in their risk of experiencing CF (Adams, 2020; Bowen & Moore, 2014; Cunningham, 2015; Johnson, 2016; Jorgensen, 2012; McCoy, 2019; Michalchuk & Martin, 2018; Moffatt, 2018; Nurse, 2020; Roman & Udipi et al., 2008). Whilst several studies described the ways in which hopelessness (Michalchuk & Martin, 2018; Roman, 2000; Udipi et al., 2008, Jorgensen, 2012) and cynicism (Killian, 2016; Johnson, 2016; Michalchuk & Martin, 2018; Nurse, 2020; Roman, 2000; Jorgensen, 2012) increased the likelihood of therapists experiencing CF, participants in five studies spoke about how holding onto hope buffered them against CF (Jorgensen, 2012; Michalchuk & Martin, 2018; Moffatt, 2018; Bowen & Moore, 2014; Adams, 2020). Hopefulness involved optimistic worldviews (Michalchuk & Martin, 2018; Moffatt, 2018), positivity about the future (Adams, 2020), and
holding in mind that not everyone is suffering (Jorgensen, 2012; Cunningham, 2015; Nurse, 2020).

5.3. Affinity for people and relationships.

“Participants invariably expressed an affinity and passion for people, as well as an aptitude for cultivating effective therapeutic relationships that helped them overcome the difficulties of trauma work.” (Michalchuk & Martin, 2018)

“Jane professed extra-sensitivity and an “intuitive ability to discern” and feel others’ energy: “The problem with that level of sensitivity is that even though it can be a real blessing...it’s a ‘double-edged sword.’” (Jorgensen, 2012)

Across 16 studies participants described their affinity for people and relationships as a “double-edged sword” that both increased their risk of CF and protected them against it (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, Gallagher, 2015; Hunter, 2012; Jorgensen, 2012; Johnson, 2016; Killian, 2016; Michalchuk & Martin, 2018; Moffatt, 2018; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008).

Therapists desire to connect meaningfully with others, combined with their ability to form strong therapeutic relationships, created a sense of fulfilment that prevented and mitigated CF (Roman, 2000; Cramond et al., 2020; Michalchuck, Hunter, 2012; Moffatt, 2018; Bowen & Moore, 2014; Jorgensen, 2012). Gaining enjoyment from their relationships with their patients was described as sustaining for therapists (Michalchuk & Martin, 2018; Nurse, 2020; Jorgensen, 2012), as they found it rewarding to identify and empathise with them (Hunter, 2012; Moffat, 2018), and took pride in their ability to maintain unconditional positive regard for their patients (Michalchuk & Martin, 2018). Having values and affinity for interpersonal relationships motivated therapists to “acknowledge and work through” difficulties they were experiencing in order to help their patients (Jorgensen, 2012; McCoy, 2019; Micalchuck, Nurse, 2020; Cramond et al., 2020; DeLange & Chigeza, 2015; Gallagher, 2015; Adams, 2020).
Conversely, participants spoke about the dangers of this desire to connect and empathise with patients in increasing the risk of them experiencing CF (Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, 2015; Gallagher, 2015; Johnson, 2016; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008, Adams, 2020). MHPs discussed countertransference, in which strong personal reactions were evoked by patients that the therapists then had to work to understand and process, and becoming overly attached to or enmeshed with their patients as creating additional emotional demands that increased their risk of experiencing CF (Killian, 2016; Benoit et al., 2007; Cramond et al., 2020; Gallagher, 2015; Hunter, 2012; Johnson, 2016; Nurse, 2020; Udipi et al., 2008, Jorgensen, 2012).

5.4. Humour.

“A sense of humour is also another fortigenic quality that assisted therapists in this study to remain calm and focused. They believed that humour relieves them from exhaustion, compassion fatigue, and burnout. ‘Sense of humour enables both you and the people around you to lighten up’.” (DeLange & Chigeza, 2015)

Participants in five studies described their sense of humour as helping to mitigate experiences of CF (Adams, 2020; DeLange & Chigeza, 2015; Gallagher, 2015; Norrman Harling et al., 2020; Udipi et al., 2008). Specifically, participants spoke about using humour with colleagues as a way of commiserating (Adams, 2020) or making light of difficult issues arising in their work (DeLange & Chigeza, 2015; Gallagher, 2015; Udipi et al., 2008). Humour was described as having a sustaining impact on all of the therapists across these five studies.

5.5. Sense of self outside of being a therapist.

“I had more room to just be myself when I’m not sitting in front of a client. I felt more like myself because I had a life again and was finding passion and joy instead of just being tired all the time. So when I am in front of a client now, I have more of myself to bring instead of being this automaton” (Jorgensen, 2012)
Four studies described how participants having a strong sense of their own identity outside of being a therapist contributed to CS and helped to mitigate their experiences of CF (Jorgensen, 2012; Moffatt, 2018; Gallagher, 2015; Bowen & Moore, 2014). Having interests and passions outside of work were associated with participants having a stronger sense of self (Jorgensen, 2012; Moffatt, 2018), which in turn was associated with participants feeling more fulfilled (Jorgensen, 2012; Moffatt, 2018; Gallagher, 2015) and better able to separate themselves from the work they were doing (Jorgensen, 2012). This separation of self and work was important in decreasing the risk of participants experiencing CF (Jorgensen, 2012).

6. Strategies

Participants across seventeen studies described the practices and strategies they made use of to prevent or mitigate CF (Adams, 2020; Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, 2015; DeLange & Chigeza, 2015; Gallagher, 2015; Johnson, 2016; Jorgensen, 2012; McCoy, 2019; Michalchuk & Martin, 2018; Moffatt, 2018; Norrman Harling et al., 2020; Nurse, 2020; Perkins & Sprang, 2013; Roman, 2000; Udipi et al., 2008).

6.1. Setting boundaries.

“Boundaries and balance are also structuring for this participant. He mentioned that he avoids compassion fatigue and burnout by making a conscious effort to keep work life and home life separate” (Nurse, 2020)

Participants in thirteen studies spoke about the importance of setting clear boundaries, both at work and separating their work and home lives, as failing to do so increased their risk of experiencing CF (Benoit et al., 2007; Bowen & Moore, 2014; Cramond et al., 2020; Cunningham, 2015; Gallagher, 2015; Johnson, 2016; Jorgensen, 2012; Killian, 2016; McCoy, 2019; Moffatt, 2018; Norrman Harling et al., 2020; Nurse, 2020; Udipi et al., 2008).
At work, participants described overworking as contributing to CF. Taking on too many demands and more responsibility than they could sustainably manage had deleterious effects on therapists (Killian, 2016; & McCoy, 2019). Further, continually going “above and beyond” for their patients, at the expense of their own well-being, was linked with ‘burnout’ and CF (Cramond et al., 2020; Cunningham, 2015; Johnson, 2016; Jorgensen, 2012). Comparatively, setting boundaries in the form of saying ‘no’ to additional demands (Jorgensen, 2012; Cunningham, 2015; Nurse, 2020; Gallagher, 2015) and asserting clear boundaries with their managers and colleagues (Jorgensen, 2012; Gallagher, 2015; Norrman Harling et al., 2020) helped to mitigate their experiences of CF.

Similarly, clearly defined work/life boundaries helped to protect against CF (McCoy, 2019; Cunningham, 2015; Nurse, 2020). Whilst some participants described bringing work home as contributing to burnout and CF (Benoit et al., 2007; Cramond et al., 2020; Killian, 2016; McCoy, 2019; Bowen & Moore, 2014; Cunningham, 2015; Gallagher, 2015), others spoke about the importance of “switching off” from work (Benoit et al., 2007; Udipi et al., 2008; Jorgensen, 2012; Moffatt, 2018; Norrman Harling et al., 2020; Cramond et al., 2020). Strategies used to create work/life boundaries included: taking “processing time” to mentally prepare themselves for work beforehand and process the day afterwards (Jorgensen & Killian, 2016) and making use of rituals and routines to distinguish home and work lives from each other (Jorgensen, 2012; Killian, 2016; Moffatt, 2018).

6.2. Recognising and responding to own needs.

“Several participants mentioned strategies to increase their own well-being, such as... monitoring their psychological and physical well-being through practices such as therapy and self-reflection”. (Norrman Harling et al., 2020)

“Some participants described taking breaks or respites from clinical work in order to mitigate their compassion fatigue by seeking some ‘alone time’. One individual described the positive effect of vacations”. (Udipi et al., 2008)
“Self-care is important... because of the nature of any kind of therapeutic work, you have to recognise that after a client leaves and if you don’t get rid of the stress then it kind of builds up pretty soon”. (McCoy, 2019)

Self-reflection and introspection.

Participants in nine studies discussed the ways in which they felt self-reflection and introspection helped them to mitigate CF (Jorgensen, 2012; DeLange & Chigeza, 2015; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Cramond et al., 2020; McCoy, 2019; Nurse, 2020; Gallagher, 2015; Adams, 2020). Taking the time to reflect on themselves and their practice enabled MHPs to monitor their own wellbeing and develop an awareness of their capacity and limitations, which in turn helped them to notice (and mitigate where necessary) CF (Jorgensen, 2012; DeLange & Chigeza, 2015; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; Cramond et al., 2020). Participants also spoke about self-reflection as reducing the risk of CF by helping them to acknowledge and respond to their own personal traumas (Jorgensen, 2012; Cramond et al., 2020) and reflect on their experiences as a “whole” instead of focusing on recent successes or failures (Jorgensen, 2012; DeLange & Chigeza, 2015). Further, revisiting their own values through processes of introspection helped to mitigate CF by reminding therapists why they are passionate about and enjoy the work they do (Jorgensen, 2012; McCoy, 2019; Micalchuck, Nurse, 2020; Cramond et al., 2020; DeLange & Chigeza, 2015; Gallagher, 2015; Adams, 2020).

Reframing difficulties.

Ten studies described participants making use of reframing strategies to help them manage the, often challenging and emotionally draining, work they do (Jorgensen, 2012; Michalchuk & Martin, 2018; McCoy, 2019; Adams, 2020; Gallagher, 2015; Benoit et al., 2007; Bowen & Moore, 2014; Moffatt, 2018; Cunningham, 2015; Johnson, 2016). Focusing on positives, such as patients’ strengths and work they felt they had been successful in, helped to
increase CS and mitigate CF (Jorgensen, 2012; Michalchuk & Martin, 2018; McCoy, 2019; Adams, 2020; Gallagher, 2015). Similarly, participants also discussed the helpfulness of reframing patients difficulties (Benoit et al., 2007; Bowen & Moore, 2014; Moffatt, 2018) and focusing on what the patient is going through instead of their own experiences of hearing the patients story (Michalchuk & Martin, 2018; Cunningham, 2015; Johnson, 2016) in reducing the risk of CF.

_Taking breaks from clinical work._

Participants in seven studies spoke about the importance of taking breaks from clinical work in reducing the risk of CF (Udipi et al., 2008, Holstein, 2011; Jorgensen, 2012; McCoy, 2019; Adams, 2020; Gallagher, 2015; Johnson, 2016). Taking regular breaks and holidays proactively protected MHPs against CF (Udipi et al., 2008, Holstein, 2011; Jorgensen, 2012; Gallager, 2015), and more reactively taking time off of work or working part-time also helped to mitigate CF they were already experiencing (Jorgensen, 2012). Breaks from clinical work were described as restorative, enjoyable and sustaining for the participants.

_Practicing self-care_

Practicing self-care was spoken about as an important strategy for preventing and mitigating CF by therapists across eleven studies (Killian, 2016; McCoy, 2019; Cramond et al., 2020; Cunningham, 2015; Bowen & Moore, 2014; Micalchuk, Norrman Harling et al., 2020; Nurse, 2020; Bowen & Moore, 2014; Gallagher, 2015; Jorgensen, 2012). Self-care was broadly defined as involving activities and practices that helped therapists to check-in with and look after themselves. The most commonly described forms of self-care included exercise (Killian, 2016; McCoy, 2019; Cramond et al., 2020; Cunningham, 2015; Bowen & Moore, 2014; Micalchuk, Norrman Harling et al., 2020; Nurse, 2020; Bowen & Moore, 2014; Gallagher, 2015; Jorgensen, 2012), relaxation techniques (Cunningham, 2015; Bowen &
Moore, 2014), time to themselves (Gallagher, 2015; Jorgensen, 2012; McCoy, 2019), and practicing strategies they would share with their patients (Jorgensen, 2012; Killian, 2016; Cramond et al., 2020).

6.3. Detachment.

“It seemed that the clinical psychologists were able to engage with patients’ emotion whilst remaining somewhat healthily detached. This was exemplified by them not feeling a pull to “fix” patients’ situations and to simply be alongside them through their experiences.” (Cramond et al., 2020).

Participants in ten studies spoke about remaining “healthily detached” from their patients and their patients distress as a way of protecting against and mitigating experiences of CF (Jorgensen, 2012; Nurse, 2020; Cunningham, 2015; Michalchuk & Martin, 2018; Adams, 2020; Bowen & Moore, 2014; Cramond et al., 2020; Udipi et al., 2008, Johnson, 2016; Roman, 2000). Strategies employed included: sharing less of themselves with their patients (Roman, 2000; Jorgensen, 2012; Cramond et al., 2020), maintaining boundaried patient/therapist relationships (Jorgensen, 2012; Nurse, 2020; Cunningham, 2015; Michalchuk & Martin, 2018; Adams, 2020; Bowen & Moore, 2014; Cramond et al., 2020; Udipi et al., 2008, Johnson, 2016), and focusing on the therapeutic work instead of the patients distress (Udipi et al., 2008, Jorgensen, 2012; Michalchuk & Martin, 2018; Bowen & Moore, 2014; Johnson, 2016).

This strategy had to be employed by therapists carefully, however, as participants described difficulties in finding the right balance of engagement with and detachment from patients distress (Jorgensen, 2012; Johnson, 2016), and how compartmentalising to excess could reduce therapists’ CS, thereby increasing their vulnerability to experiences of CF (Adams, 2020; Cramond et al., 2020).

7. Self-Compassion

“One participant described how she would actively attempt to lower her expectations of herself, to a more realistic view of what is possible during a session: (...) being super
clever and prepared with every patient—that’s not possible... If I look back on a session and think “I should have done this, I could have achieved that boost in the treatment if I had prepared better, but I haven’t”. Then it might be better if the patient gets an extra session, and that’s that.” (Norrman Harling et al., 2020)

Ten studies described therapists developing more realistic expectations of themselves and cultivating self-compassion as helping to mitigate and protect them against CF (Roman, 2000; Jorgensen, 2012; McCoy, 2019; Norrman Harling et al., 2020; Bowen & Moore, 2014; Michalchuk & Martin, 2018; Moffatt, 2018; Cramond et al., 2020; DeLange & Chigeza, 2015; Adams, 2020).

Developing more realistic expectations of themselves, their patients and their work helped to reduce the risk of MHPs experiencing CF (Roman, 2000; Jorgensen, 2012; McCoy, 2019; Norrman Harling et al., 2020; Bowen & Moore, 2014; Michalchuk & Martin, 2018; Moffatt, 2018; Cramond et al., 2020). Participants did this through accepting the limits of their role and letting go of what they could not control (Jorgensen, 2012; DeLange & Chigeza, 2015; Michalchuk & Martin, 2018; Norrman Harling et al., 2020; McCoy, 2019; Bowen & Moore, 2014), emphasising the patients agency and the impact of this on the outcomes of the work (Roman, 2000; Jorgensen, 2012; McCoy, 2019), and acknowledging the challenges of their role as therapists (Jorgensen, 2012; DeLange & Chigeza, 2015; Cramond et al., 2020; Adams, 2020).

Further, participants described how cultivating self-compassion and taking a stance of acceptance and non-judgment towards their own practice prevented and mitigated CF (Jorgensen, 2012; Norrman Harling et al., 2020; Bowen & Moore, 2014).

8. Life Factors

Participants across fourteen studies described the ways in which their lives outside of work could influence their risk of experiencing CF (Jorgensen, 2012; Killian, 2016; Cunningham, 2015; Nurse, 2020; Adams, 2020; Gallagher, 2015; Norrman Harling et al., 2020;
8.1. Feeling supported.

“G2 provided this statement: I think also spending time with family. Just sitting there and talking at the dinner table... Seeing my kids and grandkids and goofing around and having a good time with them”. (Adams, 2020)

“For me, it [spirituality/religion] impacts it [experiences with compassion] a lot... you know for me, prayer takes it off me and puts it onto God; that may not sound like coping but it’s good to be able to let go.” (Bowen & Moore, 2018)

The support of family and friends outside of work was spoken about across ten studies (Jorgensen, 2012; Killian, 2016; Cunningham, 2015; Nurse, 2020; Adams, 2020; Gallagher, 2015; Norrman Harling et al., 2020; Benoit et al., 2007; Johnson, 2016; Udipi et al., 2008). Whilst participants spoke about loving, caring support from their family and friends as helping to protect them against CF (Jorgensen, 2012; Killian, 2016; Cunningham, 2015; Nurse, 2020; Adams, 2020; Gallagher, 2015; Norrman Harling et al., 2020), others described ways in which unsupportive relationships outside of work exacerbated difficulties and contributed to CF (Cunningham, 2015; Benoit et al., 2007; Johnson, 2016; Udipi et al., 2008). In the former, participants spoke about the benefits of being able to share enjoyable, light-hearted interactions about topics other than difficulties and suffering with their family and friends. In the latter, participants described feeling frustrated and invalidated when their family and friends didn’t want to listen to or struggled to understand the nature of their work.

Further to this, participants in seven studies spoke about the importance of faith and spirituality as helping to protect them against CF (Jorgensen, 2012; Killian, 2016; Nurse, 2020; Bowen & Moore, 2014; Adams, 2020; Cunningham, 2015; Johnson, 2016). They discussed the sense of support, comfort and containment they felt as a result of their belief in a “higher power”.
8.2. A life outside of work.

“Doing things that take your mind off of work, just doing things that help you relax. I mean, ’cause when you’re dealing with people’s problems day in and day out, it takes a toll . . . so just taking time away from everything and doing something that you enjoy.” (McCoy, 2019)

Finally the ability of participants to maintain a life outside of their work, and the extent to which they experienced this life as peaceful and enjoyable, was discussed across eleven studies as a contributing or mitigating factor for CF (Jorgensen, 2012; Killian, 2016; Cunningham, 2015; Moffatt, 2018; Norrman Harling et al., 2020; Nurse, 2020; Benoit et al., 2007; Gallagher, 2015; McCoy, 2019; Johnson, 2016; Michalchuk & Martin, 2018).

For participants who described their home lives as helping to protect them against CF, home was described as a safe, calming space that reenergised them (Jorgensen, 2012; Cunningham, 2015; Nurse, 2020; Johnson, 2016) as well as a place where they could experience their passions and enjoyment outside of work (Jorgensen, 2012; Killian, 2016; Cunningham, 2015; Moffatt, 2018; Normar Harling et al., 2020; Nurse, 2020; Benoit et al., 2007; Gallagher, 2015; McCoy, 2019). They also spoke about how reduced stressors at home helped them to feel better able to manage stressors at work without becoming compassion fatigued (Jorgensen, 2012; Michalchuk & Martin, 2018).

In contrast, stressful home lives contributed to and exacerbated experiences of CF, with stressors including: divorce, bereavements and financial difficulties (Benoit et al., 2007; Cunningham, 2015; Gallagher, 2015; Norrman Harling et al., 2020).
Discussion

This review aimed to identify the factors most commonly associated with influencing MHPs’ experiences of CF. In total, findings from 20 qualitative studies were reviewed and synthesised. Eight overarching themes were identified, with related subthemes depicting factors either increasing or mitigating the risk of CF. The results of this review offer insights into the factors influencing CF in MHPs, from which areas for further research and clinical recommendations to increase CS and reduce CF may be made.

Despite variation across the studies, some factors were commonly associated with influencing experiences of CF. Appearing in more than three quarters of the studies reviewed, the following themes could be considered main factors influencing CF in MHPs: the nature of the work, CS, workplace factors, therapist factors, and strategies. Other factors influencing CF described less consistently included: understanding and awareness of CF, lifestyle factors and levels of self-compassion. Broadly speaking, the results of this review identified that it was variation in factors within these themes, rather than the presence or absence of the factors in-and-of themselves, that influenced CF.

A large number of studies described a link between the nature of therapeutic work and the development of CF in MHPs. Specifically, the more consistently emotionally intense and demanding the work was, the higher the therapists risk of experiencing CF. This finding is supported throughout the literature, with previous research identifying an increased risk of CF in therapists working in intensely emotional settings, such as trauma services (Craig & Sprang, 2010) or palliative care settings (Slocum-Gori et al., 2013), as well as findings that healthcare professionals are more likely to experience CF after bearing witness to cumulative losses or traumas (Pehlivan & Güner, 2018; Kanter, 2007). Whilst this finding should be interpreted with caution, as several of the studies included were carried out in trauma and loss related settings, it was also discussed by MHPs working in generic mental health services.
In attempting to understand the link between the nature of therapeutic work and CF, it is important to consider the role of empathy. Figley’s (2002) causal model of CF posits that empathy and the emotional energy involved in connecting with others’ pain acts as the “driving force” behind the development of CF in therapists. Throughout the literature, MHPs have been found to demonstrate higher levels of empathy than their counterparts in other healthcare professions (Reynolds & Scott, 1999; Hojat et al., 2002), and empathy has consistently been implicated in the development of CF (Figley, 2002; Bush, 2009). A quantitative review of factors influencing CF in MHPs by Turgoose and Maddox (2017) identified that higher levels of empathy may increase MHPs vulnerability, however reported that the nature of this relationship could not be made clear through the synthesis of cross-sectional studies. The qualitative nature of the current review, however, enables more in-depth consideration of the relationship between empathy and CF. Based on the findings of the current review, it may be interpreted that it is the interaction between high levels of empathy in MHPs and the intensely emotional work they often undertake that places them at heightened risk of CF. This is supported by the findings of the current review that the nature of the work often led MHPs to become desensitised or experience vicarious trauma, and the use of detachment from patients as a helpful coping strategy, which all suggest an unsustainability to the empathic responses evoked in MHPs therapeutic work.

Corroborating the findings of previous quantitative (Turgoose & Maddox, 2017) and qualitative (Thompson, 2018) reviews exploring healthcare professionals’ experiences of CF, the current review also identified CS as a main influencing factor. Specifically, this review similarly found CS to be a protective factor for MHPs, reducing their likelihood of experiencing CF. Moving beyond the findings of previous studies, which simply identified an inverse relationship between CF and CS (Tugoose & Maddox, 2017; Ortega-Campos, 2020;
Craig & Sprang, 2010), this review considered the factors MHPs described as influencing their experiences of CS.

Across the studies included, MHPs consistently reported making a positive change to their patients’ lives through their work as re-energizing, motivating, and integral to them experiencing CS. Factors increasing the likelihood of therapists being able to make a difference, such as motivated and engaged patients, reduced structural barriers/red tape, and opportunities for professional development, were associated with increased levels of CS, whereas factors hindering therapists ability to help their patients were described as decreasing CS and increasing the risk of CF.

These findings may also be interpreted as fitting with Figley’s (2002) causal model of CF, which proposes that empathy evokes compassion in therapists, which motivates them to want to help their patients, leaving them satisfied when they feel able to do so, and creating compassion stress (or ‘ethical stress’) that contributes to CF when they aren’t. In line with this, and in light of the findings of the current review, empathy may be considered to play an equally important role in the development of CS as it does CF, as it motivates MHPs to want to help their patients, contributing to the former if they are able to and the latter if they are not. This notion is supported by quantitative research indicating significant relationships between levels of empathy and CS (Tugoose & Maddox, 2017; Ortega-Campos, 2020; Craig & Sprang, 2010). Further, descriptions of CS as re-energising and motivating identified in this review are consistent with previous research (Harr et al., 2014) and provide one way in which CS may protect MHPs against CF, which is widely associated with feeling emotionally and physically drained (Mathieu, 2007; Elwood et al., 2011).

Consistent with previous research establishing a link between burnout and CF (Potter et al., 2010; Conrad & Yellar-Guenther, 2006), the current review identified several workplace factors as influencing MHPs likelihood of experiencing CF. Many of the factors described as
increasing MHPs vulnerability, such as unsustainably high workloads, “bureaucratic red tape” and workplace cultures creating barriers to help-seeking, are also associated with burnout in MHPs throughout the literature (Craig & Sprang, 2010; Bhutani et al., 2012). On the other hand, factors such as establishing and maintaining strong work/life boundaries, manageable caseloads, clearly-defined roles and responsibilities, that were associated with reducing the risk for CF have also been linked to lower levels of burnout in MHPs (Potter et al., 2010; Slatten et al., 2011). Whilst burnout and CF are similar in symptomology, and are often researched together, findings of the current review may therefore be interpreted as indicating burnout as a risk factor for CF in MHPs.

Another work-related factor described as influencing MHPs risk of CF was how supported they felt in their workplaces. Consistent with previous research (Deighton et al., 2007), supportive workplaces, in which MHPs felt able to discuss their experiences and the challenges of their work, were described as normalising and decreased the risk of CF. In comparison, expectations of therapists to be “infallible” and fear of stigma should they disclose difficulties they were experiencing, was found to increase MHPs risk of CF. This finding invites consideration of the role shame plays in the development of CF, as it may be interpreted that feeling unable to discuss difficulties experienced exacerbates the risk of CF. Further, many of the studies described MHPs being able to talk to colleagues and supervisors about difficulties they were experiencing as helping them to become aware of CF and motivating them to take action to mitigate its impact. This finding, coupled with the finding that training and experience in relation to CF helped to prevent and mitigate it, suggests that increasing MHPs awareness and understanding of CF helps to protect them against it. This is supported by previous findings in the literature that training related to CF is associated with reductions in it (Potter et al., 2015; Sprang et al., 2007).
Finally, several of the studies reviewed described therapist factors as influencing the risk of CF. Findings that self-doubt and a lack of self-compassion are associated with higher risk of CF are supported by research indicating a relationship between higher levels of self-criticism and CF (Beaumont et al., 2016b).

Limitations.

One key limitation of the current review is that, whilst a comprehensive search strategy was developed making use of a PICOD framework as recommended by Soilemezi & Linceviciute (2018), it is unlikely that every relevant article was identified. Whilst a possible criticism of any review, this limitation is particularly relevant to the current review given the significant variability in the way qualitative research is made identifiable in keywords, titles and abstracts (Timulak, 2009).

The limited number of qualitative studies directly exploring factors influencing the likelihood of MHPs experiencing CF and/or CS resulted in selection of relatively broad inclusion criteria. In turn, this resulted in variation across the studies included in this review in terms of their aims, sample sizes, research settings, participant characteristics and data analysis. Due to this heterogenous sample, caution should be taken when generalising the findings of this review to any-and-all MHPs working therapeutically. Furthermore the current review only included studies published in the English language, the vast majority of which were carried out in Western countries. In doing so, relevant studies published in other languages may have been missed, thereby limiting the richness and generalisability of these findings.

There may also be significant variation in the methodological rigour of the included studies as this review included both peer-reviewed studies and unpublished research. Whilst attempts were made to mitigate the impact of this through quality appraisal of each study using the CASP (CASP, 2018) and carrying out a sensitivity analysis, there is ongoing debate about the appropriateness of quality appraisal within qualitative meta-synthesis (Noyes et al., 2018;
Sandelowski & Barroso, 2002). In light of this, and findings that the final themes were not significantly affected by removal of the studies appraised as of lower quality, no studies were excluded on the basis of the quality appraisal. As a result, variation in the quality of the included studies may limit the findings of this review.

Finally, whilst members of a research team were consulted at various time-points and a reflective journal was kept throughout the review process, this remains a qualitative synthesis and is therefore subject to researcher bias.

**Clinical recommendations.**

The findings of this review indicate several clinical recommendations that may be made in order to prevent and/or mitigate CF in MHPs.

One key finding of this review is the protective role CS may play in reducing the risk of CF. Having explored and identified the factors commonly described as influencing CS, recommendations may be made from this review as to how services employing MHPs can cultivate CS in their employees, thereby mitigating the risk of CF. Such recommendations may include: acknowledging and celebrating successes in MHPs work (both with their patients and as valued member of their teams); reducing non-clinical demands or barriers preventing MHPs from being able to do work they deem meaningful (for example, through hiring administrative assistants); providing opportunities for continued learning and development; and allocating MHPs diverse caseloads (for example, in terms of complexity and motivation to engage in therapy).

Based upon the findings of this review, many of these recommendations may have a two-fold impact on mitigating CF, both indirectly through increasing CS and more directly by tempering CF. For example, diverse caseloads may also reduce risk factors associated with the nature of the work by protecting MHPs from the impact of repeated exposure to highly emotive or traumatic patient stories. Similarly, reducing non-clinical demands and structural barriers
to MHPs work may directly decrease MHPs risk of CF by reducing the unsustainability of their workplace cultures and frameworks. Finally, the findings of this review indicate that opportunities for continued learning and development may be most beneficial for MHPs if related to enhancing their understanding and awareness of CF. In doing so, the risk of CF may be reduced through providing opportunities for continued learning (increasing CS), helping MHPs to notice and mitigate CF, and encouraging normalisation and de-stigmatisation of CF in MHPs workplaces if delivered at a service level.

**Research implications.**

The results of this review indicate that there may be an association between empathy, CS and CF. Whilst correlations between the three have been explored in quantitative studies (Hunt et al., 2019), no research to the authors knowledge has focused on this interaction specifically in MHPs. Further, no studies have qualitatively explored MHPs experiences and perceived associations between the empathy they feel for their patients and their experiences of both CF and CS. This may therefore be an interesting areas for further research, as listening to MHPs experiences and understanding the factors influencing these phenomena will enable services to adapt to their needs, ultimately facilitating the continued compassionate provision of mental health services.
References


Hill, R., Vaccarino, O., & Daly, K. J. (2015). Understanding Compassion Fatigue.


Jorgensen, L. B. (2012). The experiences of licensed mental health professionals who have encountered and navigated through compassion fatigue.


Moffatt, L. V. (2018). *What is Strong, Not What is Wrong; An Appreciative Inquiry into What Keeps Licensed Psychologists Consistently Enthusiastic about Working with Clients with Severe Mental Illness*. Our Lady of the Lake University.


Part 2: Empirical Paper

The Acceptability of a Newly Developed Brief Compassion-Focused Intervention for Trainee Psychological Wellbeing Practitioners: A Qualitative Study.
Abstract

Aims: This study set out to explore the acceptability of a newly developed brief compassion-focused intervention for trainee mental health professionals. It was part of a wider research project that also evaluated the feasibility and effectiveness of the intervention.

Method: The intervention was developed and planned in collaboration with key stakeholders. The intervention was piloted by delivering it to trainee psychological wellbeing practitioners as part of their core teaching programme. Qualitative methods were employed to explore the acceptability of the intervention via open-ended questions sent to participants through online surveys and further in-depth semi-structured interviews. Forty-four participants provided answers to the survey questions, which were analysed using content analysis. Data from the semi-structured interviews, carried out with 10 participants, was analysed using thematic analysis.

Results: The results indicated that, whilst several suggested improvements were recommended by participants, the acceptability of the intervention was generally high. Participants reported finding the intervention helpful and described positive changes they subsequently noticed in themselves and their work. Factors facilitating engagement with and implementation of the intervention, such as interactive and experiential content, were discussed as increasing acceptability. Conversely, contextual factors, such as multiple demands and levels of support, were most consistently spoken about as preventing participants from being able to make use of the intervention.

Conclusions: The brief compassion-focused intervention was largely perceived to be acceptable and helpful. However, some aspects of the intervention and the context in which it was delivered were discussed as creating barriers to engagement and implementation, thereby reducing its acceptability. These findings have several clinical implications and highlight areas for further research.
Introduction

Compassion is defined by Gilbert (2014) as a sensitivity to suffering in oneself and others, coupled with a commitment to alleviate and prevent it. It is conceptualised as emerging from a combination of emotions, thoughts, motives and actions that enable both the courage to turn towards suffering and the wisdom to know how to relieve it (Gilbert, 2005). There are three proposed ‘flows’ of compassion: compassion directed towards others; compassion received from others; and compassion directed towards the self (self-compassion; Gilbert, 2014).

For healthcare professionals (HCPs), invariably working to alleviate the distress and suffering of their patients, compassion is an “essential tool” for effective treatment (Figley, 2002). Emphasizing its necessity, the Health and Care Professions Council (HCPC) describe a “compassionate approach” as a fundamental standard of conduct, performance and ethics for all HCPs (HCPC, 2012). The importance of compassionate care is attested to by policy makers (Department of Health, 2012), patients (Sinclair et al., 2017) and their families (Cherlin et al., 2004), with research findings demonstrating that compassion is associated with higher quality care (van der Cingel, 2014) and improved patient outcomes (Sinclair et al., 2016; Frampton et al., 2013; Dibbelt et al., 2009).

Despite this, evidence indicates that “blocks, deficits and a general lack of compassion” exist in health and social care settings (Beaumont et al., 2016b). Following a UK public enquiry in 2013, which identified a systemic lack of compassionate care within the NHS as affecting both service outcomes and patient wellbeing (Francis, 2013), much research has explored the factors negatively affecting HCPs compassionate capacity (Beaumont et al., 2016b). Workplace factors, such as high workloads (Crawford et al., 2014) and under-trained staff (Horsburgh & Ross, 2013; Sprang et al., 2007), have been consistently implicated as a block to compassionate care through association with heightened levels of stress (Sharkey &
Sharples, 2003), burnout (Day et al., 2009) and compassion fatigue (defined as a reduced ability to empathise with and feel compassionate towards others; Mathieu, 2007; Figley, 2002). Reflecting these findings, changes were implemented across the NHS in an attempt to prevent and detect problems relating to a lack of compassionate care, including: hiring additional staff; increasing training opportunities; and introducing rigorous inspection regimes (Department of Health, 2015).

However, whilst improvements in the provision of compassionate care were reported following implementation of these changes, the Department of Health stated that “significant challenges in building a consistent culture of compassion” remained (Department of Health, 2015). One possible explanation for this may be that the aforementioned changes, and much of the research into increasing compassion in healthcare services, has focused on increasing Gilbert’s (2014) first flow of compassion: compassion HCPs direct towards their patients. Instead, the literature indicates that implementing changes and interventions to promote the flow of self-compassion in HCPs may more effectively cultivate a consistent culture of compassion.

Firstly, there is a growing body of evidence demonstrating the positive impact of self-compassion, both for improving physical health (e.g. immune system effectiveness, Klimecki et al., 2012) and psychological wellbeing (Neff & Germer, 2013). In turn, happier and healthier staff teams are associated with reductions in burnout (Baumrucker, 2002), increased job satisfaction (Satuf et al., 2018), higher quality work (Moccia, 2016); and compassion satisfaction (defined as a sense of achievement and pleasure derived from being able to help others; Figley & Stamm, 1996; Bowen & Moore, 2014). Secondly, research indicates that compassion for others is closely linked to self-compassion (Figley, 2002; Kret, 2011; Gilbert, 2005). Learning to be sensitive, respectful and non-judgmental towards oneself is posited to in turn facilitate the ability to demonstrate these characteristics to others (Wiklund-Gustin &
Wagner, 2013), and indeed cultivating self-compassion has been found to result in higher levels of compassion for others and greater motivation to alleviate others’ suffering (Condon et al., 2013). Therefore, promoting self-compassion in HCPs may have a two-fold beneficial impact: increasing staff resilience, thus mitigating the impact of workplace factors that may otherwise act as a barrier to compassion, and enhancing HCPs compassionate motivation and capacity.

Compassion focused therapy (CFT) and compassionate mind training (CMT) are therapeutic approaches specifically developed to facilitate the cultivation of compassionate attitudes, attributes and skills (Gilbert, 2014). Founded upon observations that individuals experiencing high levels of shame and self-criticism were less able to access self-soothing and self-reassurance (Gilbert & Procter, 2006), and identification of a strong inverse relationship between self-criticism and self-compassion (Gilbert et al., 2004), these approaches were developed to motivate individuals to be sensitive to their own needs and distress and extend warmth and understanding towards themselves (Gilbert, 2014; Beaumont et al., 2016a). CFT is a psychotherapy often used in therapeutic settings (Kirby, 2016), which adopts an evolutionary approach to help individuals understand and non-judgmentally accept the vulnerabilities of the human brain (e.g. for rumination, negativity bias and self-critical thoughts; Baumeister et al., 2001). CMT is a central element of CFT, suitable for use with non-clinical populations, that involves teaching specific practices (such as: compassionate imagery; mindfulness, and breathing/posturing exercises) to facilitate self-grounding and the ability to take a compassionate approach to oneself, others, and life difficulties (Matos et al., 2017; Martin et al., 2021).

Throughout the literature, CFT and CMT interventions have proven effective in promoting self-compassion, reducing self-criticism and shame, and improving wellbeing in the general public (Irons & Heriot-Maitland, 2020) and across a range of clinical populations (Beaumont & Martin, 2015; Gilbert & Irons, 2004; Gilbert & Procter, 2006; Harman & Lee,
More recently, research has also indicated the effectiveness of CMT in healthcare educators (Beaumont et al., 2016a) and professionals, including: midwives (Beaumont & Martin, 2016a); nurses (McVicar et al., 2021); and healthcare practitioners (Beaumont et al., 2021). However, to date, there is little evidence exploring the effects of CMT specifically in mental health professionals (MHPs).

Compassion-focused interventions may be of particular benefit to MHPs, given that empathy and compassion are considered to be essential qualities for effective therapy (Rogers, 1957; Kohut, 2010) and evidence indicates that self-compassionate therapists are better equipped to demonstrate compassion to their patients (Heffernan et al., 2010). The challenges of working therapeutically with patients experiencing psychological difficulties are linked to personal distress (Singer & Klimecki, 2014) and self-blame/self-criticism (Wheeler et al., 2004). These may act as blocks to compassion as they have been found to correlate with symptoms of burnout, compassion fatigue and reduced psychological wellbeing (Beaumont et al., 2016a). Further, therapists providing compassion for others in the absence of self-compassion have been found to experience increased stress in their practice (Gilbert & Choden, 2013). Conversely, self-compassion has been identified as playing a “significant role in therapists’ self-care” (Raab, 2014, p.98) and high levels of self-compassion have been associated with lower levels of compassion fatigue and burnout in MHPs (Beaumont et al., 2016a).

Moreover, there may be a rationale for focusing on trainee MHPs. Students undergoing training enabling them to deliver therapy to patients may be even more vulnerable to stress, burnout and compassion fatigue than their qualified counterparts due to the nature of their roles (Beaumont & Martin, 2016b). Firstly, working with distressed patients in emotionally draining settings (DeStefano et al., 2012) alongside a variety of idiosyncratic training-related demands (e.g. academic; clinical; organisational; placement/supervision based; financial and personal...
demands) is often experienced as stressful, with 24-41% of student therapists reporting difficulties in adjusting to training and an associated deterioration in their wellbeing (Boellinghaus et al., 2013; Brooks et al., 2002). Secondly, feelings of incompetence associated with being a student (Wheeler et al., 2004) may be exacerbated by the group environment of clinical training eliciting unfavourable self-comparisons (Edwards, 2013). Rønnestad and Skovholt (2003) found that, particularly in the initial stages of training, student therapists experience increased anxiety, self-criticism and unrelenting standards to excel without making mistakes, which it is proposed may act as a block to compassion and hinder their ability to engage fully with their clinical training, placements and supervision (Beaumont & Martin, 2016a). Throughout the literature, it is proposed that interventions aiming to cultivate self-compassion in trainee MHPs may help them to: “be kinder to themselves in times of stress”; build resilience to cope with idiosyncratic demands and engage more fully with their training; improve their wellbeing; and increase their compassionate capacity (Beaumont & Martin, 2016a; Mayhew & Gilbert, 2008).

Whilst evidence indicates that stand-alone compassion-focused interventions for trainee MHPs are both acceptable and effective (Finlay-Jones et al., 2017; Matos et al., 2017), Rimes and Wingrove (2011) advocate for incorporating interventions into clinical training programmes to help students become more mindful of their own wellbeing, rather than it being presented as “their own individual responsibility” (Christopher et al., 2006). Beaumont and Martin (2016) propose that creating compassionate environments during training may provide a ‘secure base’ for trainee MHPs that may improve the long-term quality of care student therapists give to both themselves and their patients.

To the authors knowledge, only one study has previously explored the effects of integrating a compassion-focused intervention into a training programme for student MHPs. Beaumont et al. (2017) found that trainee MHPs attending 15 hours of CMT, as part of their
Cognitive Behavioural Therapy training course, reported significant increases in self-compassion and reductions in self-critical judgment. Whilst this provides promising evidence of the “immense benefit” student MHPs may gain from integrated CMT interventions (Beaumont et al., 2017, p.308), most UK clinical training courses (such as Psychological Wellbeing Practitioner [PWP] and Doctorate in Clinical Psychology [DClinPsy] training programmes) must meet strict teaching requirements in order to be accredited by professional bodies. These training courses may therefore have limited flexibility and capacity to integrate 15 hours of CMT into their regular teaching programmes.

In light of this, the current study aimed to develop and pilot a brief compassion-focused intervention for trainee MHPs. The Medical Research Council’s (MRC) guidelines for evaluating complex interventions advises piloting complex interventions, and evaluating them using a process evaluation framework (Moore et al., 2014), in order to assess feasibility, acceptability and preliminary outcomes, with the aim of preventing subsequent mainstage evaluations being undermined by issues relating to: compliance; delivery; implementation; recruitment; retention or context (Craig et al., 2008). In line with these guidelines and frameworks, the current overarching research project combined quantitative and qualitative methods to examine the interventions feasibility (implementation of the intervention); acceptability (mechanisms of impact and contextual/external influences as perceived by the participants); and preliminary outcomes. In doing so, it was hoped that it would not only indicate whether brief a compassion-focused intervention is effective for trainee MHPs, but also explain the interventions outcomes and identify ways of optimising its design and/or replicating it.

**Aims.**

The overarching research study aimed to explore whether a brief compassion-focused intervention is acceptable, feasible, and effective for trainee MHPs.
The aims were as follows:

1. To develop a brief compassion-focused workshop (2.5 hours in length), with follow-up exercises, for trainee MHPs.

2. To carry out a process evaluation of the intervention, exploring its acceptability and feasibility through use of quantitative and qualitative methods.

3. To evaluate the preliminary outcome data regarding the efficacy of the intervention, in order to explore whether the intervention significantly impacts trainee MHPs experiences of: self-compassion; wellbeing; shame; beliefs about emotions; self-criticism; social comparison; and perceived stress.

As this was a joint research project, the present article focuses only on the evaluation of the acceptability of the intervention for trainee PWPs (tPWPs). My colleague’s (SAG-A) doctoral thesis focuses on feasibility and preliminary outcome data.
Method

This study comprised two stages, informed by the MRC’s guidance on developing and evaluating complex interventions (Craig et al., 2008).

Stage 1: Intervention Planning and Development

This stage involved the planning and development of a compassion-focused intervention for tPWPs. Once the project received ethical approval from the UCL Research Ethics Committee (Project ID No: CEHP/2020/578, Appendix D), stakeholders were identified including: the researchers (myself [CG], another trainee Clinical Psychologist [SAG-A], and the main research supervisor [Dr Michelle Wilson] for the project); Course directors and tutors of London-based PWP and DClinPsy training courses; and a leading world expert in compassion-focused therapy and member of the Compassionate Mind Foundation (Dr Chris Irons). In total, the final stakeholder group comprised of four qualified and two trainee Clinical Psychologists.

In accordance with the MRC’s guidance (Craig et al., 2008), all of the stakeholders were consulted regarding the following areas in the planning and development stage:

1) Identifying the evidence base and developing theoretical rationale for the compassion-focused intervention for tPWPs
2) Practical considerations regarding implementation and delivery of the intervention (e.g. duration of the intervention, time-point of delivery, method of delivery)
3) The format and content of the intervention (e.g. workshop format, examples included in the workshop, recommended follow-up exercises)
4) Proposed procedures for piloting and evaluating the intervention
5) Consideration of resources that could be made available alongside the intervention (e.g. information about accessing support, supplementary resources)
Suggestions from every stakeholder regarding each of these areas were shared and revisions were made to the planning and development of the intervention in a cyclical process until consensus was reached amongst all of the stakeholders.

**The compassion-focused intervention.**

The agreed upon compassion-focused intervention comprised of a workshop, follow-up compassion-focused audio exercises, and a booklet.

The workshop lasted two and a half hours and was delivered by Dr Michelle Wilson as part of the tPWPs main timetabled teaching programme. It was intended to be interactive and experiential in nature, combining theory and opportunities to practice compassion-focused exercises. The content of the workshop was largely informed by Matos et al.’s (2017) Compassionate Mind Training (CMT) intervention, which was adapted in collaboration with the aforementioned stakeholders so that it may be delivered to the tPWPs.

*Compassion-focused workshop*

Broadly speaking, the workshop covered the following areas:

1) An introduction to compassion, including: defining compassion; characteristics of compassion; compassionate motivation; flows of compassion (e.g. to self, to others, from others)

2) The rationale for tPWPs practicing self-compassion, including: acknowledgment and validation of the challenges of the tPWP role; examples specific to the tPWP experience; a discussion of the evidence base

3) An introduction to CMT, including: the evolutionary theory behind CMT; the ‘three systems model’; explanations of emotion regulation and the value of self-compassion

4) Group CMT practice of the ‘Soothing Rhythm Breathing’ and ‘Compassionate Self’ exercises
5) Information about the research study, including: explanation that participation was voluntary; details about the follow-up questionnaires; and instructions for how to opt-in to the follow-up semi-structured interviews.

*Follow-up audio exercises*

The follow-up exercises comprised of four audio based CMT exercises, which were made available to all of the tPWP who attended the workshop: ‘Soothing rhythm breathing’; ‘Developing the compassionate self’; ‘Directing the compassionate self to another’; and ‘Directing the compassionate self to self’. These were recorded by Dr Michelle Wilson for continuity between the workshop and follow-up exercises.

*Post-workshop booklet*

With their consent, an amended version of the CMT booklet developed by Matos et al. (2017) was also shared with the tPWP. The content of the booklet was split into three parts:

1) Concepts at the basis of CMT
2) Important considerations regarding preparation for CMT practices
3) CMT exercises

*Stage 2: Pilot intervention and Process evaluation*

Following development with stakeholders, the acceptability and feasibility of the intervention were systematically assessed using a process evaluation framework (Moore et al., 2014), combining quantitative and qualitative methods to examine the following factors:

1) Implementation of the intervention: how the intervention was delivered and what was delivered;
2) Mechanisms of impact: how the intervention, and participants’ experiences of the intervention, triggered change;
3) Context: how external factors influenced the delivery and impact of the intervention.

In focusing on the acceptability of the intervention for tPWPs, this study predominantly outlines exploration of the latter two of these factors (mechanisms of impact and context) and how they influenced the perceived acceptability of the intervention. The first factor (implementation of the intervention) is touched upon briefly, where discussed by participants in relation to acceptability, however is explored in more detail alongside preliminary outcomes in my colleagues (SAG-A’s) thesis project.

**Design.**

Qualitatively exploring participants experiences of interventions, in order to understand how changes occur and whether interventions are experienced as acceptable, is key in the process evaluation of interventions (Grant et al., 2013). In line with this, the current study explored the acceptability of the intervention through use of qualitative methods.

Qualitative data exploring participants experiences of the intervention, any resultant changes, and facilitators/barriers to these changes, was gathered in two ways. Firstly, online surveys including brief open-ended questions were distributed to the participants two-weeks and two-months after the workshop. Secondly, in-depth semi-structured interviews were carried out with a sub-group of the participants, in order to explore the acceptability of the intervention in more detail.

**Participants.**

Participants were recruited through a London-based PWP training course. The compassion-focused workshop was delivered to five cohorts of tPWPs as part of their timetabled teaching programme. At the beginning of the workshop all of the tPWPs were informed about the research study and invited to take part, with assurance that participation was entirely voluntary.
Of the 251 tPWPs who attended the workshops in total, 194 consented to participate in the research study and completed the baseline measures. Due to the small size of the PWP training course, minimal sociodemographic data (i.e. only regarding gender and age group) was collected at this point to protect participants from being identifiable. In total, 164 female, 15 male, and 15 gender unspecified tPWPs chose to take part in the research study. The majority of participants were aged 20-24 (46%) or 25-34 (37%). Participant demographics are presented in Table 1.

Further information regarding the number of responses to the online surveys and in-depth interviews is provided in the Results section below.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants (N = 194)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>164 (84.5%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15 (8%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1 (0.5%)</td>
<td></td>
</tr>
<tr>
<td>Unanswered</td>
<td>14 (7%)</td>
<td></td>
</tr>
<tr>
<td><strong>Age range:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>91 (47%)</td>
<td></td>
</tr>
<tr>
<td>25-34</td>
<td>72 (37.5%)</td>
<td></td>
</tr>
<tr>
<td>35-44</td>
<td>13 (6.5%)</td>
<td></td>
</tr>
<tr>
<td>45-54</td>
<td>4 (2%)</td>
<td></td>
</tr>
<tr>
<td>55-60</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>60+</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Unanswered</td>
<td>14 (7%)</td>
<td></td>
</tr>
</tbody>
</table>
Setting.

The workshop was delivered to the first two cohorts of tPWPs in person in March 2020 (111 tPWP attendees in total, of which 99 completed the baseline measures). The last three cohorts of tPWPs received the workshop in November 2020, which they attended virtually via BlackBoard Collaborate online software due to restrictions relating to the COVID-19 pandemic (140 tPWP attendees in total, of which 95 completed the baseline measures).

Outcome measures and brief open-ended questions were distributed to and completed by participants using web-based Qualtrics online surveys. Semi-structured qualitative interviews took place via MicrosoftTeams video conferencing software, due to restrictions relating to the COVID-19 pandemic. The researcher had no face-to-face contact with the participants at any stage of this study.

Measures.

Online surveys

Participating tPWPs were asked to complete the same battery of standardised measures before the start of the workshop (baseline = T0), two weeks after receiving the intervention (T1), and two months after receiving the intervention (T2). This battery of measures was designed to take less than 20 minutes to complete and assessed experiences related to: self-compassion; wellbeing; shame; beliefs about emotions; self-criticism; social comparison; and perceived stress. At T1 and T2 optional open-ended questions relating to the acceptability of the intervention were added to the surveys (see Appendix E). As this study focuses on the acceptability of the intervention, only the responses to these additional questions at T1 and T2 will be discussed in the results section below. The full battery of outcome measures administered to participants as part of this joint study, and reported in my colleagues (SAG-A) thesis, are presented in Appendix F.
Semi-structured interviews

Semi-structured interviews were also used to examine and explore participants’ perceptions of the acceptability of the intervention. Informed by guidelines within the Process Evaluation framework (Moore et al., 2014), a topic guide (see Appendix G) was developed to explore: participants’ experiences of the intervention; whether they noticed any changes following the intervention; mechanisms of impact (how the intervention and participants’ experiences of it led to changes noticed); and whether contextual/external factors influenced the delivery or impact of the intervention.

Procedure.

At the recruitment stage an information sheet, containing an overview of the study and a consent form (Appendix H), was shared with participants electronically using a web-based Qualtrics survey. Participants consenting to take part in the study were redirected to a continuation of the online survey, in which they were asked to create a unique participant code. This enabled the researchers to track their responses at the different time points of the study, whilst also maintaining participant anonymity. Participants were then prompted to complete the baseline (T0) outcome measures.

Next, participants received the intervention (as described above). Directly after the workshop, all of the attendees were sent an email containing access to the follow-up audio exercises, which could be downloaded to their own devices for use offline. Participants in the first two cohorts (who attended the workshop in-person) were given paper copies of the booklet at the end of the workshop. Participants in the last three cohorts (who attended the workshop virtually) were sent an email containing a link to view the booklet online directly after the workshop. Participants were not able to download this booklet and were asked not to share it without permission. It was recommended that the participants accessed the booklet and
regularly practiced the follow-up exercises for the duration of the two-week period following the workshop.

One week after the workshop was delivered, an email was sent to all of the workshop attendees reminding them to practice the follow-up exercises. Online surveys, as described above, were sent to the participants at T1 and T2 via email.

Participants in the first two cohorts were invited to take part in follow-up semi-structured interviews regarding the acceptability of the intervention following completion of the online survey at T2. However, as only a small number of participants progressed to and completed the T2 survey, it was decided later in the study that all participants would be informed about and invited to take part in the interviews by Dr Michelle Wilson immediately after the workshop had been delivered. Participants were able to express interest in completing a follow-up interview either via the online survey or by contacting the researcher (CG) directly.

The interviews took place virtually and lasted approximately 60 minutes each. Participants were provided with an information sheet (see Appendix I) and were given the opportunity to ask the researcher questions regarding the interview prior to consenting to take part. The interviews aimed to flexibly explore the areas outlined in the interview topic guide (see Appendix G). The interviews were audio recorded using a secure device and were transcribed by the researcher.

Following completion of the interviews, participants were offered a £10 voucher or charitable donation to thank them for their time. Participants who completed the surveys at T0, T1 and T2 were entered into a prize draw to win £5, £10, or £25.

Data analysis.

Qualitative data from online surveys

Qualitative data from the open-ended acceptability-related questions included on the online surveys at T1 (n = 28) and T2 (n = 16) were collated and analysed using content analysis.
Content analysis is described as a deductive and systematic approach to “quantitatively analyse qualitative data”, by coding written text into categories or “meaning units” and counting the frequencies of occurrences within each category (Morgan, 1993; Ahuvia, 2001, p. 139). Through this process, inferences may be made about what is being communicated by considering trends, patterns and differences in the text-based data (Holsti, 1969; Krippendorff, 1989). Following Krippendorff’s (1989) content analysis research methodology, meaningful units of data were first identified before being coded and classified. The frequency of each code was considered in relation to the content of the answer in order to draw initial inferences from the data, that were subsequently used to contextualise the findings of the in-depth qualitative interviews.

Qualitative interviews

The in-depth qualitative interviews (n = 10) were analysed using thematic analysis, a “method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). Following Braun and Clarke’s (2006) framework for thematic analysis, the audio recordings of the interviews were first transcribed verbatim and read through multiple times by the researcher in order to enable familiarisation with the data. Notes were taken throughout this process and were reviewed with the research team to enable the collaborative development of preliminary ideas about the dataset prior to coding the data.

Following this, the transcripts were coded manually line-by-line, making use of NVivo qualitative data analysis software (NVivo, 2020). Once all of the data had been coded, the next stage of analysis involved collating codes that were similar in content, before considering how the codes may be combined to form overarching themes and subthemes. Virtual whiteboard software (Miro, 2021), in which the codes could be clustered and the relationship between them could be mapped, was used to create a visual representation of the codes and related concepts within the data at this stage (Braun and Clarke, 2006).
Through mapping the relationships between the codes and identifying areas where the codes clustered, an initial set of candidate themes and subthemes were developed. These candidate themes and subthemes were then refined through a gradual process, in which the individual coded data extracts collated for each theme were reviewed to determine whether they formed a coherent pattern. Once satisfied that the coded data extracts were sufficiently captured by the candidate themes, the candidate themes were checked against the transcripts to explore whether the themes provided an accurate representation of the dataset as a whole. The candidate themes, and the codes they represented, were reviewed and refined using this process until the research team were satisfied that the thematic map developed (see Appendix J) accurately represented the data.

**Methodological credibility**

Efforts were made throughout the data collection and analysis process to minimise researcher bias and increase the methodological credibility of this study.

Whilst conscious attempts were made to remain unbiased throughout the research process, the researcher (a White British female trainee clinical psychologist) held the perspective that their experiences would inexorably influence the research undertaken. In an attempt to understand and mitigate this influence, a process of constant personal reflexivity (Chinn, 2007) was employed. Bracketing interviews were carried out at various stages of the research process, including: prior to development of the interview topic guide; before and during the data collection; and during the data analysis. A reflective research diary was also kept by the researcher from inception of the study. Together, these were intended to help the researcher “bracket” and remain aware of the influence of their existing assumptions, ideas, expectations and preconceptions about the research area (Fischer, 2009).

Credibility checks were also undertaken throughout the data analysis, as recommended by Barker and Pistrang (2005). Firstly, an independent researcher (PV) coded two of the
transcripts and these codes were compared against those generated by the researcher in a meeting with the wider research team. Secondly, the main research supervisor (Dr Michelle Wilson) reviewed the mapped candidate themes against the codes they were derived from, as well as sections of the transcripts. Finally, feedback from the wider research team was sought throughout the data analysis process, as the relationship between the codes and the candidate themes was reviewed and refined to develop the themes and sub-themes presented in the results section.
Results

Online surveys

One hundred and ninety four participants completed the baseline measures survey at T0, 53 participants completed the T1 measures and 26 participants completed the T2 measures. From this sample, 53% of participants who completed the T1 survey answered the optional acceptability-related questions at T1 and 62% answered them at T2. The survey response rates are presented in Table 2.

<table>
<thead>
<tr>
<th>Time point:</th>
<th>Completion of surveys (n)</th>
<th>Completion of acceptability-related questions (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (T0)</td>
<td>194</td>
<td>N/A</td>
</tr>
<tr>
<td>2 week follow-up (T1)</td>
<td>53</td>
<td>28</td>
</tr>
<tr>
<td>2 month follow-up (T2)</td>
<td>26</td>
<td>16</td>
</tr>
</tbody>
</table>

As the same acceptability-related questions were included in the online surveys at T1 and T2, participants responses across time-points have been amalgamated. Results from the content analysis, summarising categories of responses that were identified and the frequency of responses, are described below and presented in-full in Table 3.

Participants were asked questions regarding: what they found most and least helpful about the intervention, and any suggested improvements (see Appendix E). For each of these three questions, participants frequently gave responses relating to the content (what was delivered) and the delivery (how/when it was delivered) of the intervention.

Participants described finding it helpful that the content was accessible, interesting (n = 5), and explicitly linked theory to practice (n = 2). Seven participants said they appreciated
being able to practice the exercises within the workshop, however two commented that they found it unhelpful to not be given more guidance on how to practice the exercises after the workshop and three suggested more clarity regarding this as a way of improving the intervention. Several of the responses described being given access to resources, including the follow-up exercises (n = 7) and booklet (n = 1), as helpful. However, one participant commented that they found the lack of variety in follow-up exercises unhelpful.

Nine participants described finding aspects of how the workshop was delivered helpful, with comments made that they appreciated the facilitator engaging with them (n = 3), creating a reflective space (n = 3), and delivering interactive content (n = 2). In contrast, however, one response suggested the workshop could be improved by making it more interactive. Participants described aspects of how the intervention was delivered that they found unhelpful, including: not receiving the workshop presentation slides in advance (n = 2) and not being able to download the booklet (n = 1). One participant said they found the infrequency of reminders to practice the follow-up exercises unhelpful, with two suggesting more reminders to practice would improve the intervention. Further, responses indicated that participants felt the workshop could be improved by being longer in duration (n = 1) and delivered earlier in the year (n = 4).

In response to the question asking what participants found most helpful about the intervention, a cluster of ten responses related to the perceived message of the intervention as something the tPWPs found particularly helpful. These responses described a novelty to the intervention focusing on them (instead of their patients), referring to it as a valuable “reminder” of self-compassion (n = 4) and to take time for themselves (n = 3).

A unique category of responses was also identified in participants answers to what they found most unhelpful about the intervention. Seven responses described contextual barriers that made the intervention less helpful for the tPWPs, including: not having time to practice
the exercises (n = 4) and the intervention not feeling integrated with the rest of their training (n = 1).
Table 3. Content analysis of survey responses at T1 and T2: Themes and subthemes.

<table>
<thead>
<tr>
<th>Question</th>
<th>Category</th>
<th>Sub-categories</th>
<th>Frequency (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Helpful about the intervention</td>
<td>Content of the intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accessible and interesting content</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Linking theory and practice</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practicing the exercises</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audio follow-up exercises</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Booklet as helpful</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Delivery of the workshop</td>
<td>Engaging lecturer</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interactive</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supportive and safe environment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A reflective space</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Message of the intervention</td>
<td>Reminder to take time for self</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focusing on selves</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Importance of self-compassion</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Unhelpful about the intervention</td>
<td>Content of the intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not enough clarification of how to practice</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not enough variety of follow-up exercises</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Delivery of the intervention</td>
<td>Not having enough reminders to practice</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not being able to download the booklet</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not receiving the workshop slides in advance</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Contextual barriers to the</td>
<td>Not having the time to practice</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>intervention</td>
<td>Intervention not integrated within the course</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Suggested improvements for the</td>
<td>Content of the intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>intervention</td>
<td>More clarity regarding how to practice</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More clarity regarding who the content is for</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Delivery of the intervention</td>
<td>More interactive</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More reminders to practice</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Longer workshop</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intervention earlier in the year</td>
<td>4</td>
</tr>
</tbody>
</table>
Qualitative interviews

Ten participants (9 female, 1 male) completed in-depth semi-structured interviews exploring the acceptability of the intervention after the T2 measures had been completed. Demographic data, aside from participants gender, was not collected at this stage of the study in order to protect their anonymity.

Table 4 presents the themes and sub-themes identified from the interviews, which are described in detail below along with illustrative quotes from the interviews. Where sections of interviews are omitted ellipses are used. Text within square brackets indicates clarifications by the researcher.

Please refer to Appendix K for a visual representation of the distribution of themes amongst the participants.
<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Context</td>
<td>1.1 The tPWP experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internal pressures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>External pressures</td>
<td></td>
</tr>
<tr>
<td>2. Experiences of the intervention:</td>
<td>2.1 The workshop</td>
<td></td>
</tr>
<tr>
<td>facilitators of change</td>
<td>Content of the workshop</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Format of the workshop</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Timing of the workshop</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practical facilitators</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Motivation to practice</td>
<td></td>
</tr>
<tr>
<td>2.2 The follow-up exercises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Impact of the intervention</td>
<td>3.1 Changes in themselves</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Awareness and understanding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Responding differently</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Openness to sharing difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Focusing on self</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved wellbeing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2 Changes in clinical work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approach to supervision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approach to clinical work</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3 Changes in academic work</td>
<td></td>
</tr>
<tr>
<td>4. Barriers</td>
<td>4.1 Barriers to the workshop</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.2 Barriers to the follow-up exercises</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.3 Contextual barriers to implementation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being a trainee PWP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The COVID-19 pandemic</td>
<td></td>
</tr>
<tr>
<td>5. Suggested improvements</td>
<td>5.1 Improving the workshop</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.2 Improving the follow-up exercises</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.3 Improving implementation of the intervention</td>
<td>A more consistent message</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support to implement the intervention</td>
</tr>
</tbody>
</table>

Table 4. *Thematic analysis of semi-structured interviews: Themes and sub-themes.*
1. Context

In answering questions about the acceptability of the intervention, every participant provided contextual information about their experiences as tPWP, despite not being asked about this explicitly.

1.1. The tPWP experience

Participants described both internal and external pressures they had been subject to prior to delivery of the intervention, which subsequently influenced how they experienced it.

Internal pressures

Participants spoke about having perfectionistic and self-critical tendencies, commenting that they often put a lot of pressure on themselves to meet their own high standards.

“I have a lot of that perfectionist “everything has to go perfectly” thinking... if I go off subject in a session or it runs over... I do tend to think I’ve done something wrong and it’s my fault.” (P3)

“I am the worst perfectionist... I spend so much time on my work, it's ridiculous... I can never do a rough draught because I just put too much pressure on myself.” (P9)

“My expectations for myself were very high... I think I felt like I needed to be a particular type of PWP... I felt I needed to be perfect.” (P8)

Participants also described finding it much easier to be kind and compassionate towards others, than they did themselves.

“I think, as people in healthcare roles, we kind of have this idea that compassion is only about you helping other people... I think myself and a lot of my colleagues would describe themselves as very compassionate towards other people, but maybe not so much towards themselves.” (P2)

External pressures

In addition to, and oftentimes exacerbating, self-criticism and the pressure they put on themselves participants reported finding their training course to be highly demanding, inflexible and unsupportive.
“For me it was a combination of personally being a bit self-critical, but then the course doesn’t give too much leeway in thinking about how sessions might go differently or how patients are not always suitable... so you go off subject in a session or it runs over and you tend to think you’ve done something wrong and it’s your fault.” (P3)

“I felt the course wasn’t supportive enough throughout our training... It’s an intense programme... Whenever we had [course] meetings it was more about “am I on top of my work?” rather than how I was feeling or how things were going.” (P6)

They described the clinical aspects of their training as stressful, with high caseloads, little time for themselves, and high expectations of their capabilities.

“The demands of the PWP role has got its own specific challenges... high caseloads, not working with people for very long... there’s a really specific set of things about it that are difficult. There’s a lot of pressure and never enough time... I think risk of burnout is high.” (P1)

Further, participants said that prior to the intervention being delivered they had little sense of other tPWPs struggling as there was no space or precedent for them to share difficulties experienced with each other.

“[On the PWP course] we are a group of people that are reluctant to share our experiences, what we’re going through and what worries we’re having...It can be difficult for that first person to speak up because of prejudice and judgments.” (P6)

“In [lectures] people are more likely to say that everything’s going great and err on the polite side of things... [we] tend not to talk about the negative side of things... no one really speaks about it.” (P3)

2. Experiences of the intervention: facilitators of change

All of the participants were asked about their experiences of the intervention. When answering this question participants spoke about the workshop and the follow-up exercises, commenting on how they engaged with and received each of these.

2.1. The workshop

Participants generally spoke positively about their experiences of the workshop, commenting on the ways in which they found it helpful and engaging.
Content of the workshop

Almost all of the participants described the content of the workshop as largely new to them, which they said peaked their interest and made the workshop more memorable.

“I found the topic particularly interesting as I didn’t know much about it… that kind of hooked me a little bit from the start.” (P7)

As such, the majority of participants spoke positively about the content of the workshop as accessible and providing a good introduction to compassion-focused approaches. In particular, participants appreciated time being taken to help them understand the theory behind the approach and different aspects of the model.

“I liked understanding the theory side... the evolutionary brain and the psychoeducation was helpful to give some backing to [the exercises]... I think that was quite a good introduction.” (P3)

“I really liked not just being told ‘this is something that’s good for you, this is what you do’... I think going through the theory and the rationale... it was in depth enough to kind of go ‘OK right I can get that this is really important for me’.” (P7)

Participants also reflected on the content of the workshop being directed towards themselves, instead of their patients. In particular, they described the use of examples specifically relating to their experiences as tPWP (e.g. self-critical responses to patient outcomes not improving) within the workshop as normalising. In turn, participants described feeling more open to the workshop potentially being something they may benefit from, which helped them to attend to the workshop.

“I really liked how we talked through the model using relevant examples of things I had experienced... that helped me to connect to it and understand it.” (P5)

“The thing I found most helpful was that in the workshop it linked to... the role itself of the PWP... I found it helpful that it was quite normalizing. And then I think, as a result, you were more likely to practice the exercises and think about it a bit more outside of the session than you would have been if it had been just more generic content.” (P3)

They spoke about receiving a message that it is important to look after and be compassionate towards themselves from the workshop, that made them feel valued and motivated them to engage with the content.
“I think what it did do for me is start me thinking about looking after myself more. It was very nice to be reminded that it is okay and important to be compassionate to myself… that was my main takeaway message.” (P10)

Format of the workshop

The interactive and experiential nature of the workshop was commonly described as helpful and engaging. In addition to the use of tPWP-specific examples, participants spoke about appreciating space for normalising discussions of shared difficulties within the workshop. Several participants commented that this helped them to feel less alone and less hesitant to make use of the ideas from the workshop, as well as finding it encouraging to hear other tPWPs experiences and reflections of practicing the exercises within the session.

“[Having attended the workshop] it’s easier to talk about difficulties now that we’ve had that open acknowledgement that lots of people find the course difficult or find treatment difficult... and knowing that has just opened up the conversation.” (P3)

“Before [the workshop] I was like ‘oh I feel really alone’, ‘is anyone else going through this?’ But [discussions in the workshop] really normalised those feelings of incompetence and gave me the assurance that there were things I could do things to help myself... to be more compassionate to myself.” (P4)

Participants said that having space within the workshop to practice the exercises helped them to make theory-practice links, facilitating their understanding of the theoretical content of the workshop and the rationale as to why the exercises would be important for them to practice.

“I think I was tuned into those internal experiences during the exercises better because we’d talked about the theory beforehand. I experienced it more fully because we had talked about it before.” (P1)

“It’s like I had to experience it to believe it... and once I had it left me thinking ‘there’s a lot I could take from that’, which enhanced how I saw the content as well... they kind of reinforced each other.” (P2)

Participants also spoke about finding the exercises enjoyable and relaxing, commenting that practicing the exercises in the workshop gave them a felt-sense for how the exercises may be helpful for them outside of the workshop. Participants spoke appreciatively about the
workshop highlighting and helping them to understand that they may experience difficulties in relation to self-criticism and self-compassion and, importantly, then offering them practicable solutions to help them resolve or manage these difficulties.

“I felt really calm when I was doing them... and I remember thinking how nice it was to have an image of a compassionate self in my mind and that it would be good to be able to picture this and use it in the future.” (P9)

“What I found nice was that... it offered a solution to the challenges that are almost consistently thrown at you as a [tPWP].” (P1)

Timing of the workshop

There was little consensus amongst the participants regarding how long the workshop should have been, however the majority (6/10) agreed that they would not have wanted it to be shorter. Some participants said they would have liked it to have been longer so that they could have practiced more of the exercises and had more discussion, however others queried whether the potential gains from extending the workshop would justify them losing out on other teaching.

“I don’t think it should have been any shorter... If anything, I would have welcomed more time to think about and discuss everything in more detail.” (P6)

 “[If you extended the workshop] I guess it would depend on what you would fill that time with... because they’d be extending the workshop at the expense of something else.” (P1)

Almost all of the participants spoke about how their experiences of the workshop may have been different had it been delivered at a different time-point in their training, however this is discussed further in section 4.3 (barriers to the implementation) below.

2.2. The follow-up exercises

When asked about their experiences of the follow-up exercises, participants described practical and motivational factors that increased their acceptability.
Practical facilitators

The majority of participants described the content and delivery of the follow-up exercises as making them more useful and easy to engage with. Participants spoke about being able to download the exercises for use whenever they wanted to listen to them, and the recordings being high quality, as encouraging them to make use of them.

“I found it helpful to download them... to just have the files and be able to play them without needing an internet connection... I could even listen to them on my phone, they were easily to hand.” (P2)

“I thought [the recordings] were really good, really clear.” (P7)

Participants appreciated the content of the follow-up exercises directly relating to the content of the workshop, commenting that this consolidated the ideas from the workshop whilst helping the exercises feel familiar and accessible. Participants also liked that the follow-up exercises started more generic and became increasingly compassion-specific, as they felt this eased them into the practice and motivated them to keep progressing.

“I think that having access to exercises that directly related to the content of the workshop was very, very important... whilst I took a lot away from the session... what made it sustainable as a way of thinking was the exercises for continuous practice.” (P1)

“The first [exercises] were quite good in terms of getting settled in... I found it more difficult towards the end when it focused more on imagining your compassionate self... I liked that each one got easier the more I did them and then I could move onto the next one.” (P5)

Further, participants spoke about practical factors that helped them to practice the follow-up exercises. A lot of the participants described protecting time to practice the exercises and incorporating them into their routine as integral to facilitating ongoing practice. In particular, participants felt the exercises were more acceptable if they were able to practice them in their working hours.

“I felt motivated following the workshops... I was trying to do [the follow-up exercises] every night... and then they just became part of my regular routine.” (P3)
“Commitment to doing [the exercises in work-time was important. Protecting that time for myself] in my work context cemented for me that it was something that I needed to do almost as a sort of professional responsibility. And also as a responsibility to myself.” (P1)

In line with this, support and encouragement from colleagues and peers to practice the follow-up exercises was described as facilitating use of them. In general, participants commented that workplace cultures prioritising self-compassion and self-care increased the acceptability of the follow-up exercises.

“My team [on placement], are very conscious about self-care, so I think that in itself encouraged me to use the exercises more.” (P4)

“My supervisor has helped me to really take that space and time to discuss what we’ve learned and practice self-compassion… I think that has really helped… to have an authoritative figure helping you to protect time for yourself.” (P6)

Motivation to practice

All of the participants spoke about feeling motivated to practice the exercises as increasing their usefulness and acceptability. One key motivating factor was an increased awareness of self-criticism and self-compassion. Participants described noticing themselves being self-critical or uncompassionate in times of difficulty, coupled with awareness of the potential for more self-compassionate responses, as driving them to practice the follow-up exercises.

“I think sometimes if you tend to be self-critical you don’t even recognise that its happening? [The intervention] brought it into focus.” (P3)

“It made us more aware of our own thought processes... allowing us to say “actually I notice I’m feeling like this, what can I do about it?” helped me feel a bit more motivated to practice self-care, be more compassionate with myself and look after myself.” (P4)

This was particularly true once participants began practicing the exercises and noticing the benefits of doing so. Several participants described having found the exercises helpful as a motivating reminder to keep practicing them, especially at times when they felt reluctant to (e.g. when tired or after a bad day at work).
“When I noticed [practicing the exercises] translated into something in the real world... I felt like it was beneficial and helpful and that’s what motivated me to keep going back and doing [the exercises], even when I’d had a long day or a bad day and didn’t want to do them, I knew I’d feel better if I did them.” (P7)

Another motivating factor was the participants wanting to create time and space for themselves. Participants spoke about using the exercises to reflect on their work, ground themselves, and practice self-care.

“It was nice to have space for a bit of reflection on my day and my work... thinking ‘okay that did go well’ and maybe ‘that wasn’t so good, I could ask for help with that’.” (P5)

Further, some of the participants described feeling motivated to practice the follow-up exercises in order to improve their wellbeing in the future. Participants spoke of the challenges of their work and a motivation to familiarise themselves with the exercises now, in order to prevent burnout and manage difficulties arising over the course of their careers.

“As we advance professionally, I think there will be more stressors and I think that doesn’t tend itself to compassionate thinking... Being made aware at the beginning of the workshop that these ideas and exercises could give us skills to help prevent us becoming exhausted and burnt out... people were then like ‘oh I might have something to learn, these exercises might be helpful for me.’” (P2)

A few participants also discussed wanting to practice the exercises so that they may apply the strategies and skills gained to their clinical work, in the hope this may help them to become better clinicians.

“When we're seeing clients it could be like: I've learned these self-compassion strategies, now I can support [my patient] a bit more in being self-compassionate.” (P6)

“It was really nice to have something that was about us as practitioners... to be reminded to think about [ourselves]... and also, how that can make us better practitioners.” (P5)

3. Impact of the intervention

Each of the participants interviewed described noticing changes following the intervention. They spoke about changes in their approach to themselves, their clinical work, and academic work.
3.1. Changes in themselves

Following the intervention, participants described noticing the impact it had had on their understanding, feelings, focus, ways of responding, and overall wellbeing.

Awareness and understanding

One of the first changes most of the participants described was in their understanding of and ability to reflect on themselves, both as people and clinicians. Participants spoke about learning to notice self-criticism and a lack of self-compassion, which in turn helped them to develop a greater awareness of when these unhelpful thinking patterns may be triggered. Awareness of this helped the participants to stop self-critical thoughts and respond differently to themselves, which they described resulting in more long-term changes in thinking styles as a result of the intervention.

“I felt like [the intervention] made me understand more about myself and it helped me to kind of notice those triggers for self-criticism?... Knowing what kind of things are likely to affect me and how... and that’s allowed me to keep track of those and consider how I can be more compassionate towards myself instead.” (P4)

Responding differently

Participants described a range of ways in which they were responding differently to themselves following the intervention, including: being more accepting of difficulties and challenges they experience; developing more realistic standards for themselves; doing only what they can and accepting what they cannot; feeling more confident in their own skills and abilities; taking less personal responsibility for patient outcomes/progress; and developing more balanced ways of thinking. Participants also described a multitude of ways in which they were responding more compassionately to themselves, including: being more forgiving and understanding of themselves; recognising they are only human; imagining what others may say to them at times when they feel self-critical; and responding to themselves with kindness.
“It’s not that the thoughts didn’t come, but how I then responded was different... [after the intervention] I could think, “no, that’s fine, these things happen”, instead of beating myself up or being self-critical or being hard on myself.” (P1)

“It’s been so helpful to be a bit more compassionate towards myself and accept [my] mistakes as part of being a trainee and things I am learning from... just being gentler and more forgiving with myself.” (P7)

Openness to sharing difficulties

Participants described the significant impact of the intervention creating a normalising space for tPWPs to acknowledge and share difficulties they had experienced. They spoke about feeling relieved to know they were not the only ones experiencing difficulties, and the destigmatising impact of this in encouraging them to feel more comfortable sharing difficulties, exposing their vulnerabilities, and seeking help.

“I’ve started telling [my colleagues] what I’m finding difficult, which I didn’t really feel comfortable doing before. So I’ve been doing that and hearing other people’s advice and experiences has been really helpful in making me feel less alone... and I think it opens you up to different ways of looking at things because you don’t have the shame of the self-criticism telling you it’s all to do with you.” (P3)

“Generally I’m just finding it easier to be really honest... if I'm having a bad day or if the workloads really high I'll just be like “OK today doesn't feel great, I'm struggling”. (P10)

Focusing on self

The normalising and validating nature of the intervention was also spoken about as helping participants feel able to prioritise their own wellbeing. They described the intervention as highlighting the importance of looking after themselves, which in turn led them to protect time for practicing self-compassion or their own forms of self-care.

“The [intervention] focusing on us as PWPs definitely gave me a message about the importance of being compassionate to myself, that I'm only human. I can't be expected to do any more than my best and my best includes not only working hard but properly taking care of myself... resting and setting boundaries and practicing self-care and being compassionate to myself.” (P8)
**Improved wellbeing**

Several participants also spoke about noticing changes to their overall wellbeing, which they speculated may have been associated with changes they had observed and made since the intervention. Improvements in wellbeing discussed by the participants included: feeling less burnt out; less overwhelmed; better able to manage stressors; reductions in anxiety; and sleeping better at night.

“I think it has made a difference to my wellbeing in general... I feel less anxious and have less bad moods... I also think I’ve been sleeping better.” (P7)

**3.2. Changes in clinical work**

Participants gave examples of the ways in which they felt the aforementioned changes had impacted their clinical work.

**Approach to supervision**

Six of the participants described feeling more self-reflective following the intervention. This, coupled with feeling more comfortable in the knowledge that their peers and colleagues likely also experienced difficulties in their work, led participants to bring more of themselves to supervision. Participants spoke about being more honest and open to asking for help from their supervisors, as well as feeling more comfortable reflecting on and celebrating pieces of work they felt had gone well.

“Before I would have been more likely to just try [things] and not really ask for help, whereas now I find it a lot easier just to email my supervisor and say “do you know of any materials that can help me or that I can use” or to say to them “I’m finding this difficult”. (P3)

“Before [the intervention] I wouldn’t normally take cases I’d discharged to supervision... But afterwards I did a few times.... just to think about what went well, which was really nice.” (P5)
Approach to clinical work

Participants also reported noticing a difference in their approach to clinical work. They spoke about increased confidence in their abilities and acceptance of challenges that will inevitably occur as helping them to take a step back from their clinical work and adopt a more flexible approach with their patients. They also described feeling better able to take a more balanced perspective, appreciating the different factors that might influence patient outcomes and separating their sense of worth as a clinician from the progress made by their patients.

“I feel more confident in myself now, and in my general ability as a clinician... I'm more able to think about my interventions holistically and knowing I didn't necessarily do anything wrong if a patient hasn't improved... I feel more able to defend my decisions at work.” (P10)

3.3. Changes in academic work

Most commonly, participants said they had found the intervention helpful in reducing the pressure they put on themselves for their academic work to be perfect. Participants spoke about noticing the temptation to ensure their academic work met their own incredibly high standards and, instead of burning themselves out in the process of meeting these standards, recognising and accepting minor imperfections in their work. Participants spoke about finding better work/life balance and taking time to look after their own wellbeing, which two of them felt led to them producing better quality academic work than they would have prior to the intervention.

“After the [intervention] there was a point when I had all these assignments to do, and I was able to say to myself that I didn't need to stay up all night working on it... that I could do just what I needed to, which meant I could still do things I enjoyed and needed to do outside of studying.” (P8)

A couple of the participants described feeling more engaged with the academic component of their training course following the intervention, as it had helped them to feel valued and as though the course cared about their wellbeing.
“Receiving [the intervention] made me feel a bit more grateful for the course and more engaged with it... I felt more positive about the course in that way because it felt like they were thinking about us and what we need.” (P5)

4. Barriers

In addition to describing aspects of the intervention that participants experienced as helpful and the ways in which they felt it led to meaningful change, thereby indicating its acceptability, the participants also described barriers that reduced the acceptability of the intervention by hindering their ability to access, engage with and make use of it. Across the interviews, participants described barriers relating specifically to the workshop and follow-up exercises, as well as broader contextual factors that made it more difficult for them to implement ideas from the intervention.

4.1. Barriers to the workshop

In line with participants’ comments that they found interaction and discussions within the workshop helpful, their main criticism was that they wanted more space to discuss their reflections and experiences. Participants commented that, at times, the workshop felt less interactive and more like a lecture, which perpetuated a reluctance to share their experiences for fear of judgment from their peers.

“If it was more interactive and had more discussion it would have felt less like a lecture and I think that would have been better... I would have liked to share my experiences but didn’t because it still felt a bit uncomfortable to do so in the limited discussion spaces.” (P8)

Criticisms of the workshop lacking space for discussion and interaction were more common and exaggerated in the participants who received the workshop virtually. These participants spoke about feeling distant from and less engaged in the content of the workshop, as well as connecting less to the experiential elements of the workshop (e.g. when practicing the exercises). They commented that they felt this was due to screen fatigue and resultant
difficulties in attending to the workshop; distractions at home preventing them from concentrating on what was delivered; not experiencing the exercises as a group or seeing others practicing them; and less discussion with their peers about how they found the exercises (e.g. in the workshop and in breaks in their teaching that day).

“It was all online so I felt a little bit removed and a little bit distant from things.” (P9)

“I think the workshop exercises would have had more of an impact if there had been less distractions in my home around me, and if I’d been able to see everyone in the room closing their eyes and doing the exercises.” (P8)

“Naturally it would have been great to [have the workshop] in the room... We would have felt more comfortable speaking to each other, both in the lecture and in our breaks.” (P4)

Participants spoke about the ways in which these workshop-related barriers reduced the acceptability of the intervention by making it more difficult for them to establish their motivation to make use of it.

“I was finding it difficult to concentrate on the screen for so long, and there was a point when I realised I’d missed a lot of it... and I felt like I didn’t understand how some of the content or exercises were relevant, which probably made me less inclined to practice them.” (P8)

“[In online teaching] everyone kind of acts as if they don’t exist and becomes reluctant to give their opinions of share their ideas.” (P6)

4.2. Barriers to the follow-up exercises

When discussing their experiences of the follow-up exercises, participants described factors specific to their content and delivery that made them less acceptable.

Participants who did not access the follow-up exercises spoke about confusion regarding how (e.g. in what order, how frequently) and when (e.g. in or outside of work-time) to practice them following the workshop. This uncertainty acted as a barrier to them practicing the exercises as they did not want to do so incorrectly.

“I wasn’t sure of the order of how to [practice the exercises]... Like were we supposed to do them in order? Or just jumble them up? Or like what times would be best, in the morning or afternoon? I wasn’t sure, which made it harder to just practice them.” (P9)
Another factor preventing participants from accessing the follow-up exercises was their duration, as several commented that the audio recordings were too long and that they did not have time to listen to them.

“I kind of sighed when I saw how long they each were, in a sense you go ‘do I really have time for that?’” (P7)

For participants who did access and practice the follow-up exercises, their limited variety became a barrier to continued practice as participants became bored with repeatedly listening to the same exercises. Participants described wanting to progress in their practices, and being deterred from accessing the follow-up exercises as they became tedious and less impactful.

“You get to this point, where you can perhaps visualise that compassion yourself and know how to use that... but then I guess I don’t really know where to go from there? Because I don’t really want to listen to the same thing over and over again, I’m not going to listen to that everyday.” (P5)

4.3. Contextual barriers to implementation of the intervention

In addition to discussing what was delivered as part of the intervention, participants spoke about broader contextual factors that influenced the acceptability of the intervention for them. External contexts discussed by participants included their training course and the COVID-19 pandemic.

*Being a tPWP*

Almost all of the participants spoke about wanting to practice the follow-up exercises and implement the ideas from the intervention, however described ways in which the demands and expectations required of them as tPWPs prevented them from being able to do so. Participants discussed how balancing academic demands from their course and clinical demands from their placements, as well as internally and externally generated pressures to
achieve high standards in both, resulted in implementing the intervention as low in their list of priorities.

“Whenever I planned to take time out of my day [to practice the exercises] I would just end up getting caught up in admin things or uni tasks, using the extra time to take longer over them than I needed to, to get them perfect... I always prioritised those over doing whatever it was I planned that was for me.” (P5)

Participants described a range of factors influencing how they prioritised tasks, and why accessing and making use of the intervention was felt to be less important than their other demands. Firstly, participants spoke about being held accountable for their clinical and academic work, whereas no one was checking if they were making use of the intervention.

“It’s hard to prioritise doing things for yourself when no one’s holding you accountable for those. The course tells you if you’ve missed a deadline, or your supervisor checks in if your clinical work is slipping... you get in trouble... but no one cares if you’ve done 10 minutes of self-care every day, other than you.” (P9)

Participants spoke about emphasis being placed on them learning and practicing skills to help their patients throughout their training, whereas very little focus had been given to how they could look after their own wellbeing.

“I sometimes feel like we tend to maybe focus more on what we can do and learn for our patients, but maybe there’s not enough room to speak about ourselves and how this work affects us and what we can do about it... we’re not used to thinking about us.” (P4)

Whilst participants appreciated the intervention being delivered as part of their core teaching programme, commenting that this helped them to feel valued and as though self-compassion is an important part of their role, they also reflected on receiving the intervention as a one-off event towards the end of their training. In these reflections, participants described the infrequency with which they were told to prioritise their own well-being as making this seem superfluous to their roles as tPWPs. In turn, participants spoke about often intending to implement ideas from the intervention but feeling unable to as other tasks took priority.

“We only really talked about compassion at the end of training. I didn’t find it a consistent message, I know obviously the importance of clinical skills, and that it’s so important to maintain our knowledge, but at the same time maybe I feel that we don't
“focus a lot on self-compassion, which made it hard to do and to prioritise over our other tasks.” (P9)

Conversely to this, a few participants spoke about working in services where their own wellbeing was prioritised, and how this facilitated them being able to implement ideas from the intervention. Support to protect time for regular CMT practice within their work schedule, encouragement to actively reflect on the ideas from the intervention in supervision, and practicing alongside colleagues were all spoken about as helping participants to make use of the intervention, thereby increasing its acceptability.

“What’s really helped is that within my team’s service, and in my supervision, we have check-ins and well-being hours where it’s almost guaranteed I can make use of the [intervention].” (P4)

Participants also spoke about not being able to implement ideas from the intervention at times when they felt busy or overwhelmed as the concepts were new to them and therefore effortful to practice. Participants recognised times they may have found CMT practices helpful, however made use of existing coping strategies instead as they either did not have the energy to learn new skills or were uncertain about whether they would be helpful (i.e. worth the effort).

“There are doubts, you know inevitably, when you don’t know if something will be helpful and if it’s therefore worth the effort of learning something new.” (P6)

Sometimes I worry about tapping into more compassionate responses when they’re not the responses I’ve always learnt to use and feel practiced at using.” (P9)

The COVID-19 pandemic

Exacerbating existing demands placed upon the participants in their roles as tPWPs, the COVID-19 pandemic introduced a number of changes to the ways in which the participants studied, worked and lived. Adjusting to these changes, and related concerns for the wellbeing of themselves and others due to the pandemic, made it even more difficult for participants to implement the intervention.
“Shortly after [the intervention] we went into lockdown... so that was another shift to accommodate, more changes and things to accommodate... that just made it really difficult to prioritise the exercises.” (P1)

Participants spoke about the ways in which working from home made the intervention less acceptable. Several participants who were living in shared housing said that they no longer had as much time on their own (e.g. not commuting to work), which prevented them from making use of the formal practices.

“Lockdown is a big part of [what has made it difficult to implement the intervention], because I don’t have as much time on my own. I’m not commuting and I live with my partner... not having the space for myself has made it much harder.” (P10)

Others also said that they felt less likely to notice self-critical thoughts and less motivated to practice the exercises when working from home, as they did not have contact with colleagues that they could discuss these and share ideas with.

“Obviously if we were in the office we would talk about sessions and be more conscious about things like self-criticism and self-compassion because we would be encouraged to talk about them by colleagues... we don’t get that working from home.” (P4)

Conversely, however, several participants spoke about working from home and having less collegial support as motivating them to implement the intervention, in an attempt to recreate the support or generate alternative perspectives they felt they were missing out on.

“I think the fact that I haven’t been able to get compassion from other people, just as a function of working from home and not seeing each other... that almost made me more likely to practice the exercises and hone in on self-compassion, because I needed it. And I might not have felt as motivated if I was still receiving loads of compassion from other people.” (P2)

5. Suggested improvements

Each of the participants suggested ways in which they felt the intervention could be improved, so that it may be more acceptable to tPWP. Specific recommendations were made regarding the workshop and the follow-up exercises delivered as part of the intervention, as well as for how to better facilitate implementation of the intervention.
5.1. Improving the workshop

In line with previously discussed facilitators and barriers of the workshop, the most commonly suggested improvement for the workshop was to increase the amount of interactive content. Participants felt that this may have a three-fold impact on enhancing the acceptability of the intervention. Firstly, through increasing opportunities to hear about other tPWPs experiences and normalising the need for more self-compassionate responses.

“I think it would have been nice to have discussions in smaller groups to learn more about other [tPWPs] experiences. I think I would have felt more comfortable to share in smaller groups, which would have been even more normalising and more valuable.” (P8)

Secondly, by acknowledging more self-compassionate responses as a shared need and using this to establish a rationale and motivation for tPWPs to implement the intervention into their practice. Several participants felt that discussion with their peers regarding their motivation to practice would have made them more likely to implement the intervention, as would hearing from previous recipients of the intervention who had found it helpful.

“I would have been interested to know what other people took away from the [intervention] and how they thought it might be helpful. Getting different perspectives on why people wanted to, or didn’t want to, do the exercises would have been interesting for me.” (P1)

“I think it would have been really reinforcing and motivating to hear someone with first-hand experience, maybe a qualified PWP, who’s had the intervention and been able to really reflect on how it has impacted them.” (P6)

Thirdly, participants felt more space for discussion in the workshop may have enabled consideration of how and when they could implement ideas from the workshop. Participants hypothesised that hearing others intending to prioritise implementing the intervention or practicing the follow-up exercises in work-time may have emboldened them to do the same.

“I’d have been interested to hear from other people what they would take away from the [intervention] and how they were going to put that into practice... Certainly if I heard good ways of implementing the practices I would try to use them myself too.” (P1)
5.2. Improving the follow-up exercises

Broadly speaking, participants found the follow-up exercises accessible and helpful. However a few participants commented that they would have found either more variety of CMT exercises, or being signposted to where they could access additional resources, helpful for sustaining their practice more long-term.

“I probably would have engaged more with the exercises if there was more variation, even if it wasn’t like completely different types of exercises... different imagery or different meditations would have increased my interest and engagement, especially over time.” (P8)

5.3. Improving implementation of the intervention

When discussing ways of facilitating tPWPs to implement the intervention, participants described the potential benefit of receiving a more consistent message throughout their training about the importance of looking after their own well-being, as well as more support to practice this.

A more consistent message

The majority of participants said that increasing the consistency of the message that looking after their own wellbeing was important would have helped them to make use of the intervention. They described the ways in which hearing this message from the start of their training, and throughout their training, may have helped them feel better able to prioritise practices that may benefit their own wellbeing.

“Having a more consistent message of being self-compassionate throughout training would have helped me... at times where I was really stuck and I needed to talk to someone or I needed some extra support around managing my caseload and the training work... being more aware of these ideas throughout training may have helped me to look after myself and manage these times better.” (P6)

They also wondered whether receiving this message earlier in their training experience may have helped to stop patterns of self-critical thinking and perfectionism from developing,
or at least prevented them from being exacerbated during their training, which in turn may have made it easier for them to practice more compassionate responses.

“I think having more discussion of self-compassion across the course would have been helpful to develop strategies to reassure yourself and look after yourself... because before [the intervention] I was kind of indirectly seeking reassurance that I was doing well from my clients and my supervisor, and that’s not a habit I wanted to get into.” (P6)

Participants suggested that better integrating the intervention with the PWP training course may improve the intervention by making it more acceptable to tPWPs. Recommendations for how to do this included: delivering the intervention at an earlier time-point; delivering the intervention over multiple sessions across their teaching programme (e.g. at the start, middle and end); or having regular check-in sessions with peers/tutors/supervisors following the intervention to keep the ideas active in their minds.

“If the workshop was delivered at the very beginning, that would help us enter the work in a different headspace. Then maybe we could have a few people that we stay in touch with throughout training to touch base with, solely speaking about compassion as a gentle reminder. And then having a follow-up workshop towards the end of the training... to talk about our experiences, what do we do consciously to look after ourselves, anything that didn't work, any final messages etc. That would be amazing.” (P4)

Support to implement the intervention

Participants spoke about the online surveys sent to them as part of the research study as helpful reminders of the intervention content and to practice the exercises. They subsequently wondered whether the acceptability of the intervention could be improved upon by ensuring they had support to continue implementing the intervention throughout their training. Suggestions were made that follow-up support from the course, either with tutors or seminar groups, may help to remind them of the intervention whilst also motivating them to practice by holding them accountable for doing so.

“Maybe I would have been more likely to use the ideas [from the intervention] if it was compulsory, or if there was some follow-up or support from the course in some shape or form, just as a motivation to prioritise [the intervention].” (P6)
“I think it would have been helpful to link up with other trainees to practice the exercises, that would have been a nice way to do it. Having a group to discuss it with might have helped me be more reflective?” (P5)

Further, participants felt it may have been helpful for their supervisors to be made aware of the intervention so that they may support them to implement the intervention (e.g. by helping them to protect time for practice in their work-day, discussing the ideas in supervision etc.)

“Maybe encouraging us to have shared [the intervention] with our [workplaces] might have meant that more people were supported to use the ideas? Sometimes as a [tPWP] you don’t have the power to say ‘I’m going to do this’, but someone in authority can say or do that for you.” (P9)
Discussion

This study aimed to evaluate the acceptability of a newly developed compassion-focused intervention for tPWP's. Open-ended survey questions and semi-structured interviews, informed by the MRCs Process Evaluation framework (Moore et al., 2014), explored participants’ experiences of the intervention, perceived mechanisms of change, and the influence of external/contextual factors. The findings of this study indicate that, broadly, participants found the intervention to be acceptable. All of the participants described making use of the intervention and the resultant changes they felt it had led to, as well as factors facilitating engagement and change. Nevertheless, participants also spoke about barriers to the intervention that reduced its acceptability, as well as making suggestions for how these could be mitigated and the intervention could be improved.

One key finding of this study is that all of the participants described noticing changes in themselves, their clinical work, and/or their academic work following the intervention. Similarly to previous research exploring the effectiveness of a lengthier CMT intervention for trainee MHP's (Beaumont et al., 2017), participants reported more self-compassionate and less self-critical thinking and responses, as well as improvements in their overall wellbeing following the intervention. Further to this, participants in this study also described feeling more confident in their skills and more accepting of difficulties they may experience. These changes were associated with them reporting greater openness to sharing their experiences and seeking help, putting less pressure on themselves, and being able to think more flexibly across the different contexts of their clinical training.

These findings are consistent with quantitative research identifying a significant relationship between increases in self-compassion, greater perceived confidence and lesser fear of failure (Neff et al., 2005), as well as theory and evidence suggesting that self-compassion encourages disclosure through reductions in shame, stigma and perceived isolation (Heath et
The self-reported changes participants noticed following the intervention provide support for Beaumont et al.’s (2017) hypothesis that compassion-focused interventions could help students “gain more value and support from clinical supervision and training” (pg. 301) and the effectiveness of brief CMT interventions for trainee MHPs more broadly.

Whilst the changes participants described as resulting from the intervention indicate that it was at least somewhat acceptable to them, as whether an intervention works is dependent on how its intended audience responds to it (Moore et al., 2014), MRC guidance emphasises the importance of qualitative exploration of participants experiences in order to understand how interventions produce change and, thereby, their acceptability (Craig et al., 2008; Moore et al., 2014).

Participants described a range of intervention-specific factors that influenced their experiences of it and the changes they felt it led to. Firstly, interactive aspects of the workshop were spoken about as normalising and facilitating engagement. Participants discussed the value of the workshop explicitly focusing on the tPWP experience (e.g. through use of PWP-specific examples to demonstrate concepts), as this helped them to become aware of and understand their own experiences of low self-compassion and high self-criticism. Further, consistent with research demonstrating that shared experience facilitates learning (Shytenberg & Apfelbaum, 2013), they said that having the opportunity to discuss these and hear that their peers had experienced difficulties similar to their own helped them to feel less alone and motivated them to make use of the intervention.

Neff and Volk (2009) propose that compassion-focused approaches are effective in helping individuals to perceive failure and imperfection as an inevitable part of human learning, which “lessens the need to defend one’s ego” (p.39) and makes it easier to admit to mistakes and limitations. The aforementioned aspects of the intervention may therefore have increased
its acceptability by having a normalising impact that helped participants to feel less defended against and better able to acknowledge their own struggles, and subsequently more open to attempting the compassion-focused strategies/solutions offered.

Secondly, the experiential nature of the workshop was described as enhancing the acceptability of the intervention as a whole. Consistent with experiential learning theory, which posits that “the core condition of learning is participation” (Yardley et al., 2012, p.163; Kolb, 1984), participants described having the opportunity to practice the exercises within the workshop as helping them to understand the concepts shared and make theory-practice links. Participants also spoke about how noticing the benefits of practicing the exercises in the workshop, such as feeling: calm; relaxed; and able to imagine a compassionate other, motivated them to practice the follow up exercises afterwards (i.e. as an effective form of self-care, to help them manage future stressors and prevent burnout etc.). The embodied sense of calmness and compassion described by participants indicates that the workshop exercises were effective in activating the soothing system, as intended in CFT and CMT (Gilbert, 2010), and supports previous findings that compassion-based experiential exercises are effective in student populations (Beaumont et al., 2016, 2017; Boellinghaus et al., 2013).

Supporting the importance of interactive and experiential elements of the workshop as increasing the acceptability of the intervention, participants receiving the workshop virtually generally reported being less engaged in the workshop, wanting more space for peer-discussion, and feeling less motivated to practice the strategies recommended than the participants who received it in-person. This indicates that the workshop may best be delivered in-person and that it should be adapted to incorporate more space for setting up/practicing the exercises and interactive discussions if delivered virtually.

Thirdly, factors making the intervention clearer and easier for participants to implement were said to increase its acceptability. Consistency between the workshop and follow-up
exercises (e.g. the same exercises, the same facilitator guiding the practices) was spoken about as creating a sense of familiarity and mastery for some participants, that facilitated them making use of the intervention after the workshop. On the other hand, other participants spoke about uncertainty regarding how to practice the follow-up exercises (e.g. when and how often to practice them) as a barrier to them implementing the intervention. Thériault et al., (2009) suggest that low confidence and feelings of incompetence increase the perceived threat associated with failure, thereby making individuals less open to trying new skills they are likely to make mistakes in learning. Providing participants with the opportunity to practice the compassion-focused exercises within the workshop may therefore have played an important role in increasing the interventions acceptability by helping them to feel more confident in, and thus more likely to practice, the follow-up exercises. Supporting this, measures taken to increase the accessibility of the intervention (e.g. downloadable follow-up exercises and booklet) were also described as increasing its acceptability, by making it easier for participants to implement. Providing clarity in the workshop regarding when and how to practice the exercises may further increase the acceptability of the intervention, by similarly reducing threat of failure for participants expressing uncertainty regarding the practices.

In discussing the link between the accessibility of the intervention and its acceptability, participants frequently spoke about the influence of contextual/external factors. Namely, measures taken to increase the accessibility of the intervention enhanced its acceptability in part due to the limited time and resources available to them in their roles as tPWPs. As documented in several previous studies regarding trainee MHP wellbeing (Summers et al., 2021; Parkinson, 2018; Rønnestad & Skovholt, 2003), all of the participants in this study spoke about having high workloads of academic and clinical tasks, as well as internally and externally generated pressure to achieve high standards in both. Whilst supportive workplace environments encouraging participants to make use of the intervention (e.g. by helping them
to protect time for the strategies in their work schedules and discussing the intervention in supervision) were described as facilitating implementation, a lack of such support made it difficult for them to prioritise making use of the intervention over their other tasks. Further, the additional demands/pressures and reduced support available resulting from the COVID-19 pandemic were broadly described as making it more difficult for participants to implement the intervention.

Participants also spoke about the uniqueness of the intervention in that it was focused on them specifically and improving their wellbeing. Although this was found to be engaging, as they noted the vast majority of their prior teaching had focused on how they helped their patients, it was also somewhat unhelpful as this was therefore not a consistent message throughout their training. Almost all of the participants said that they would have preferred the intervention to be either delivered earlier in their training, or at several points throughout, to increase the consistency of the message to look after themselves and help them feel more practiced in doing so as part of their role. These findings support Luoma and Platt’s (2015) proposal that intervening during the early stages of training may be “beneficial in preventing the development of stigmatised attitudes to self-care as selfish” (pg.100), as failing to do so created barriers to implementation that reduced the acceptability of the intervention.

Limitations.

The aim of qualitative research is not to generate findings that can be generalised on a wide scale, however discussing the clinical implications of this study requires generalisation of sorts. It is therefore important to note that, as a piloting study, the sample was recruited from one London-based PWP training course. Whilst courses across the UK are broadly similar, as they must meet the same requirements for accreditation with regulatory bodies, they vary in: size; staff-student ratios; and location, amongst other things. It is therefore possible that the factors described as influencing the interventions acceptability, such as external demands and
the accessibility of the content, may not be as significant across other courses. Due to its limited sample, caution should be taken when generalising the findings of this study to any-and-all trainee MHPs, especially those undertaking training outside of the UK.

Further, recruiting participants from the same course meant that sociodemographic information could not be collected, in order to protect the anonymity of the participants. This prevented consideration of how participant-specific contextual factors, such as ethnicity and age, may have influenced participants experiences of the intervention and its acceptability.

Comparative to the sample of tPWP who received the intervention, relatively few completed the online surveys and even fewer volunteered to participate in the semi-structured interviews. As a result, participants descriptions of the acceptability of the intervention may not be representative of the sample as a whole. In particular, the findings of this study may overestimate the acceptability of the intervention as the participants who benefitted most from the intervention may have been more motivated to complete the online surveys at T2 and participate in the follow-up interviews.

The positioning of the researcher must also be considered. As a trainee clinical psychologist, I frequently reflected on my own experiences of working in busy NHS services and balancing the multiple demands of academic and clinical work throughout my training. Whilst I attempted to explore the influence of this on the interviews I carried out and my analysis of the data, both independently and through use of bracketing interviews, it is possible that these may have biased the data collection and analysis process.

Finally, this research was carried out during the COVID-19 pandemic. Although every attempt was made to maintain the fidelity of the intervention, there was inevitable variation in its delivery across the participants receiving it before and during the pandemic (e.g. in-person versus virtual delivery), which affected the overarching research study. In particular, this may limit conclusions being drawn and generalisations being made about the feasibility and
effectiveness of the intervention (reported in my colleagues [SAG-A’s] doctoral thesis), as these were evaluated quantitatively. The qualitative nature of this specific study, however, allowed for exploration of such variation in delivery which in turn provided valuable insight into the importance of factors (e.g. the workshop being interactive/experiential, additional demands/stressors, having support to implement the intervention) in affecting acceptability.

**Implications of the research and future directions.**

Overall, the findings of this study indicate that the acceptability of the intervention was high. Participants spoke about valuing the intervention being delivered within their training programme and discussed several factors that enhanced their experience of it and facilitated the subsequent changes they noticed. They also discussed barriers to implementation of the intervention, which reduced its acceptability. These findings have several clinical implications and highlight areas for further research.

Participants in this study described observing positive changes in themselves (such as increases in self-compassion and reductions in self-criticism), their wellbeing, and their approach to the clinical and academic components of their training. This is consistent with the literature and indicates that the current brief intervention may be of similar benefit to trainee MHPs as previously established lengthier compassion-focused interventions (Barnard and Curry, 2011; Beaumont et al., 2016; Boellinghaus et al., 2013). Incorporating this intervention into teaching programmes for MHPs may therefore enhance students wellbeing and engagement with their training (e.g. facilitating better management of multiple demands, more openness to disclose difficulties experienced with course staff/supervisors), as well as potentially protecting them from symptoms associated with burnout and compassion fatigue later in their careers. This may in turn have wider benefits for healthcare provision, for example through improving staff retention and the delivery of compassionate care.
Taking into account suggested recommendations for improving the intervention (such as increasing the amount of interactive content, explicitly discussing ways of implementing the strategies described, and providing additional follow-up resources) the current study indicates that, from an acceptability point of view, the brief compassion-focused intervention piloted may be beneficially included as part of the curriculum for trainee MHPs. However, the findings of this study must be considered alongside findings relating to the feasibility and preliminary outcomes of the intervention (as reported in my colleague [SAG-A’s] doctoral thesis) in order to better understand the impact of the intervention and the rationale for developing it further.

If indicated, further development and more widespread implementation of the intervention should take into consideration the contextual factors participants described as influencing its acceptability. Firstly, participants reported that receiving the intervention towards the end of their training programme made it more difficult for them to implement the ideas and strategies as they were not used to prioritising their own wellbeing or practicing self-care. Exacerbating this, they spoke about a culture of high standards and expectations of them as trainee MHPs, that had been present throughout the majority of their training. It may therefore be helpful for future research to explore the feasibility and acceptability of either delivering the intervention earlier or more consistently throughout MH training programmes, in the hope that this may prevent the development of stigmatised views of self-care as selfish and instead promote trainee MHPs looking after themselves as fundamental to their work.

Further, several participants discussed the helpfulness of support from others in enabling them to implement and make use of the intervention. This took several forms, including discussion of self-compassion/self-criticism in supervision and support from (often more senior professionals) to protect time to practice the strategies. It is possible that, as trainee MHPs are often perceived as relatively junior members of staff and are routinely assessed in their work, it is difficult for them to assert their needs without perceived permission from more
senior members of staff. In light of this, it may be helpful to consider delivering future iterations of the intervention more systemically (e.g. to course staff and clinical supervisors in the region). It is possible that this may enhance the acceptability of the intervention by conveying the message that trainee wellbeing is a shared responsibility (between trainee MHPs, course staff and clinical placements), thereby encouraging all parties to protect time to practice and discuss the intervention.

Finally, despite a substantial drop-out rate at each subsequent time-point (e.g. T0, T1, T2), this research study did not explore the acceptability of the evaluation processes and procedures adopted (e.g. the outcome measures used, the format and delivery of the online surveys etc.). This may therefore be a helpful area for consideration if the intervention were to be further developed and evaluated.

**Conclusion.**

This study has identified that the brief compassion-focused intervention for tPWP was generally perceived to be acceptable and beneficial. However, some aspects of the intervention and the context in which it was delivered were discussed as creating barriers to engagement and implementation, thereby reducing its acceptability. The intervention may therefore be improved upon by addressing these, following which it may be helpfully implemented across training courses for MHPs.
References

Ahuvia, A. (2001). Traditional, interpretive, and reception based content analyses: Improving the ability of content analysis to address issues of pragmatic and theoretical concern. *Social indicators research, 54*(2), 139-172.


Part 3: Critical Appraisal
Overview

This critical appraisal focuses on the empirical study described in part two, and is presented in three sections. The first describes an exploration of personal and epistemological reflexivity in relation to the research undertaken. The second section expands upon the first, discussing my experiences of developing and carrying out the research, before considering my personal learning and areas for further development and evaluation of the intervention in the third section.

1. Self-Reflexivity

Qualitative research involves exploration of people’s subjective experiences, allowing for more nuanced and complex understandings to be developed than quantitative methodologies may allow for. As researchers in qualitative research are considered to be “the primary instrument or medium through which the research is conducted” (Lofland et al., 2006, p. 3), their assumptions and beliefs about the research inevitably influence the data collection and analysis (Barker et al., 2015). In order to address this, it is recommended that qualitative researchers engage in a process of “reflexivity” whereby they explore how their subjective ideas and experiences may have shaped their research planning, methodology and findings (Fischer, 2009).

Reflexivity requires “an awareness of the researcher’s contribution to the construction of meanings throughout the research process” (Willig, 2018, p. 10). There are two distinct forms of reflexivity: personal and epistemological (Willig, 2013). Personal reflexivity involves reflecting on how one’s own beliefs, values, social identity and experiences have shaped the research, as well as how the research itself may have influenced and changed the researcher. Epistemological reflexivity encourages reflection upon the assumptions made about what kind of knowledge can be gained, and how these may have influenced the research and its findings.
**Epistemological Reflexivity**

According to Willig (2012), each researcher’s own epistemological position influences how they think about and make use of reflexivity within their research. I approached the research from a ‘critical realist’ position, seeking to extract data that reflected a truth about the external world, whilst acknowledging that any findings would be filtered through my own assumptions, experiences and theories (Barnett-Page & Thomas, 2009). This position influenced the interviews and analysis I carried out as, whilst I took the stance that participants descriptions reflected their true experiences of the intervention, I also recognised that the interview topic guide I developed, the questions I asked, participants responses, and my interpretation of the data, would be influenced by each of our own experiences and beliefs.

Prior to beginning this research study, I had a keen interest in and a good theoretical understanding of compassion-focused approaches and interventions, including compassion-focused therapy (Gilbert, 2009) and compassionate mind training (Gilbert & Irons, 2005). This, coupled with working with stakeholders highly specialised in compassion-focused interventions in order to develop the intervention, meant that I had a clear sense of how the intervention was (theoretically) proposed to influence change in the participants. For example, psychoeducation has an important role in compassion-focused therapy to help individuals gain insight into their motivations and actions from an evolutionary perspective, which is intended to have a normalising impact that facilitates self-compassion (Gilbert, 2020). Further, compassion-focused exercises aim to activate basic motivational systems and create inner capacities for feeling soothed, safe and supported (Gilbert et al., 2008). Whilst I attempted to stay open to hearing participants own descriptions of how they responded to the intervention and felt it influenced change, ‘bracketing’ and putting to one side my knowledge of the theoretical underpinnings of compassion-focused approaches (Fischer, 2009), it is possible that this knowledge influenced my data collection and analysis. I found collaboratively developing
the topic guide for the interviews and reviewing my data analysis with my research team a helpful way of noticing and minimising the impact of this.

**Personal Reflexivity.**

Through engaging in this process of reflection, researchers are able to ‘bracket’ their own personal perspectives (Finlay, 2008): acknowledging and setting them aside in order to “mitigate the potentially deleterious effects of unacknowledged preconceptions” (Tufford & Newman, 2012, p. 81). Whilst ‘bracketing’ aims to create openness to the possibility that research findings may differ from the researchers expectations (Starks & Trinidad, 2007), entirely ‘bracketing’ one’s own beliefs is near impossible. Instead, Finlay (2008) likens the process of personal reflexivity to a ‘dance’ wherein there is a constant trade-off between setting aside one’s assumptions and using them as a source of insight.

Reflecting on my own position, I was in many ways both an insider and an outsider in this research. This is an important area of consideration within qualitative research as the researcher is the ‘instrument’ for data collection and analysis (Starks & Trinidad, 2007). Insiders, who belong to the sample group in some way, may benefit from being able to identify more easily with their participants: thereby enabling greater rapport and depth of coverage. However, outsiders more detached from their participants may hold a more genuinely curious position that facilitates an open style of questioning and protects them against making false assumptions (Hellawell, 2006; Dwyer & Buckle, 2009).

As a trainee mental health professional (MHP), I was an insider in this research. Throughout the data collection process, which could be conceived as a conversation between two trainee MHPs, several of the ideas discussed felt familiar. I resonated with participants descriptions of internally generated perfectionistic tendencies and unrelenting standards, exacerbated by the demands of their training courses and a propensity to prioritise others’ wellbeing over their own, as making it difficult to look after themselves. Whilst my similar
experiences (i.e. of the multiple demands of clinical training and more comfortably adopting a ‘helper’ rather than ‘helped’ role) created a shared understanding that may have facilitated greater rapport and more in-depth disclosure from participants (Berger, 2015), I wonder whether a researcher from another professional background may have asked different questions or responded differently to participants descriptions.

More specifically as a trainee clinical psychologist, I was an outsider in this research with trainee Psychological Wellbeing Practitioners (PWPs). Whilst there are similarities between training courses for clinical psychologists and PWPs (i.e. balancing clinical and academic demands, clinical placements typically based in NHS mental health services etc.) I have never trained as a PWP, nor have I ever worked in an Increasing Access to Psychological Therapies (IAPT) service, where the majority of trainee PWPs would carry out their clinical placements. Both prior to and during my clinical psychology training I have worked alongside PWPs, as well as knowing peers from my cohort as they undertook placements in IAPT services. Despite being an outsider, genuinely interested in and curious about the experience of trainee PWPs, I also therefore had some awareness of the role and what it entails. Prior to beginning the interviews I spent time ‘bracketing’ my assumptions of PWP training as fast-paced (with a high patient throughput), intense, outcomes-based and skills-focused through use of bracketing interviews and a reflective journal. Upon acknowledgment of these assumptions, I spent time challenging them in the hope of facilitating openness to alternative narratives of PWP training and preventing myself from developing expectations that may influence the data I collected.

2. Reflections on the research process

   Developing the intervention

   As a trainee MHP myself, I felt acutely aware of the demands and challenges of training. This manifested in a strong desire to both develop an intervention that trainee MHPs
would find helpful and be able to make use of, as well as wanting to ensure that the research would be taken forward in a meaningful way. The first stage of this research project was to work with stakeholders in order to develop a brief compassion-focused intervention for trainee MHPs, as well as planning how best to deliver and evaluate it.

Whilst the stakeholders, many of whom were experts in compassion-focused approaches and/or programme directors on UK-based training courses, led discussions around the content and implementation of the intervention, I reflected upon my experiences as a current trainee MHP to inform the development of the intervention and its evaluation. I felt that, being closer to training myself, I brought a unique perspective within the stakeholder group as to what may or may not be acceptable and feasible for trainee MHPs. However, mindful of my previously described insider/outsider position in this research, I attempted to remain aware of when I was making assumptions about PWP training based upon my own experiences of training and found working collaboratively with staff from a PWP training course helpful in challenging these when they arose.

Aware that many of the trainee PWPs may not have had much prior experience of compassion-focused approaches, I found it helpful to draw upon times in my own training experience when new psychological theory or models had been well-introduced. Recalling finding it more accessible when lectures felt relevant to my clinical work, and less so when ideas felt abstract or irrelevant, the researchers and stakeholders developed trainee MHP specific examples to demonstrate compassion-focused concepts within the workshop.

Balancing writing a clinical case report (as required by my training course), planning my own research project, and adjusting to a new clinical placement at the time of developing the intervention led me to question whether trainee MHPs would have the time and energy to implement the intervention, regardless of how they felt about its content. This sparked a curiosity in me regarding whether the intervention would be acceptable for trainee PWPs,
driving both the focus for this research project and attempts to make the intervention as easy to implement as possible. Such developments included ensuring the follow-up exercises could be downloaded (so that participants could practice them on their commutes etc.) and limiting the number of outcome measures included in the follow-up questionnaires as far as was possible in this pilot study.

Carrying out the interviews

As a clinician-researcher I often found holding a researcher position, seeking to learn from participants instead of helping them in some way, challenging. Whilst both research interviews and therapeutic sessions involve use of similar interpersonal skills, such as: eliciting information; listening; and summarising to establish understanding (Cicconi, 2018), the underlying intent of these interactions are different. Josselson (2013) proposes that patients seek help from therapists that want to help them in therapeutic relationships, whereas in research it is the researcher who seeks help from their participants. I found that holding this distinction in mind helped me to acknowledge and accept that I needed the participants to help me to understand their experiences at this point in the research process, which in turn created a sense of freedom as I felt my responsibility was purely to listen to and hear their stories. Over time I noticed that adopting this stance elicited open and detailed responses from the participants, which in turn helped me to feel increasingly confident and flexible in my interviewing style. In particular, I found being led by participants descriptions and asking follow-up questions about interesting comments they made, instead of rigidly sticking to the interview topic guide (Smith, 1995), often led to them sharing fruitful and relevant information, that may otherwise have been missed.

Early on in the data collection process, I met with members of my research team to review my first few transcripts and reflective research journal, in order to explore any blind-spots, assumptions or biases in my interviewing style (Lowes & Gill, 2006). In doing so, I was
helped to notice that I tended to shift more towards a therapist position at times when participants discussed hardships they had experienced during their clinical training. With support from my research supervisor and reflective practices throughout the data collection process, I was reminded that people often want to feel heard instead of being given advice or guidance (Rogers, 1957) and encouraged to respond with humanity and empathy in the moment whilst maintaining my position as a researcher (Josselson, 2013; Thompson & Russo, 2012). Whilst listening to and being with participants in their distress, instead of attempting to help them in some way, was challenging at times, noticing how this helped me to really understand their experiences has been hugely valuable in my role as a researcher, clinician, and as an individual.

**Analysing the results**

Overall, I found the process of analysing the results to be a challenging, yet incredibly rewarding, experience. From the outset of the analysis I noticed myself wanting to produce meaningful results that captured the breadth and depth of participants descriptions. Having carried out the interviews myself, I felt that this motivation was driven both by the participants and myself. The participants, as many had commented that they had found the intervention helpful and hoped that their answers would help to improve it so that others may benefit from it in the future. Myself, as I think on some level I wanted to reciprocate the time and energy each participant had invested in the interviews by providing an accurate summary that encapsulated what they had told me and would in turn enable further developments of both the intervention and the research.

Having heard participants descriptions of feeling largely unsupported as they navigated clinical training, especially during a global pandemic, I noticed myself feeling aligned with the participants. In particular, I was struck by how protective I felt of them and the disappointment I felt towards the more experienced clinicians they were taught and supervised by for not
supporting them better. In a follow-up to their seminal paper on thematic analysis (TA; Braun & Clarke, 2006), Braun and Clarke (2019) emphasise the “centrality of researcher subjectivity and reflexivity” in the process of TA and highlight the importance of researchers explicitly acknowledging and unpacking their own positions in order to mitigate these influencing the analysis.

Together with my research supervisor, I reflected on my own position as an insider and outsider to this research prior to and during the analysis. From an insider position, I bracketed my own experiences of finding support from supervisors and course staff invaluable in navigating the challenges of training, as well as difficulties I had experienced when such support was not available. As an outsider, I also explored and bracketed assumptions I held about there being more demands/pressures and less support available on the trainee PWP course than on the trainee clinical psychology course. As posited by Braun and Clarke (2019), I found discussing and reflecting upon these beliefs and assumptions with my research supervisor invaluable in helping me to understand my emotional responses to the data, set them aside, and focus instead on how the data I had collected answered my research questions.

3. Learning

Finally, not only was the research influenced by my beliefs, assumptions and experiences, but I was also shaped by carrying out the research.

Reflecting on the research project as a whole I am mindful of key learning points I will take away, including the importance of making use of reflexive practices throughout the process; seeking guidance from knowledgeable stakeholders; and establishing close working relationships with co-researchers and supervisors. I am also aware of what I may do differently if I were to carry out the research again, such as reducing the number of outcome measures administered to participants. My own reflections on the busyness of being a trainee MHP, and having heard participants descriptions of the demands and stressors of their roles as preventing
them from being able to make use of the intervention, has led me to question whether the high participant attrition rate at each data collection time-point may have been due to participants perceiving the battery of outcome measures as too long and time-consuming. Whilst attempts were made to limit the number of outcome measures administered to participants, these were balanced by a desire from the wider research team to gather as much data as possible regarding the efficacy of the intervention. In hindsight, I wonder if including only essential outcome measures (i.e. those pertaining to self-compassion and self-criticism) in the surveys may have increased the acceptability of the evaluation, thereby reducing participant attrition rates, allowing for more data to be collected, and providing a larger sample from which participants could be recruited for the semi-structured interviews.

I have also noticed a broader shift in my perspective over the course of this research project. Starting out, awareness of the challenges of clinical training and an overarching lack of self-compassion in MHPs led to the development of this intervention for trainee MHPs. Wanting to deliver it as part of trainees core teaching, in order to promote the importance of looking after themselves from early-on in their careers, we worked with stakeholders from UK training courses to consider the format and delivery of the intervention. In doing so, a brief one-off intervention delivered to trainees towards the end of their teaching was agreed upon, taking into account the limited teaching time available and time-points when trainees may find the intervention of most benefit.

The overarching aim of this intervention was to share compassion-focused theory and practical exercises with trainee MHPs to increase self-compassion and reduce self-criticism, thereby helping them to manage the challenges of their roles and potentially leading to long-term benefits such as being better equipped to manage the stressors of life as a qualified MHP, reductions in burnout, and increases in compassionate care (Beaumont & Martin, 2016; Beaumont et al., 2016; Boellinghaus et al., 2013). However, having heard participants
descriptions of the pivotal role contextual factors (such as demands placed upon them and support from supervisors/course staff) played in their ability to make use of the intervention, I have since wondered whether the intervention may have been of greater benefit had it been delivered in a more systemic way.

Participants descriptions suggested that, without support from senior professionals helping them to make use of the intervention in their work, practicing ideas and strategies from the intervention was often seen as an additional demand on their time, energy and resources. By delivering the intervention to the trainee MHPs, we may therefore have inadvertently located the problem of a lack of self-compassion (and the responsibility to resolve it) within themselves. Towards the end of the research project, I noticed a shift in my thinking towards acknowledging a lack of compassion for trainee MHPs existing both within themselves and the systems they work in. I have therefore found myself drawn to ways of addressing this, and have since wondered whether delivering the intervention to course staff and clinical supervisors of trainee MHPs, as well as the trainees themselves, may have better facilitated implementation of the intervention by making it a shared responsibility.

**Closing Summary**

This research study has provided valuable insights into the acceptability of a brief compassion-focused intervention for trainee MHPs, aiming to increase self-compassion and reduce self-criticism. Both the development of this intervention, and the process of evaluating it, were influenced by my personal experiences and epistemological position. My reflections on the process and the learning points described in this critical appraisal indicate ways in which the research procedures could be revised and improved upon, such as by reducing the number of outcome measures participants were asked to complete. Furthermore, the potential value of future research developing and evaluating a more systemically-implemented iteration of the intervention is highlighted. It is hoped that ongoing research in this area may identify ways of
increasing the acceptability of the intervention, as well as creating a more consistent culture of compassion in both MHPs and the services they work in.
References


Berger, R. (2015). Now I see it, now I don’t: Researcher’s position and reflexivity in qualitative research. *Qualitative research, 15*(2), 219-234.


Appendices
Appendix A: Joint Research Project Declaration
Outline of each Trainee Clinical Psychologist’s Contribution to this Joint Research Project

This research study was carried out as part of a joint project with another trainee clinical psychologist (SAG-A) at University College London. We each had different focuses for our research projects. Whereas I sought to qualitatively explore the acceptability of the brief compassion-focused intervention for trainee mental health professionals, my colleague (SAG-A) focused on quantitatively evaluating feasibility and preliminary outcomes.

Throughout the research process we regularly attended joint research meetings with our supervisor, Dr Michelle Wilson, in which we discussed the development and planning of the study, the allocation of tasks, progress made, and challenges encountered. We also attended meetings with stakeholders, informing the development of the intervention. As the research progressed, we began attending separate meetings with our research supervisor, regarding the specific separate focuses of our research studies, analysis processes, and write-ups.

We worked together throughout the initial planning and development phases of the project, but divided the tasks between us. For example, we each researched and trialled different Compassionate Mind Training exercises for the follow-up exercises and created different sections of the online surveys distributed to participants at the data collection timepoints. Bigger tasks, such as developing the information sheet and consent form or applying for ethical approval for the study, were split and each was initially allocated to one of the two researchers to focus on. Once a draft had been developed, the other researcher would usually then provide feedback and/or make revisions in accordance with guidance from the wider research team.

During the data collection process, we jointly decided upon which outcome measures and acceptability-related questions to include in the online surveys distributed to participants, in collaboration with stakeholders and our research supervisor. We then each extracted separate data relevant to our individual research questions from the survey responses for analysis. For
my qualitative study, I separately recruited and interviewed ten participants regarding their experiences of the intervention. The interview schedule used to guide this process was developed by myself, in consultation with stakeholders and Dr Michelle Wilson.

The data analysis and write-up of the empirical paper were completed independently.
Appendix B: Initial Thematic Map/Hierarchy (Systematic Review)
Image Depicting the Thematic Map/Hierarchy Initially Developed during the Systematic Review Analysis Process
Appendix C: Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist
(Removed from copy for reasons relating to copyright)
Appendix D: Confirmation of Ethical Approval
(Removed from copy to protect the researchers’ anonymity)
Appendix E: Acceptability-Related Questions Distributed via Online Surveys
What, in particular, did you find helpful about the workshop and / or follow-up practices?

What, in particular, did you find unhelpful about the workshop and / or follow-up practices?

Was there anything about the workshop and / or follow-up exercises that you think could have been improved upon?

(Please take into consideration the delivery of the workshop, the length of the workshop, the content of the workshop and follow-up exercises, and the accessibility of the follow-up exercises)
Appendix F: Full Battery of Outcome Measures Administered
(Removed from copy for reasons relating to copyright)
Appendix G: Interview Topic Guide
(Removed from copy to protect the researchers’ anonymity)
Appendix H: Research Study Information Sheet and Consent Form
(Removed from copy to protect the researchers’ anonymity)
Appendix I: Interview Information Sheet and Consent Form
(Removed from copy to protect the researchers’ anonymity)
Appendix J: Mapping the Relationship between Codes using Virtual Whiteboard Software (Miro, 2021)
Thematic Map (Whole Overview)
Thematic Map by Section (‘Context’ Theme)

PWP experience

Internal pressures
- Anxiety
- Perfectionism
- Self-criticism
- Put less pressure on self

External pressures
- Multiple demands
- Inflexible demands
- Academic demands
- Clinical demands
- Loss of external pressure
- Hard on self
- Feel unheard by course
- Studying is inexorable
- Stressful
- High workload
- Less of burnout
- For your consideration
- Attended everything
- Too hard to share difficulties
- Late assignments
- Staking

Predisposition factors:
Thematic Map by Section (‘Experiences of the Intervention: Facilitators of Change’ Theme)
Thematic Map by Section (‘Suggested Improvements’ Theme)
Appendix K: Table Depicting the Frequency of Themes being Described by Participants in the Empirical Study (Part 2)
Table Depicting the Frequency of Themes being Described by Participants in the
Empirical Study (Part 2)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Interview participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Context</td>
<td>1.1 The tPWP Experience</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Internal pressures</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- External pressures</td>
<td>Ppt</td>
</tr>
<tr>
<td>2. Experiences of the intervention: facilitators of change</td>
<td>2.1 The workshop</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Content of the workshop</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Format of the workshop</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Timing of the workshop</td>
<td>Ppt</td>
</tr>
<tr>
<td>2.2 Follow-up exercises</td>
<td></td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Practical facilitators</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Motivation to practice</td>
<td>Ppt</td>
</tr>
<tr>
<td>3. Impact of the intervention</td>
<td>3.1 Changes in themselves</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Awareness and understanding</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Responding differently</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Openness to sharing difficulties</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Focusing on oneself</td>
<td>Ppt</td>
</tr>
<tr>
<td></td>
<td>- Improved wellbeing</td>
<td>Ppt</td>
</tr>
<tr>
<td>3.2 Changes in clinical work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <em>Approach to supervision</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <em>Approach to clinical work</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Changes in academic work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Barriers

<table>
<thead>
<tr>
<th>4.1 Barriers to the workshop</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2 Barriers to the follow-up exercises</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.3 Contextual barriers to implementation of the intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <em>Being a trainee PWP</em></td>
</tr>
<tr>
<td>- <em>The COVID-19 pandemic</em></td>
</tr>
</tbody>
</table>

5. Suggested improvements

<table>
<thead>
<tr>
<th>5.1 Improving the workshop</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2 Improving the follow-up exercises</td>
</tr>
<tr>
<td>5.3 Improving implementation of the intervention</td>
</tr>
<tr>
<td>- <em>A more consistent message</em></td>
</tr>
<tr>
<td>- <em>Support to implement the intervention</em></td>
</tr>
</tbody>
</table>

*Note:* A dot indicates that the theme/sub-theme was described by the participant during the semi-structured interview carried out with them as part of the empirical study (part 2).