A case study exploring the impact of compassion focused clinical supervision on compassion in practice amongst student nurses and during their transition to registered practitioner.

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Summary

Rationale: Gilbert (2010) proposes that the lack of compassion seen in nursing is the result of a threat culture which leads to professionals acting in a way that best suits their survival instincts. Compassion Focused Clinical Supervision (CFCS) encourages the practitioner to pay attention and to apply reasoning to subsequent behaviours and responses towards each other through a process of threat alleviation and prevention. This can lead to individuals developing skills to regulate their response to threat and monitor their own wellbeing via the application of mindfulness based stress reduction strategies and positive reframing focused on challenging the internal self-critic.

Intervention: A team of nursing academics where trained in the principles and practice of CFCS and engaged in ongoing peer supervision throughout the intervention period. Pre-registration nursing students received CFCS on a two weekly basis throughout the final six months of their programme.

Methodology: Case study methodology was utilised to explore how the characteristics associated with the expression and maintenance of compassion had been influenced by the intervention. Data was collected through both pre-validated questionnaires and focus groups at three time points; T1. Immediately prior to the intervention; T2. At the end of the intervention period and T3. Six months' post intervention. Data was analysed by pattern matching to theoretical propositions developed following an in-depth literature review in line with conventions advocated by Yin (2014).

Findings: Participants expressed positive experiences of CFCS. Their perception of the importance of self-compassion increased. They continued to demonstrate competencies of compassion following six months of working as qualified nurses regardless of complexities within the workplace. As qualified nurse's percipients recognised the implications of limited time and resources on the expression of compassion, however they externalised this as an organisation failing as opposed to a personal inadequacy.

Conclusion: CFCS has the potential to support individuals in developing competencies that will allow them to recognise threats and utilise alleviation strategies in order to maintain levels of compassion via self-care and challenging the internal critical voice. This has the potential to increase levels of resilience and reduce compassion fatigue where individuals and the organisation commit to sustaining a focus on staff well-being over time.

Introduction

Compassion, or more arguably a lack of compassion in healthcare is an international concern (Wolf, 2012). It is a term used frequently in the media and throughout various reports when discussions are taking place regarding nursing and healthcare standards. Compassion can be defined as 'how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care.' (Department of Health (DoH), 2012, pg 13). Similarly the Dalai Lama (1995) describes compassion as "…a *sensitivity* to the suffering of self and others, with a deep *commitment* to try to relieve it." These definitions emphasise key components of compassion including the ability to recognise another's distress and a desire or motivation to alleviate it.

The Francis Report published in the UK highlighted serious concerns regarding healthcare workers, at all levels, ability to express compassion towards others. It highlighted that patients were subjected to appalling suffering and staff lacked the ability to provide basic care (Francis, 2013). Other reports have also highlighted similar concerns regarding healthcare professionals; with patients experiencing poor care, lack of communication and concerns regarding professionals ability to express empathy and compassion (The Patients Association, 2015).

This lack of compassion in nursing has been partially linked to criticisms of pre-registration nurse education; arguing that this is currently overly theoretical and detached from the reality of clinical practice. This leading to nurses lacking a commitment towards fundamental caring and becoming labelled as "too posh to wash", or "too clever to care" (Adams, 2012; Smith 2012). Despite these negative connotations, an in-depth report into the future of nursing education carried out in the UK concluded that there were no shortcomings responsible for poor standards of care (Willis, 2012). Higher levels of education have actually been shown to have a positive outcome on quality of care interactions and patient mortality (Aiken et al., 2013).

Mills et al. (2015) argue individuals are motivated to pursue a career in healthcare due to a desire to demonstrate compassion towards others. It is suggested that the lack of compassion expressed in healthcare is therefore not due to individual factors but more a result of the healthcare professional's constant defensive reaction to threats within the system (Gilbert, 2010). A Royal College of Nursing (RCN) (2013) survey found that current staff felt there were a number of reasons that they could not carry out the high level of care that they wished to do. These included heavy workloads, staff shortages, feeling fatigued by shift working, missed breaks, increase in paperwork targets and lack of resources. The research found that 55% of the survey respondents felt unwell due to stress associated with these factors (RCN, 2013). These stressors are not confined to the UK and with a global workforce crisis (Van Den Heede and Aiken, 2013) workers internationally are also facing these pressures.

Compassionate engagement is time intensive and requires staff to be able to listen as opposed to being in a state of stress, anxiety and against time pressures (Crawford et al., 2013). Expressing compassion to others can also have an impact on psychological staff well-being known as compassion fatigue. This describes an acute onset of physical, psychological and work related symptoms as a result of being exposed to recurrent interactions requiring high levels of empathic engagement (Figley, 2002; Lombardo & Eyre, 2010). This results in practitioners employing distancing techniques to protect themselves from the implications of this emotional labour. These techniques could be externally recognised as failing to demonstrate compassion. Examples include limiting contact time with patients, seemingly ignoring patients' requests for assistance or engaging in patient related derogatory mockery.

As well as experienced nurses there are also increased pressures on pre-registration and newly qualified nurses (RCN, 2013). The transition from student nurse to newly qualified nurse can be an extremely stressful period of time for individuals (Mooney, 2007, Pickens & Fargostein, 2006). Research has found that students initially see compassion and empathy as central to their role (Curtis et al., 2012); However increases in pressure can soon lead individuals to feel overwhelmed and frustrated with levels of compassion reducing towards the

end of pre-registration courses and following qualification (Kumara & Carney, 2014, Mackintosh, 2006, Murphy et al., 2009). Pre-registration education is a crucial part of developing the future workforce (Darbyshire and Mckenna, 2013). Currently, there is very little focus on resilience and reducing compassion fatigue, skills that are vital in order for individuals to survive in the current climate integrated with pre-registration nurse education (Grant & Kinman, 2014). This paper will report on an educational intervention which aimed to address this deficit and explore the impact.

Background

Gilbert (2010) identifies features which constitute a compassionate mind and maintains that both self-compassion and the desire to care for another activates these facets. Alternatively threat-focused emotions act to turn off these components and result in ones which are focused on self-preservation and protection. These facets include; care for the wellbeing of others; a capacity to be sensitive to the nature and complexity of distress; to be emotionally moved by both the distress and the joys of other people; the ability to tolerate and think about the distress of others; to experience empathy; to engage with the complexities of people's (and our own) emotions and lives without condemningly judging them and to display warmth.

Compassion Focused Clinical Supervision (CFCS) is underpinned by an awareness of the facets identified above. It aims to enable the practitioner to notice suffering amongst others through engaging and tolerating distress in a way that communicates empathy, understanding and non-judgment. This involves the practitioner being mindful of their personal motivation to respond to another's suffering (Gilbert 2010).

CFCS encourages the practitioner to identify these motivations and explore how they can be addressed. This is achieved through a facilitated process of alleviation and prevention whereby the practitioner is encouraged to pay attention to what is helpful and apply reasoning to subsequent behaviours and responses toward others. The model maintains that behaviours are motivated by three emotional regulatory systems which are underpinned by a desire to; 1. Protect the self from threat; 2. Compete with the self or others for external validation and success; and 3. Sooth the self to enable contentment and self-acceptance. Whilst each of these emotional regulatory systems are effective for some circumstances the ability to recognize and make choices about the most beneficial position to be responding from, is a key aspect of CFCS.

There is a growing evidence base which supports the efficacy of compassion focused approaches on outcomes for patients in a range of settings (Laithwaite et al., 2009; Judge et al., 2012; Goss and Allan, 2014; Lucre and Corten, 2012; Frederickson et al., 2008; Gilbert and Proctor, 2006). Heriot-Maitland et al. (2014) reflected with staff members following their attendance at therapy groups. They reported that staff on an acute mental health ward felt an increased sense of resilience and ability to tolerate the distressful situations and the inherent threat system that was being triggered due to the stressful working environment. Additionally evidence suggests that by focusing on and practicing compassion, individuals can influence both their neurological and immune systems in a positive way (Klimecki et al., 2014; Pace et al., 2009). This suggests that by utilising these strategies healthcare workers, regardless of level or specialty may developed increased levels of resilience and a reduction in compassion fatigue.

The aim of the educational intervention was for pre-registration nursing students to develop competencies that enable them to regulate their response to threat and monitor their own well-being whilst also paying attention to the complex social context within which these competencies need to be applied.

Educational Intervention

Nursing students from all fields of practice received CFCS on a two weekly basis during clinical placement in the final six months of their programme. This was a two-hour session facilitated by a nursing academic who had attended a three day training course, aided by Compassion Focused Therapy practitioners. Nurse academics engaged in ongoing peer supervision throughout the intervention period to promote continued fidelity to the CFCS model. 120 students received CFCS supervision from adult, child and mental health fields of practice.

Each session commenced with a grounding or mindfulness exercise, encouraging the use of the imagery skill (Gilbert, 2014) and ensuring that individual's minds were in the present moment. Following this facilitators would support students to explore feelings underpinning emotionally challenging situations and attempt to encourage individuals to utilise the skills identified as beneficial in supporting the competencies of a compassionate mind; reasoning, attention, behaviour, sensation and feeling. The three emotional systems where used as an underpinning framework for discussion whereby students were encouraged to consider what was motivating their feelings and how alternative motivations may lead to more preferable outcomes. Most importantly, the facilitator promote an environment of warmth where individuals where encouraged to "notice and explore" their difficulties (Gilbert, 2010). The guiding format of the sessions is given in appendix 1.

Methodology

The aim of this research was to evaluate the perceived impact of this innovation, including individual's experiences, attitudes and also the implications for transition to practice. This was done through the method of exploratory case study underpinned by a social constructivist theoretical framework (Goffman, 1959; Berger and Luckmann, 1967).

This theoretical position focuses on experience being individual and reality being construct through individual knowledge and experience (Bryman, 2004). Compassion, and in particular, self-compassion is a relatively new construct (Neff, 2003). Individuals have personalised identities and also differ in their actions when they are expressing compassion. There are also other factors that may affect an individual's view of compassion including past experiences, knowledge, gender, class and race (Blackstone, 2009). This is also true for how individuals may perceive CFCS.

The research design utilised was that of an exploratory case study. A case study can be defined as 'an empirical enquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between the phenomenon and context may not be clearly evident' (Yin, 2014, pp16). Yin (2014) argues that a case study should be utilised if the research is looking to answer a 'why' or how' question; they cannot manipulate behaviour; they want to explore context or they cannot differentiate between the phenomenon and context. For this research project the case in question was: CFCS as an educational intervention.

A central concern of case studies is generalisability. Statistical generalization, the most recognisable, is not advisable with just one case. However, Yin (2014) argues that by developing theoretical propositions arising from in-depth consideration of the existing literature, it allows you to generalize at a conceptual level known as analytical generalisation. The utilisation of analytic generalisation in this case allowed the researcher to corroborate, modify and reject theoretical concepts based on an in-depth literature review of the case. The

following theoretical propositions were developed from consideration of the background literature:

- Proposition 1: CFCS has the potential to influence the maintenance of the ability to express compassion towards others despite complex social process involved.
- Proposition 2: CFCS has the potential to influence an increased level of resilience and ability to deal with distress which will have positive implications for compassion fatigue and transition to practice.
- Proposition 3: The underpinning framework of CFCS could further enhance the value of clinical supervision in pre-registration nurse education

In order to evaluate the perceived efficacy of the innovation, students who received the innovation were all invited to partake in the research study. Both qualitative and quantitative data sources were utilised.

Research Design

Pre-validated surveys were administered at three time points; T1. Immediately prior to the intervention; T2. At the end of the intervention period and T3. Six months' post intervention. The aim of this was to capture baseline characteristics and to explore any sustained effects. The surveys used were;

- Fears of Compassion Scale, Cronbach's alphas are 0.92 for fear of compassion for self; 0.85 for fear of compassion from others and 0.84 for fear of compassion for others. (Gilbert et al., 2012)
- The Self-compassion Scale, Cronbach's alpha scores range from 0.75 to 0.81 (Neff, 2003)
- The professional quality of life scale, Cronbach's alpha scores are 0.88 for compassion Satisfaction; 0.75 for burnout and 0.81 for secondary Traumatic Stress (Stamm, 2010).

At these same time points focus groups were carried out by the research team, Stacey and Cook, with a small group of students (T1n=9, T2n=8, T3n=4). The aim of these groups was to explore the experience and perceived effect of CFCS. Students were asked to relay stories of emotionally meaningful experiences and then prompted to discuss their thoughts and feelings around these and their perception of how they had responded to them. The focus group schedule is provided in appendix 2. The aim of this was to explore the identified facets of compassion and if these changed over the time periods. Additionally, a focus group was ran with a sample of the nursing academics (n=5) who had undergone the training for CFCS and facilitated group supervision. The aim of this was to explore their experiences around the supervision model and how they thought students had responded. Each focus group was treated as a unit of data which contributed to the exploration of the case.

Data Analysis

Data was analysed using a pattern matching approach advocated by Yin (2014). This involved comparing patterns emerging from the empirical data with the theoretical propositions developed from an in-depth literature review (Yin, 2014). Qualitative data analysis was conducted using Nvivo software to enhance the transparency and organisation of the process. Interviews were transcribed verbatim and entered into Nvivo. Analysis was conducted independently by three members of the research team, followed by a process of analytical synthesis through ongoing discussion to ensure rigour.

The following section highlights the most significant findings for each proposition which have been synthesised from the analytical process. The findings take into account the different time points and experiences of CFCS from the perspective of students and tutors. It is suggested by Yin (2014) that the following types of patterns will emerge from the data:

- Expected outcomes as a pattern: predicted patterns are found and alternative patterns are absent

- Rival explanations as patterns: alternative explanations are present and others which are established in the literature are absent
- Simpler patterns: predicted patterns are present but in a different form
- Time-series analysis: patterns of trends of events which occur over time. (Yin 2014)

Findings

Quantitative Findings

Forty seven participants took part in the quantitative aspect of the data analysis at three different time points. These participants were purposively allocated into 'supervision as usual' (n=23) and 'Compassion focussed clinical supervision' (n=24) groups on the basis of the clinical supervisors expertise. At baseline all 45 participants completed the Fears of Compassion Scale, the Self-compassion Scale and the professional quality of life scale and no significant differences were found between the two groups.

Six months later, 22 participants in the 'supervision as usual' group and 24 in the Compassion focussed Clinical supervision group completed the 3 scales. Independent sample t-test were carried out between the 'Clinical supervision as usual' and 'Compassion focussed clinical supervision groups' across the three scales. No significant difference was found between the two groups on the Self Compassion scale or Compassion Satisfaction scale. On the Fears of Compassion scale, no significant difference was found on the 'fear of compassion for self' or 'fear of compassion from others' sub-scales. However a significant difference was found between the groups on the 'fear of compassion for others ' sub-scale in that the 'Compassion focused Clinical Supervision' group were less fearful of demonstrating compassion towards others than the 'Supervision as usual' group; $t(45) = 2.83$, $p = 0.006$.

Six months post qualification, thirteen participants in the 'Supervision as usual' group and eight in the 'Compassion focussed Clinical supervision group' once again completed the 3 scales. Independent sample t-test were carried out between the 'Clinical supervision as usual' and 'Compassion focussed clinical supervision groups' across the three scales. No significant difference was found between the two groups on the Self Compassion scale or Compassion Satisfaction scale. On the Fears of Compassion scale, no significant difference was found on the 'fear of compassion for others' or 'fear of compassion from others' sub-scales. However a significant difference was found between the groups on the 'fear of compassion for self' sub-

scale in that the 'Compassion focused Clinical Supervision' group were less fearful of demonstrating compassion towards themselves than the 'Supervision as usual' group; t (20) =1.12, p =0.02.

Finally, repeated measures t -tests were carried out between the time point 2 (at qualification) and time point 3 (post qualification). For the 'Clinical supervision as usual' group, on the Fears of Compassion scale, a significant difference was found between the two time points on the subscales of 'fear of compassion for self'; t(12) = 3.411, p = 0.05 ; ' fear of compassion from others' (t (12) =4.356, p =0.001 and 'fear of compassion for others'; t (12) = 5.054, p = 0.00. On the Self-compassion Scale, a significant difference was found between the two time points; t (12) =11.58, p = 0.00. On the professional quality of life scale, a significant difference was found between the two time points on the subscales of 'Compassion Satisfaction; t (12) = 17.232, p = 0.00. 'Burnout'; t (12) = 22.04, p = 0.00 and 'Secondary Traumatic Stress; t (12) = 16.69, p = 0.00. These finding suggest that 'Clinical supervision as usual' will over time, increase Self-compassion and professional quality of life and, will decrease fear of compassion.

For the 'Compassion focussed clinical supervision' group, on the Fears of Compassion scale, a significant difference was found between the two time points on the subscales of 'fear of compassion for self'; t(7) = 3.270, p = 0.02 ; ' fear of compassion from others'; t (7) =3.427, p =0.007 and 'fear of compassion for others'; t (7) = 4.124, p = 0.006. On the Self-compassion Scale, a significant difference was found between the two time points; t (7) =10.39, p = 0.00. On the professional quality of life scale, a significant difference was found between the two time points on the subscales of 'Compassion Satisfaction; t (7) = 30.102, p = 0.00. 'Burnout'; t (17) = 13.95, p = 0.00 and 'Secondary Traumatic Stress; t (7) = 9.39, p = 0.00. These finding suggest that CFCS will over time, increase Self-compassion and professional quality of life and, will decrease fear of compassion.

Although the quantitative findings would suggest that there is a trend developing in terms of the role of standard and CFCS in increasing self-compassion and professional quality of life

and, in decreasing fear of compassion, it is important to note that the small sample size does not allow us to generalise these findings more widely or, make strong claims in terms of the potential benefits of clinical supervision on the basis of this data alone. However, when triangulated with the qualitative findings (below) a much clearer picture of the potential benefits of clinical supervision and in particular compassion focussed clinical supervision, begin to emerge.

Qualitative Findings

Theoretical Proposition 1: CFCS has the potential to influence the development and maintenance of the components of a compassionate mind despite the complex social process involved.

The nature of the emotionally meaningful event identified by students at the pre intervention stage related to a range of scenarios including; the potential for the student to be a victim of physical harm in the workplace; encountering human suffering which surpassed any prior experiences; and significant self-criticism related to standards applied to self and for the care of others which were not being promoted in the clinical environment. Linked to this was the perception of self as different to dominate the view and approaches to practice which left the student feeling vulnerable to external criticism directed from the established professionals. Encouragingly Nvivo analysis demonstrated that 34.54% of the pre intervention focus group coverage was attributed to the participants expressing compassion towards others. The nature of the compassionate act was directly associated with their emotionally meaningful event and included examples of high levels of warmth and empathy expressed towards others;

> *"…the fact I want to be able to see the whole person and not just a condition."*

> *"…you've got like the personal side where, I just…. want to give her a hug she's so upset."*

In terms of the distinct components of compassion, six of the participants displayed an ability to tolerate distress within their situation and sit with uncomfortable feelings;

> *"I was just like quite frightened I tried to just like stay calm and not give him like a frightened reaction"*

"My mentor asked do you still feel uncomfortable talking to her about it and I said I do… but if I don't… then it's just gonna be uncomfortable forever."

The participants reflections on what motivated their response to the emotionally meaningful situation were clearly underpinned by a sensitivity towards the distress of others and a desire to alleviate that this distress. Their motivations included a deep empathy with the individuals they encountered and a passion to ensure they provided care which protect their dignity and considered their holistic needs.

"I think my motivation was I saw someone in distress and I wanted to try and ease that distress."

"…mine was just wanting to do… right… by… the patient and kind of make sure they had the dignity that people deserve in death"

7.23% of pre-intervention data was attributed to factors which were in conflict with the expression of compassion. All data identified as conflicting with compassion in practice related to negative views participants held of established staff. Four participants expressed discontent with the way they observed established staff responding to people in distress. Participants were able to reflect on possible reasons for the non-compassionate practice they had observed however their tolerance and empathy for this remained limited.

"Looking at it from one perspective they maybe don't have a broad experience of people with a history of drug use, they maybe haven't… had… exposure to… different… people with different backgrounds so maybe they are… responding… in the best way they can do."

"I don't think it's a valid excuse, I think something needs to be done to challenge that, it's not acceptable to maintain that… that belief or that view of a person."

Overall, the pre-intervention data demonstrates a high level of motivation to respond to patients in a way which elevates suffering and offers them an empathetic space. Participants were critical of practice which did not demonstrate these attributes. Whilst they attempted to understand what might underpin this response, they remained judgemental and positioned themselves as different to the established workforce.

During the post intervention focus group, as well as the previous competencies associated with the compassionate mind model, others had also developed, with 28.29% of coverage indicating development of model specific competences. There was an evident difference in the emotionally meaningful situations participants chose to discuss at the post intervention time point with a significant proportion of the discussion focusing on a situation where they felt "targeted" by a patient. This referred to situations where a patient expressed verbal and or physical aggression towards the student for a prolonged period of time.

> *"About five days in a row basically, constantly targeting me, he could be quite volatile, quite abusive, you know it got to the point where every day he would threaten to knock me out."*

Despite the high threat levels posed in these scenarios, participants continued to perceives themselves as compassionate towards others and different from the dominate view in practice;

> *"Staff were saying 'oh don't, don't engage with him' but I thought that's just, just gonna show more rejection so I was trying to work with him, I'm not like them."*

Participants also expressed concerns towards other patients whose care may have been negatively influenced as a result of the high need of one individual;

> *"it neglects a lot of care towards other patients as well it's like the focus has to be always on them."*

This reflected the dissonance they were experiencing in relation to a sensitivity to multiple people in distress and competing motivations to relieve this. This dissonance appeared to raise questions of self-doubt whereby participants were concerned about their personal emotional response to these situations and lack of ability to "switch off" outside of placement hours.

> *"Yeah it's, it's upset me, I've found it really quite difficult and it's the sort of thing that I talk about a lot at home the things that have upset me in that day."*

Participant's reflected that this may be as a result of the increased responsibility they now felt for the outcome of these situations and the greater investment they had in the external approval of others due to the requirement to be positively assessed in order to pass their program of study. They were beginning to recognise the need to find some way of managing the internalisation of such emotions and discussed strategies such as maintaining a focus on understanding the person behind the targeting behaviour and attempting to work with the person's strengths as opposed to problems.

In summary at the post intervention stage the complexity of the social processes participants are engaging in is evident. This is demonstrated by the dissonance they describe regarding their motivation to express compassion to people within the context of competing demands. The personal implication of this at this stage is significant.

As qualified nurses there was a definitive shift in the amount of perceived compassion individuals felt able to express towards others;

> *"I find it difficult to be compassionate just because there may not be opportunity to be compassionate"*

> *"So in a way do you kind of feel more distant from people, from patients rather than being kind of emotionally involved."*

Data identified as reflecting the expression of compassion to others decreased slightly to 25.58%. All participants at this stage expressed a belief that this was due to organisational factors such as resources;

> "*I suppose there's a bit of inadequacy for me I don't think I'm doing something wrong I just don't think I'm being allowed to do it right so I don't have the time or the resources to do it correctly."*

This was opposed to a lack of desire or personal ability to express compassion;

> *"I just feel, quite sad as well that this isn't why I trained. And those few moments that I do get where I will make that effort, I'm gonna go and speak to my named patients today and even if I just have a few minutes just to go in and say hello."*

The data arising from this focus group highlights the participant's awareness of the constraints which impact on their perceived ability to express compassion to others. There is a dissatisfaction with this situation and a sustained desire to work around constraints to make a connection with patients. This demonstrates that the desire to uphold a compassionate philosophy of practice can be sustained alongside practice which appears more distant from these principles. Whilst participants were clearly frustrated with this position they did not internalise responsibility for their response. This mediated the self-criticism and moral conflict which was previously present at the post intervention stage.

Theoretical Proposition 2: CFCS has the potential to influence an increased level of resilience and ability to deal with distress which will have positive implications for reduced compassion fatigue.

At the pre-intervention stage participants displayed a conscious awareness of their own feelings and emotions, particularly around personal triggers within the emotionally challenging situations;

> *"I guess with my situation, usually you've kind of got the patient, the professional and… because I related to her so much that kinda made me go oh my gosh it's so linked and it kind of broke down those traditional barriers."*

The participant's desire and motivation to express compassion was acknowledged to have potentially negative implications for them. Failure to enact the compassionate response due to organisational or relational restrictions led to some self-criticism and shame.

> *"Well I thought I managed it, quite badly actually. I took it, I took it home with me… I kept thinking about it… erm… kept thinking about it and actually not really talk about it."*

> *"I still feel a bit guilty."*

> *"I dunno it was horrible you know you just feel so useless and your like well was that my fault [mmm] did I cause all that?"*

The increased level of self-criticism identified at the post intervention stage in proposition one appeared to be associated with an increased awareness of the need to priorities their self-compassion. It was acknowledged that this would have a positive impact on their ability to remain in their role in the longer term;

> *"So I just need to work on that and recognise that I probably need to do that a little bit more."*

As identified previously some participants had difficulties “switching off” after placement and felt that they were taking their heightened emotions at situations home with them;

> *“I don’t know where to put it,”*

At the post intervention stage two participants had utilised mindfulness and grounding techniques independently to support this;

> *“…when on a late I cannot sleep when I come back on a late, my heads whirring and then you’re thinking what about the breathing exercises that the tutors did the last supervision. You’re thinking, actually I’ve just done that without knowing… and I wouldn’t have done that a year ago. I think I sat and… moaned and probably got fed up.”*

Furthermore, overtime participants appeared to be demonstrating a developing ability to accept what may not be within their control as a counter argument to the previously held internalisation of responsibility arising from the prominent critical voice;

> *“Well I didn’t actually deal with it until after I’d left the shift but I rationalised it in terms of I couldn’t have predicted what he’d do.”*

> *“But it’s, it’s something you don’t actually have any control over it because people make their own decisions and it’s learning to accept that as well. You do what you can, ultimately it’s what they choose to do, it’s not anything that you’ve done.”*

At the post intervention stage participants remained critical of practice which they view as undermining a compassionate philosophy of practice and appeared to make a more concrete association between the role of self-compassion in maintaining compassionate values.

Associated with this, as qualified nurses, participants discussed the coping strategies they utilised to manage the ongoing exposure to the suffering of others. One of these was the maintenance of boundaries which they conceptualised as a form of self-protection. It was

recognised by two participants that this could be done in a compassionate way, which also helps individuals to maintain compassion to both self and others;

> *"So I suppose that's sort of against being compassionate but I, I try and limit it so it doesn't back me in too far, in case it takes out too much of my, too much compassionate out of my compassion reservoir. So I don't want to run on empty at any point just in case. Yeah it is, it is a barrier I put up but it's a safety barrier. That's how I rationalise it is it's a safety barrier for me and also for them so they then don't get too dependent on me."*

Despite criticising established practitioners for maintaining this distance in previous focus group, they now appeared to view this as an essential coping strategy which represents a shift is perception. The difficulties individuals had had in taking emotions and distress home with them appeared to have decreased following six months in practice and there was an heightened awareness that failure to do this may lead to burnout;

> *"I have a really rigid rule that if I leave the ward as I go past the double, double doors I just that's it, no more."*

One participant at times found this difficult at times, however utilised strategies in order to manage this;

> *"I sometimes take home the frustration that I'm feeling of being in that environment where…I need more support and I can't get it. But then I try and look for another job, I try and do something constructive with that and try and find ways of doing something about the situation."*

All participants at this stage had utilised grounding and mindfulness as a coping strategy, two of which utilised these during work time;

> *"…sometimes I try and do the, like the mindful breathing and things like that. I'll go and have a little moment. Yeah most of the time it can help. Sometimes*

I walk back onto the ward and the situation on the ward is exactly as it was but it can help to just make me pause and then go rather than just continuing to go. And. Yeah…just having that erm that moment to just think before I act. Yeah, I've found it really helpful."

Finally, as detailed above, by virtue of maintaining boundaries and challenging their self-critic, all individuals felt levels of self-compassion had increased. This was recognised as a conscious effort which had beneficial effects on ability to manage stressors;

"…deal with things that are thrown at me without kind of…you know blaming myself or you know having the same sorts of feelings towards things that I was then and I really struggled then and I think I would have found it quite hard if I still felt like that."

"I am quite compassionate towards myself now (laugh) erm and I…don't think I did used to be. I think, I dunno maybe its survival instincts cause if you're not compassionate and you know the stuff that we did and you know when we were still at uni… Made me realise that you know you do need to be able to you know, this sort of job can actually be really quite…unpleasant. You can't be compassionate towards yourself when you're doing it."

The significance placed on self-compassion is increasingly prominent over time with a rising emphasis on the link between limited self-compassion and non-compassionate practice.

Theoretical Proposition 3: The underpinning framework of CFCS could enhance the value of clinical supervision in pre-registration nurse education

Prior to commencement of CFCS there were inconsistent views around supervision. This experience appeared to be highly dependent on quality and consistency of facilitator. Students appreciated a collaborative style which had a clear structure and process leading to a resolution. Factors which undermined this process included the dominance of negative views amongst peers which were viewed to have no direction or outcome. There could be a tendency for some students to focus on themselves and their own priorities. Finally whilst the opportunity to learn from others could be a valuable outcome, some students compared themselves which reinforced self-criticism.

> *"People just use it as a platform to moan really without anything constructive."*
>
> *"I've definitely felt that way… before… that there were people who dominated conversation"*

Despite the varied experience students agreed supervision offered opportunity to reflect on practice, clarify values, consider alternative perspectives, and think about the bigger picture. Individuals that currently found supervision helpful reported on the importance of the quality of facilitation in promoting a reflective space and addressing group dynamics;

> *"I think your experience of it is based on the lead… whoever's leading the supervision."*

Following the implantation of the CFCS six participants felt that there had been minimal change to their supervision experience due to continuing to find it beneficial;

> *"…erm ours hasn't changed a whole lot. Since this compassion models been introduced, I have found our groups, because of the facilitator, have all been absolutely brilliant."*

The other two participants felt there was a marked difference in their supervision sessions noting the change in structure, a focus on positive reframing and the integration of mindfulness;

> *"It's a more… productive way to address things that happen…every day. I found, I hardly used to go to clinical supervision cause I just couldn't stand all the whining but I've gone to every one since."*

Of the six participants who felt there was not a difference, all of them expressed that they felt there supervision sessions may have been compassion focused prior to the facilitators training;

> *"I think our supervision group was compassion focused even before we had all the grounding exercises."*

Again, there was an expression that facilitator relationship and group dynamics were the most important aspect;

> *"I think it's worked because we are quite free in talking about, you know trust each other"*

From the perspective of the facilitators, all expressed that they had personally found the training beneficial, most noticeably, being mindful of the here and now;

> *"I'm a lot more aware of, you know, what's happening now."*

Four of the facilitators expressed positive opinions around the model;

> *"The actual structure the model, the emotional regulatory system circles are absolutely fantastic, really useful, really beneficial. Having the model in the room, keep it as a midpoint that we all refer to and think about you know how are we feeling, how are we responding, how are we reacting, where do we fit. That's absolutely superb, lovely."*

Of the other two, one had not facilitated many sessions, expressing still feeling at the "de-skilling stage". The other had the following thoughts;

"I've been modelling that mindfulness approach as far as I know. I've read nothing to make me think I haven't been you know I've made no adjustment apart from I tried a few of the grounding exercises,"

This was also echoed by one other facilitator. This mapped with the above students experiences around supervision who did not feel that there had been a noted change in supervision. This led to the question which others also agreed with;

"I just wonder really if, as long as, the group, you know the facilitator is modelling kindness and support. I'm just wondering isn't that all you kind of need.

Two facilitators reflected on the difference between previous supervision groups and this one, with the thought that students had been more able to develop independent coping skills;

"the stuff that came out today was totally different from normal so in some ways it, they they've felt they've had the permission to explore outside you know, this standard oh I dunno how I'm going to do this and how I'm going to do that. More about the feelings. erm and showing compassion for themselves"

As qualified nurses none of the participants were receiving clinical supervision in their workplace. There was a motivation to seek out this type of support and advocate for its benefits amongst the group however the limited prevision appears to emphasise the importance of self-care strategies.

Discussion

The above findings suggest that CFCS has potential to support individuals in the development of the components of a compassionate mind, taking into consideration the complex social processes they are exposed to. This is positively associated with increased levels of resilience as newly qualified nurse engage in mindfulness based stress reduction strategies and utilise positive reframing as a method of internalising personal blame for organisational limitations.

In-line with the established evidence base (Curtis et al 2012), participants at the pre-intervention stage demonstrated high levels of sensitivity to the suffering of the people they were caring for. Their motivation to alleviate this suffering demonstrated the presence of a number of the components of a compassionate mind including empathy, non-judgement and distress tolerance. This obligation developed over the CFCS intervention period whereby a commitment to the well-being of others appeared to be the overarching motivation for the participant's response to a situation.

Participants displayed the ability to utilise individualised skills introduced, rehearsed and reinforced within CFCS in order to manage with complex processes they were exposed to, both following CFCS and also six months after qualifying. This effect corroborates with findings previously from Heriot-Maitland et al., (2014), who upon reflecting with staff felt better able to deal with situations following attendance at compassion focused group therapy sessions.

Initially participants were critical of established professionals who they judged as distancing themselves from the suffering of patients by dismissing their distress or discouraging active engagement. The judgmental attitudes participants were expose to were not tolerated and, whilst they attempted to understand what might underpin them, they did not view them as acceptable. This continued throughout the intervention period despite their acknowledgement of the supervision offering them the opportunity to step into the shoes of others to better understand their response. There appeared to be an increased distinction between "them" and "us" ("them" being the established workforce and "us" being the student participants).

Associated with this was the participant's difficulty with applying the principles of compassion to themselves. It was evident that they had high standards for themselves in terms of both delivering high quality care and being perceived by their practice assessors as competent and confident. A number recognised their difficulty with "switching off" from the emotional impact of their work and noted the implications this was having on their well-being due to self-criticism and personalisation of responsibility. At the post intervention stage the need to refocus this commitment to self was acknowledged as the link between the distancing practices of those they had been critical of and the lack of self-care was clearly recognised.

A focus on self-care was more evident in the follow up focus group as participants as newly qualified nurses spoke about strategies they had utilised to protect themselves in order to sustain their compassion and personal wellbeing. These included mindfulness and grounding exercises, maintenance of boundaries between themselves and the patient, positive reframing of challenging situations to identify the limitation of their influence and the responsibility of the organisation and cognitive strategies which aided a distinction between work and home. It is evident that some of the strategies employed could have been viewed as distancing techniques which were similar to those employed by the established workforce they had previously been critical of. However, participants offered a clear rational for these approaches which they described as offering consistency and safety to the patient whilst also enabling them to maintain their "compassion reserves".

In terms of times series analysis, the data demonstrates a maintained commitment to compassion towards others with increasing awareness of the complex social processes and organisational constraints over time. These impacted on the expression of compassion in practice and raise conflict and dissonance amongst the participants which they were acutely conscious of and actively attempting to manage.

This represents a simpler pattern. Whilst it appears participants have maintained their commitment to expressing compassion towards others, as predicted from the literature, a

complex psychological process of internal dissonance, alleviation and prevention is occurring. Furthermore a rival pattern associated with the participant's ability to depersonalise responsibility for implications of orgainsational constraints, such as poor resources, exists. This has previously been reported as the erosion of compassion amongst newly qualified nurses due to the desire to prioritise efficiency and tasks (Kumara & Carney, 2014, Mackintosh, 2006, Murphy et al., 2009). This data suggests however that this is an active strategy whereby participants recognise the limited influence they have on the wider system and exercise self-compassion by acknowledge they are often doing the best they can within the challenging circumstance they are working within.

Participants expressed that the CFCS model encouraged a more constantly positive experience of clinical supervision whereby their relationship with their facilitator was aided by the structure and format of the process. Previous research has found that the most important factor in clinical supervision in a supportive yet challenging professional relationship with the facilitator (Severinsson and Sand, 2010). The importance of this was reflected throughout the project and a safe, trusting space was seen as being beneficial to all participants. This aspect is viewed as an essential component of the CFCS model as it advocates that all interactions are enacted with warmth (Gilbert, 2010). This warmth is likely to produce a safe space that individuals feel comfortable disclosing and also challenging thoughts.

The findings demonstrate significant learning which has occurred over time in relation to the challenges of enacting the components of compassion in practice. It is acknowledged that a number of factors could have influenced this learning process and the ability to distinguish the direct connection with CFCS is not possible. It is clear, however that students and facilitators value the space supervision offers to explore these challenges. Furthermore it appears that the structure and format of CFCS has acted to address some of the criticisms previously expressed towards supervision and create an experience which is more constantly in line with the student's support needs. Furthermore the practice of mindfulness appears to be a valued feature which is transferable outside of the supervision setting. This is particularly relevant as

no participants were receiving any form of clinical supervision as qualified nurses. These findings confirm the proposition that the underpinning framework of CFCS could enhance the value of clinical supervision in pre-registration nurse education.

Further it suggests that an ongoing commitment amongst individuals and organisations to the practice of CFCS could have longer term positive implications for well-being. It was evident that there is a lack of support for individuals following becoming qualified practitioners. Many newly qualified nurses feel overwhelmed and frustrated with the lack of support (Kumara and Carney, 2014) which was reflected within this project. It has been argued that newly qualified nurses should be invested in at an early stage in their career (Hollywood, 2011) and the Care Quality Commission (CQC, 2013) advocate clinical supervision as beneficial in doing this.

Limitations

This research was carried out with a small sample size within one University. Although the findings corroborated the theoretical propositions based upon compassion focused therapy there are no other research studies associated with utilising compassion focused clinical supervision. Therefore further research is required within different populations, including newly qualified nurses, in order to further evaluate the efficacy of this innovation.

Conclusion:

CFCS has the potential to support individuals in developing competencies that will allow them to recognise threats and utilise the components of a compassionate mind to maintain levels of compassion. This potentially may increase levels of resilience and reduce compassion fatigue within individuals who fully engage with CFCS. However, the need for continued commitment and practice of the approach is required at both an individual and organisational level. The exploratory nature of this single case study presents a positive grounding to justify further implementation and research.

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Appendix 1: Compassion Focused Clinical Supervision Format

1. **Grounding Exercise**

This can be in any format that you feel comfortable with.

2. **Check in**

A brief 'check in' of how people have been. This could be started by, 'so how are we all feeling today?'

3. **Set agenda**

Are there any themes you have identified from the check in? Is there anything attendees are keen to discuss? Have people had similar experiences?

Pick out 3 or 4 of these, starting with what you have identified as the most important.

4. **Main Discussion**

Remember to *'Notice and Explore'*

Use the picture of the emotional regulation systems as a tool. This could be in the centre of the room and can be used to bring the focus back to what emotional system someone may be in at that moment.

Remember the critical voice, this may answer the question initially. You may be able to explore this: name it, be aware of it.

You are there to enable others to make their own decision, take a step back, do not become a problem solver.

Some prompts for the different facets of a compassionate mind:

- *Care for the wellbeing of others*

What did you feel you wanted to do in this situation?
What was your aim in doing this?

- *Distress and need sensitivity*

Were you aware of how they were feeling at that point? Did you understand why?

What emotional cues did you see? How did you respond to them?

- *Sympathy*

How did supporting someone in that emotional state make you feel?

- *Distress tolerance*

How did you behave in that way despite your thoughts at the time?

How did it affect your mood?

How did you deal with this?

- *Empathy*

Did you feel like you were able to relate to this persons feelings?

Did you feel like you understood these feelings?

How did you communicate your understanding?

- *Non-judgement*

How do you think you would behave in the situation?

How do you think you would feel?

How do you think they were feeling at this time? What thoughts do you think they had?

- *Warmth*

How were you feeling at this time?
How did you portray this?

For all facets…
How did you behave in this instance?
What influenced you to do that?
What were you thinking?
What were you feeling?
Would you expect others to react like that?
How does everyone else think you would feel if you were in that situation? How do you think this would impact on your behaviours?
Can anyone else relate to this situation?
Did you feel like you were being compassionate at this point?

5. Summarise/Round of Appreciation

Summarise what you have discussed and the main learning points.

You could also do a round of appreciation where everyone in the room says thank you to another person for something they have done.

6. Get supervision

If you need any support do not hesitate to contact someone. We will run supervision groups for those that have attended the training as well.

The most important thing to remember is you are creating a safe space for people… there is no right or wrong way to do this!

Appendix 2: Focus Group Schedule

Introduction:

Hello and welcome to the meeting. First of all we would like to thank you for coming and taking part in this focus group, we look forward to hearing your views.
I am… (Introduce facilitators and there role.)
As you know we are currently researching the role compassion focused clinical supervision may have in developing your skills as a student nurse. The aim of this focus group is to discuss compassion in care and what your thoughts and experience of this has been.

Starter:

Can everyone introduce themselves and what branch of nursing they are currently training for?

**Ground rules.

Before we begin I would like to establish some ground rules:

1. Feel free to speak what you think; it does not matter if your thoughts differ from others.
2. Anything said in this room should be kept confidential.
3. Don't speak over each other.
4. Can you turn off your phones?
5. Notes will be taken during the session.

Summarise previous input/focus group.

Key Questions:

Can we please begin by talking about a situation that you may or may not have already discussed in your supervision, and what your thoughts and feelings are around this? Can each person share an experience during the last six months that has impacted you and you may have found emotionally challenging?

What was your motivation in this situation?

What were your thoughts and feelings throughout this and how did you manage these?

Has anyone used any skills they may have learnt in supervision to manage these experiences?

Some prompts:
To help identify the different facets of a compassionate mind seen in different situations.

- *Care for the wellbeing of others*

What did you feel you wanted to do in this situation?

What was your aim in doing this?

- *Distress and need sensitivity*

Were you aware of how they were feeling at that point? Did you understand why?

What emotional cues did you see? How did you respond to them?

- *Sympathy*

How did supporting someone in that emotional state make you feel?

- *Distress tolerance*

How did you behave in that way despite your thoughts at the time?

How did it affect your mood?

How did you deal with this?

- *Empathy*

Did you feel like you were able to relate to this persons feelings?

Did you feel like you understood these feelings?

How did you communicate your understanding?

- *Non-judgement*

How do you think you would behave in the situation?

How do you think you would feel?

How do you think they were feeling at this time? What thoughts do you think they had?

- *Warmth*

How were you feeling at this time?
How did you portray this?

For all facets…
How did you behave in this instance?
What influenced you to do that?
What were you thinking?
What were you feeling?
Would you expect others to react like that?
How does everyone else think you would feel if you were in that situation? How do you think this would impact on your behaviours?
Can anyone else relate to this situation?
Did you feel like you were being compassionate at this point?

Supervision focus:
What thoughts do you have around supervision?
Attendance
Impact

Learning and development

Ending question:

Do you at this moment feel that you are compassionate towards yourself?

Summary of discussion