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An exploration of the application and understanding of  
compassion from the perspective of parents and Mental Health  
Nursing Students

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This thesis has been submitted in part fulfilment of the requirements for the degree  
of Doctorate in Clinical Psychology

Coventry University, Faculty of Health and Life Sciences  
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## List of Abbreviations

ACE	Adverse Childhood Experiences
ASD	Autism Spectrum Disorder
CBIs	Compassion-based Interventions
CFT	Compassion Focused Therapy
CGT	Constructivist Grounded Theory
COP	Compassion in Practice
DASS	Depression, Anxiety and Stress Scales
DASS-SF	Depression, Anxiety and Stress Scales - Short Form
EBPPs	Evidence Based Parenting Programmes
KBM	Kindness-based Meditations
MHNS(s)	Mental Health Nursing Student(s)
NHS	National Health Service
NMC	Nursing and Midwifery Council
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
SCS	Self-compassion Scale
SCS-SF	Self-Compassion Scale - Short Form
QAT	Quality Assessment Tools
RCT	Randomised Controlled Trials
UK	United Kingdom

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## Declaration

This thesis has been submitted for the Doctorate in Clinical Psychology at the Universities of Coventry and Warwick and has not been submitted for any other qualifications at any other institution. This thesis is an original piece of my own work undertaken with the academic and clinical supervision of Dr Jo Kucharska, Dr Magda Marczak and Dr Hannah Andrews from Coventry University. All supervisors assisted the development of the research idea and offered feedback on drafts of the chapters. A colleague cross-rated the quality appraisal checks in the systematic literature review to ensure reliability.

The systematic literature review was written in preparation for submission to Parenting. The empirical paper was written for submission to Journal of Clinical Nursing. Findings from the empirical paper will be presented as a presentation to the School of Nursing, Midwifery and Health at Coventry University.

## Summary

This thesis explores the application and understanding of compassion. Chapter one examines the application of compassion through Compassion-based Interventions (CBIs) for parents. Chapter two investigates the understanding of compassion from the perspective of Mental Health Nursing Students (MHNSs).

Chapter one is a systematic literature review investigating CBIs for parents. The aims were to evaluate the effectiveness of CBIs on psychological factors, examine qualitative themes and integrate quantitative and qualitative knowledge. Ten moderate to high quality studies published between 2018 and 2020 were evaluated using a mixed studies design (Pluye & Hong, 2014). Samples were small and biased, limiting the strength of conclusions. CBIs show promise for improving self-compassion in some mothers. More research is needed to strengthen other conclusions. Integration of quantitative and qualitative data suggests interventions with evidence of qualitative themes (*sharing experiences, self-acceptance, reflecting on difficulties and hope and trust for the future*) may yield more significant and larger effects than those without.

Chapter two is a qualitative research study using Constructivist Grounded Theory (CGT) methodology to investigate MHNSs' understanding of compassion. Nine MHNSs were interviewed. Following CGT analysis, a theoretical model was constructed. Compassion was understood as an interrelated set of areas, namely "*Pure concern for other*"; *Doing good, being good*; *Safe to learn*; "*We're all in this together*" and *Care for self for others* leading to a core concept of '*Connecting*'. For MHNSs, compassion involves primarily connecting with their patients alongside connecting with values, their course and mentors, their cohort and tentatively with themselves.

Chapter three is a first-person reflective account of the author's research experience. The account is shaped by the three systems of emotion regulation from Gilbert (2009). Personal and systemic factors affecting the author's threat, drive and soothe systems are discussed before concluding with a focus on the future.

**Overall word count: 19,815** (at submission; excluding abstracts, tables, figures, references and appendices)

## Chapter 1: Systematic Literature Review

Compassion-based Interventions for current and prospective parents: A mixed studies  
systematic review

*Written in preparation for submission to Parenting: Science and Practice (See  
Appendix A for author guidelines)*

Overall chapter word count at submission (excluding abstract, tables, figures and  
references): 7996

## 1.0 Abstract

This review aimed to evaluate the effectiveness of compassion-based interventions (CBIs) for prospective and current parents on measures of compassion, self-compassion, anxiety, depression, stress, psychological distress, shame or wellbeing, examine the main themes emerging from qualitative data and integrate quantitative and qualitative knowledge on the topic. A systematic search of the literature investigating CBIs for parents was carried out in March 2020 within PsycINFO, AMED, CINAHL, MEDLINE and Web of Science. Of 1599 studies identified, ten studies met inclusion criteria. All studies were assessed as moderate to high quality. Eight quantitative, one mixed method and one qualitative study were analysed using a mixed studies result-based convergent synthesis design. There was high heterogeneity between studies and samples were small and biased. CBIs show promise for improving self-compassion in some mothers and possibly increasing compassion, increasing wellbeing, decreasing depression and decreasing parenting stress. No conclusions could be made about effectiveness of interventions on anxiety, shame or psychological distress. Generalised stress in mothers may not be affected. Integration of quantitative and qualitative data suggested interventions with evidence of more qualitative themes (*sharing experiences, self-acceptance, reflecting on difficulties and hope and trust for the future*) may yield more significant and larger effects than those without. Conclusions are cautious due to limited quality and quantity of qualitative data. Further studies are needed to improve robustness of findings. Limitations and strengths are considered. Policy, practice and research implications are discussed.

**Word count:** 234 words

**Keywords:** *Parenting, compassion, mixed-studies systematic review*

## 1.1 Introduction

### 1.1.1 Review subject and definitions

The subject area of this review is compassion-based interventions (CBIs) for current and prospective parents. Compassion is a term without an agreed definition. Strauss et al. (2016) reviewed the compassion literature and proposed compassion is likely to consist of the following elements: recognizing and understanding the universality of human suffering, feeling for the person suffering, tolerating uncomfortable feelings, and motivation to act and/or acting to alleviate suffering. Self-compassion definitions most often included three elements i.e. kindness, common humanity and mindfulness that are distinct yet interact with each other (Neff, 2003b). In this review, the term 'CBIs' refers to any intervention with a main focus on compassion to or from the self as defined above, irrespective of the mode of delivery. As there appears to be important physiological differences in general mindfulness and mindful compassion (Valk et al., 2017), general mindfulness will be excluded from the review. The review aims to synthesise information regarding outcomes and/or experiences, attitudes, meanings or opinions related to compassion, self-compassion, anxiety, depression, stress, psychological distress, shame or wellbeing.

The term 'parent' refers to the primary caregiver for a child aged 0-17 years old. This includes biological parents, adoptive parents<sup>1</sup>, foster carers<sup>2</sup> or others acting as a

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<sup>1</sup> The term 'adoptive parent' refers to a non-biological parent who has been granted permanent legal guardianship of a child.

<sup>2</sup> The term 'foster carer' refers to an individual who is undertaking the parental role whilst the child remains under the legal care of the local authority.

primary caregiver and prospective parents<sup>3</sup>. A child is defined as “every human being below the age of eighteen years” (United Nations Children's Fund [Unicef], 1989, p. 4).

## **1.1.2 Research Significance**

### ***1.1.2.1 Parenting and Compassion***

The parenting a child receives in the first two years of life is a significant predictor of attachment security, which is strongly associated with later wellbeing and mental health (Barlow, 2013). Children showing secure attachment in infancy tend to function better educationally, emotionally, socially and behaviourally than those without secure attachment (Sroufe, 2005; Berlin et al., 2008). Providing compassion and care during a child’s early development impacts on a range of physical factors such as epigenetics, the immune system and brain development (Cowan et al., 2016; Pace et al., 2009; Pace et al., 2013; Siegel, 2015) and psychological factors such as emotion regulation and self-confidence (Mikulincer & Shaver, 2016). Recent brain imaging studies on compassion tentatively offer further support for the link between compassion and parental nurturance (Pillmer, 2019). Nurturing, compassionate caring from parents to children is crucial for child development. Care and compassion received as a child has far-reaching impact on our ability to care and have compassion in adulthood (Gillath et al., 2005).

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<sup>3</sup> The term ‘prospective parent’ refers to women who are pregnant and/or their partner

### ***1.1.2.2 Parental Distress***

Parents' ability to offer sensitive, attuned and compassionate caring can be affected by parental stress, depression or anxiety; these are prevalent in parents globally. A review of prevalence of parenting stress in the United States of America reported 13% of children living with at least one parent with high parenting stress (Raphael et al., 2010). Prevalence of parenting stress appears increased in single mothers (26%) compared with partnered mothers (16%) in Germany (Liang et al., 2019). Thirty eight percent of mothers of children with epilepsy in the United Kingdom (UK) also report significant parenting stress (Reilly et al., 2018). Studies indicate an increase in the prevalence of depression in parents caring for children with additional needs. Further, 70.5 % of parents in Iraq caring for children with cancer were depressed (Al-Maliki et al., 2019), as were 76.8% of mothers in India caring for children with Autism Spectrum Disorder (Jose et al., 2017). Barreto et al. (2019) reported 95.7% of mothers and 83.3% of fathers of children with cerebral palsy had some degree of depression. Elevations in anxiety in parents of children with cystic fibrosis were found in 48% of mothers and 36% of fathers (Quittner, 2014). A systematic review and meta-analysis of anxiety in the perinatal period indicated self-reported anxiety as high as 24.6% in the third trimester of pregnancy, with 15.2% of those meeting criteria for a clinical diagnosis of an anxiety disorder (Dennis et al., 2017). Parental distress in the form of stress, depression and anxiety is common and warrants attention.

### ***1.1.2.3 Impact of Parental Distress on Children***

Parental distress has a negative impact on children's physical and psychological development. Parental mental illness was cited as an Adverse Childhood Experience

(ACE) in Felitti et al. (1998). Felitti et al. (1998) stated 18.8% of 9,508 adults reported a household member was depressed or mentally ill and/or that a household member attempted suicide during their childhood. The ACE study showed a graded dose-response relationship between experiencing ACEs in childhood and negative health and well-being outcomes in adulthood including injuries, mental health, maternal health, infectious diseases, chronic disease, risky behaviours and a lack of educational and occupational opportunities (Felitti et al., 1998). Poor parental mental health is linked to children's mental health difficulties (National Centre for Social Research [NCSR], 2018; Bennett et al., 2012; Connell & Goodman, 2002; Lieb et al., 2002; Manning & Gregoire, 2009). Prevalence of depression in children living with a primary caregiver with fair or poor mental or emotional health was 13% compared with 3.2% in those living with a primary caregiver with good, very good or excellent mental health (Ghandour et al., 2019). Although much of research focuses on mothers, there is evidence of an association between depressive symptoms in fathers and depressive symptoms in their adolescent children (Lewis et al., 2017).

There is a negative impact on the relationship between parents who are distressed and their children. Depressed mothers are less engaged with their children (Pelaez et al., 2008) and demonstrate less warmth, less emotional attunement and sensitivity than those without depression (Goodman & Gotlib, 2002; Hoffman et al., 2006). Infants of mothers with depression show significantly reduced likelihood of secure attachment (Martins & Gaffan, 2000). Insecurity of attachment has implications for future health and wellbeing. Supporting parents is therefore an international priority in policies (Heckman, 2017) and has typically taken the form of parenting programmes.

#### ***1.1.2.4 Parenting programmes***

Reviews of traditional Evidence Based Parenting Programmes (EBPPs) focus attention on children's social, emotional and behavioural outcomes (Kirby & Sanders, 2012; Sanders et al., 2014) with parents' outcomes limited to parenting practices, satisfaction, adjustment or the parental relationship with their partner (Sanders et al., 2014). Barlow et al. (2014) recognised the need to synthesise parental psychosocial wellbeing outcomes reported in parenting interventions. Barlow et al. (2014) conducted a meta-analysis to determine effectiveness of parenting programmes in improving parental wellbeing; specifically depression, anxiety, stress, anger, guilt, confidence, partner relationship and self-esteem. The review reported statistically significant improvements up to three months post-intervention in all areas apart from self-esteem. Only stress and confidence remained significant at six-months post-intervention and none were significant after a year. The studies reviewed were grouped into 'behavioural', 'cognitive-behavioural' and 'multimodal' types of intervention, with no CBIs included. A limitation of this review is the search was completed in 2011. Since 2011 there has been an increase in studies reporting parental psychosocial outcomes. A further limitation is the meta-analysis included only randomised controlled trials (RCTs) or quasi-RCTs. Recently noted challenges for policy-makers and parenting intervention providers are that some parents do not engage with EBPPs (Axford et al., 2012; Mytton et al., 2014) and others who engage do not respond to EBPPs (Sanders et al., 2014). Reviewing qualitative studies of parents invited to parenting programmes may elucidate these issues.

Butler et al. (2019) aimed to explore parents' experiences and perceptions of parenting programmes. Their systematic review and meta-synthesis of qualitative literature searched databases in July 2018 and reviewed 26 qualitative studies. Three main themes of 'a family's journey', 'aspects perceived to be important or valuable' and 'challenges or difficulties' were identified. No reviewed study interventions were CBIs. Butler et al.'s (2019) recommendations were to improve provision of accessible, clinically and cost-effective interventions for parents and provide sensitivity to parental adversity. Parents fear judgment from professionals and/or other parents (Allen, 2011). Professionals providing parental interventions need to adopt a non-judgmental approach and acknowledge parental effort (Allen, 2011).

Fear of judgment from others activates shame, which within the parenting role is a stronger predictor of psychological controlling (authoritarian) parenting style than psychological flexibility, parental mental health or fear of compassion (Kirby et al., 2019). Children whose parents are described as authoritarian show worse outcomes in health and wellbeing than children whose parents adopt any other parenting style (Scott, 2008). In comparison, children who have experienced authoritative parenting characterised by high warmth and positive assertive control have the best health and wellbeing outcomes including more prosocial skills, being more academically and socially competent and having less symptoms of disorders (Scott, 2008).

CBIs with their focus on the importance of social roles, the impact of caring, and recognition of the impact of self-criticism and shame are well placed to support parents experiencing distress. Including compassion-focused elements in interventions for

parents can increase the likelihood of attachment security and pro-social behaviour in children (Mikulincer et al., 2005). In addition, a study designed to assess dysfunctional attitudes towards motherhood, negative automatic thoughts, depressive symptoms and self-compassion reported self-compassion may exert a buffer effect on the relationship between dysfunctional attitudes or beliefs about motherhood and depressive symptoms (Fonseca, 2018).

#### **1.1.2.5 CBIs**

Compassion-focused therapy (CFT; Gilbert, 2006, 2009a, 2009b, 2014) posits there are two 'psychologies' or aspects of compassion: attributes/engagement and skills/alleviation/prevention and these exist within an environment of 'warmth'. Other CBI such as Compassion Cultivation Training (Jazaieri et al., 2013) aim to promote feelings of open-heartedness, warmth or connection to others. The environment of warmth promotes non-judgmental attitudes, which is important to parents (Allen, 2011). A key intervention target in CFT is shame and self-criticism. Gilbert et al. (2001) purport compassion and the experience of compassion is one of the most powerful antidotes to shame.

Reviews of CBIs show promise; Leaviss and Uttley (2015) reviewed fourteen studies and concluded CFT showed potential as an intervention for mood disorders, particularly for those high in self-criticism. Kirby et al. (2017) aimed to examine the effects of CBIs on a range of outcomes. Twenty-one RCTs were included in their meta-analysis. Kirby et al. (2017) concluded there are potential benefits of CBIs on compassion, self-compassion, mindfulness, depression, anxiety, psychological distress and wellbeing.

Kirby et al.'s (2017) meta-analysis design excluded 42 non-RCT studies. Analysis of these studies may have yielded different outcomes. This review aims to meet this limitation by broadening the inclusion criteria to all types of study design.

A limitation of both compassion reviews in respect of this planned review is that parents were not reported as a separate group and interventions were not specifically for parents. This review aims to meet this limitation by looking specifically at CBIs for parents.

#### ***1.1.2.6 CBIs for parents***

There is a need to review this area as previous reviews have focused on CBIs for the general adult population or reviews of parenting interventions without a compassion focus. Recent years have seen an increase in literature regarding CBIs for parents such as 'The compassionate mind approach to postnatal-depression' (Cree, 2015), and study protocols registered for trials such as those by Kelman et al. (2016) and Sacristan-Martin et al. (2019). The recent increase in interest of CBIs for parents warrants further attention. The author is not aware of any previous systematic reviews of CBIs for parents, therefore this review will be the first to synthesise current knowledge in this area.

Previous reviews suggest that CBIs may be helpful in reducing distress in adults (Leaviss & Uttley, 2015; Kirby et al., 2017) and CBIs have been suggested as a helpful adjunct or alternative to existing EBPPs (Kirby, 2016; 2020). At present there is limited knowledge about the effectiveness and experience of CBIs for parents. A review of this area is

important in order that the evidence base for CBIs for parents is analysed. If the review shows that CBIs are effective for modifying psychological factors for parents then it offers another avenue of intervention for reducing parental distress (and/or increasing parental wellbeing). Reviewing qualitative studies of CBIs may provide insights into the experience for parents, which could be useful in modifying or developing interventions to increase effectiveness, acceptability or experience. The review would also be important if it determined that CBIs were ineffective or unsuitable as it may prompt further research and steer clinicians in a different direction.

### **1.1.3 Aims**

This systematic review aims to provide a narrative synthesis of CBIs for prospective and current parents.

This review has the following aims:

- 1) To evaluate the effectiveness of CBIs for future and current parents on measures of compassion, self-compassion, anxiety, depression, stress, psychological distress, shame or wellbeing compared to comparison groups (if present);
- 2) To examine the main themes emerging from the qualitative and mixed-method studies, to understand the appropriateness, acceptability or nature of the experience of the intervention;
- 3) To provide integration of quantitative and qualitative knowledge on the topic

## 1.2 Methods

### 1.2.1 Systematic Literature Search

#### 1.2.1.1 Search Process

Following ethical approval from Coventry University Ethics (Appendix B), the following databases were searched, PsycINFO, Allied and Complementary Medicine Database (AMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE and Web of Science. The search was carried out on 5th March 2020. Reference lists of relevant articles were hand-searched. Grey literature were searched using Grey Matters and Open Grey (<https://www.cadth.ca/resources/finding-evidence/grey-matters>; <http://www.opengrey.eu/>). Articles identified in grey literature and subsequently published following peer review were included.

#### 1.2.1.2 Search Terms

The search terms are shown in Table 1.1 (below).

Table 1.1: PICO search terms

Population	Parent*, mother*, father*, 'foster carer', 'primary caregiver', pregnan*
Intervention	Compassion*, kindness
Comparison	No other intervention, active intervention, care as usual, waiting list control
Outcome	Compassion, self-compassion, anxiety*, depression, stress, 'psychological distress', shame, well*

The PICO model is used as a tool to structure research questions (Schardt et al., 2007) and defines P (population), I (intervention), C (comparison) and O (outcome). Population terms were parent\*, mother\*, father\*, 'foster carer', 'primary caregiver' and pregnan\* (to search for pregnant or pregnancy). Adoptive parents were included

in the target population but not specified as a search term as they were picked up by parent\*, mother\* or father\*. Others acting as a primary caregiver were searched for using the term, 'primary caregiver'. Intervention terms were compassion\* or kindness. Comparison terms were not used in the search as initial scoping determined comparison terms reduce specificity of the search. Outcome terms were self-compassion, anxiety\*, depression, stress, 'psychological distress', shame and well\* (to search for well-being, wellbeing or wellness). The term 'compassion' was used once in intervention search terms. The location was title, abstract, keywords. Terms were combined with OR between each population term, OR between each intervention term and OR between each outcome term then combined with AND, as shown in Figure 1.1.

Figure 1.1: Search strategy



### 1.2.1.3 Inclusion and Exclusion Criteria

Table 1.2 details inclusion and exclusion criteria used for screening. Studies had any or no comparison group. Articles written in the English language were included. Quantitative, qualitative and mixed-method studies were included with any method of data collection, any sample size including single case reports and any recruitment method. Peer-reviewed studies were included. There were no date or country of study restrictions.

Table 1.2: Inclusion and Exclusion Criteria

Criterion	Inclusion	Exclusion
Population	Biological parents, adoptive parents, foster carers, other family members or friends acting in the role of primary caregiver, pregnant women, pregnant women's partners	Residential home staff, teachers
Intervention	Any compassion-based intervention for current and prospective parents	Any intervention not primarily compassion-based
Comparison	Any or no comparison group	
Outcome	At least one reported quantitative outcome or reported qualitative experience, attitude, meaning or opinion related to: compassion, self-compassion, anxiety, depression, stress, psychological distress, shame or wellbeing	No reported quantitative or qualitative outcomes related to: compassion, self-compassion, anxiety, depression, stress, psychological distress, shame or wellbeing
Language	English language	Not available in English language
Study design	Quantitative including RCT and non-RCT, qualitative and mixed method studies	
Article Type	Peer-reviewed studies	Dissertations, expert opinion

### 1.2.1.4 Classification of Studies

The process of study selection is reported below (Figure 1.2) on a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram (Moher et al., 2009).

Figure 1.2: PRISMA Flow diagram for systematic reviews (Moher et al., 2009).

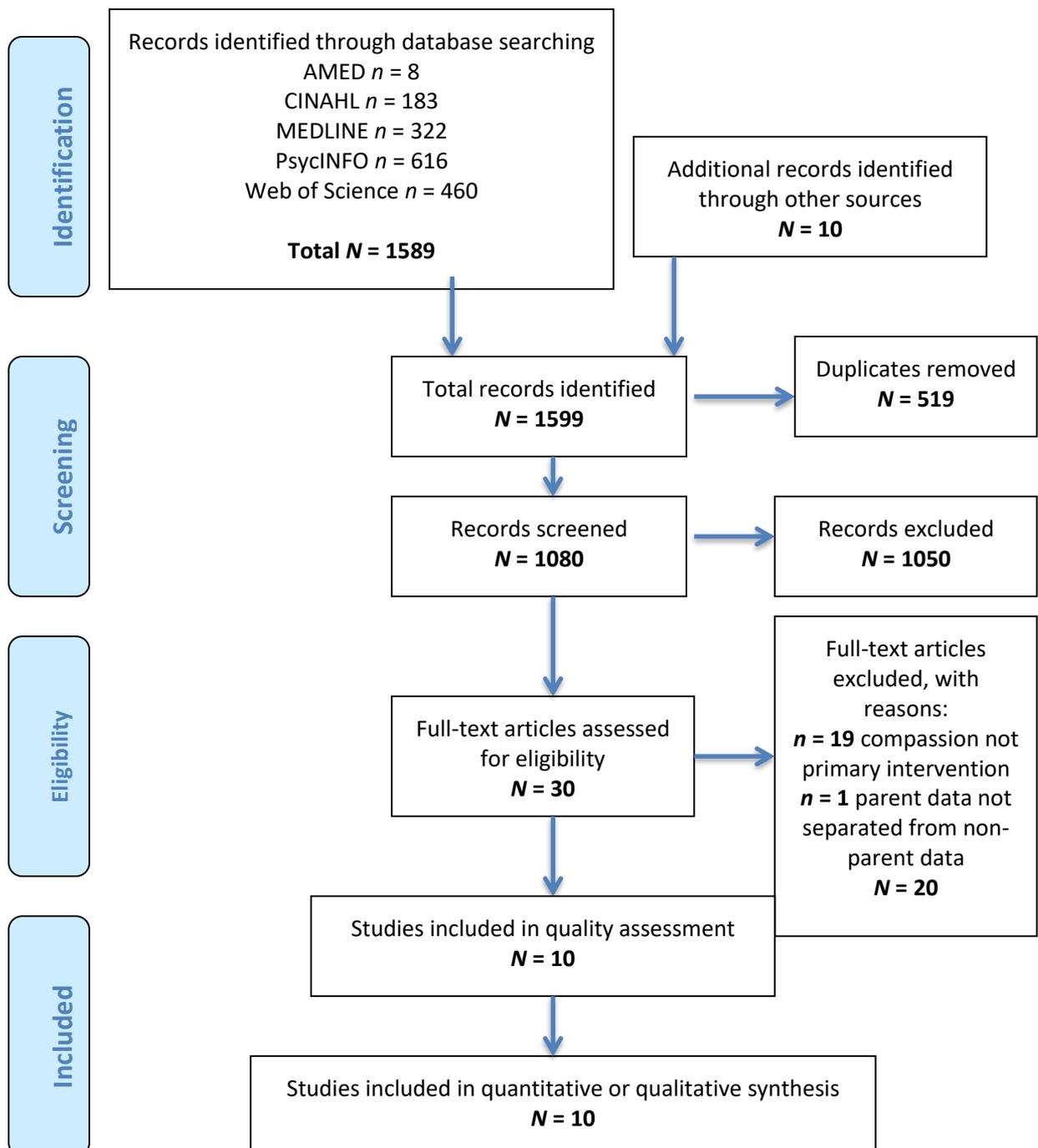


Figure 1.2 shows the process of identification, screening, determining eligibility and including studies. A total of 1589 records were identified through database searching with none identified through hand searching of references. Ten studies were identified in grey literature. Five hundred and nineteen duplicates were removed leaving 1080 records. The 1080 records were screened via title and abstract, of which 1050 were excluded due to not meeting inclusion criteria. Thirty full-text articles were screened for eligibility and 20 excluded. Nineteen articles were excluded, as the intervention was not primarily compassion-based. One study was excluded, as parent-related outcome data was not separated from non-parent-related data. Ten studies remained eligible for quality assessment. Eight quantitative studies, one mixed method study and one qualitative study were included in synthesis.

## **1.2.2 Quality Assessment**

### ***1.2.2.1 Quality Assessment Checks***

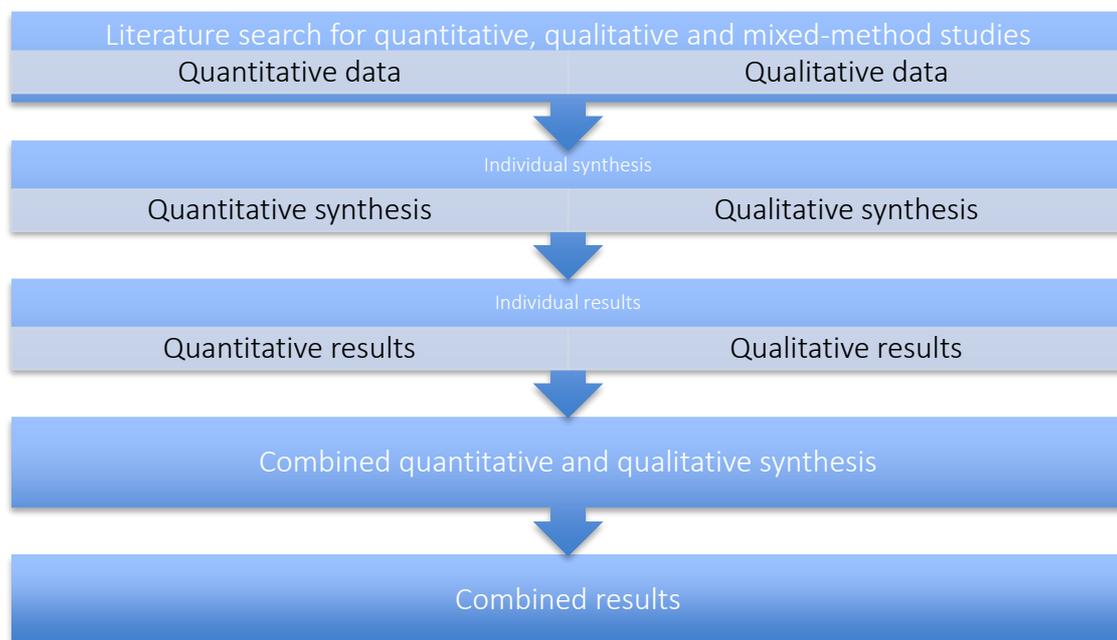
The PRISMA statement recommends quality assessment in systematic reviews (Moher et al., 2009). Quality assessment was performed to ensure methodological quality of included studies. Different designs and methods used in each study can make quality comparisons problematic (Hong et al. 2019). This was addressed by combining two quality assessment tools to ensure mixed-method, quantitative and qualitative studies could be rated contemporaneously. The quality assessment tools (QAT) were Caldwell et al. (2005) and Pluye et al. (2009). Details of QATs can be found in Appendix C. The mixed-method study was moderate quality (58.9%). Qualitative and quantitative studies were high quality (72% to 92%). Quality ratings are reported in Table 1.3. To

enhance reliability, articles were independently reviewed and inter-rater reliability tests carried out. Kappa coefficient ranged from .70 to 1 with an overall Kappa of .81.

### 1.2.3 Analytic Review Strategy

Studies were analysed using a mixed studies result-based convergent synthesis design (Pluye & Hong, 2014). Figure 1.3 (below) details analysis stages.

Figure 1.3: Mixed studies result-based convergent synthesis design stages



Further details of the aim, suitability and process of this design can be found in Appendix D.

## 1.3 Results

Table 1.3 shows the characteristics of the ten studies included within this systematic review.

Table 1.3: Characteristics of the literature of included studies

Authors, Date, Country, Quality Rating (QR; %), Kappa ( $\kappa$ )	Aims	Study design  Sampling method	Characteristics of participants (where stated)	Methods of data collection  Methods of data analysis	Key Findings
Bratt, Svensson & Rusner  2019  Sweden  QR = 91.7%  $\kappa = .77$	- To describe the lived experience of group-based Compassion Focused Therapy (CFT; Gilbert, 2009a; 2009b) for parents of adolescents treated in a psychiatric clinic for mental health problems	Qualitative  Purposive sampling	N = 11  Gender: n = 6 (55%) female  Age range: 35-57 years  Relationship status: - n = 6 (55%) divorced; - n = 5 (45%) married  Child age range: 12 - 17	In-depth interviews either one interviewer to one parent or one interviewer to two parents  <b>Lived experience</b> Reflective Lifeworld Research (Dahlberg, Dahlberg & Nyström, 2008)	The essential meaning of participation in the parent intervention was: 'finding confidence and inner trust as a parent'  The different aspects of the essential meaning has three constituents: a) taking care of oneself and one's child; b) being open and sharing experiences; and c) acceptance and hope for the future
Fernandez-Carriba, Gonzalez-Garcia, Bradshaw, Gillespie, Mendelson ... & Herndon	- To explore the feasibility of Cognitively Based Compassion Therapy (CBCT) as a stress management	Mixed Method  Purposive sampling	N = 15  Gender: 85.7% female  Age: M = 45 years (SD = 5.9)	<b>Efficacy</b> <i>Parenting Stress:</i> Parenting Stress Index/Short Form (Abidin, 1995)  <i>Stress:</i> Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983)	<b>Efficacy</b> <i>Parenting Stress:</i> Significant improvement in parenting stress with large effect size from pre to post intervention (delta M = 22.4, SD = 7.4, p = 0.003, d = 3.03)  <i>Stress:</i>

<p>2019</p> <p>USA</p> <p>QR = 58.9%</p> <p><math>\kappa = 1</math></p>	<p>intervention with parents of children with Autism Spectrum Disorder (ASD)</p> <p>- To examine instruments to evaluate the efficacy of CBCT</p> <p>- To establish averages and variances of the measures used to inform future studies</p>		<p>Ethnicity: 50% white, 50% African American, Asian or Hispanic.</p> <p>Relationship status: 20% single parent households</p> <p>Parent educational level: 85.7% at least 4 years of college education</p>	<p><i>Empathy and compassion:</i> Interpersonal Reactivity Index (Davis, 1980)</p> <p><i>Mindfulness:</i> Mindful Attention Awareness Scale (Brown &amp; Ryan, 2003)</p> <p><i>Child behaviour:</i> Aberrant Behavior Checklist, irritability subscale (Aman et al. 1985)</p> <p>Behavior Rating Inventory of Executive Function- Adult Version (Roth, Isquith &amp; Gioia, 2000)</p> <p><i>Parenting competence:</i> Parenting Sense of Competence Scale (Gibaud-Wallston &amp; Wandersman, 1978)</p> <p><b>Quantitative</b> Pre-post change (delta-<math>\Delta</math>), paired <i>t</i>-tests, Cohen's <i>d</i> for effect sizes, two sample <i>t</i>-tests</p> <p><b>Qualitative</b> Qualitative analysis method not specified</p>	<p>Significant improvement in perceived stress with large effect size from pre to post intervention (delta <math>M = -10.5</math>, <math>SD = 5.39</math>, <math>p = 0.005</math>, <math>d = 1.95</math>)</p> <p><i>Empathy and compassion:</i> Significant improvement in empathic concern with large effect size from pre to post intervention (delta <math>M = 4</math>, <math>SD = 3.58</math>, <math>p = 0.041</math>, <math>d = 1.12</math>). No significant differences in perspective taking (<math>p = 0.166</math>), fantasy <math>p = 0.441</math> or personal distress (<math>p = 0.541</math>) subscales of the IRI*.</p> <p><i>Mindfulness:</i> Significant improvement in mindful attention with large effect size from pre to post intervention (delta <math>M = 24.8</math>, <math>SD = 9.01</math>, <math>p = 0.004</math>, <math>d = 2.75</math>)</p> <p><i>Child behaviour:</i> Significant improvement in severity of child behaviour with large effect size from pre to post intervention (delta <math>M = -3.2</math>, <math>SD = 1.48</math>, <math>p = 0.009</math>, <math>d = 2.16</math>)</p> <p>Significant improvement in global executive function with large effect size from pre to post intervention (delta <math>M = -18.83</math>, <math>SD = 5.19</math>, <math>p &lt; 0.001</math>, <math>d = 3.63</math>)</p> <p><i>Parenting competence:</i> Significant improvement in parenting competence with large effect size from pre to post intervention (delta <math>M = 11.8</math>, <math>SD = 5.4</math>, <math>p = 0.008</math>, <math>d = 2.19</math>).</p> <p><b>Feasibility</b> <i>Demand and recruitment:</i></p>
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					<p>After a year of advertisement, more than 50 people were interested and 16 people started the programme.</p> <p><i>Attendance, questionnaire submission and homework completion:</i>  Four parents attended less than four sessions. The remaining parents attended 80.6% of the sessions. Six parents attended questionnaires at two time points. Six parents returned seven or more homework logs. The average weekly homework time was 65.32 minutes.</p> <p><i>Surveys of satisfaction:</i>  Eleven of twelve participants rated the programme maximal satisfaction and all participants would recommend it to a friend.</p> <p><i>Statistical analysis of questionnaires:</i>  There were significant differences at baseline between parents who participated in 75% or more of the intervention compared with those who participated less; with those participating more perceiving lower severity of their child's symptoms (<math>p = 0.002</math>, <math>d = 2.23</math>); having less stress (<math>p = 0.003</math>, <math>d = 1.99</math>) and having more empathy and compassion (<math>p = 0.021</math>, <math>d = 1.42</math>).</p> <p>There were no significant differences at baseline between parents who participated in 75% or more of the intervention compared with those who participated less in parenting stress, mindfulness, executive function or parenting competence (<math>p &gt; 0.05</math>).</p> <p>Qualitative Feedback  Five participants gave qualitative feedback.</p>
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					Common themes were self-growth and a feeling of compassion, shared experience of participation in training and normalisation of personal struggles.
Gammer, Hartley-Jones & Jones 2020 UK QR = 81% $\kappa = .75$	- To evaluate <i>Kindness For Mums Online (KFMO)</i> , an online compassion-based intervention targeting maternal psychological wellbeing in the first year postpartum	Quantitative  Randomised Control Trial (RCT); KFMO compared with waitlist control  Convenience and snowball sampling	N = 206  Gender: 100% female  Age: M = 35.19 (SD = 4.04)  Ethnicity: 93.7% White, 5.9% Black and Minority Ethnic  Child age: M = 5.18 months (SD = 3.23)  Parent educational level: 91.7% degree level	<b>Efficacy</b> Online self-report outcome measures at baseline, post-intervention and follow up (6-weeks post intervention)  <i>Well-being:</i> Warwick-Edinburgh Mental Well-being Scale (Tennant et al. 2007)  <i>Self-compassion:</i> Self-Compassion Scale Short Form (Raes et al. 2011)  <i>Self-criticism and self reassurance:</i> The Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (et al. 2004)  <i>Depression, Anxiety and Stress:</i> Depression, Anxiety and Stress Scales short form (Lovibond and Lovibond 1995; Henry and Crawford 2005)  <b>Accessibility and acceptability</b> Likert scale at post-intervention only: Ease of use from 1 (not at all easy) to 10 (extremely easy); satisfaction	<b>Efficacy</b> <i>Wellbeing:</i> The intervention group showed a significantly greater baseline to post-intervention increase in well-being than controls ( $U = 1637.50, Z = -2.37, p = 0.017, r = -0.21$ ) and self-compassion (SCS-SF; $U = 1443.0, Z = 3.259, p = 0.001, r = -0.28$ )  Change in well-being from baseline to follow-up did not significantly differ between groups ( $U = 1731.50, Z = -1.169, p = 0.242, r = -0.01$ )  <i>Self-compassion:</i> Change in self-compassion from baseline to follow up was maintained in the intervention group ( $U = 1393.50, Z = -2.820, p = 0.005, r = -0.25$ )  <i>Self-criticism and self reassurance, Depression, Anxiety and Stress:</i> Change between baseline and post-intervention or baseline and follow up did not differ significantly between groups on self-criticism and self reassurance or depression, anxiety and stress (post-intervention $ps > 0.33$ ; follow up $ps > 0.34$ )  <b>Mediation</b> Change in self-compassion statistically mediated the effect of KFMO on change in well-being (significant indirect effect $CI = 0.275$ to $2.325$ )  <b>Moderation</b>

				<p>from 1 (not at all satisfied) to 10 (extremely satisfied)</p> <p>Mann-Whitney <i>U</i> tests, Rosenthal's (1991) <i>r</i> statistic, independent sample <i>t</i> tests, Hayes's (2013) bias-corrected bootstrapping procedure, post hoc moderation and sub-group analysis</p>	<p>Participants with lower baseline wellbeing showed larger intervention effects (moderation effect -0.525 to -0.006). Sub-group analysis with participants below median on WEMWBS* showed significantly greater change from baseline to post-intervention in the intervention group compared with controls (<math>U = 1637.50, Z = -2.375, p = 0.018</math>) though this did not maintain to follow up (<math>ps &gt; 0.24</math>).</p> <p><b>Attrition</b> Attrition was higher amongst the intervention group (<math>n = 51; 48.6%</math>) compared with the control group (<math>n = 20; 19.45</math>) (<math>\chi^2(1) = 18.22, p = &lt;0.001</math>)</p> <p><b>Engagement</b> Of the 105 participants allocated to the KFMO intervention, 58 (55%) accessed at least half of the sessions</p> <p><b>Accessibility and acceptability</b> Forty-seven intervention participants gave feedback on accessibility and acceptability. Ease of use ratings ranged from 6 to 10 (<math>Mdn = 9, IQR = 2.0</math>). Satisfaction ratings ranged from 2 to 10 (<math>Mdn = 8, IQR = 2.0</math>)</p>
<p>Guo, Zhang, Mu &amp; Ze</p> <p>2020</p> <p>China</p> <p>QR = 72%</p> <p><math>\kappa = 1</math></p>	<p>- To evaluate the effectiveness of a web-based, antenatal Mindful self-compassion program (MBSP) for preventing the</p>	<p>Quantitative</p> <p>Randomised controlled trial; MBSP compared with wait-list control.</p>	<p><math>N = 354</math></p> <p>Gender: 100% female</p> <p>Age: <math>M = 30.6</math> years (<math>SD = 5.95</math>)</p>	<p><b>Efficacy</b> Self-report outcome measures taken at baseline (T0), third month postpartum (T1) and one year postpartum (T2)</p> <p><i>Wellbeing:</i> Chinese version of the Well-Being Index World Health Organization Five (Hajos et al., 2013)</p>	<p><b>Efficacy</b> <i>Wellbeing:</i> The intervention group showed significant improvement in maternal wellbeing at three months (<math>p = 0.0135</math>) and one year (<math>p = 0.0087</math>) postpartum when compared with the control group.</p> <p><i>Self-compassion:</i> The intervention group showed a significant improvement in self-compassion from T0 to T1 (<math>p = 0.0124</math>) and from T0 to T2 (<math>p = 0.0441</math>). Authors report significant improvement in self-compassion in the intervention group compared with the</p>

	development of postpartum depression (PPD) among women with high risk for PPD	Sampling method not reported	<p>Relationship status: 91.7% married</p> <p>Child age: unborn (2<sup>nd</sup> or 3<sup>rd</sup> trimester of pregnancy)</p> <p>Parent educational level: 55.41% higher education or above</p>	<p><i>Self-compassion:</i> Chinese Self compassion Scale (author constructed, based on Neff, 2003a)</p> <p><i>Depression and Anxiety:</i> Edinburgh Postnatal Depression Scale (Cox, Holden &amp; Sagovsky, 1987); State-Trait Anxiety Inventory I and II (Metzger, 1976); Beck Depression Inventory II (Beck, Steer &amp; Brown, 1996)</p> <p><i>Parenting Stress:</i> Chinese Parenting Stress Index (author constructed, based on Haskett et al., 2006)</p> <p><i>Mindfulness:</i> Chinese Mindfulness Attention Awareness Scale (author constructed, based on Brown and Ryan, 2003)</p> <p><i>Maternal warmth towards baby:</i> Warmth and negativity scales of Comprehensive Parenting Behavior Questionnaire 1-year Chinese version (Majdandžic, Vente &amp; Bögels., 2015)</p> <p><i>Infant temperament:</i></p>	<p>control group, though results are not shown.</p> <p><i>Depression and Anxiety:</i> EPDS* reduced to less than nine (likely no depression present) in the intervention group at T1 and T2. No reduction in EPDS scores in control group at T1, significant change in EPDS scores at T2 compared to T0 in the control group. Significant improvement in scores in intervention group compared to controls at T1 and T2 (<math>p &lt; 0.01</math>).</p> <p>STAI I and II* and BDI II* results not reported.</p> <p><i>Parenting Stress:</i> Improvement in maternal parenting stress was observed in both groups at T1 and T2. The intervention group showed significantly higher improvement at T1 (<math>p &lt; 0.05</math>) only.</p> <p><i>Mindfulness:</i> The intervention group showed a significant improvement in mindfulness from T0 to T1 (<math>p = 0.0096</math>) and from T0 to T2 (<math>p = 0.0017</math>). Authors report significant improvement in mindfulness in the intervention group compared with the control group, though results are not shown.</p> <p><i>Maternal warmth towards baby:</i> Five of seven subscales on CPBQ-1* showed significant improvement from T0 to T1 in the intervention group compared with the control group; warmth (<math>p = 0.0124</math>); attention (<math>p = 0.0448</math>); responsibility (<math>p = 0.0385</math>); negativity (<math>p = 0.0430</math>) and hostility (<math>p = 0.0114</math>). Four subscales continued to be significant at T2; warmth (<math>p = 0.0041</math>); attention (<math>p = 0.0253</math>); affection (<math>p = 0.0404</math>) and responsivity (<math>p = 0.0387</math>)</p>
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				<p>Infant Behavior Questionnaire very short form (author modified, based on Putnam et al., 2014)</p> <p><b>Feasibility and acceptability</b> Number of participants completing intervention compared with controls. Post-test survey (no details given by authors)</p> <p>Analysis of variance followed by post hoc Tamhane's tests, Chi-square test, Paired-sample t-test or Wilcoxon test</p>	<p><i>Infant temperament:</i> The positive affectivity/surgency subscale of infant temperament improved at T1 (<math>p = 0.0135</math>) and T2 (<math>p = 0.0376</math>) compared with controls. There was no significant difference in orienting/regulatory capacity or negative emotionality.</p> <p><b>Feasibility and acceptability</b> Overall attendance rate was 91.8% with no significant difference between intervention and control groups (<math>\chi^2 = 0.84, p = 0.56</math>). 95% of participants filled out a post-test evaluation and results indicated 'high acceptability'.</p>
<p>Kirby &amp; Baldwin 2018 Australia QR = 86% <math>\kappa = .77</math></p>	<p>- To examine the efficacy of Loving Kindness Meditation (LKM) in parenting and the influence this might have on parenting practices.</p> <p>- To examine the acceptability of LKM for parents</p>	<p>Quantitative</p> <p>Between groups experimental micro-trial with random allocation. LKM compared with Focused Imagery (FI) control.</p> <p>Convenience sampling</p>	<p><math>N = 61</math></p> <p>Gender: 82% female</p> <p>Age: <math>M = 38.41</math> years (<math>SD = 6.11</math>)</p> <p>Relationship status: 67% married</p> <p>Ethnicity: White Australian 89%</p> <p>Child age: 2-12 years old</p>	<p><b>Baseline</b> <i>Child behaviour:</i> Strengths and Difficulties Questionnaire (Goodman 1997)</p> <p><i>Parenting Style:</i> Parenting Scale (Arnold et al., 1993)</p> <p><i>Depression, anxiety and stress:</i> <i>Depression Anxiety Stress Scale</i> (Lovibond &amp; Lovibond, 1995)</p> <p><i>Fears of compassion:</i> Fears of compassion scale (Gilbert et al., 2011)</p> <p><b>Efficacy</b> <i>Self-compassion:</i> Self-compassion scale (Neff, 2003a)</p>	<p><b>Baseline</b> Bivariate correlations showed significant correlations between all four baseline measures (<math>p &gt; .001</math>) with no significant differences between the groups <math>F(4,56) = 0.34, p = .848</math>.</p> <p><b>Manipulation</b> There was no significant differences in participants attention to instructions between the groups <math>t(59) = .81, p = .419</math>.</p> <p><b>Efficacy</b> There was a significant multivariate effect between groups on measures of self-compassion, compassion to others and compassion motivation (with a covariate of social desirability) <math>F(3,56) = 2.97, p = .040, Wilk's \Lambda = 0.863, \eta^2 = .14</math>.</p> <p><i>Self-compassion:</i> Participants in the LKM intervention group scored significantly higher in self-compassion than those in comparison (Focused</p>

				<p><i>Compassion to others:</i> Compassion to others scale (Pommier, 2011)</p> <p><i>Compassion motivation:</i> Compassion motivation scale (created by authors)</p> <p><i>Parent-child vignettes:</i> Created by authors consisting of 'The emotional scale' consisting of anxiety, stress, sadness, anger, frustration, calmness and sympathy; 'The cognitive appraisal scale' consisting of kindness, mindfulness, common humanity, over-identifying, judgement, and isolation and 'The behavioural response scale' consisting of en different parenting strategies in response to the child's behavior.</p> <p><b>Manipulation</b> Two questions assessing participants' engagement (created by authors)</p> <p><b>Acceptability</b> Acceptability questionnaire (created by authors, based on Kirby &amp; Sanders, 2013)</p>	<p>Imagery; FI) group, (<math>M = 3.19</math>, <math>SD = 0.68</math>) compared with (<math>M = 2.81</math>, <math>SD = 0.57</math>), <math>F(1,58) = 6.86</math>, <math>p &lt; .011</math>, <math>\eta^2 = .11</math>.</p> <p><i>Compassion motivation:</i> Participants in the LKM group scored significantly higher in compassion motivation than those in the FI group, (<math>M = 4.06</math>, <math>SD = 0.49</math>) compared with (<math>M = 3.53</math>, <math>SD = 0.88</math>), <math>F(1,58) = 5.25</math>, <math>p = .010</math>, <math>\eta^2 = .11</math>.</p> <p><i>Parent-child vignettes:</i> <i>Emotions</i> There was a significant multivariate effect across the seven emotional responses (with a covariate of social desirability) <math>F(7,52) = 2.56</math>, <math>p = .024</math>, <i>Wilk's <math>\Lambda</math></i> = 0.744, <math>\eta^2 = .26</math>.</p> <p>Following application of Bonferroni correction, mean scores on four of the seven emotions were significant; anger <math>F(7,58) = 5.64</math>, <math>p = .021</math>, <math>\eta^2 = .38</math>; frustration <math>F(7,58) = 5.64</math>, <math>p = .021</math>, <math>\eta^2 = .74</math>; calm <math>F(7,58) = 5.64</math>, <math>p = .021</math>, <math>\eta^2 = .62</math>; and sympathy <math>F(7,58) = 5.64</math>, <math>p = .021</math>, <math>\eta^2 = .58</math>.</p> <p><i>Cognitive appraisal:</i> The effect of condition on participants cognitive responses was approaching significance <math>F(6,53) = 2.21</math>, <math>p = .057</math>, <i>Wilk's <math>\Lambda</math></i> = 0.799, <math>\eta^2 = .20</math>.</p> <p><i>Behavioral response:</i> There was no significant difference in behavioural responses between groups, <math>F(10, 47) = 0.94</math>, <math>p = .506</math>, <i>Wilk's <math>\Lambda</math></i> = 0.833, <math>\eta^2 = .17</math>.</p> <p><b>Acceptability</b></p>
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				<p>Between groups chi-square tests (for categorical variables), t-tests and a MANOVA (for continuous variables).</p> <p>Bivariate correlations on pre-measures.</p> <p>Effect of condition on all dependent measures, using one-way MANOVAs and subsequent one-way ANOVAs.</p>	<p>Most participants found LKM acceptable (81.40%), and useful (55.81%). Most participants stated that they would use LKM again (67.44%), most likely in an online (60.47%) or mobile app (58.14%) format. Only 6.98% of participants would not use LKM again with the majority (60.78%) likely to participate weekly.</p>
<p>Kirby, Grzazek &amp; Gilbert 2019 Australia QR = 83% <math>\kappa = .70</math></p>	<p>- To examine the impact of priming mothers with different goal orientations and exploring their emotional responses to difficult mother-child interactions.</p>	<p>Quantitative  Between groups experimental design with random allocation to a compassion goal, self-image goal or control group  Convenience and snowball sampling</p>	<p><math>N = 198</math>  Gender: 100% female  Age: <math>M = 36.05</math> years (<math>SD = 6.10</math>)  Child age: three to nine years (<math>M = 5.43</math>, <math>SD = 2.02</math>)</p>	<p><b>Baseline</b> <i>Psychological control:</i> Parental psychological control measure (Olsen et al., 2002)</p> <p><b>Efficacy</b> <i>Emotional Responses:</i> Six scenarios describing problematic child behaviour (created by the authors, based on Kirby et al., 2019)</p> <p><i>Emotions:</i> Emotional responses were measured by participants indicating the strength of anxiety, stress, sadness, anger, frustration, calmness and sympathy felt in response to the scenarios (Kirby et al., 2019)</p>	<p><b>Baseline</b> <i>Psychological control</i> There was no significant difference between groups in psychological control <math>F(2, 195) = 1.10</math> <math>p = 0.336</math>.</p> <p><b>Efficacy</b> There was no significant difference between the three conditions across the seven emotions; anxiety <math>F(2, 195) = 0.00</math>, <math>p = 0.998</math>; stress <math>F(2, 195) = 0.22</math>, <math>p = 0.806</math>; sadness <math>F(2, 195) = 0.87</math>, <math>p = 0.423</math>; anger <math>F(2, 195) = 0.33</math>, <math>p = 0.718</math>; frustration <math>F(2, 195) = 0.13</math>, <math>p = 0.876</math>; calmness <math>F(2, 195) = 4.35</math>, <math>p = 0.014</math>; sympathy <math>F(2, 195) = 3.36</math>, <math>p = 0.037</math>.</p> <p>There was no significant difference between the three conditions in the three reflected shame items; incompetent parent <math>F(2, 195) = 1.63</math>, <math>p = 0.198</math>; looked down on <math>F(2, 195) = 2.64</math>, <math>p = 0.074</math>; bad parent <math>F(2, 195) = 1.49</math>, <math>p = 0.227</math>.</p> <p>There were no significant differences in the emotional responses reported by parents across a child's age.</p>

				<p><i>Reflected shame:</i> Three questions assessing reflected shame; “To what extent would you worry that other people would... (1) <i>See you as an incompetent parent</i>, (2) <i>Look down on you</i>, (3) <i>See you as a bad parent</i> (Kirby et al., 2019)</p> <p><b>Manipulation</b> Three questions assessing participants’ engagement (created by authors)</p> <p>One way between groups ANOVAs, post hoc comparisons using Tukey HSD test</p>	<p><b>Manipulation</b> There was no significant difference between the conditions in memory for the instructions <math>F(2, 195) = 3.02, p = 0.051</math>. Participants in the control condition (<math>M = 3.30, SD = 1.90</math>) were less likely to have closely read the instructions compared to the compassion (<math>M = 2.10, SD = 1.37</math>) and self-image (<math>M = 1.99, SD = 1.35</math>) conditions. Participants in the control condition (<math>M = 4.49, SD = 1.75</math>) felt less compassionate compared to the compassion (<math>M = 3.77, SD = 1.75</math>) and self-image (<math>M = 3.49, SD = 1.55</math>) conditions.</p>
<p>Mitchell, Whittingham, Steindl &amp; Kirby 2018 Australia &amp; New Zealand QR = 86% <math>\kappa = .75</math></p>	<p>- To evaluate the acceptability, feasibility and utility of online resources designed to improve self-compassion for mothers who are less than 24 months post-partum</p>	<p>Quantitative Within-group repeated measures longitudinal study with no control group.  Convenience sampling</p>	<p><math>N = 262</math> Gender: 100% female Age: 52.3% aged 30-34 years Ethnicity: 54.6% unspecified, 41.2% Caucasian Relationship status: 98.1%</p>	<p>Measures repeated at pre-intervention and one month post intervention.</p> <p><b>Acceptability</b> Six items examining online resource use, participant perceived changes in self-compassion and usefulness of the resources for new mothers.</p> <p><b>Efficacy</b> <i>Self-compassion:</i> Self-Compassion Scale–Short Form (Raes et al. 2011)</p> <p><i>Psychological flexibility:</i></p>	<p><b>Acceptability</b> Half of the participants (49.8%) reported using some or all of the intervention resources. A total of 39.2% reported trying to apply the advice in everyday life. The biggest barrier for use was lack of time (42.5%).</p> <p>Nearly all participants thought self-compassion is helpful for mothers coping with difficult birth (96.7%), breastfeeding (96.3%). Three quarters (74%) would recommend the resource to others.</p> <p><b>Efficacy</b> There were significantly more mothers who accessed the intervention reporting feeling more self-compassionate (59.3%) compared to of those who did not access the resources (35.5%), <math>\chi^2(1, n = 247) = 14.11, df = 1, p &lt; .001</math>.</p>

			<p>married/ living with partner</p> <p>Child age: 0-24 months</p> <p>Parent educational level: 78.2% university or postgraduate degree</p>	<p>The Acceptance and Action Questionnaire (Bond et al., 2011)</p> <p><i>Shame in the mothering role:</i> The Other as Shamer Scale (Goss et al., 1994)</p> <p><i>Post-traumatic stress symptoms:</i> The Impact of Event Scale– Revised (Weiss, 2007)</p> <p><i>Subjective breastfeeding experience:</i> The Maternal Breastfeeding Evaluation Scale (Leff et al., 1994)</p> <p>Paired sample <i>t</i> tests</p>	<p><i>Self-compassion:</i> Self-compassion significantly increased from post compared with pre-intervention with a small effect size (<math>p = .002, d = .11</math>).</p> <p><i>Psychological flexibility:</i> There was no change in psychological flexibility at post compared with pre (<math>p = .413</math>).</p> <p><i>Shame in the mothering role:</i> There was no change in shame in the mothering role at post compared with pre (<math>p = .193</math>).</p> <p><i>Post traumatic stress symptoms:</i> Post- traumatic stress symptoms decreased from pre- to post-intervention with a small effect size (<math>p = .002, d = .11</math>) with 61.3% of the mothers who were in the clinical range at pre assessment moving into the sub-clinical range at one month post-intervention.</p> <p><i>Breastfeeding</i> Satisfaction with breastfeeding improved from pre to post intervention (<math>p &lt; .001</math>) with the total MBFES* score showing significant improvement from pre to post (<math>p = .033</math>)</p>
<p>Navab, Dehghani &amp; Salehi</p> <p>2019</p> <p>Iran</p> <p>QR = 83%</p>	<p>- To investigate the effect of Compassion Focused Therapy (CFT) on mothers of children with Attention Deficit</p>	<p>Quantitative</p> <p>Quasi-experimental pre-test / post-test design. CFT compared with wait-list control.</p>	<p><math>N = 20</math></p> <p>Gender: 100% female</p> <p>Age: <math>M = 30.65</math> years (<math>SD = 2.94</math>)</p>	<p>Measures taken at pre and one week post-intervention</p> <p><b>Efficacy</b></p> <p><i>Depression, anxiety and stress:</i> <i>Depression Anxiety Stress Scale</i> (Lovibond &amp; Lovibond, 1995)</p> <p>Mann-Whitney <i>U</i>, Wilcoxon test</p>	<p><b>Efficacy</b></p> <p><i>Depression, anxiety and stress:</i> Psychological symptoms in the intervention group (<math>M = 33.40, SD = 4.28</math>) were significantly lower than those in the intervention group at post-intervention (<math>M = 39.10, SD = 6.77</math>) <math>p = 0.037</math>.</p> <p>The depression subscale saw significant improvement in the intervention group (<math>M = 9.40, SD = 2.74</math>) compared with the control group (<math>M = 12.70, SD = 2.49</math>), <math>p = 0.01</math>. There was also</p>

<p><math>\kappa = .85</math></p>	<p>Hyperactivity Disorder (ADHD)</p>	<p>Targeted sampling</p>	<p>Parent educational level: 75% degree or higher</p>		<p>significant difference from pre to post intervention in depression within the intervention group (<math>p = 0.023</math>).</p> <p>The anxiety subscale saw significant improvement in the intervention group (<math>M = 8.20, SD = 2.65</math>) compared with control group (<math>M = 11.90, SD = 2.84</math>), <math>p = 0.007</math>. There was also significant difference from pre to post intervention in anxiety within the intervention group (<math>p = 0.015</math>)</p> <p>The stress subscale did not show any significant difference between the two groups (<math>p = 0.273</math>) or within groups (<math>p = 0.212</math>).</p>
<p>Poehlmann-Tynan, Engbretson, Vigna, Weymouth ... &amp; Raison</p> <p>2020</p> <p>USA</p> <p>QR = 81%</p> <p><math>\kappa = .75</math></p>	<p>- To examine the effects of Cognitively Based Compassion Training (CBCT) on parents' perceived stress, mindfulness and self-compassion and parents and children's hair cortisol concentration (HCCs)</p>	<p>Quantitative</p> <p>Randomised controlled trial. CBCT compared with wait-list control.</p> <p>Targeted sampling</p>	<p><math>N = 38</math></p> <p>Gender: 86.7% female</p> <p>Age: <math>M = 36.7</math> years</p> <p>Ethnicity: 81.6% white</p> <p>Relationship status: 94.7% married</p> <p>Child age: 9 months – 5 years 4 months</p>	<p>Measures taken at pre and one month post-intervention</p> <p><b>Efficacy</b></p> <p><i>Self-compassion:</i> Self-compassion scale (Neff, 2003a)</p> <p><i>Stress:</i> Calgary Symptoms of Stress Inventory (Carlson &amp; Thomas, 2007)</p> <p><i>Parenting stress:</i> Parenting Daily Hassles Scale (Crnic &amp; Greenberg, 1990)</p> <p>Parenting Stress Index-Short Form (Abidin, 1990; Haskett et al., 2006).</p> <p><i>Mindfulness:</i> The Five Facet Mindfulness Questionnaire (Baer et al., 2006)</p>	<p><b>Efficacy</b></p> <p><i>Self-compassion:</i> Participants in the intervention group did not show significant differences in self-compassion compared with controls at post-intervention (statistics not reported).</p> <p><i>Stress:</i> Participants in the intervention group did not show significant differences in stress compared with controls at post-intervention (statistics not reported).</p> <p><i>Parenting stress:</i> Overall, participants in the intervention group did not show significant differences in parenting stress compared with controls at post-intervention (statistics not reported) but there was a small positive effect of the intervention on <i>clinical</i> levels of parenting stress (<math>RR = 1.59, p &lt; .01, 95\% CI: 1.14 - 2.20</math>).</p> <p><i>Mindfulness:</i></p>

			Parent educational level: 100% degree level or above	<p><i>Physiological stress:</i> Parents and children's hair cortisol concentrations (HCCs)</p> <p>One way ANCOVAs</p>	<p>Participants in the intervention group did not show significant differences in mindfulness compared with controls at post-intervention (statistics not reported).</p> <p><i>Physiological stress:</i> There was no significant effect of intervention on parent HCCs between groups <math>F(1, 33) = 1.625, p = .211, \eta^2 = .03</math>. There was a significant effect of intervention on child HCCs between groups <math>F(1, 33) = 4.515, p = .041, \eta^2 = .12</math>.</p>
Sirois, Bögels & Emerson 2019 UK QR = 81% $\kappa = .75$	- To test the role of self-compassion (both dispositional and induced) for reducing parental guilt and shame after recalling a difficult parenting event.	Quantitative  Quasi experimental between groups with randomisation  Convenience sampling	<p><math>N = 167</math></p> <p>Gender: 83.1% female</p> <p>Age: <math>M = 37.23</math> years (<math>SD = 6.73</math>)</p> <p>Ethnicity: 81.2% white</p> <p>Child age: 1 – 12 years</p> <p>Parent educational level: 94.6% degree level or above</p>	<p><b>Efficacy</b> <i>Self-compassion (dispositional)</i> Self-Compassion scale twelve item (Raes et al., 2011)</p> <p><i>Self-compassion (state)</i> Five items assessing state self-compassion (created by authors, based on Breines &amp; Chen, 2012)</p> <p><b>Manipulation</b> <i>Guilt and shame</i> Two adjectives from the Positive and Negative Affect Schedule; participants rated the extent to which they were felt "guilty" and "ashamed" right now (Watson, Clark, &amp; Tellegen, 1988)</p> <p>Two-way ANCOVAs, post hoc one-way MANCOVA</p>	<p><b>Manipulation</b> <i>Guilt and shame</i> Guilt and shame increased significantly after recall of the challenging parenting events in both the guilt (guilt <math>t(82) = -11.28, p &lt; 0.0001</math>; shame <math>t(82) = -7.22, p &lt; 0.0001</math>) and shame (guilt <math>t(83) = -8.76, p &lt; 0.0001</math>; shame <math>t(83) = -7.96, p &lt; 0.0001</math>).</p> <p><b>Efficacy</b> <i>Self-compassion (state)</i> There was a significant interaction between state self-compassion and the self-compassion condition <math>F(1, 164) = 36.09, p &lt; 0.0001</math>, partial eta squared = 0.181; with higher levels of self-compassion in the self-compassion condition (<math>M = 4.82, SE = 0.10</math>) compared to controls (<math>M = 3.97, SE = 0.10</math>).</p> <p><i>Guilt</i> Feelings of guilt were significantly reduced in the self-compassion manipulation group compared with controls <math>F(1, 162) = 3.74, p = 0.055</math>, partial eta squared = 0.023. There was no significant difference in reduction of guilt between the shame-related and guilt-related prompts <math>F(1, 162) = 0.67, p = 0.383</math>, partial eta squared = 0.005.</p> <p><i>Shame</i></p>

					<p>Feelings of shame were significantly reduced in the self-compassion manipulation group compared with controls <math>F(1,162) = 7.37, p = 0.007</math>, partial eta squared = 0.044.</p> <p>There was no significant difference in reduction of shame between the shame-related and guilt-related prompts <math>F(1,162) = 0.28, p = 0.552</math>, partial eta squared = 0.001.</p> <p><i>Guilt and shame</i>  Approximately 8% of the variation in the linear combination of post-task guilt and shame, was accounted for by allocation to the self-compassion versus the control condition.</p>
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**\*Key:** IRI - Interpersonal Reactivity Index; WEMWBS - Warwick-Edinburgh Mental Well-being Scale; EPDS - Edinburgh Postnatal Depression Scale; STAI I and II - State-Trait Anxiety Inventory I and II; BDI - Beck Depression Inventory II; CBQ-1 - Comprehensive Parenting Behavior Questionnaire 1-year Chinese version; MBFES - The Maternal Breastfeeding Evaluation Scale

### 1.3.1 Characteristics of the Studies

Detailed characteristics of included studies are reported in Appendix E.

### 1.3.2 Quantitative Synthesis and Results

This review aimed to evaluate the effectiveness of CBIs for prospective and current parents on measures of compassion, self-compassion, anxiety, depression, stress, psychological distress, shame or wellbeing compared to comparison groups (if present<sup>4</sup>).

#### *Compassion*

There was significant improvement ( $p = 0.041$ ) with large effect size ( $d = 1.12$ ) from pre to post intervention in empathic concern measured by the Interpersonal Reactivity Index (IRI; Davis, 1980) in a moderate quality study (Fernandez-Carriba et al., 2019). There were no significant differences in other IRI subscales (perspective taking  $p = 0.166$ ; fantasy  $p = 0.441$ ; personal distress  $p = 0.541$ ). Intervention participants scored significantly higher in compassion motivation ( $p = 0.01$ ) than comparison with moderate effect size ( $d = 0.75$ ) measured by an author-created scale in Kirby and Baldwin's (2018) high quality study. Intervention participants scored higher in compassion to others ( $p < 0.026$ ) measured by the Compassion to Others Scale (Pommier, 2011) with moderate effect size ( $d = 0.70$ ) compared with comparison in Kirby and Baldwin (2018). This difference was only significant prior to Bonferroni correction.

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<sup>4</sup> Only three studies featured an active comparison group (Kirby & Baldwin, 2018; Kirby et al., 2019; Sirois et al., 2019).

### *Self-compassion*

Self-compassion in all studies was measured using the Self-compassion Scale (SCS; Neff, 2003a), Self-Compassion Scale - Short Form (SCS-SF; Raes et al., 2011) or an author-translated Chinese SCS. Self-compassion significantly increased from pre to post intervention on three moderately-high to high quality studies ( $p = 0.002$ , Mitchell et al., 2018;  $p = 0.001$ , Gammer et al., 2020;  $p = 0.012$ , Guo et al., 2020) with an average small effect size ( $d = 0.3$ ), equivalent to the mean effect size of control groups ( $d = 0.3$ ). Self-compassion significantly increased from pre to follow-up on two moderately high to high quality studies ( $p = 0.005$ , Gammer et al., 2020;  $p = 0.044$ , Guo et al., 2020) with a mean medium effect size of  $d = 0.5$ , whereas mean effect size for control groups was  $d = 0.68$  at follow-up.

Intervention participants scored significantly higher on self-compassion than comparison ( $F(1,58) = 6.86, p < .011, \eta^2 = .11$ ) with medium effect size ( $d = 0.61$ ) in Kirby and Baldwin (2018). In contrast, Poehlmann-Tynan et al. (2020) reported no significant difference in self-compassion compared with controls at post intervention<sup>5</sup>. Sirois et al. (2019) reported a significant interaction between state self-compassion and the self-compassion condition ( $F(1,164) = 36.09, p < 0.0001$ ) with a large effect size ( $d = 0.93$ ). Mitchell et al. (2018) reported results from a 5-point Likert scale questionnaire stating participants thought self-compassion is helpful for mothers coping with difficult birth (96.7%) and breastfeeding (96.3%).

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<sup>5</sup> Statistics not reported

### *Anxiety*

There was no significant difference in anxiety between intervention and control groups ( $p > 0.33$ ) with no effect ( $d = 0.11$ ) measured by the anxiety subscale of Depression, Anxiety and Stress Scales short form (DASS-SF; Henry & Crawford, 2005) in a high quality study (Gammer et al., 2020). There was no significant difference between conditions in anxiety ( $p = 0.998$ ) measured using an author-constructed scale in Kirby et al. (2019). There was significant improvement in anxiety measured by the anxiety subscale of the Depression, Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1995) in the intervention group compared with control ( $p = 0.007$ ) with a very large effect size ( $d = 1.35$ ) in a high quality study (Navab et al., 2019).

There was no significant difference between pre and post intervention on anxiety as measured by DASS-SF in Gammer et al.'s study (2020) however there was significant improvement in anxiety measured by DASS between pre and post intervention ( $p = 0.015$ ) with moderate effect ( $d = 0.77$ ) reported by Navab et al. (2019). Guo et al. (2020) did not report results of anxiety scales.

### *Depression*

There was no significant difference in depression between intervention and control groups ( $p > 0.33$ ) with a small effect ( $d = 0.3$ ) measured by the depression subscale of DASS-SF in one high quality study (Gammer et al., 2020). There were significant improvements in depression in the intervention group compared with controls at post intervention and follow up ( $p < 0.01$ ) with a very large effect size ( $d = 1.93$ ) as measured by the Edinburgh Postnatal Depression Scale (Cox et al., 1987) in a moderately-high

quality study (Guo et al., 2020). There was significant improvement in depression measured by the depression subscale of DASS in the intervention group compared with control ( $p = 0.01$ ) with large effect size ( $d = 1.26$ ) in a high quality study (Navab et al., 2019). There was a significant improvement in depression measured by the depression subscale of DASS between pre and post intervention ( $p = 0.023$ ) with a medium effect ( $d = 0.59$ ) reported by Navab et al. (2019). There was a large mean effect size ( $d = 1.02$ ) when comparing pre to post scores in intervention groups compared with no effect ( $d = 0.11$ ) of control groups.

### *Stress*

Studies measured generalised stress and 'parenting stress'. Results are reported separately.

### *Generalised Stress*

A moderate quality study (Fernandez-Carriba et al., 2019) measured stress using the Perceived Stress Scale (Cohen et al., 1983) and reported significant improvement in perceived stress with large effect size from pre to post intervention ( $p = 0.005$ ,  $d = 1.95$ ). Gammer et al.'s (2020) high quality study reported no significant difference in stress ( $ps > 0.33$ ) measured by the stress subscale of DASS-SF between groups. Kirby et al.'s (2019) study reported no significant difference between three conditions in stress ( $p = 0.806$ ) when measured with an author-constructed scale. A large mean effect size of  $d = 1.02$  for the intervention group is in contrast with a small mean effect size of the control group ( $d = 0.21$ ).

There was no significant difference in stress ( $p = 0.273$ ) between intervention and control groups and no significant difference in stress from pre to post intervention ( $p = 0.212$ ) measured by the stress subscale of DASS in a high quality study (Navab et al., 2019). Participants in the intervention group did not show significant difference in stress measured by Calgary Symptoms of Stress Inventory (Carlson & Thomas, 2007) nor measures of physiological stress compared with controls at post-intervention in a high quality study<sup>6</sup> (Poehlmann-Tynan et al., 2020).

### *Parenting stress*

Three studies measured parenting stress. One moderate quality study (Fernandez-Carriba et al., 2019) reported significant reduction in parenting stress measured by Parenting Stress Index/Short Form (Abidin, 1995) with very large effect size from pre to post intervention ( $p = 0.003$ ,  $d = 3.03$ ). In a moderately-high quality study (Guo et al. 2020), improvement in maternal parenting stress measured by an author-constructed Chinese Parenting Stress Index was observed in both intervention and control groups at post intervention and follow up. The intervention group showed significantly higher improvement in parenting stress with a small effect size ( $p < 0.05$ ,  $d = 0.33$ ) at post intervention compared to control.

There was no significant difference between groups in parenting stress measured by Parenting Daily Hassles Scale (Crnic & Greenberg, 1990) at post-intervention in a high quality study<sup>7</sup> (Poehlmann-Tynan et al., 2020) but there was a small positive effect of

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<sup>6</sup> Statistics not reported

<sup>7</sup> Statistics not reported

the intervention on *clinical* levels of parenting stress ( $RR = 1.59, p < .01, 95\% CI: 1.14 - 2.20$ ).

### *Psychological distress*

There was a statistically significant reduction ( $p = 0.02$ ) in post-traumatic stress symptoms with no effect ( $d = 0.11$ ) from pre to post intervention on the Impact of Event Scale–Revised (Weiss, 2007) in the intervention group in Mitchell et al.'s (2018) high quality study.

### *Shame*

There was no significant difference and no effect between three conditions in reflected shame in an author-constructed measure in Kirby et al.'s (2019) high quality study (incompetent parent,  $p = 0.198, d = 0.17$ ; looked down on,  $p = 0.074, d = 0.11$ ; bad parent,  $p = 0.227, d = 0.14$ ). There was no significant difference in levels of shame in the mothering role measured by The Other as Shamer Scale (Goss et al., 1994) at post intervention compared with pre with no effect ( $p = 0.193, d = 0.05$ ) in Mitchell et al.'s (2018) high quality study. Feelings of shame were significantly reduced in the intervention group ( $p = 0.007$ ) with small effect size ( $\eta p^2 = 0.044$ ) compared with controls in a high quality study (Sirois et al., 2019).

### *Wellbeing*

The intervention group showed a significant increase in wellbeing ( $p = 0.017$ ) with a medium effect ( $d = 0.42$ ) from pre to post intervention measured by Warwick-Edinburgh Mental Well-being Scale (Tennant et al. 2007) compared with controls in a

high quality study (Gammer et al., 2020). The intervention group in the moderately high quality study by Guo et al. (2020) showed significant improvement in maternal wellbeing with small effect size measured by Chinese Well-Being Index World Health Organization Five (Hajos et al., 2013) at three months ( $p = 0.0135$ ,  $d = 0.31$ ) and one year ( $p = 0.0087$ ,  $d = 0.24$ ) postpartum when compared with control. The mean effect size of wellbeing between groups at post intervention was small ( $d = 0.37$ ).

### 1.3.3 Qualitative Synthesis and Results

This review aimed to examine the main themes emerging from qualitative and mixed-method studies to understand the appropriateness, acceptability or nature of the experience of participation in CBIs. Four themes derived from two studies (Bratt et al., 2019 and Fernandez-Carriba et al., 2019) focus on the nature of the experience of participating in a CBI. Quotations from original studies are used to ensure parental views are retained. Due to limited quality and quantity of qualitative data, these results should be interpreted with caution.

#### *Sharing experiences*

Both studies reported themes relating to the importance of sharing experiences with other parents. Sharing experiences with other parents helped them recognise the universality of their difficulties amongst other parents, *“So it’s really, really nice to hear other parents who have problems, that you’re not alone, not different in any way”* (Bratt et al., 2019, p. 5).

### *Self-acceptance*

Both studies reported themes relating to self-acceptance. Self-acceptance was linked to self-understanding and acceptance of feelings. A participant in Bratt et al. (2019) described self-acceptance of their situation and their feelings, *"It's going to take a while. I end up in the ditch every day, but if I realise, 'this is what I feel', then I've succeeded"* (p. 5).

### *Reflecting on difficulties*

The studies reported themes relating to the importance of reflecting upon hardships and difficulties. A participant in Fernandez-Carriba et al. (2019) reflected upon how she was able to recognise the difficulty of feeling overwhelmed by her own emotions and how this was impacting on her ability to care for her children, *"All you see is burden. It was robbing me of so much I could give to them"* (p. 799). Participants in Bratt et al. (2019) recognised the importance of reflecting without attempting to avoid pain.

### *Hope and trust for the future*

The theme of 'hope and trust for the future' was seen across both studies in relation to parents having hope in their capacity to face challenges and confidence and trust that things will work out in the future. One participant in Bratt et al. (2019) described this inner trust about the future, *"... you know somewhere inside yourself that things are going to be okay"* (p. 6). One participant in Fernandez-Carriba et al. (2019) reported the impact of hope and trust on their child, *"Mommy, I'm so proud of you. Because I know that you love me even more now"* (p. 799).

### 1.3.4 Combined Results

The final aim of this review was to provide integration of quantitative and qualitative knowledge on CBIs for parents. Table 1.4 shows qualitative themes in each study.

Table 1.4: Qualitative themes present in studies with quantitative data

Authors & Date	Sharing experiences	Self-acceptance	Reflecting on difficulties	Hope and trust for the future	Area of outcome	Significance (Sig* or No sig*) and effect sizes (N*, S*, M*, L*, XL*)
Fernandez-Carriba et al. 2019	✓	?	✓	✓	Compassion Stress Parental stress	Sig L Sig L Sig XL
Gammer et al. 2020	X	✓	X	✓	Self compassion Anxiety Depression Stress Wellbeing	Sig S No sig No sig No sig Sig M
Guo et al. 2020	?	?	✓	?	Self compassion Depression Parental stress Wellbeing	Sig S Sig XL Sig S Sig S
Kirby & Baldwin 2018	X	✓	✓	X	Compassion Self compassion	Sig M Sig M
Kirby et al. 2019	X	X	X	X	Anxiety Stress Shame	No sig No sig No sig
Mitchell et al. 2018	?	?	?	?	Self compassion Distress Shame	Sig S Sig N No sig
Navab et al. 2019	✓	✓	✓	✓	Anxiety Depression Stress	Sig XL Sig L / M No Sig
Poehlmann-Tynan et al. 2020	✓	X	X	X	Self compassion Stress Parental stress	No sig No sig No sig
Sirois et al. 2019	X	✓	✓	X	Self compassion	Sig L

\*Key: Sig = significant result, No sig = no significant results; N = no effect; S = small effect size; M = moderate effect size; L = large effect size; XL = very large effect size<sup>8</sup>; ✓ = qualitative theme present; ? = presence of qualitative theme unknown; X = qualitative theme not present

<sup>8</sup> Very large effect size, is described by Sawilowsky (2009) as  $d \geq 1.2$

The CBI from each study with quantitative data was assessed to determine the likely presence of the qualitative themes. Presence of qualitative themes in three studies (Fernandez-Carriba et al., 2019; Guo et al., 2020; Mitchell et al., 2019) could not be fully determined. The most common qualitative theme was *reflecting on difficulties*, which appeared in five studies.

Studies with evidence of one or less qualitative themes reported no significant results in the outcome areas (Kirby et al., 2019; Poelhmann-Tynan et al., 2020). One study with evidence of two themes reported a mixture of non-significant and significant results with small and moderate effects sizes (Gammer et al., 2020). Two studies with evidence of two themes reported significant results with moderate effects (Kirby & Baldwin, 2018) and significant results with large effect size (Sirois et al., 2019). Studies with evidence of three (Fernandez-Carriba et al., 2019) and four (Navab et al., 2019) qualitative themes reported significance with moderate to very large effect sizes with the exception of the outcome of stress in Navab et al. (2019). All five studies with evidence of *reflecting on difficulties* reported significant results, with the exception of the outcome of stress in Navab et al. (2019). Two of three studies without evidence of *reflecting on difficulties* reported non-significant results.

It could be tentatively stated that evidence of more qualitative themes in the CBI is related to significant results. Increased evidence of qualitative themes may be linked with greater effect size of results. Evidence of *reflecting on difficulties* may relate to significant results. These possible relationships need to be taken with caution due to

the inability to fully rate all studies and one non-significant result in Navab et al. (2019), which does not fit the trend.

### **1.3.5 Critique of included studies**

#### **1.3.5.1 Samples**

The main quality concern of studies in this review was with non-representative study samples, which limits transferability and generalisability of results. Some sample sizes were small, ranging from 11 (Bratt et al., 2019) to 354 (Guo et al., 2020). Samples were often self-selected with five of ten studies using convenience sampling (Gammer et al., 2020; Kirby & Baldwin, 2018; Kirby et al., 2019; Mitchell et al., 2018; Sirois et al. 2019), which increases chance of bias and reduces generalisability of results. The samples were also, where stated, predominantly of white ethnicity with the exception of Fernandez-Carriba et al. (2019), reducing the ability to generalise this review outcome to other ethnicities. All study samples, where stated, reported a high level of parental education, which increases chances of floor and ceiling effects and reduces ability to generalise results to parents with a lower level of education. Six studies reported socioeconomic status, with five of these reporting samples with a medium to high income (Gammer et al., 2020; Guo et al., 2020; Kirby & Baldwin, 2018; Mitchell et al., 2018; Poehlmann-Tynan et al., 2020), which reduces ability to generalise to parents with lower incomes.

All samples were majority to exclusively female. All other types of parents/caregivers apart from biological mothers were underrepresented in study samples, reducing the generalisability of the results to other parental roles. All but one study samples (Guo

et al., 2020) were non-clinical populations. Guo et al. (2020) and Navab et al. (2019) excluded parents with previous chronic mental health problems or taking psychiatric medication. Review results are limited in generalisability to clinical populations, especially parents with severe or chronic presentations of mental health problems.

#### **1.3.5.2 Qualitative and mixed-method studies**

Fernandez-Carriba et al. (2019) did not disclose qualitative methodology or detail how researchers' subjectivity was managed, reducing credibility of results. Only five of the possible 15 participants gave qualitative feedback in Fernandez-Carriba et al. (2019) and only those who found the intervention helpful gave data in Bratt et al. (2019), meaning only positive experiences about interventions were captured, biasing results. There was no integration of qualitative and quantitative results in Fernandez-Carriba et al. (2019).

#### **1.3.5.3 Quantitative studies**

Only one quantitative study (Poehlmann-Tynan et al., 2020) included a measure of treatment fidelity, which reduces confidence in the quality of the interventions given. Fernandez-Carriba et al. (2019) and Poehlmann-Tynan et al. (2020) reported training credentials of the CBCT teacher and details of the certification process, supporting the validity of the intervention. Attrition was high in some studies, with 26% attrition in Fernandez-Carriba et al. (2019) and 46.6% of the intervention group in Gammer et al. (2020) and only 49.8% accessed some or all intervention resources in Mitchell et al. (2018). There were no noticeable differences between participants who dropped out

compared to those who completed. The high attrition rate questions the acceptability of interventions or study protocols.

Only three studies contained follow up data (Fernandez-Carriba et al., 2019; Gammer et al., 2020; Guo et al., 2020), reducing the ability to draw conclusions about longitudinal outcomes. Levels of home practice varied from none to weekly homework tasks (Fernandez-Carriba et al., 2019; Guo et al., 2020; Poehlmann-Tynan et al., 2020). Home practice time was not measured and so cannot be separated from other possible mechanisms of change.

Only three studies had active control groups (Kirby & Baldwin, 2018; Kirby et al. 2019; Sirois et al., 2019) so validity of results can be questioned, especially in cases where intervention and control effect sizes were equivalent. In studies with control groups, only two studies (Gammer et al., 2020; Kirby et al., 2019) reported power calculations. Results need to be taken with caution, as it is unclear if the studies were underpowered.

All studies used self-report measures, which can be affected by mood and social desirability biases. Only two self-report measures, the Parenting Stress Index (Cox et al., 1987; Fernandez-Carriba et al., 2019) and Edinburgh Postnatal Depression Scale (Abidin, 1990; Guo et al., 2020) were specific to the perinatal and parent population.

Studies in this review used the total score for SCS and SCS-SF. Factor analysis suggests separate self-compassion and self-coldness scales should be used rather than a total score for SCS (Kumlander et al., 2018) and separate self-care and self-disparagement factors should be used for the short form (Hayes et al., 2016), which reduces validity of

these results. In addition, the Chinese SCS used in Guo et al. (2020) was independently translated rather than using the Chinese translation from the SCS author's website ([www.self-compassion.org](http://www.self-compassion.org)), which may affect reliability and validity of Guo et al.'s (2020) results.

## **1.4 Discussion**

### **1.4.1 Overall Summary**

This review aimed to evaluate the effectiveness of CBIs for prospective and current parents on measures of compassion, self-compassion, anxiety, depression, stress, psychological distress, shame or wellbeing, examine the main themes emerging from qualitative data and integrate quantitative and qualitative knowledge on the topic. Ten moderate to high quality studies published between 2018 and 2020 were evaluated.

### **1.4.2 Aim 1: To evaluate the effectiveness of CBIs**

Samples consisted of mainly white biological mothers of high educational status therefore conclusions can be drawn for this group only. It can be concluded that self-compassion in some mothers may be increased by CBIs. It can be tentatively stated that CBIs show promise in increasing compassion, increasing wellbeing, decreasing depression and decreasing parenting stress in some mothers. Conclusions cannot be made about the effect of CBIs on anxiety, shame or psychological distress. Generalised stress in mothers may not be affected by CBIs. No outcomes were negatively affected by CBIs.

### *Compassion*

This review suggests CBIs may be effective in increasing compassion, aligning with previous reviews of similar interventions with adults. Kirby et al.'s (2017) meta-analysis of compassion-focused interventions for adults reported significant moderate effects on compassion ( $p < 0.001$ ,  $d = 0.55$ ). Galante et al. (2014) reported a favourable effect of Kindness-Based Meditations (KBM) for adults on compassion compared to control. Only two studies in this review measured compassion despite interventions being compassion-based. Strauss et al. (2016) highlighted the lack of self-report measures for measuring compassion, which is likely to have impacted on measurement selection in the studies. The Compassion Engagement and Action Scale (Gilbert et al., 2017) is cited by Kirby et al. (2017) as a helpful scale to measure compassion motivation and could be used in future research.

### *Anxiety*

Conclusions could not be made about effectiveness of interventions on anxiety due to heterogeneity of results. Ferrari et al.'s (2019) meta-analysis of self-compassion interventions for adults reported moderate heterogeneity for anxiety. Ferrari et al.'s (2019) review reported moderate significant improvement for anxiety compared with control ( $g = 0.57$ ) however, results became non-significant when compared with an active comparison group. In comparison, Kirby et al. (2017) reported non-significant heterogeneity and a significant small to moderate effect of interventions on anxiety ( $p < 0.001$ ,  $d = 0.49$ ), which was maintained when compared with active control ( $p < 0.001$ ,  $d = 0.42$ ).

### *Depression*

The current review tentatively suggests CBIs may reduce depressive symptoms in some mothers. The results resemble Kirby et al.'s (2017) meta-analysis, which reported significant moderate effect for depression ( $p < 0.001$ ,  $d = 0.64$ ). This conclusion supports Leaviss and Uttley (2017), who reported CFT is effective for reducing depressive symptoms in adults, especially those high in self-criticism. Reviews Kindness-based meditations (KBM) for adults and self-compassion interventions for adults also report significant moderate effects on depression (Galante et al., 2014,  $g = -0.61$ ; Ferrari et al. 2019,  $g = 0.66$ ).

### *Generalised Stress*

Generalised stress in this review did not appear to be affected by CBIs. Galante et al.'s (2014) review of KBM for adults reported inconsistent results leading to an inability to make conclusions. Self-compassion interventions significantly improved stress with moderate effect size in Ferrari et al.'s (2019) meta-analysis with adults. It may be that CBIs do not affect generalised stress but self-compassion interventions do. It may be that non-parents' generalised stress is modifiable using CBIs but parents' stress is not.

### *Parenting stress*

CBIs for reducing parenting stress show some promise. Fernandez-Carriba et al. (2019) recruited parents of children with ASD who have greater levels of parenting stress than parents of neuro-typical children (Hayes & Watson, 2012; Nikmat et al., 2008). This may partially account for the study's large effect size. Rutherford et al.'s (2019) review

of psychological interventions for parents of children with ASD demonstrated significant medium effect of interventions, though these were not compassion specific.

### *Psychological distress*

This review could not make conclusions regarding psychological distress due to only one study measuring this outcome. Kirby et al.'s (2017) meta-analysis of compassion interventions for adults reported significant small to moderate effects on psychological distress ( $p < 0.001$ ,  $d = 0.70$ ). The scale used to measure psychological distress in this review was the Impact of Events Scale - Revised (IES-R; Weiss, 2007), used to measure symptoms of Post Traumatic Stress Disorder (PTSD). Westerman et al. (2020) reviewed mindfulness and compassion interventions for adults and reported decreases in symptom severity for two studies though results were significant in only one study (Goldsmith et al., 2014). Beaumont and Hollins-Martin (2015) reported significant improvements in psychological distress when CFT was combined with approaches such as Cognitive Behavioural Therapy (CBT).

### *Wellbeing*

The tentative effectiveness of interventions to improve wellbeing aligns with previous meta-analyses. Kirby et al. (2017) reported significant moderate effects of compassion interventions on wellbeing ( $p < 0.001$ ,  $d = 0.51$ ). Ferrari et al. (2019) reported small significant effects of self-compassion interventions on life satisfaction ( $g = 0.40$ ).

### *Shame*

This review could not make conclusions about the effectiveness of interventions on shame. Kirby et al. (2019) suggested the brevity of intervention explained the non-significant decrease in shame in their study, as shame requires time to change. Shame is a useful target in interventions as parents experience shame in relation to perceived parenting mistakes (Haslam et al., 2015). The CBI CFT was designed for people experiencing high levels of self-criticism and feelings of shame (Gilbert, 2011). Eight studies reviewed in Westerman et al.'s (2020) review of mindfulness and compassion interventions for adults reported significant decreases in shame. Kuyken et al. (2010) suggest mindfulness and compassion interventions mediate reductions in shame through the cultivation of self-compassion.

### *Self-compassion*

This review concluded self-compassion in some mothers may be increased by CBIs. This supports Kirby et al.'s (2017) meta-analysis of compassion interventions for adults, which reported significant moderate effects on self-compassion ( $p < 0.001$ ,  $d = 0.70$ ). Ferrari et al.'s (2019) review of self-compassion interventions reported significant moderate effects ( $g = 0.75$ ). Galante et al.'s (2014) review of KBM reported small significant effects ( $g = 0.45$ ). The robustness of this review's conclusion on self-compassion is reduced due to the use of the full scale Self-Compassion Scale (SCS; Neff, 2003a) in studies rather than sub scales, as sub scales are more reliable than the full scale score (Kumlander et al., 2018; Hayes et al., 2016).

#### **1.4.3 Aim 2: To examine the main themes emerging from qualitative data**

The four themes relating to the nature of experiencing CBIs were; *sharing experiences*, *self-acceptance*, *reflecting on difficulties* and *hope and trust for the future*. *Sharing experiences* was highlighted as important in Butler et al.'s (2020) review of parents' experiences and perceptions of parenting programmes under the subtheme 'value of the group'. Group experience was a facilitator of participating in parenting programmes in Mytton et al.'s (2014) qualitative review. Kane et al.'s (2007) qualitative synthesis of parenting programmes reported acceptance and support from other parents enabled gains from interventions. In Kane et al. (2007), *sharing experiences* enabled *self-acceptance* and led to a reduction of guilt in parents. da Paz and Wallander (2017) concluded acceptance was an area of interest for interventions that improve parental mental health. The theme, *hope and trust for the future* incorporated confidence for dealing with parenting challenges. Kane et al. (2007) described how interventions led to increased confidence in dealing with children's behaviour. The theme *reflecting on difficulties* was novel to parenting intervention research and is more likely to relate to the compassion element of the intervention, as awareness of struggling or suffering are inherent to many definitions of compassion.

#### **1.4.4 Aim 3: To provide integration of quantitative and qualitative data**

This review is novel in integrating quantitative and qualitative data on CBIs for parents. The stress outcome in Navab et al. (2019) was an outlier to tentative relationships made between qualitative themes and significance and effect size of interventions. Stress was the one outcome in this review that appeared to lack improvement from CBIs. Bonis' (2016) literature review of parents of children with ASD reported parents

continue to describe high levels of stress even when other outcomes have improved. The parental group in Navab et al. (2019) was parents of children with Attention Deficit Hyperactivity Disorder (ADHD). Coates et al.'s (2014) review of (non-compassion based) parenting interventions identified stress was not significantly improved by intervention. It may be that stress is not amenable to change in some parents however, this is still unclear and warrants further investigation.

Due to small samples, it is unclear if non-significant results would change with larger samples. It is unclear how effective interventions are for parents other than biological mothers who are white and educated to degree level and above. It is unknown from this review which CBI is most effective and in what format or duration. It is also unclear what mechanism of change is involved and the effect of home practice. Most studies in the review did not capture reasons why participants dropped out so it is unclear why participants did not complete interventions. Due to limited follow up data, little is known about longitudinal outcomes.

#### **1.4.5 Policy and Practice Implications**

Policy and practice implications are limited and based on the tentative conclusion that CBIs may positively influence self-compassion in some mothers. Midwives, health visitors, children's centre workers, mental health service workers and those in non-statutory services could integrate CBIs into their contacts with mothers to support improvements in self-compassion. Services offering CBIs could improve data collection and ask specifically if a participant is a parent. Following ethics approval this data could

support further research into effectiveness and experiences of parents accessing interventions compared with individuals who are not parents.

In terms of provisional clinical practice-based changes, mental health providers can develop CBIs for parents as an alternative or adjunct to existing services. Results from this review are tentatively promising for a number of areas (self-compassion, compassion, wellbeing, depression and parenting stress) and did not lead to deterioration in symptoms. CBIs could take into account the qualitative outcome *sharing experiences* as this theme appeared important in this review and previous reviews of parenting programmes (Butler et al., 2020). Other qualitative outcomes need replication in further studies before influencing intervention design.

#### **1.4.6 Limitations and Strengths**

Selection bias may have been introduced by searching only studies in English. Three of ten studies were authored by Kirby, which may have introduced author bias. Study samples were small ( $N = 11$  to  $N = 354$ ) and biased, limiting generalisability and transferability of results. The strength of qualitative results was limited by only two studies with qualitative data. The views of parents who dropped out or found intervention unhelpful are likely under-represented. The main limitation of this review is the high heterogeneity including variation in intervention type and length and differing study methodologies, disabling the ability for meta-analysis and limiting conclusions. The mechanisms of change, necessary duration, format and content of interventions are still unknown. As all studies were published in the last three years, it is likely that more studies will soon follow. One strength and limitation of the review is

the inclusion of only peer-reviewed studies, possibility introducing publication bias into the review. The strength of this strategy is to safeguard the quality of studies included; studies in this review were of moderate to high quality (between 58.9% to 91.7% quality rating).

The main strength of this review is its novelty as the first to investigate outcomes relating to CBIs for current and prospective parents. This review addresses the study design limitation of Kirby et al. (2017) by including and analysing non-RCT designs. A further strength is integration of quantitative and qualitative studies using mixed studies result-based convergent synthesis design (Pluye & Hong, 2014). The integration of quantitative and qualitative data enables tentative conclusions to be made about how to improve effectiveness and experiences of CBIs for parents. The possible explanatory ability of qualitative themes in regard to quantitative outcomes offer a new direction of thinking when developing clinical interventions and research trials to ensure participant experience is considered and reported.

#### **1.4.7 Future research**

More studies need to be carried out with larger, more representative samples including parents who are not biological mothers, younger parents, parents with disabilities, parents of different ethnicities and clinical parent samples. RCTs with active control groups would discover benefits to CBIs compared with treatment as usual. Further qualitative studies to understand all participants' experiences and reasons for drop out are needed.

## 1.5 Conclusion

This review evaluated ten recent studies of CBIs for parents. Conclusions made are tentative due to the heterogeneity of studies and small, biased samples. Interventions show promise for improving self-compassion in some mothers and possibly increasing compassion, increasing wellbeing, decreasing depression and decreasing parenting stress in some mothers though further studies are needed to improve the robustness of these findings. No conclusions could be made about the effectiveness of interventions on anxiety, shame or psychological distress. Generalised stress in mothers may not be affected. No conclusions can be made about parents other than some biological mothers. Integration of quantitative and qualitative data suggests interventions with evidence of more qualitative themes (*sharing experiences, self-acceptance, reflecting on difficulties and hope and trust for the future*) may yield more significant and larger effects than interventions without these elements. Although seemingly explanatory, caution needs to be taken with this conclusion due to the limited quality and quantity of qualitative data.

Although results in this review are tentative, none of the outcomes were negatively affected by CBIs. There is no doubt that interest in this subject is blossoming and CBIs for current and prospective parents should be open to further consideration.

## 1.6 References

- Abidin, R. R. (1990). *Parenting stress index-short form* (3rd ed.). Charlottesville, VA: Pediatric Psychology Press.
- Allen, G. (2011). *Early intervention: The next steps: An independent report to her majesty's government*.  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/284086/early-intervention-next-steps2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf)
- Al-Maliki, S. K., Al-Asadi, J., Al-Waely, A., & Agha, S. (2016). Prevalence and levels of depression among parents of children with cancer in Basrah, Iraq. *Sultan Qaboos University Medical Journal*, 16(3), Article e329.  
<https://doi.org/10.18295/squmj.2016.16.03.011>
- Aman, M. G., Singh, N. N., Stewart, A. W., & Field, C. J. (1985). The aberrant behavior checklist: a behavior rating scale for the assessment of treatment effects. *American journal of mental deficiency*, 89(5), 485-491.
- Arnold, D. S., O'Leary, S. G., Wolff, L. S., & Acker, M. M. (1993). The parenting scale: A measure of dysfunctional parenting in discipline situations. *Psychological Assessment*, 5, 137-144. <https://doi.org/10.1037/1040-3590.5.2.137>
- Axford, N., Lehtonen, M., Kaoukji, D., Tobin, K., & Berry, V. (2012). Engaging parents in parenting programs: Lessons from research and practice. *Children and Youth Services Review*, 34, 2061 - 2071.  
<https://doi.org/10.1016/j.childyouth.2012.06.011>
- Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment*, 13, 27-45.  
<https://doi.org/10.1177/1073191105283504>
- Barreto, T. M., Bento, M. N., Barreto, T. M., Jagersbacher, J. G., Jones, N. S., Lucena, R., & Bandeira, I. D. (2020). Prevalence of depression, anxiety, and substance-related disorders in parents of children with cerebral palsy: a systematic review. *Developmental Medicine & Child Neurology*, 62(2), 163-168.  
<https://doi.org/10.1111/dmcn.14321>
- Beaumont, E., & Hollins Martin, C. J. (2015). A narrative review exploring the effectiveness of Compassion-Focused Therapy. *Counselling Psychology Review*, 30(1), 21-32. <http://usir.salford.ac.uk/id/eprint/34103>
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck depression inventory-II*. San Antonio, TX: Psychological Corporation
- Bennett, A. C., Brewer, K. C., Rankin, K. M. (2012). The association of child mental health conditions and parent mental health status among US children, 2007.

*Maternal Child Health Journal*, 16, 1266-75. <https://doi.org/10.1007/s10995-011-0888-4>

- Bohadana, G., Morrissey, S., & Paynter, J. (2019). Self-compassion: a novel predictor of stress and quality of life in parents of children with autism spectrum disorder. *Journal of autism and developmental disorders*, 49(10), 4039-4052. <https://doi.org/10.1007/s10803-019-04121-x>
- Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T. & Zettle, R. D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionnaire–II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior therapy*, 42(4), 676-688. <https://doi.org/10.1016/j.beth.2011.03.007>
- Bratt, A. S., Svensson, I., & Rusner, M. (2019). Finding confidence and inner trust as a parent: experiences of group-based compassion-focused therapy for the parents of adolescents with mental health problems. *International journal of qualitative studies on health and well-being*, 14(1), 1684166. <https://doi.org/10.1080/17482631.2019.1684166>
- Breines, J. G., & Chen, S. (2012). Self-compassion increases self-improvement motivation. *Personality and Social Psychology Bulletin*, 38(9), 1133–1143. <https://doi.org/10.1177/0146167212445599>
- Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: mindfulness and its role in psychological well-being. *Journal of personality and social psychology*, 84(4), <https://doi.org/10.1037/0022-3514.84.4.822>
- Butler, J., Gregg, L., Calam, R. & Wittkowski, A. (2020). Parents' Perceptions and Experiences of Parenting Programmes: A Systematic Review and Metasynthesis of the Qualitative Literature. *Clinical Child and Family Psychology Review*, 23, 176–204. <https://doi.org/10.1007/s10567-019-00307-y>
- Caldwell, K., Henshaw, L., & Taylor, G. (2005). Developing a framework for critiquing health research. *Journal of Health, Social and Environmental Issues*, 6(1), 45-54. <http://eprints.mdx.ac.uk/2981/>
- Caldwell, K., Henshaw, L., & Taylor, G. (2011). Developing a framework for critiquing health research: an early evaluation. *Nurse Education Today*, 31(8), Article e1-e7. <https://doi.org/10.1016/j.nedt.2010.11.025>
- Carlson, L. E., & Thomas, B. C. (2007). Development of the Calgary Symptoms of Stress Inventory (C-SOSI). *International Journal of Behavioral Medicine*, 14(4), 249–256. <https://doi.org/10.1007/BF03003000>
- Catalano, D., Holloway, L., & Mpofu, E. (2018). Mental health interventions for parent carers of children with autistic spectrum disorder: practice guidelines from a

- critical interpretive synthesis (CIS) systematic review. *International Journal of Environmental Research and Public Health*, 15(2), 341. <https://doi.org/10.3390/ijerph15020341>.
- Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of health and social behavior*, 385-396. <https://doi.org/10.2307/2136404>
- Connell, A. M. & Goodman, S. H. (2002). The association between psychopathology in fathers versus mothers and children's internalizing and externalizing behavior problems: a meta-analysis. *Psychological Bulletin*, 128, 746-73. <https://doi.org/10.1037/0033-2909.128.5.746>
- Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *The British journal of psychiatry*, 150(6), 782-786. <https://doi.org/10.1192/bjp.150.6.782>
- Crnic, K. A., & Greenberg, M. T. (1990). Minor parenting stresses with young children. *Child Development*, 61, 1628–1637. <https://doi.org/10.1111/j.1467-8624.1990.tb02889.x>
- Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective Lifeworld Research*, 2nd. Ed. Lund, Studentlitteratur.
- da Paz, N. S., & Wallander, J. L. (2017). Interventions that target improvements in mental health for parents of children with autism spectrum disorders: A narrative review. *Clinical psychology review*, 51, 1-14. <https://doi.org/10.1016/j.cpr.2016.10.006>
- Davis, M. H. (1980). A multidimensional approach to individual differences in empathy. *JSAS (Journal Supplement Abstrac Service) Catalog of Selected Documents in Psychology*, 10, 85.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, 14(4), 245-258. [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)
- Fernandez-Carriba, S., González-García, M., Bradshaw, J., Gillespie, S., Mendelson, J. L., Jarzabek, E., Saulnier, C., Klin, A., Negi, L. T., & Herndon, J. (2019). Learning to connect: a feasibility study of a mindfulness and compassion training for parents of children with autism spectrum disorder. *Mental Health and Family Medicine*, 15, 794-804. [https://www.researchgate.net/profile/Marian\\_Gonzalez-Garcia2/publication/331564267\\_Learning\\_to\\_connect\\_a\\_feasibility\\_study\\_of\\_a\\_mindfulness\\_and\\_compassion\\_training\\_for\\_parents\\_of\\_children\\_with\\_au](https://www.researchgate.net/profile/Marian_Gonzalez-Garcia2/publication/331564267_Learning_to_connect_a_feasibility_study_of_a_mindfulness_and_compassion_training_for_parents_of_children_with_au)

[tism\\_spectrum\\_disorder/links/5c80f35b458515831f8b4518/Learning-to-connect-a-feasibility-study-of-a-mindfulness-and-compassion-training-for-parents-of-children-with-autism-spectrum-disorder.pdf](https://doi.org/10.1177/1558689815581222)

- Fetters, M. D. & Freshwater, D. (2015) The 1 + 1 + 3 Integration Challenge. *Journal of Mixed Methods Research*, 9(2), 115-117.  
<https://doi.org/10.1177/1558689815581222>
- Fonseca, A., & Canavarro, M. C. (2018). Exploring the paths between dysfunctional attitudes towards motherhood and postpartum depressive symptoms: The moderating role of self-compassion. *Clinical psychology & psychotherapy*, 25(1), Article e96-e106. <https://doi.org/10.1002/cpp.2145>
- Galante, J., Galante, I., Bekkers, M.-J., & Gallacher, J. (2014). Effect of kindness-based meditation on health and well-being: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology*, 82(6), 1101-1114. <https://doi.org/10.1037/a0037249>
- Gammer, I., Hartley-Jones, C. & Jones, F.W. (2020). A Randomized Controlled Trial of an Online, Compassion-Based Intervention for Maternal Psychological Well-Being in the First Year Postpartum. *Mindfulness*, 11, 928–939.  
<https://doi.org/10.1007/s12671-020-01306-9>
- Gibaud-Wallston, J., & Wandersmann, L. P. (1978). *Development and utility of the Parenting Sense of Competence Scale*. John F. Kennedy center for research on education and human development.
- Gilbert, P. (2009a). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, 15(3), 199-208. <https://doi.org/10.1192/apt.bp.107.005264>
- Gilbert, P. (2009b). *The Compassionate Mind*. London: Constable-Robinson.
- Gilbert, P. (2011). Shame in psychotherapy and the role of compassion focused therapy. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour*, (pp. 325–354). American Psychological Association.  
<https://doi.org/10.1037/12326-014>
- Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., Ceresatto, L., Duarte, J., Pinto-Gouveia, J., & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, 4(4). <http://dx.doi.org/10.1186/s40639-017-0033-33>
- Gilbert, P., & Choden. (2013). *Mindful compassion*. London: Constable & Robinson.
- Gilbert, P., Clarke, M., Hempel, S., Miles, J. N., & Irons, C. (2004). Criticizing and reassuring oneself: An exploration of forms, styles and reasons in female

- students. *British Journal of Clinical Psychology*, 43(1), 31–50.  
<https://doi.org/10.1348/014466504772812959>
- Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, research and practice*, 84(3), 239-255.  
<https://doi.org/10.1348/147608310X526511>
- Gilbert, P. & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: A pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, 13, 353-379. <https://doi.org/10.1002/cpp.507>
- Gillath, O., Shaver, P. R., & Mikulincer, M. (2005). An attachment-theoretical approach to compassion and altruism. In P Gilbert (Ed.), *Compassion Conceptualisations, research and use in psychotherapy* (pp. 133-159). Routledge.
- Gilroy, A. (2006). *Art Therapy, Research and Evidence-Based Practice*. Sage Publications Ltd: London.
- Goldsmith, R. E., Gerhart, J. I., Chesney, S. A., Burns, J. W., Kleinman, B., & Hood, M. (2014). Mindfulness-based stress reduction for posttraumatic stress symptoms: Building acceptance and decreasing shame. *Journal of Evidence-Based Complementary and Alternative Medicine*, 19(4), 227 -234.  
<https://doi.org/10.1177/2156587214533703>.
- Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 38, 581–586.  
<https://doi.org/10.1111/j.1469-7610.1997.tb01545.x>
- Goodman, S. H., & Gotlib, I. H. (2002). Children of depressed parents: Mechanisms of risk and implications for treatment. *Psychological Review*, 106(3), 458-490.  
<https://doi.org/10.1037/10449-000>
- Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures—I: The other as Shamer scale. *Personality and Individual Differences*, 17(5), 713-717.  
[https://doi.org/10.1016/0191-8869\(94\)90149-X](https://doi.org/10.1016/0191-8869(94)90149-X)
- Guo, L., Zhang, J., Mu, L., & Ye, Z. (2020). Preventing Postpartum Depression With Mindful Self-Compassion Intervention: A Randomized Control Study. *The Journal of Nervous and Mental Disease*, 208(2), 101-107.  
<https://doi.org/10.1097/NMD.0000000000001096>
- Hajos, T. R., Pouwer, F., Skovlund, S. E., Den Oudsten, B. L., Geelhoed-Duijvestijn, P. H., Tack, C. J., Snoek, F. J. (2013). Psychometric and screening properties of the WHO-5 Well-Being Index in adult outpatients with type 1 or type 2 diabetes mellitus. *Diabetic Medicine*. 30:e63–e69.  
<https://doi.org/10.1111/dme.12040>

- Haskett, M. E., Ahern, L. S., Ward, C. S., & Allaire, J. C. (2006). Factor structure and validity of the parenting stress index-short form. *Journal of Clinical Child & Adolescent Psychology, 35*(2), 302-312. [https://doi.org/10.1207/s15374424jccp3502\\_14](https://doi.org/10.1207/s15374424jccp3502_14)
- Haslam, D.M., Patrick, P., & Kirby, J.N. (2015). Giving voice to working mothers: A consumer informed study to program design for working mothers. *Journal of Child and Family Studies, 24*, 2463–2473. <https://doi.org/10.1007/s10826-014-0049-7>
- Hayes, J. A., Lockard, A. J., Janis, R. A., & Locke, B. D. (2016). Construct validity of the Self-Compassion Scale-Short Form among psychotherapy clients. *Counselling Psychology Quarterly, 29*(4), 405-422. <https://doi.org/10.1080/09515070.2016.1138397>
- Hayes, S. A., & Watson, S. L. (2013). The impact of parenting stress: A meta-analysis of studies comparing the experience of parenting stress in parents of children with and without autism spectrum disorder. *Journal of autism and developmental disorders, 43*(3), 629-642. <https://doi.org/10.1007/s10803-012-1604-y>
- Henry, J. D., & Crawford, J. R. (2005). The short-form version of the depression anxiety stress scales (DASS-21): Construct validity and normative data in a large non-clinical sample. *British Journal of Clinical Psychology, 44*(2), 227–239. <https://doi.org/10.1348/014466505X29657>
- Hoffman, C., Crnic, K. A., & Baker, J. K. (2006). Maternal depression and parenting: Implications for children's emergent emotion regulation and behavioral functioning. *Parenting: Science and Practice, 6*(4), 271-295. [https://doi.org/10.1207/s15327922par0604\\_1](https://doi.org/10.1207/s15327922par0604_1)
- Hoffmann, S. G., Grossman, P., & Hinton, D. E. (2011). Loving-kindness and compassion meditation: potential for psychological intervention. *Clinical Psychology Review, 13*, 1126–1132. <https://doi.org/10.1016/j.cpr.2011.07.003>
- Hong, Q. N., Pluye, P., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenaise, P., Gagnon, M-P., Griffiths, F., Nicolau, B., O’Cathain, A., Rousseau, M-C., & Vedela, I. (2019). Improving the content validity of the mixed methods appraisal tool: a modified e-Delphi study. *Journal of clinical epidemiology, 111*, 49-59. <https://doi.org/10.1016/j.jclinepi.2019.03.008>
- Kane, G. A., Wood, V. A., & Barlow, J. (2007). Parenting programmes: a systematic review and synthesis of qualitative research. *Child: care, health and development, 33*(6), 784-793. <https://doi.org/10.1111/j.1365-2214.2007.00750.x>

- Kelman, A. R., Stanley, M. L., Barrera, A. Z., Cree, M., Heineberg, Y. & Gilbert P. (2016). Comparing brief internet-based compassionate mind training and cognitive behavioral therapy for perinatal women: study protocol for a randomized controlled trial. *JMIR Research Protocols*, 5(2). Article e65. <https://doi.org/10.2196/resprot.5332>
- Kirby, J. N. (2016). The role of mindfulness and compassion in enhancing nurturing family environments. *Clinical Psychology: Science and Practice*, 23(2), 142-157. <https://doi.org/10.1111/cpsp.12149>
- Kirby, J. N. (2020). Nurturing Family Environments for Children: Compassion-Focused Parenting as a Form of Parenting Intervention. *Education Sciences*, 10(1), 3. <https://doi.org/10.3390/educsci10010003>
- Kirby, J. N., & Baldwin, S. (2018). A randomized micro-trial of a loving-kindness meditation to help parents respond to difficult child behavior vignettes. *Journal of Child and Family Studies*, 27(5), 1614-1628. <https://doi.org/10.1007/s10826-017-0989-9>
- Kirby, J. N., Grzazek, O., & Gilbert, P. (2019). The role of compassionate and self-image goals in predicting psychological controlling and facilitative parenting styles. *Frontiers in psychology*, 10. <https://doi.org/10.3389/fpsyg.2019.01041>
- Kirby, J. N., Sampson, H., Day, J., Hayes, A., & Gilbert, P. (2019). Human evolution and culture in relationship to shame in the parenting role: implications for psychology and psychotherapy. *Psychology and Psychotherapy: Theory Research and Practice*, 92, 238–260. <https://doi.org/10.1111/papt.12223>
- Kirby, J. N., & Sanders, M. R. (2012). Using consumer input to tailor evidence-based parenting interventions to the needs of grandparents. *Journal of Child and Family Studies*, 21, 626–636. <https://doi.org/10.1007/s10826-011-9514-8>
- Kirby, J. N., & Sanders, M. R. (2014). The acceptability of parenting strategies for grandparents providing care to their grandchildren. *Prevention Science*, 15(5), 777-787. <https://doi.org/10.1007/s11121-013-0428-0>
- Kirby, J. N., Tellegen, C. L., & Steindl, S. R. (2017). A meta-analysis of CBIs: current state of knowledge and future directions. *Behavior Therapy*, 48, 778–792. <https://doi.org/10.1016/j.beth.2017.06.003>
- Kumlander, S., Lahtinen, O., Turunen, T., & Salmivalli, C. (2018). Two is more valid than one, but is six even better? The factor structure of the Self-Compassion Scale (SCS). *PLoS one*, 13(12). <https://doi.org/10.1371/journal.pone.0207706>
- Leaviss, J., & Uttley, L. (2015). Psychotherapeutic benefits of compassion-focused therapy: An early systematic review. *Psychological medicine*, 45(5), 927-945. <https://doi.org/10.1017/S0033291714002141>

- Leff, E. W., Jefferis, S. C., & Gagne, M. P. (1994). The development of the maternal breastfeeding evaluation scale. *Journal of Human Lactation*, *10*(2), 105-111. <https://doi.org/10.1177/089033449401000217>
- Lewis, G., Neary, M., Polek, E., Flouri, E., & Lewis, G. (2017). The association between paternal and adolescent depressive symptoms: evidence from two population-based cohorts. *The Lancet Psychiatry*, *4*(12), 920-926. [https://doi.org/10.1016/S2215-0366\(17\)30408-X](https://doi.org/10.1016/S2215-0366(17)30408-X)
- Liang, L. A., Berger, U., & Brand, C. (2019). Psychosocial factors associated with symptoms of depression, anxiety and stress among single mothers with young children: a population-based study. *Journal of affective disorders*, *242*, 255-264. <https://doi.org/10.1016/j.jad.2018.08.013>
- Lichtlé, J., Downes, N., Engelberg, A., & Cappe, E. (2019). The Effects of Parent Training Programs on the Quality of Life and Stress Levels of Parents Raising a Child with Autism Spectrum Disorder: a Systematic Review of the Literature. *Review Journal of Autism and Developmental Disorders*, *7*, 242-262. <https://doi.org/10.1007/s40489-019-00190-x>
- Lieb, R., Isensee, B., Höfler, M., Pfister, H. & Wittchen, H. U. (2002). Parental major depression and the risk of depression and other mental disorders in offspring: a prospective-longitudinal community study. *Archives of General Psychiatry*, *59*, 365-74. <https://doi.org/10.1001/archpsyc.59.4.365>
- Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with the beck depression and anxiety inventories. *Behaviour Research and Therapy*, *33*(3), 335–343. [https://doi.org/10.1016/0005-7967\(94\)00075-u](https://doi.org/10.1016/0005-7967(94)00075-u)
- Majdandžić, M., Vente, W., & Bögels, S. M. (2015). Challenging parenting behavior from infancy to toddlerhood: etiology, measurement, and differences between fathers and mothers. *Infancy*, *21*(4), 423-452. <https://doi.org/10.1111/infa.12125>
- Manning, C, & Gregoire, A. (2009). Effects of parental mental illness on children. *Psychiatry*, *8*, 7-9. <https://doi.org/10.1016/j.mppsy.2008.10.012>
- Martins, C., & Gaffan, E. A. (2000). Effects of early maternal depression on patterns of infant–mother attachment: A meta-analytic investigation. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, *41*(6), 737-746. <https://doi.org/10.1111/1469-7610.00661>
- Metzger, R. L. (1976). A reliability and validity study of the State-Trait Anxiety Inventory. *Journal of Clinical Psychology*, *32*(2), 276–278.

[https://doi.org/10.1002/1097-4679\(197604\)32:2<276::AID-JCLP2270320215>3.0.CO;2-G](https://doi.org/10.1002/1097-4679(197604)32:2<276::AID-JCLP2270320215>3.0.CO;2-G)

- Mikulincer, M., & Shaver, P. R. (2016). Adult attachment and emotion regulation. *Handbook of attachment: Theory, research, and clinical applications*, 3, 507-533.
- Mikulincer, M., Shaver, P. R., Gillath, O., & Nitzberg, R. A. (2005). Attachment, Caregiving, and Altruism: Boosting Attachment Security Increases Compassion and Helping. *Journal of Personality and Social Psychology*, 89(5), 817–839. <https://doi.org/10.1037/0022-3514.89.5.817>
- Mitchell, A. E., Whittingham, K., Steindl, S., & Kirby, J. (2018). Feasibility and acceptability of a brief online self-compassion intervention for mothers of infants. *Archives of women's mental health*, 21(5), 553-561. <https://doi.org/10.1007/s00737-018-0829-y>
- Moher, D., Liberati, A., Tetzlaff, J. & Altman, D.G. (2009). 'Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement'. *Annals of Internal Medicine*, 151(4), 264-269. <https://doi.org/10.7326/0003-4819-151-4-200908180-00135>
- Moreira, H., Gouveia, M. J., Carona, C., Silva, N., & Canavarro, M. C. (2014). Maternal attachment and children's quality of life: The mediating role of self-compassion and parenting stress. *Journal of Child and Family Studies*, 24, 2332-2344. <https://doi:10.1007/s10826-014-0036-z>
- Mytton, J., Ingram, J., Manns, S., & Thomas, J. (2014). Facilitators and barriers to engagement in parenting programs: A qualitative systematic review. *Health Education and Behavior*, 41(2), 127–137. <https://doi.org/10.1177/1090198113485755>.
- National Centre for Social Research (NCSR), Office of National Statistics and Youthinmind. (2018). *Mental Health of Children and Young People in England*. <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017#key-facts>
- NHS England. (2016) *Better births. Improving outcomes of maternity services in England. A five year forward view for maternity care*. <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>
- Navab, M., Dehghani, A., & Salehi, M. (2019). Effect of compassion-focused group therapy on psychological symptoms in mothers of attention-deficit hyperactivity disorder children: A pilot study. *Counselling and Psychotherapy Research*, 19(2), 149-157. <https://doi.org/10.1002/capr.12212>

- Neff, K. D. (2003a). Development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223-250.  
<https://doi.org/10.1080/15298860390209035>
- Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2, 85-102.  
<https://doi.org/10.1080/15298860309032>
- Nikmat, A. W., Ahmad, M., Oon, N. L., & Razali, S. (2008). Stress and psychological wellbeing among parents of children with autism spectrum disorder. *ASEAN Journal of Psychiatry*, 9, 2, 65-72.  
[https://www.researchgate.net/profile/Azlina\\_wati\\_Nikmat2/publication/257368168\\_Stress\\_and\\_psychological\\_wellbeing\\_among\\_parents\\_of\\_children\\_with\\_autism\\_spectrum\\_disorder/links/02e7e525266002f3f8000000/Stress-and-psychological-wellbeing-among-parents-of-children-with-autism-spectrum-disorder.pdf](https://www.researchgate.net/profile/Azlina_wati_Nikmat2/publication/257368168_Stress_and_psychological_wellbeing_among_parents_of_children_with_autism_spectrum_disorder/links/02e7e525266002f3f8000000/Stress-and-psychological-wellbeing-among-parents-of-children-with-autism-spectrum-disorder.pdf)
- Olsen, S. F., Yang, C., Hart, C. H., Robinson, C. C., Wu, P., Nelson, D. A., Nelson, L. J., Jin, S., & Wo, J. (2002). Maternal psychological control and preschool children's behavioral outcomes in China, Russia, and the United States. In B. K. Barber (Ed.), *Intrusive parenting: How psychological control affects children and adolescents* (p. 235–262). American Psychological Association. <https://doi.org/10.1037/10422-008>
- Pluye, P., Gagnon, M. P., Griffiths, F., & Johnson-Lafleur, J. (2009). A scoring system for appraising mixed methods research, and concomitantly appraising qualitative, quantitative and mixed methods primary studies in Mixed Studies Reviews. *International journal of nursing studies*, 46(4), 529-546.  
<https://doi.org/10.1016/j.ijnurstu.2009.01.009>
- Pluye, P., & Hong, Q. N. (2014). Combining the power of stories and the power of numbers: mixed methods research and mixed studies reviews. *Annual review of public health*, 35, 29-45. <https://doi.org/10.1146/annurev-publhealth-032013-182440>
- Poehlmann-Tynan, J., Engbretson, A., Vigna, A. B., Weymouth, L. A., Burnson, C., Zahn-Waxler, C., Kapoor, A., Gerstein, E. D., Fanning, K. A., & Raison, C. L. (2020). Cognitively-Based Compassion Training for parents reduces cortisol in infants and young children. *Infant Mental Health Journal*, 41(1), 126-144.  
<https://doi.org/10.1002/imhj.21831>
- Pommier, E. (2011). The Compassion Scale. [Doctoral dissertation, The University of Texas at Austin, Texas, United States). *Dissertation Abstracts International Section A: Humanities and Social Sciences* (1174).
- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K. & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in

systematic reviews. *A product from the ESRC methods programme Version, 1*, b92.

[https://www.researchgate.net/profile/Mark\\_Rodgers4/publication/233866356\\_Guidance\\_on\\_the\\_conduct\\_of\\_narrative\\_synthesis\\_in\\_systematic\\_reviews\\_A\\_product\\_from\\_the\\_ESRC\\_Methods\\_Programme/links/02e7e5231e8f3a6183000000/Guidance-on-the-conduct-of-narrative-synthesis-in-systematic-reviews-A-product-from-the-ESRC-Methods-Programme.pdf](https://www.researchgate.net/profile/Mark_Rodgers4/publication/233866356_Guidance_on_the_conduct_of_narrative_synthesis_in_systematic_reviews_A_product_from_the_ESRC_Methods_Programme/links/02e7e5231e8f3a6183000000/Guidance-on-the-conduct-of-narrative-synthesis-in-systematic-reviews-A-product-from-the-ESRC-Methods-Programme.pdf)

Putnam, S.P., Helbig, A.L., Gartstein, M.A., Rothbart, M.K., Leerkes, E. (2014). Development and Assessment of Short and Very Short Forms of the Infant Behavior Questionnaire–Revised. *Journal of Personality Assessment*, 96(4), 445-458. <https://doi.org/10.1080/00223891.2013.841171>

Quittner, A. L., Goldbeck, L., Abbott, J., Duff, A., Lambrecht, P., Solé, A., Tibosch, M. M., Bergsten Brucefors, A., Yüksel, H., Catastini, P., Blackwell, L., & Barker, D. (2014). Prevalence of depression and anxiety in patients with cystic fibrosis and parent caregivers: results of The International Depression Epidemiological Study across nine countries. *Thorax*, 69, 12, 1090-1097. <http://dx.doi.org/10.1136/thoraxjnl-2014-205983>

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the self-compassion scale. *Clinical Psychology & Psychotherapy*, 18(3), 250–255. <https://doi.org/10.1002/cpp.702>

Raphael, J. L., Zhang, Y., Liu, H., & Giardino, A. P. (2010). Parenting stress in US families: Implications for paediatric healthcare utilization. *Child: care, health and development*, 36(2), 216-224. <https://doi.org/10.1111/j.1365-2214.2009.01052.x>

Reilly, C., Atkinson, P., Memon, A., Jones, C., Dabydeen, L., Das, K. B., Cross, J. H., Neville, B. G. R., Gillberg, C., & Scott, R. C. (2018). Parenting stress and perceived stigma in mothers of young children with epilepsy: A case–control study. *Epilepsy & Behavior*, 89, 112-117. <https://doi.org/10.1016/j.yebeh.2018.10.016>

Roth, R. M., Isquith, P. K., & Gioia, G. A. (2005). *BRIEF—A Behavior Rating Inventory of Executive Function*. Australia: PAR.

Rutherford, M., Singh-Roy, A., Rush, R., McCartney, D., O’Hare, A., & Forsyth, K. (2019). Parent focused interventions for older children or adults with ASD and parent wellbeing outcomes: A systematic review with meta-analysis. *Research in Autism Spectrum Disorders*, 68, 101450. <https://doi.org/10.1016/j.rasd.2019.101450>

Sacristan-Martin, O., Santed, M. A., Garcia-Campayo, J., Duncan, L. G., Bardacke, N., Fernandez-Alonso, C., Garcia-Sacristan, G., Garcia-Sacristan, D., Barcelo-Soler, A., & Montero-Marin, J. (2019). A mindfulness and compassion-based

- program applied to pregnant women and their partners to decrease depression symptoms during pregnancy and postpartum: study protocol for a randomized controlled trial. *Trials*, 20(1), 654.  
<https://doi.org/10.1186/s13063-019-3739-z>
- Sanders, M. R., Kirby, J. N., Tellegen, C. L., & Day, J. J. (2014). The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support. *Clinical psychology review*, 34(4), 337-357.  
<https://doi.org/10.1016/j.cpr.2014.04.003>
- Sawilowsky, S. S. (2009). New effect size rules of thumb. *Journal of Modern Applied Statistical Methods*, 8(2), 26. <https://10.22237/jmasm/1257035100>
- Schardt, C., Adams, M. B., Owens, T., Keitz, S., & Fontelo, P. (2007). Utilization of the PICO framework to improve searching PubMed for clinical questions. *BMC medical informatics and decision making*, 7(1), 16.  
<https://doi.org/10.1186/1472-6947-7-16>
- Scott, S. (2008). Parenting Programs In M. Rutter, D. V. M. Bishop, D. S. Pine, S. Scott, J. Stevenson, E. Taylor, & A. Thapar (Eds.). *Rutter's Child and Adolescent Psychiatry, 5th Edition*. Blackwell Publishing Limited.
- Sirois, F. M., Bögels, S., & Emerson, L. M. (2019). Self-compassion improves parental well-being in response to challenging parenting events. *The Journal of psychology*, 153(3), 327-341.  
<https://doi.org/10.1080/00223980.2018.1523123>
- Strauss, C., Taylor, B. L., Gu, J., Kuyken, W., Baer, R., Jones, F., & Cavanagh, K. (2016). What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review*, 47, 15–27.  
<http://dx.doi.org/10.1016/j.cpr.2016.05.004>
- Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J. & Stewart-Brown, S. (2007). The Warwick–Edinburgh Mental Well-Being Scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes*, 5, 63–73.  
<https://doi.org/10.1186/1477-7525-5-63>
- Unicef. (1989). *The United Nations Convention on the Rights of the Child*.  
[https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC\\_united\\_nations\\_convention\\_on\\_the\\_rights\\_of\\_the\\_child.pdf?\\_ga=2.60369261.1581649059.1583330924-529531267.1583330924](https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf?_ga=2.60369261.1581649059.1583330924-529531267.1583330924)
- Valk, S. L., Bernhardt, B. C., Trautwein, F. M., Böckler, A., Kanske, P., Guizard, N., Collins, D. L., & Singer, T. (2017). Structural plasticity of the social brain:

differential change after socio- affective and cognitive mental training. *Science Advances*, 3(10). Article e1700489. <https://doi.org/10.1126/sciadv.1700489>

Van den Bergh, B. R., van den Heuvel, M. I., Lahti, M., Braeken, M., de Rooij, S. R., Entringer, S., Hoyer, D., Roseboom, T., Räikkönen, K., King, S., & Schwab, M. (2017). Prenatal developmental origins of behavior and mental health: The influence of maternal stress in pregnancy. *Neuroscience & Biobehavioral Reviews*. <https://doi.org/10.1016/j.neubiorev.2017.07.003>

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of Positive and Negative Affect: The PANAS scales. *Journal of Personality and Social Psychology*, 54(6), 1063–1070. <https://doi.org/10.1037/0022-3514.54.6.1063>

Weiss, D. S. (2007). The impact of event scale: revised. In J. P. Wilson & T. M. Keane (Eds.) *Cross-cultural assessment of psychological trauma and PTSD* (pp. 219-238). Springer.

Westerman, G., McCann, E., & Sparkes, E. (2020). Evaluating the Effectiveness of Mindfulness and Compassion-Based Programs on Shame and Associated Psychological Distress with Potential Issues of Salience for Adult Survivors of Childhood Sexual Abuse: a Systematic Review. *Mindfulness*, 11, 1827-1847. <https://doi.org/10.1007/s12671-020-01340-7>

## Chapter 2: Empirical paper

### Constructing, Connecting and Compassion: Constructivist Grounded Theory on the Understanding of Compassion in Mental Health Nursing Students

*Written in preparation for submission to Journal of Clinical Nursing (See Appendix F for author guidelines)*

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## 2.0 Abstract

**Aims and objectives:** The aim of this study was to produce a data-driven model or theory to answer the question: how do Mental Health Nursing Students (MHNSs) understand compassion?

**Background:** Compassion is fundamental to mental health practice and is essential for mental health recovery. Mental Health Nurses may face more challenges to delivering compassionate care than other nurses and need a greater understanding of compassion. Mental Health Nurses have been unable to define compassion. Higher Education Institutions need a clearer concept of compassion in nursing and nursing education. Investigating MHNSs understanding of compassion may provide greater clarity for Mental Health Nursing and nursing education.

**Design:** This study employed a Constructivist Grounded Theory (CGT) methodology.

**Methods:** Between July 2019 and March 2020, nine MHNSs were interviewed once using a semi-structured interview. Data was analysed using CGT.

**Findings:** A theoretical model with a core concept 'Connecting' was constructed. Within the core concept there are five categories; "Pure concern for other"; Doing good, being good; Safe to learn; "We're all in this together" and Care for self for others. For MHNSs, compassion involves primarily connecting with their patients alongside

connecting with their values, their course, mentors, their peers and tentatively with themselves.

**Conclusions:** The theoretical model aligns with previous research in compassion and nursing. It is novel in the centrality of the core concept, 'Connecting'. This study suggests compassion is a relational construct rather than an individual entity; a view that needs to be incorporated in future compassion measurement, training and research. Limitations and research implications are discussed.

**Relevance to clinical practice:** The model has implications for MNHS recruitment, training and practice. Further support for MHNSs to make tangible and connect with their own needs is needed to safeguard them during their transition to a qualified Mental Health Nurse.

**Word count:** 296

**Keywords:** *Mental Health Nursing Student, Compassion, Constructivist Grounded Theory, Qualitative*

## 2.1 Introduction

The purpose of this study is to gain an understanding of the concept of compassion from the perspective of Mental Health Nursing Students (MHNSs). The research question is:

How do Mental Health Nursing Students understand compassion?

'Mental Health Nursing Student' is defined as an adult studying on a full-time degree meeting the Nursing and Midwifery Council's (NMC) standards of education and training (NMC, 2018) leading to a qualification in Mental Health Nursing. For this study the institution was a university in the West Midlands, United Kingdom (UK).

Mental Health Nursing Training in the UK is a three-year full-time course, structured in line with NMC standards with reference to The Code (NMC, 2018a; 2018b; 2018c; 2018d). Training assumes a biopsychosocial orientation with theoretical instruction in nursing, basic sciences and social sciences alongside clinical instruction. Theoretical instruction is typically delivered in a variety of formats including lecture-style teaching and simulation<sup>9</sup>. Clinical instruction takes the form of placements within practice learning partner organisations, which are typically local NHS Trusts. MHNSs experience a number of different placement settings throughout training. Assessment is carried out by practice assessors in the clinical setting and by academic assessors in the education setting.

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<sup>9</sup> Simulation is an artificial representation of a real world practice scenario

It is hoped that the research will produce a data-driven model or theory explaining MHNSs' understanding of compassion to inform Mental Health Nursing training on the concept of compassion. Theory-driven training is more likely to be effective (Nation et al., 2003). It is anticipated effective training would better support MHNSs as they transition onto qualification as a Mental Health Nurse.

The National Health Service (NHS) is the fifth biggest employer in the world (Nuffield Trust, 2017). Nursing, midwifery and care staff form the largest proportion of the health and care workforce (NHS England, 2016b), with 285,745 nurses employed in NHS Hospital and Community Health Services in March 2018 (NHS Digital, 2018). Compassion is a core value from the NHS Constitution (Department of Health [DOH], 2009). The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) reported lack of compassionate care from nursing staff contributed to serious failings in the NHS and recommended compassion training for nurses and values-based recruitment to nursing programmes. As a response, NHS England created 'Compassion in Practice (COP) - Our Vision and Strategy' (Cummings & Bennett, 2012). COP was built on the 6Cs; Care, Compassion, Communication, Courage, Competence, and Commitment. Three years after implementation, the strategy was not always well understood by frontline practitioners, in particular those in Mental Health Trusts (NHS England, 2016a).

COP has a focus on acute health nurses (NHS England, 2016a). Mental health trusts are the least aware of COP in comparison to acute and community settings and the needs

of Mental Health Nurses require further study (NHS England, 2016a). There were 67,800 NHS Mental Health Nursing posts in England in 2016 (Health Education England, 2017). From September 2010-2019 there was a 9% decrease in Mental Health Nurses in the NHS (National Audit Office [NAO], 2020). Vacancy rates for nursing in mental health trusts were 16% in July-September 2019 (NAO, 2020). The attrition rate for mental health nursing training in 2017 was 12.1% (Health Education England [HEE], 2017). Higher morale in clinical teams has been linked to higher empathic communication and compassionate healthcare cultures (Christiansen et al., 2015; Lown, 2014). Investigating understanding of compassion in MHNSs may offer insights into attrition. Focusing on reducing attrition in nursing training could significantly improve nursing students' experience and have positive impacts on the NHS and UK taxpayers (Kings Fund, 2019).

There is limited specificity in definitions of compassion in nursing (McCaffrey & McConnell, 2015; Perez-Bret et al., 2016). Compassion is fundamental to mental health practice (Barron et al., 2017) and compassion is essential for mental health recovery (Spandler & Stickley, 2011). Despite this, Mental Health Nurses have been unable to define compassion (Barron et al., 2017). Mental Health Nurses may face more challenges to delivering compassionate care than other nurses (Hunter et al., 2018) and need a greater understanding of compassion (Barron et al., 2017).

### **2.1.1 Background**

There is a dearth of information about the understanding of compassion by student nurses (Barton, 2016). Studies have focused on conceptualising compassion using

quantitative methodology (Gilbert et al., 2017) but this is not specific to nursing. Stamm (2009) used quantitative methodology to create the Professional Quality of Life (ProQOL), which measures 'compassion satisfaction'<sup>10</sup> and 'compassion fatigue'<sup>11</sup> in nursing rather than 'compassion'. Some studies aim to measure compassion in nurses (Burnell & Agan, 2013; Kemper et al., 2015; Lee & Seomun, 2016) but define compassion differently indicating there is no shared understanding. Kneafsey et al. (2016) identified a unified definition of compassion is challenging. Substantive and functional definitions of compassion remain elusive (Williams & Kabat-Zinn, 2013).

Studies relating to compassion in nursing have increased dramatically in the last five years. There are questions about nurses' expectations regarding compassion and uncertainty about the ability of practice environments to support nurses' compassion (McCaffrey & McConnell, 2015). Durkin et al.'s (2018) systematic review aimed to identify qualities of a compassionate nurse, investigate how compassion is taught to nursing students and identify instruments to measure compassion in nursing. Durkin et al. (2018) concluded there is no clearly defined theoretical framework for compassion in nursing.

More research is needed in nurse education to elucidate whether and how compassion can be taught (Durkin et al., 2018). Nurse education research may offer insights into how to measure compassion (Durkin et al. 2018). Higher Education Institutions need a

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<sup>10</sup> 'Compassion satisfaction' in nursing is defined as "intrinsic feelings of gratification" from the nursing role (Sacco & Copel, 2018, p. 79).

<sup>11</sup> 'Compassion fatigue' is defined as a combination of exhaustion, frustration or anger and trauma from the work environment (Stamm, 2009).

clearer concept of compassion in nursing and nursing education to successfully implement values-based recruitment (Kneafsey et al., 2016).

Kneafsey et al. (2016) employed a 'pragmatic' qualitative approach to identify perspectives on compassion from health and social care stakeholders. They reported four themes; participants' definitions of compassion; identification of compassionate behaviours; barriers to compassionate practice and solutions to difficulties within health care environments. MHNSs were not separated from other stakeholders in analysis. Kneafsey et al. (2016) suggested their sample may not be representative of larger stakeholder populations.

Hunter et al. (2018) interviewed adult nursing students working in Emergency Care using qualitative exploratory design. Hunter et al. (2018) reported two themes; 'doing the little things' and 'a strange new world: the uniqueness of the ED'. The second theme relates to the Emergency Care environment, making it less transferable to MHNSs working in mental health settings.

Sinclair et al. (2018) conducted Straussian grounded theory to investigate healthcare providers' understandings and experiences of compassion. Five categories and 13 themes were reported, generating a definition of compassion as 'a virtuous and intentional response to know a person, to discern their needs and ameliorate their suffering through relational understanding and action' (p. 5). Participants did not include MNHSs. Sinclair et al. (2018) suggested study of other settings and specialties

was needed. A limitation of Sinclair et al. (2018) was five of ten focus group questions asked about 'compassionate care' rather than 'compassion'.

Durkin et al. (2019) systematically reviewed 11 studies using meta-ethnography to determine views of patients and nurses on compassion. They reported nurses embody and enact compassion through spending time and communicating effectively with patients whereas patients experience compassion through a sense of togetherness with nurses. Data from the above studies may not be representative of MHNS population.

A weakness of previous literature is no clearly defined theoretical framework for compassion in nursing (Durkin et al., 2019; McCaffrey & McConnell, 2015; Dewar & Nolan, 2013). Studies include too few MHNSs to apply findings to this group. Qualitative methodology in many studies is summative, rather than a recognised qualitative methodology that generates workable theories. This research will attempt to overcome these limitations by interviewing only MHNSs and using Constructivist Grounded Theory (CGT) methodology (Charmaz, 2006; 2014) to generate a theory applicable for practice grounded in the data collected.

It is important to investigate compassion in mental health nursing as compassion may be less well understood by mental health nurses due to national strategies focusing less on mental health nursing settings (NHS England, 2016a). Compassion and empathy are vital to the formation of patient-nurse relationships (Brunero et al., 2010) and relationships contribute to recovery in mental health settings (Zuroff & Blatt, 2006;

Spandler & Stickley, 2011), therefore compassion is fundamental to mental health nursing.

It is important to understand how MHNSs understand compassion as the development of the ability to provide compassionate care takes place in nursing training (Msiska et al., 2014). Nursing training is also viewed as opportunity to develop self-compassion in nurses (Andrews et al., 2020) and has been recommended as an avenue for promoting self-compassion concepts (Andrews et al., 2020). No previous studies have investigated compassion in MHNSs therefore this study is valuable in providing a baseline for current understanding.

If a theory is generated, it may offer insights into MHNSs' working model of compassion. Working models can help to promote greater understanding and highlight areas of development in compassion for MHNSs. As no current conceptual standard exists for compassion for MHNSs, this study aims to establish a standard. The overall aim of the study was to produce a data-driven model or theory to answer the question: how do MHNSs understand compassion?

## **2.2 Methods**

### **2.2.1 Research Design**

The epistemological position is social constructivism with a theoretical lens of interpretivism. The research design is CGT (Charmaz, 2000; 2006; 2014). The study used non-probability research design with purposive sampling. Following initial

interviews, theoretical sampling<sup>12</sup> was utilised, in line with CGT recommendations (Charmaz, 2000). Theoretical sampling strengthens theoretical constructs. Charmaz (2006; 2014) recommends 20-30 participants for CGT and argues very small samples can produce studies of lasting significance (Charmaz, 2014). Further information about research design can be found in Appendix M.

### 2.2.2 Procedure

Participants were accessed from a university in the West Midlands, UK, via staff from the Mental Health Nursing course. MHNSs showing interest were contacted via e-mail and given the Participant Information Sheet (PIS; Appendix G). The researcher’s role as a researcher rather than clinician was stated. Following initial purposive sampling, theoretical sampling was employed to follow leads in the data. Recruitment ended at theoretical saturation as no new properties, dimensions or relationships emerged.

### 2.2.3 Inclusion and exclusion criteria

The inclusion and exclusion criteria are stated in Table 2.1.

Table 2.1: Inclusion and exclusion criteria

	<b>Inclusion</b>	<b>Exclusion</b>
Age	18 years and above	Less than 18 years
Course Type	Mental Health Nursing (meeting NMC standards)	Any other course type or no course
Student Status	Currently studying in years 1, 2 or 3	Pre-training or post-qualification

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<sup>12</sup> Theoretical sampling is a type of purposeful sampling based on categories developed through data analysis, allowing the researcher to follow leads within the data (Charmaz, 2006; 2014).

The inclusion criteria were individuals of at least eighteen years old<sup>13</sup>. Participants were required to be currently enrolled on a UK Mental Health Nurse Training Degree meeting NMC standards of education and training. Those on other courses or pre or post training were excluded, as the study aim was to investigate understanding of current students.

#### 2.2.4 Participant characteristics

This study recruited nine participants, each interviewed once. Demographic details of participants are detailed in Table 2.2 (below).

Table 2.2: Participant demographic information

Participant <sup>†</sup>	Age	Gender	Ethnic Group	Year of Study
Jade	n.s. <sup>‡</sup>	n.s. <sup>‡</sup>	White	1
Phoebe	26-29	Female	White	2
Sally	22-25	Female	White	2
Leah	18-21	Female	White	2
Courtney	26-29	Female	White	2
John	26-29	Male	White	3
Sarah	18-21	Female	Mixed	3
Joe	n.s. <sup>‡</sup>	n.s. <sup>‡</sup>	White	3
Lauren	18-21	Female	White	3

<sup>†</sup> Pseudonyms used to protect participant confidentiality, <sup>‡</sup> n.s. – not stated

Of participants who answered demographic questions, the age range was 18-29 ( $M_{age}$  = 23.5 years). Six participants identified as female, one as male with two not stated. Eight participants stated their ethnic group as White (English/Welsh/Scottish/Northern Irish/British) and one as Mixed (Any other Mixed/Multiple ethnic background). All participants were UK citizens. One participant was in first year, four in second and four

<sup>13</sup> Eighteen is the minimum age necessary to access training

were in their third year of training. No participants refused to participate or dropped out. The researcher briefly met three participants on clinical training placements.

### **2.2.5 Materials**

An interview guide with several broad, open-ended questions gathered from review of the literature was used to collect data (Appendix H). The interview guide was not prescriptive and was adapted to follow leads in the data in line with CGT methodology (Charmaz, 2006; 2014). The final interview guide contained additional questions investigating leads (Appendix I).

### **2.2.6 Method of Data Collection**

Data collection took place via face-to-face individual interviews with the researcher and participant in a private room at university between July 2019 and March 2020. Interviews were audio recorded to enable transcription of data for analysis. Interview length ranged from 22 to 55 minutes. ( $M = 35$  minutes). Following each interview, the researcher recorded initial thoughts and feelings in a reflexive journal in line with CGT (Charmaz, 2006; 2014). Following verbatim transcription, transcripts were returned to participants for comment or correction. No participants suggested changes.

### **2.2.7 Ethical Considerations**

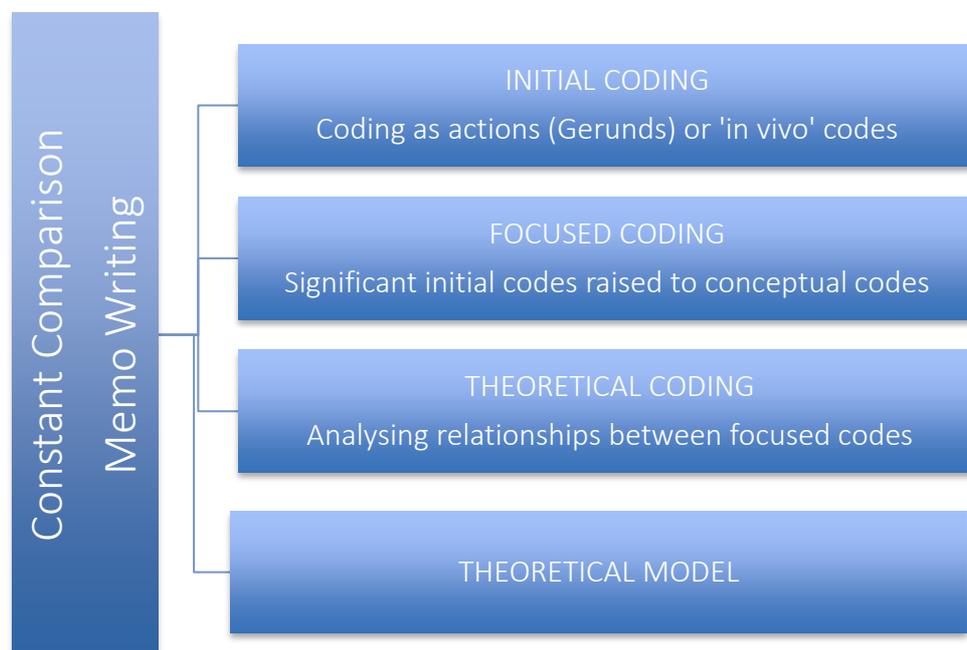
In order to address informed consent issues, participants were given a Participant Information Sheet ([PIS], Appendix G). The researcher familiarised herself with university safeguarding policies. Participants completed an Informed Consent form (Appendix J) and chose a pseudonym. Written consent was given for audio recording.

Participants were provided with a debrief sheet at each interview (Appendix K). During transcription identifiable information was removed. Ethical approval was sought and gained from Coventry University Ethics (Appendix L). Other codes guiding research were from the BPS and Coventry University (BPS, 2010; BPS, 2008; Coventry University, 2018).

### 2.2.8 Method of Data Analysis

CGT (Charmaz 2006; 2014) analysis was employed. The stages of CGT are presented in Figure 2.1. Although presented linearly, stages of CGT overlap and can be revisited, with constant comparison and memo writing present throughout analysis.

Figure 2.1: Stages of CGT



Following transcription, initial coding took place (see Appendix N for example codes and process). Transcripts were coded line-by-line using actions (Gerunds) and 'in vivo'

codes<sup>14</sup>. Transcript one was coded in parallel with a supervisor to assess subjectivity and support credibility of findings.

Following initial coding, focused coding raised the most frequent or significant initial codes and developed conceptual codes for greater amounts of data (see Appendix O for an example). Focused coding can inform topics needing more attention (Charmaz, 2014). Following focused coding, theoretical coding was utilised to hypothesise relationships between focused codes and steer coding towards a theory (Appendix P).

Coding in CGT is necessarily emergent (Charmaz, 2008) and constant comparative analysis was used. Throughout analysis, memos<sup>15</sup> were written (Appendix Q). Analysis was contemporaneous with data collection through theoretical sampling. Following coding, theoretical sorting, integrating of memos, and alongside researcher reflexivity, a theoretical model was constructed.

### 2.2.9 Reflexivity

The researcher's reflexivity was monitored through CGT memo-writing process, a bracketing interview and discussion with supervisors. Further details of reflexivity are described in Appendix R. Analysis is reported in line with Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007; Appendix S) as specified in *Journal of Clinical Nursing* author guidance (Appendix F). Qualitative reporting guidance can strengthen the standard of qualitative nursing research (Hale &

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<sup>14</sup> 'In vivo' codes are when participants' language is preserved.

<sup>15</sup> Memos are informal written notes about data, codes, categories and theories and form the 'core' of grounded theory (Charmaz, 2006).

Griffiths, 2015) to facilitate greater contributions to individual and population health (Smith et al., 2017).

### 2.3 Findings

The aim of this study was to determine how MHNSs understand compassion. A theoretical model with the core concept 'Connecting' was constructed through analysis of data in line with CGT (Charmaz, 2006; 2014). The theoretical model (Figure 2.2) will be described, followed by a detailed description of the codes, categories and the core concept contributing to the model (Figure 2.3). All participants contributed to categories (Appendix T). Verbatim quotations are used to illustrate category development.

Figure 2.2: The theoretical model

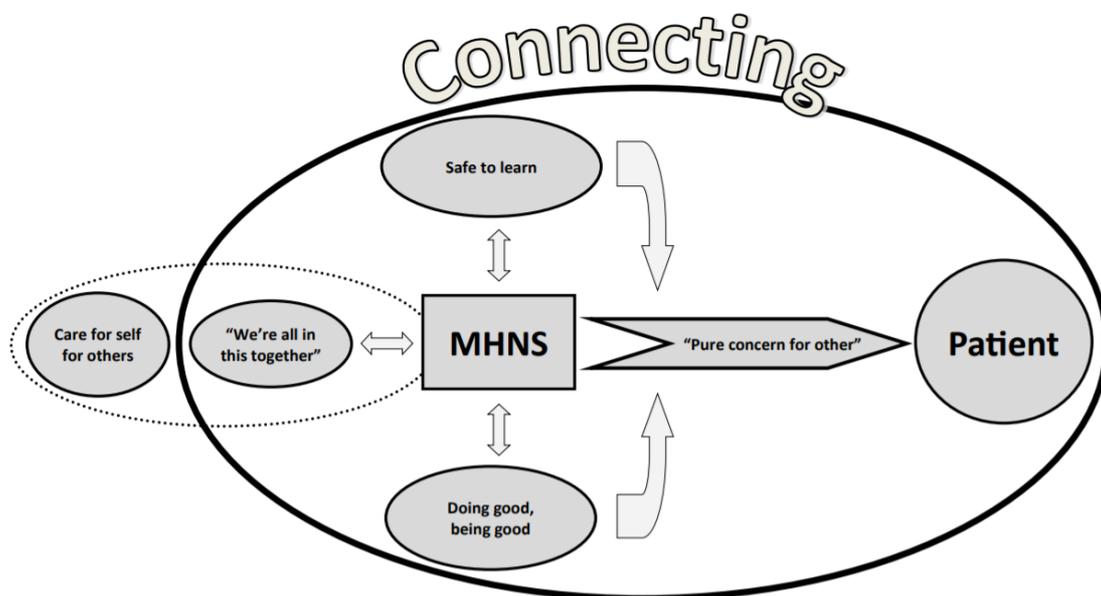
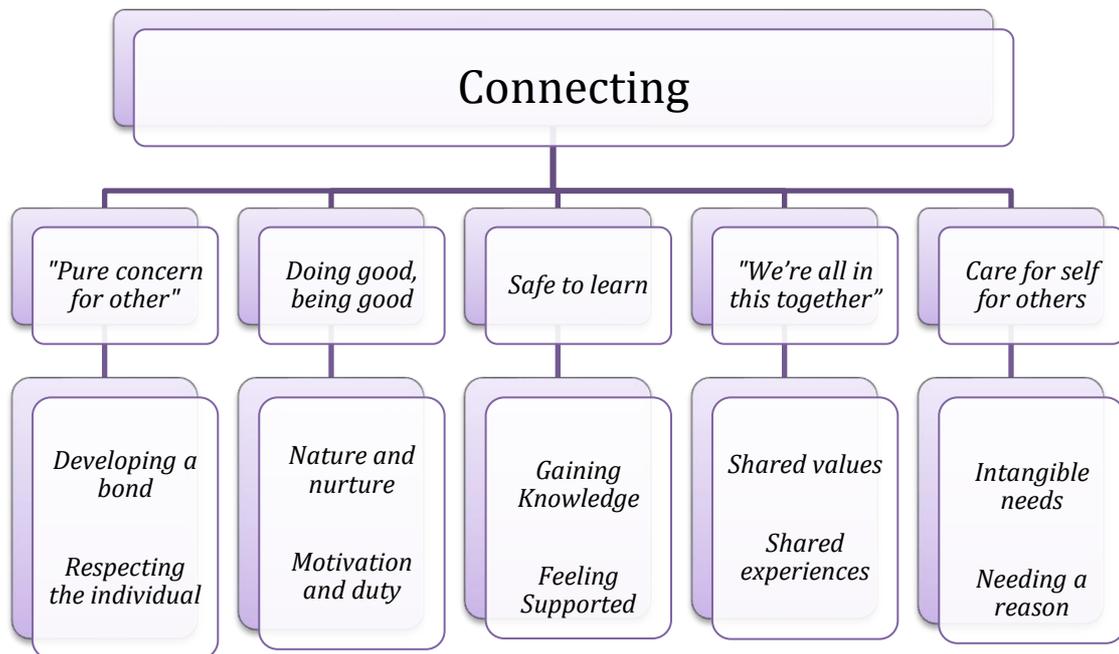


Figure 2.3: The core concept, categories and codes contributing to the construction of the final theoretical model



### 2.3.1 The theoretical model

Within the core concept ‘Connecting’ there are five categories; “Pure concern for other”; Doing good, being good; Safe to learn; “We’re all in this together” and Care for self for others.

‘Connecting’ surrounds all categories apart from Care for self for others, representing genuine connection described by participants to these areas. The most prominent connection is “Pure concern for other” signifying the importance of the relationship between the MHNS and the patient.

*Doing good, being good, Safe to learn and “We’re all in this together”* are connected to the MHNS with a bidirectional arrow. In *Doing good, being good*, the bidirectional

relationship signifies how values influenced participants' choice of course and role, and how the role motivates and fulfils their value base, connecting them with their values. In *Safe to learn*, the bidirectional arrow represents how most participants seek safety and learning from training and how feeling safe and learning motivated participants to stay connected to the course. The bidirectional arrow between MHNS and "*We're all in this together*" represents the seamless reciprocal relationship between peers described by all but one participant. *Doing good, being good* and *Safe to learn* have an additional arrow feeding into "*Pure concern for other*" as these connections strengthen the MHNS-patient relationship.

*Care for self for others* sits inside and outside the boundary as connecting is conditional and limited. *Care for self for others* is linked to the MHNS with a dotted line to show the indirect relationship, described by all participants, which is primarily focused on the patient rather than MHNSs genuinely connecting with themselves. Ten codes and five categories that contributed to and link to the core concept are described below.

### **2.3.2 Category 1: "*Pure concern for other*"**

Table 2.3 shows coding resulting in development of the category "pure concern for other". Participants were asked to share their understanding of 'compassion', which was primarily described as a sense of connecting with their patient(s) through developing a bond and respecting each individual patient. The category "*pure concern for other*" links to the core concept of 'connecting' throughout participants' accounts and is related to connecting with a patient.

Table 2.3: Category 1: “Pure concern for other”

Category	
<i>“Pure concern for other”</i>	
Codes	
<i>Developing a bond</i>	<i>Respecting the individual</i>

*Developing a bond*

Developing a bond with patients consisted of having a caring attitude, being genuinely interested and seeing patients as deserving of compassion. There was a clear distinction made between surface-level and genuinely connecting with patients. Surface-level connecting was defined as connecting with an absence of emotions, because of self-interest or for a transaction. Genuinely connecting involved empathy and care for the other person and the ability to focus completely on their needs, as described by Joe:

*“I guess that genuinely caring is not caring because it’s interesting or because it’s sort of, is the thing that you relate to necessarily but just, and I’m sure it’s rare, but that sort of undiluted just interest on behalf of someone else, pure concern for other.” (Joe, p. 1)*

Participants discussed the social nature of working with patients and the importance of building a relationship. Participants described how the deepening of this relationship is important in order to provide care, as suggested by Leah:

*“So you need to sort of get to know somebody first and then dig deeper in what you think they need and then don’t just go off that, talk to them and say, right,*

*to me it seems that you feel this or feel that and then develop that therapeutic relationship to try to provide them with that” (Leah, p. 1)*

Participants highlighted how it was easier to form effective bonds with some patients compared with others. This had an impact on the amount of compassion given to patients but did not stop them from being caring to everyone:

*“I don’t think for one second if you don’t have a natural click with someone that you won’t care for them in the way that you should, it’s just the whole therapeutic relationship thing probably isn’t as strong as you have with some other patients; but yeah, I guess you’d have more compassion for those that you had a sort of like bond with than those that you don’t.” (John, p. 5)*

Some participants appeared hesitant to state some people need more compassion than others. The specific groups mentioned needing more were those with a diagnosis of Personality Disorder, Dementia, Eating Disorders, those with limited support networks or those newly admitted to inpatient settings.

#### *Respecting the individual*

Participants stated compassion would look different for everyone as each person has different histories and needs. Identifying individual factors can influence how participants care for their patients:

*“Everyone’s got an individual history, individual behaviours, and it’s getting to know the person, getting to know their, like, their personality traits, what they’ve been through, how their illness presents and that kind of thing that can then influence how we care for them”* (Sally, p. 4)

The idea of individualised care links to NMC Code standards of treating people as individuals and responding to their preferences (NMC, 2018d). Recognising past and present experiences and behaviour links to psychological formulation used in mental health services (Johnson, 2018). Participants thought they may need to think more deeply about their patients than those working in physical health settings:

*“Because I do mental health nursing so it’s different in that it’s not looking at someone and saying, “right, your leg is broken” or “you’ve got a bruise” or whatever else, it’s a bit deeper than that.”* (Leah, p. 1)

Participants felt compassion was demonstrated in being collaborative with patients and *“being on their level”* (Jade, p. 1). Participants highlighted the importance of respecting individual patients’ choices and perspectives through recognising others may have different views to themselves. Participants recognised the need for MHNSs to have capacity to suspend their own views to respect individual patients. Some participants described failure to suspend personal perspectives was a barrier to connecting with the patient and demonstrating compassion:

*“Urm, that inability when everything stops going well to take it completely un-personally, to remove themselves from it and focus on the other person and trying to get an understanding of them [...] At that swearsy, hostile moment, they can’t just step outside of the person, and I think that completely stops people being compassionate.” (Joe, p. 4)*

### 2.3.3 Category 2: *Doing good, being good*

Analysis of the data pointed to participants’ views that compassion is ‘good’ for humans, especially MHNSs. Table 2.4 displays the codes that build this category. In continuing to discuss compassion, participants shared their views of the inherent nature of compassion alongside the importance of early nurturance from key caregivers. Data demonstrated how motivation and duty were important for participants. Participants were motivated to demonstrate compassion and in doing so they were connecting with their personal and professional values. Showing compassion was also recognised by some as being their ‘duty’ as a MHNS.

Table 2.4: Category 2: *Doing good, being good*.

Category	
<i>Doing good, being good</i>	
Codes	
<i>Nature and nurture</i>	<i>Motivation and duty</i>

#### *Nature and nurture*

There were conflicts in the data about whether compassion is innate, whether it is a result of early relational experiences or a combination of both. Some participants held the same conflict within themselves, questioning the origins of compassion:

*“I think everyone has compassion, I don’t think, I think it’s like different extents of it. [...] I feel like some people have just kind of like this, like, inner care that they just feel the need to make sure everyone’s ok. I think it’s just how you’re raised or maybe it’s just who you are?” (Sarah, p. 4)*

Participants understood compassion as something that cannot be taught as an adult but can be developed in adulthood. In order for compassion to be developed, adults needed to have capacity to be compassionate.

#### *Motivation and duty*

A commonality in all participants’ accounts was that compassion was ‘good’. The word ‘good’ had a number of meanings throughout the data. For some, it was linked to a moral virtue and to a concept of social good:

*“So yeah, maybe being proud of yourself and knowing you are being a good person. Hoping that you being a good person can reflect on other people, hopefully.” (Courtney, p. 4).*

Connection with these values enabled participants to feel ‘good’ about themselves. The quotation above names pride however many other participants struggled to name emotions, instead stating compassion made them feel ‘good’ which motivated further compassion.

Compassion was seen as a part of human nature or “*human instinct*” (John, p. 2) and failing to be compassionate generated a feeling of having “*failed as a human*” (Leah, p. 3). This suggests negative motivation away from failure as well as positive motivation towards feeling, doing and being ‘good’. Participants discussed motivation towards their job role. Participants described being motivated to train as a Mental Health Nurse and continue as a MHNS, citing the essence of the role is to connect and be compassionate to others. John suggested removing compassion from the MHNS role would eliminate the reason this vocation was chosen:

*“If you took compassion out of it, it would be like a factory wouldn’t it? It would just be a process. [...] If you took compassion out of care, there’d be no point in doing healthcare, you may as well go and work in a factory doing a step by step process.”* (John, p. 7)

Alongside a human duty and motivation for compassion, participants discussed compassion was part of the ‘duty’ of being a MHNS. Repeated statements in the data related to compassion as doing what you are “*supposed to*” (Joe, p. 7) or “*have to*” (Sally, p. 2.) Participants felt giving compassion was part of the duty of a MHNS and the duty of being a social being:

*“With compassion at work, it, it’s sort of like you’re doing, doing it because you know it’s what you’re supposed to do. You’re also doing it because, it’s hard, it’s like, a bit like they’re your family member.”* (Leah, p. 3)

### 2.3.5 Category 3: *Safe to learn*

Compassion was able to flourish and develop when participants were given opportunities for gaining knowledge they could connect with real patients and when they felt supported and connected with team members, especially mentors<sup>16</sup>. Table 2.5 shows the codes contributing to the category ‘Safe to learn’.

Table 2.5: Category 3: *Safe to learn*

Category	
<i>Safe to learn</i>	
Codes	
<i>Gaining knowledge</i>	<i>Feeling supported</i>

#### *Gaining knowledge*

Participants felt they came on training with compassion but learning about mental health issues and hearing patient stories helped compassion develop further. Data suggested participants’ practice placement experiences enabled the greatest gain in knowledge of compassion. Participants reported a connection with patient stories and connection with their own responses to patient suffering, as articulated by Leah:

*“Urm, yeah, probably just more placements. More practical experiences, meeting new people and hearing their stories and seeing what difficulties they have and thinking about how I’d feel if it was me and things like that. A lot of it is practical based, like urm, you can’t be taught how to be compassionate.”*

(Leah, p. 13)

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<sup>16</sup> Nursing standards (NMC, 2018a) have replaced the nurse mentor role with ‘practice assessors’ and ‘practice supervisors’. The term ‘mentor’ will be used to describe these roles.

Some participants discussed how having more placements enabled them to develop confidence in connecting with patients:

*“Your confidence increases the more placements you do, the more individuals you work with, maybe like your confidence in portraying your compassion to others, urm, I think just going that little bit further in being compassionate to people because you feel more confident...”* (Courtney, p. 9)

### *Feeling supported*

Data led to the importance of feeling supported by team members. Support was described as receiving compassion from and having a connection with team members. Feeling supported was needed in order to survive difficult placement experiences:

*“They’d just talk to me and say, “I’m here for you.” [...] I think if I didn’t have that I honestly would have really struggled. It was a difficult placement. And I really enjoyed it in the end because of the constant support of the staff. If I weren’t to have that I really would have buckled I think.”* (Leah, p. 10)

When participants felt safe and supported by their team, they could learn. Providing safe environments was especially important for the role of mentor. Negative mentor experiences were smaller in number than positive experiences. Negative experiences happened when participants felt scrutinised, smothered or accused. Feeling unsupported by a mentor impacted negatively on participants’ ability to continue with

the course. Participants had to focus on connecting with patients in order to continue training:

*“That can determine if you want to do the course. You wanna do the course because you’re not there for them [the mentor], you’re there for the patients who need ya and that’s what keeps you carrying on.” (Lauren, p. 11)*

When mentors connected to participants’ experiences of training and demonstrated compassion towards MHNSs and patients, this promoted a sense of belongingness and safety in participants. Further helpful mentor qualities were paying attention to others, respecting individual needs, being non-judgmental and trying to help, as described by Courtney:

*“All of my mentors, yeah, they’ve all been really good. Urm, in terms of just recognising that things might be a little difficult for me or I’m, I don’t know certain things and explained it in a really friendly manner and never expressed that I should know these sort of things, their understanding, yeah, I think to me and urm, demonstrating compassion in front of me, I think that massively made the difference, yeah” (Courtney, p. 11)*

These qualities were closely aligned with the qualities between participants and patients.

#### Category 4: *“We’re all in this together”*

Data suggested the majority of participants felt strongly connected to their peers through a perception of shared values and shared experiences. Table 2.6 shows codes used to build the category *“We’re all in this together”*.

Table 2.6: Category 4: *“We’re all in this together”*

Category	
<i>“We’re all in this together”</i>	
Codes	
<i>Shared values</i>	<i>Shared experiences</i>

#### *Shared values*

Data suggested that most participants saw their peers as being similar to themselves in respect of having similar personalities and values:

*“I think mental health nursing students they all sort of have a type of personality, and I think they have a lot of similar values, they might not all have the same ones, but have similar core ones where they want to make a difference. And compassion I, is as a by-product of those.” (Phoebe, p. 11)*

Participants, when discussing their peers, described themselves as having an equal level of compassion when compared to other MHNSs in their cohort:

*“I’d like to think all of the people that I sort of know in my cohort are compassionate [...] I’d like to think we’re all, pretty much on the same level in terms of compassion.” (Courtney, p. 7)*

Data suggested most participants described themselves as a connected unit with shared values and this enabled comparisons between themselves and other staff groups. Nearly all participants thought MHNSs valued skills in observing people, being studious and keen to work hard. Many participants made comparisons between MHNSs values and staff who had been working for a long time. Some participants saw themselves as having more compassion than some longer-standing staff:

*“I have noticed, like, I think nursing students are more compassionate than people who have been there a long time.” (Sarah, p. 7)*

#### *Shared experiences*

The sense of connection was strengthened through shared experiences in training. This included a sense that peers were an ‘us’ group and non-cohort members were a ‘them’ group:

*“We’ve all had it where people have come in and are like, “Are you done yet? Are you finished working? And you just wanna scream and it’s only people that are in it and can understand it and can help you and actually feel compassion towards the fact that you’re in a bit of a black hole with it.” (Phoebe, p. 5)*

This quotation highlights the themes of suffering and compassion, which have appeared in compassion definitions such as those by His Holiness the Dalai Lama (Dalai Lama, 2001). Data suggested training was conceptualised as a challenge, which

appeared to activate a sense of threat in participants. This threat appeared modified by a view of being ‘all in the same boat’.

The relationship between peers when described by participants, was labelled as reciprocal, with members of the group taking equal turns to show compassion and support each other in a non-transactional manner. The sense of connection derived from sharing values, experiences and supporting each other as a group made participants feel better and stronger as individuals.

### 2.3.6 Category 5: *Care for self for others*

All but one participant struggled to discuss compassion when directed towards the self, asking for clarification about what was meant by ‘self-compassion’. This was markedly different from the fluency with which they discussed compassion to others. Table 2.7 shows coding leading to the category *Care for self for others*.

Table 2.7: Category 5: *Care for self for others*

Category	
<i>Care for self for others</i>	
Codes	
<i>Intangible needs</i>	<i>Needing a reason</i>

#### *Intangible needs*

Participants found it difficult to describe compassion towards the self, with some appearing perplexed and others avoiding the topic. Participants described forgetting to think of themselves, describing their personal needs as secondary to patients. Some participants used humour to describe what self-compassion might be:

*“Self-care and all that malarkey that we throw around these days!”*

(Phoebe, p. 7)

Using humour appeared to be a strategy to distract from feeling guilty about thinking about themselves rather than their patients. The humour seemed like a barrier to connecting to their own needs. When given permission in the interview to think about themselves, data showed participants noted difficulties in describing their own emotions:

*“It’s difficult to voice your feelings sort of thing. That’s very difficult urm, I dunno. You just get on with it, don’t ya? You just, yeah, that’s the only way because yeah, I apologise but it’s very hard to word your feelings, sort of thing.*

(John, p. 10)

Another barrier to self-compassion and connecting with their own needs was the view that compassion is limited or finite. When describing self-compassion, all but one participant used language to imply self-compassion should be limited, such as *“be a little bit compassionate”* (Sally, p. 12); *“You can be compassionate to yourself but that can only go so far”* (Phoebe, p. 7). Data was filled with information about amounts of compassion and the discrepancy between compassion given to patients compared with what is left for themselves:

*“You’re doing such long shifts where you put so much compassion into other people its difficult to go home and then say, ‘it’s time to be compassionate to myself now’.” (Sally, p. 12).*

### *Needing a reason*

During interviews, most participants began to recognise ways they could be compassionate towards themselves, such as recognising difficulties, being kind, self-praise and gratitude. Participants demonstrated self-compassion only when a specific need was highlighted:

*“I think there has to be a need to be compassionate. You can only, if you continue to be compassionate to yourself all the time there is no need. There has to be a reason. I never knew I felt like that but there has to be a reason! It feels like there needs to be like, a cause to be compassionate.” (Phoebe, p. 8)*

The main reason for being self-compassionate was driven by connection with the patient. Participants appeared to give themselves permission for self-compassion if it would be beneficial to the patient. Participants described caring for themselves in order to care indirectly for their patient, as this quotation demonstrates:

*“I’m doing a long shift which is all about helping other people, urm and at the end of the day you have to remember to be a little bit compassionate to yourself in order to then be strong for the next long day of offering compassion to other people.” (Sally, p. 12)*

## 2.4 Discussion

The aim of this study was to explore how MHNSs understand compassion. Data from nine interviews with MHNSs was analysed in accordance with CGT Charmaz (2006; 2014). A theoretical model with the core concept '*Connecting*' was constructed. Within the core concept '*Connecting*' there are five categories; "*Pure concern for other*"; *Doing good, being good*; *Safe to learn*; "*We're all in this together*" and *Care for self for others*.

### 2.4.1 "*Pure concern for other*"

The importance of MHNSs '*developing a bond*' with a patient aligns with descriptions of compassionate care as an interpersonal and relational process (Dewar et al., 2014). The initial focus of participants was the patient. This falls in line with NMC Code of Practice (NMC, 2018d), in which the first standard is to 'prioritise people' meaning to, "put the interests of people using or needing nursing or midwifery services first" (NMC, 2018d, p. 6). The category aligns with historical nursing perspectives, which remain consistent to the present day (Bradshaw, 2011). The theme '*respecting the individual*' encompassed being able to recognise another person's thoughts as different from ones own, namely having Theory of Mind<sup>17</sup> (ToM; Premack & Woodruff, 1978). Preckel et al. (2018) suggest ToM, compassion<sup>18</sup> and empathy work together to support prosocial helping behaviour in complex social situations.

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<sup>17</sup> Theory of Mind (ToM) is the concept that you can have cognitive understanding of others' thoughts or emotions and see them as distinct from your own

<sup>18</sup> Compassion is defined in their study as feeling concern for another

Codes in this category align with categories in Sinclair et al.'s (2018) Straussian grounded theory study with healthcare providers. Sinclair et al. (2018) recruited 57 healthcare providers to gather their understandings and experiences of compassion. A Healthcare Provider Compassion Model<sup>[11]</sup> with five categories was created. Although no participants were MNHSs, the category 'Coming to know the person' from Sinclair et al. (2018) is similar to the code '*developing a bond*'. The theme 'accepting the person where they are at' from Sinclair et al. (2018) reflects the code '*respecting the individual*'.

Participants in this study suggested more compassion was needed for patients with particular diagnoses such as personality disorders, Dementia or eating disorders. Relational difficulties are part of the criteria for personality disorder diagnoses (American Psychiatric Association, 2013). Interventions such as Dialectical Behavioural Therapy ([DBT], Linehan, 1993) focus on improving interpersonal skills. People with personality disorders also have deficits in self-compassion (Naismith et al., 2019). Shame and self-criticism are recognised difficulties for people with eating disorders (Goss & Allan, 2014). CFT (Gilbert, 2010) aims to develop affiliative motives (connecting) and compassion and is effective for people with eating disorders (Gale et al., 2014). People with relational and self-compassion deficits may need more compassion through connecting with MNHSs.

The need for greater compassion through connection for people with Dementia aligns with Bickford et al.'s (2018) thematic analysis. The study with medical and nursing students caring for people with Dementia highlighted connection as both a theme to

describe compassion and a barrier or facilitator in compassion. Participants in the current study described people needing more compassion in positive terms and were motivated towards connecting. This contrasts previous research where patients with complex needs were described as challenging (Bos et al., 2012) and mental health needs were seen as a barrier to compassion (Hunter et al., 2018).

#### **2.4.2 *Doing good, being good.***

The category '*nature and nurture*' fits with previous research purporting compassion as mutually innate *and* amenable to learning or enhancement (Fotaki, 2015; Lown, 2015; Bray et al., 2014). Durkin et al. (2019) suggested a larger nature/nurture divide, with some who felt compassion could be taught, and those who felt compassion came naturally. Bradshaw (2009) suggests compassion is a virtue that nurses can access when needed.

The category '*motivation and duty*' is suggestive of compassion satisfaction (Phelps et al., 2009) where gratification is received from caregiving. Compassion was described as a moral virtue, which links with von Dietze and Orb's (2000) description of compassion as an essential moral virtue in nursing. Compassion was described as a social good, meaning a service to achieving human wellbeing (Mor Barak, 2018). Evolutionarily, creating happiness for others is often rewarding (Gilbert, 1984) and this was reflected in study outcomes. 'Good' feelings associated with connecting and being compassionate further motivated MHNSs. Caramanzana's (2020) phenomenological study of connection between patients and nurses discovered connecting influences motivation, "In a profession that is challenging, both physically and emotionally,

forming connections with patients sustains the passion to help and care about other human beings” (Caramanzana, 2020, p. 27). ‘Duty’ statements in the data related to compassion as doing what you’re ‘meant to’ linking with the Nursing Code (NMC, 2018d) that nurses have a duty of care to their patients.

### **2.4.3 Safe to learn**

The importance of placement learning as described in ‘*gaining knowledge*’ is echoed in Caramanzana (2020). Millennial nurses reported learning through simulation or in practice enabled gaining knowledge about caring connections. The code ‘*gaining knowledge*’ also encompassed the impact of gaining confidence. Trained nurses are expected to be self-confident and assertive to advocate for patients (Brown & Chronister, 2009) so development of confidence in MHNSs is important for post-qualification practice in delivering compassionate care. Ledoux et al. (2018) reported a positive relationship between psychological empowerment and nurse compassion, with more confident nurses capable of providing more compassionate care.

The code ‘*feeling supported*’ related especially to the nurse mentor role. Lack of support from mentors is strongly related to student nurse attrition (ten Hoeve et al., 2017). The nurse mentor has an important part to play in role modeling and cultivating belongingness (Vinales, 2015). When MHNSs felt safe, they were able to learn and develop compassion. Scully (2011) reported a good relationship between nursing student and mentor facilitates integration of theory and practice. Andrews et al.’s (2020) CGT study with nurses reported feeling safe and secure facilitated nurses’ ability to be self-caring and self-compassionate. The category ‘*safe to learn*’ aligns with the

concept '*Needing a stable base*' from Andrews et al. (2020). Andrews et al.'s (2020) focus was self-compassion. The category '*safe to learn*' fits with Bray et al. (2014), who reported healthcare professionals and pre-registration students cite clinical placements, mentors and role models as significantly influencing compassion development.

#### **2.4.4 "*We're all in this together*"**

Data in this study led to the code '*shared experiences*' where participants described coping with MHNS challenges through connecting with peers. MHNSs saw themselves as 'in the same boat' as course peers. Being 'in the same boat' or having interdependence of fate as described by Lewin (1948) is a common group process, especially whilst threatened. Nursing students experience a high level of stress (Reeve et al., 2013) and students studied in Reeve et al. (2013) were most likely to use fellow nursing students as support in times of stress. Activating affiliative motives through connecting with peers makes sense in the context of CFT (Gilbert, 2010) where threat can be tempered by activating the soothing/safety system through connection with non-threatening others.

#### **2.4.5 *Care for self for others***

Describing self-compassion was difficult for participants. Having difficulties describing self-compassion is common in nursing (Andrews et al., 2020). Spending time talking about themselves appeared to activate guilt in some MHNSs, who used humour or avoidance to regulate guilt. The idea MHNSs should prioritise their needs was uncomfortable. Participants described their needs as secondary to patients, a view

likely reinforced by NMC Code (NMC, 2018d). Participants struggled to describe self-compassion or self-care needs. There appeared a difficulty in balancing their own needs alongside needs of their patients. The code '*intangible needs*' incorporates how participants struggled with alexithymia. Emotional intelligence has been positively related to self-compassion in quantitative studies of nurses and nursing students (Heffernan et al., 2010; Senyuva et al., 2013). Developing emotional intelligence may be helpful for developing self-compassion in MHNSs.

Andrews et al.'s (2020) CGT study reported nurses need permission from themselves or others for self-care and self-compassion. Self-permission was given in the current study if self-compassion would benefit patients. Self-care and self-compassion appeared limited. The role of nursing student provides a 'safety net' for wellbeing (Michalec et al., 2013), perhaps rendering self-compassion less necessary. Nurse training has been described as the 'calm before the storm' (Michalec et al., 2013). Most nursing students think burnout is inevitable following qualification (Michalec et al., 2013). Transition from student to professional nurse is particularly difficult in terms of burnout and compassion fatigue (Duchscher, 2009; Laschinger et al., 2009). Self-compassion is important for qualified nurses, as it is protective against burnout (Durkin et al. 2016). Developing self-compassion and self-care skills on training would be helpful for MHNSs following qualification.

#### **2.4.6 Connecting**

The concept of '*connecting*' aligns with much research in compassion and nursing. Connecting is one of the 'seven C's of caring conversations' (Dewar & Nolan, 2013),

developed to improve compassionate care. Connection was deemed a characteristic of a compassionate nurse in two recent reviews (Durkin et al., 2019; Durkin et al. 2018). In line with this study, connecting with patient stories was cited as a way nursing students can learn about compassion (Durkin et al., 2019). MHNSs' overall experience of connecting fits with Taylor's (2009) study of student nurses. Taylor (2009) developed a 'connections continuum' reporting nursing students connecting across a range of areas had a more positive experience and were more likely to finish training than those less connected. Nursing students who feel better connected are more able to demonstrate compassion to others (Adam & Taylor, 2014; Jones et al., 2016). Connecting is often an element of nursing compassion research, whereas in this study, connecting was the core concept.

The concept of connecting is closely aligned with attachment theory (Bowlby, 1979). Mental health problems are likely to stimulate attachment behaviour due to the threat to internal and external safety (Adshead, 1998). Mental health professionals may be acting as temporary attachment figures where connecting facilitates secure attachment. Attachment behaviour can be modified by supportive interpersonal experiences (Fonagy et al., 1996). So, connecting is likely to support patients' recovery. Boniwell et al. (2015) suggested qualified mental health nurses lacked understanding of attachment theory and suggested training is warranted.

Connecting in this study's data was seen as positive and facilitating. A lack of connecting with patients due to institutional conflict leads to 'moral distress' in nurses (Jameton, 1984; Lee, 2015). However, an inability to disconnect from work and

patients was seen in accounts of qualified nurses experience of compassion fatigue (Shepphard, 2015). Therefore, connecting may result in negative effects for some qualified nurses. More research is needed to gather information about levels of connecting needed or if the model can be applied to qualified mental health nurses.

#### **2.4.7 Clinical Implications**

The model has practice implications for MHNS recruitment and training. Values-based recruitment should continue to recruit MNHSs who meet NHS values (Department of Health and Social Care, 2015), specifically the value of compassion. The theoretical model suggests the NHS values 'working together for patients' and 'respect and dignity' are integral parts of compassion. Recruitment should focus on assessing potential students' ability to connect with patients, their personal and nursing values, fellow students, mentors and themselves. The model could offer insights into areas of connecting needed for MNHSs' compassion development.

MNHS training should increase opportunities for placements to ensure chances for connecting with patients and gaining knowledge by ensuring MNHSs maintain supernumerary status. A review of the balance of theory and practice learning could be undertaken. Specific training normalising the increased need for connecting with patient groups mentioned by participants would be helpful. Practice supervisor and assessor training should continue to encourage connection with MNHSs as the model suggests this is crucial in helping MNHSs feel safe to learn and continue training.

Training courses should give opportunities for MHNSs to connect with their cohort, perhaps offering group supervision or reflective practice groups to enable discussion of shared experiences. Schwartz Rounds may be useful, if effort is made to promote safe sharing as Rounds can promote connectedness within teams for healthcare students (Clancy et al., 2020). Evidence for online and digital-based reflective learning for teaching compassion did not convincingly demonstrate effectiveness in Durkin et al.'s (2018) review. The long-term plan proposes an online nursing degree from 2020 (NHS Improvement, 2019). This study suggests online teaching would need to ensure opportunities for connecting in all five areas.

Supervision or reflective practice may aid MHNSs to make tangible and connect with their own needs. Education for MHNSs on reasons for developing self-compassion and emotional intelligence would support permission to be self-compassionate, reducing the likelihood of future burnout. Personal reflection was considered an effective way of developing self-awareness in Durkin et al.'s (2019) thematic analysis with nurses, students, educators and service users. MHNSs could be asked about how connected they feel during regular appraisal meetings and difficulties discussed and supported. This study suggests compassion is a relational construct rather than an individual entity; a view that needs to be incorporated in future compassion measurement and training.

Newly qualified nurses in the UK find the transition from student to qualified nurse stressful, with the majority of nurses experiencing frustration and some level of burnout within two years of qualification. The source of stress can be partly attributed to a perceived lack of support from others compared to training (Higgins et al., 2010;

Lavoie-Tremblay et al., 2008). This model suggests extending opportunities for newly qualified nurses to connect with their peers and colleagues would be helpful. This recommendation is in line with previous research suggesting newly qualified nurses require high-quality collegial working relationships to remain in work and prevent burnout (Laschinger et al., 2009; Elias & Day, 2020; van Rooyen et al., 2018). The structure of support may include mentoring, supervision or reflective practice. Connecting between newly qualified and more qualified staff through mentoring can foster supportive workforces and aid nurse retention (Zhang et al., 2016; 2019). A review of clinical supervision in nursing reported peer support and stress relief for nurses (Brunero & Stein-Parbury, 2008). Reflective practice groups in mental health settings is deemed valuable and can yield emotional benefits (Fenton & Kidd, 2019). Based on this model, support for newly qualified nurses is likely to support transition and reduce burnout and attrition, a key area for NHS workforce policy (Beech et al., 2019).

#### **2.4.8 Limitations**

The sample was representative of UK mental health nursing in terms of ethnicity and gender (National Audit Office, 2019). Interviewing participants from different ethnic backgrounds and from different home countries would improve transferability. Only one student from year one participated, reducing the ability of the model to be applied to first year students. The initial purposive sampling method may have introduced selection bias leading to only MHNSs who held strong views about compassion volunteering for the study. For the present study, informed consent was prioritised over this potential source of bias. The analytic method was new to the researcher and

so supervision was sought throughout analysis to improve robustness. There was no objective observational data to validate findings, which may be helpful as compassion was deemed a relational concept.

#### **2.4.9 Research Implications**

This study could be replicated with MHNSs from different ethnic groups, international students and other nursing specialities. It would be helpful to understand how understanding of compassion develops from prior training to post qualification. It would be helpful to review the current nature of compassion teaching on mental health nursing courses by completing an environmental scan. This would enable evaluation of future changes and audit against current best practice. The addition of observational studies would offer an objective perspective on connecting between MHNSs and patients, peers and mentors. It would be helpful to develop a measure based on connecting to monitor MNHSS' compassion development.

### **2.5 Conclusion**

This study is novel in constructing a theoretical model of how MHNSs understand compassion. Compassion is understood as an interrelated set of areas, namely *"Pure concern for other"; Doing good, being good; Safe to learn; "We're all in this together"* and *Care for self for others* leading to a core concept of *'Connecting'*. For MHNSs, compassion involves primarily connecting with their patients but also connecting with their personal and professional values, their course and mentors, their cohort and tentatively with themselves.

## 2.6 References

- Adam, D., & Taylor, R. (2014). Compassionate care: Empowering students through nurse education. *Nurse Education Today*, 34(9), 1242-1245. <https://doi.org/10.1016/j.nedt.2013.07.011>
- Adshead, G. (1998). Psychiatric staff as attachment figures: Understanding management problems in psychiatric services in the light of attachment theory. In G. Adshead & C. Jacob (Eds.) *Personality Disorder: The Definitive Reader*, 131-145. [https://books.google.co.uk/books?hl=en&lr=&id=NHaHcA8sDoUC&oi=fnd&pg=PA131&ots=CefUrvmUfH&sig=m611\\_Ax3gKAARzg\\_6l-88FolbTQ&redir\\_esc=y#v=onepage&q&f=false](https://books.google.co.uk/books?hl=en&lr=&id=NHaHcA8sDoUC&oi=fnd&pg=PA131&ots=CefUrvmUfH&sig=m611_Ax3gKAARzg_6l-88FolbTQ&redir_esc=y#v=onepage&q&f=false)
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: APA.
- Andrews, H., Tierney, S., & Seers, K. (2020). Needing permission: The experience of self-care and self-compassion in nursing: A constructivist grounded theory study. *International Journal of Nursing Studies*, 101, 103436. <https://doi.org/10.1016/j.ijnurstu.2019.103436>
- Barron, K., Deery, R., & Sloan, G. (2017). Community mental health nurses' and compassion: an interpretative approach. *Journal of psychiatric and mental health nursing*, 24(4), 211-220. <https://doi.org/10.1111/jpm.12379>
- Barton, J. (2016). *Student nurses' perceptions of compassion*. [Unpublished Doctoral Dissertation, University of Chester]. University of Chester Open Repository. <https://chesterrep.openrepository.com/handle/10034/620332>
- Beech, J., Bottery, S., Charlesworth, A., Evans, H., Gershlick, B., Hemmings, N., Imison, C., Kahtan, P., McKenna, H., Murray, R., & Palmer, W. (2019). Closing the gap: key areas for action on the health and care workforce. London, UK: Kings Fund. <https://www.kingsfund.org.uk/sites/default/files/2019-06/closing-the-gap-full-report-2019.pdf>
- Bickford, B., Daley, S., Sleater, G., Hebditch, M., & Banerjee, S. (2019). Understanding compassion for people with dementia in medical and nursing students. *BMC medical education*, 19, 1, 1-8. <https://doi.org/10.1186/s12909-019-1460-y>
- Blumer, H. (1969). *Symbolic Interactionism: Perspective and Method*. Prentice- Hall.
- Boniwell, N., Etheridge, L., Bagshaw, R., Sullivan, J., & Watt, A. (2015). Mental health nurses' perceptions of attachment style as a construct in a medium secure hospital: a thematic analysis. *The Journal of Mental Health Training, Education and Practice*, 10, 4, 218-233. <https://doi.org/10.1108/JMHTEP-01-2015-0002>

- Bos, M. V., Kool-Goudzwaard, N., Gamel, C. J., Koekkoek, B., & Van Meijel, B. (2012). The treatment of 'difficult' patients in a secure unit of a specialized psychiatric hospital: the patient's perspective. *Journal of Psychiatric and Mental Health Nursing*, 19(6), 528-535. <https://doi.org/10.1111/j.1365-2850.2011.01827.x>
- Bowlby, J. (1979). On knowing what you are not supposed to know and feeling what you are not supposed to feel. *The Canadian Journal of Psychiatry*, 24(5), 403-408. <https://doi.org/10.1177/070674377902400506>
- Bradshaw, A. (2009). Measuring nursing care and compassion: the McDonaldised nurse?. *Journal of Medical Ethics*, 35(8), 465-468. <http://dx.doi.org/10.1136/jme.2008.028530>
- Bradshaw, A. (2011). Compassion: what history teaches us. *Nursing times*, 107(19-20), 12-14. <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=ovftl&NEWS=N&AN=00006203-201105170-00003>
- Bray, L., O'Brien, M. R., Kirton, J., Zubairu, K., & Christiansen, A. (2014). The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions of health professionals and pre-registration students. *Nurse education today*, 34, 3, 480-486. <https://doi.org/10.1016/j.nedt.2013.06.017>
- British Psychological Society. (2008). *Professional Practice Guidelines*. British Psychological Society.
- British Psychological Society. (2010). *Code of human research ethics*. British Psychological Society.
- Brown, D., & Chronister, C. (2009). The effect of simulation learning on critical thinking and self-confidence when incorporated into an electrocardiogram nursing course. *Clinical Simulation in Nursing*, 5(1), e45-e52. <https://doi.org/10.1016/j.ecns.2008.11.001>
- Brunero, S., Lamont, S. & Coates, M. (2010). A review of empathy education in nursing. *Nursing Inquiry*, 17, 65– 74. <https://doi.org/10.1111/j.1440-1800.2009.00482.x>
- Brunero, S., & Stein-Parbury, J. (2008). The effectiveness of clinical supervision in nursing: an evidenced based literature review. *Australian journal of advanced nursing*, 25(3), 86 – 94. <http://hdl.handle.net/10453/12822>
- Burnell, L. & Agan, D.L. (2013). Compassionate care: can it be defined and measured? The development of the Compassionate Care Assessment Tool. *International Journal of Caring Sciences*, 6, 180–187.

- Charmaz, K. (2000). Constructivist and objectivist grounded theory. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research. (2nd ed)* (pp. 509-539). Sage.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.
- Charmaz, K. (2008). Grounded theory as an emergent method. In S. N. Hesse-Biber & P. Leavy (Eds.) *Handbook of emergent methods*, (pp. 155-172), Guildford Press.
- Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative analysis (2<sup>nd</sup> ed.)*. Sage.
- Christiansen, A., O'Brien, M. R., Kirton, J. A., Zubairu, K., & Bray, L. (2015). Delivering compassionate care: the enablers and barriers. *British Journal of Nursing*, 24(16), 833-837. <https://doi.org/10.12968/bjon.2015.24.16.833>
- Clancy, D., Mitchell, A., & Smart, C. (2020). A qualitative exploration of the experiences of students attending interprofessional Schwartz Rounds in a University context. *Journal of Interprofessional Care*, 34(3), 287-296. <https://doi.org/10.1080/13561820.2019.1692797>
- Coventry University. (2018). *Principles and Standards of Conduct on the Governance of Applied Research*. Retrieved December 21, 2019, from [https://www.coventry.ac.uk/Global/policy\\_governance\\_good\\_applied\\_research\\_conduct\\_rev0912.pdf](https://www.coventry.ac.uk/Global/policy_governance_good_applied_research_conduct_rev0912.pdf)
- Cummings, J., & Bennett, V. (2012). *Compassion in practice*. NHS Commissioning Board, Department of Health. <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>
- Dalai Lama (2001) *An Open Heart: Practising Compassion in Everyday Life*. Hodder & Stoughton.
- Department of Health. (2009). *The handbook to the NHS constitution for England*. Department of Health. Retrieved November 13, 2019, from <https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england>
- Department of Health and Social Care. (2015). The NHS Constitution for England. Retrieved March 16, 2020, from <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>
- Dewar, B., Adamson, E., Smith, S., Surfleet, J., & King, L. (2014). Clarifying misconceptions about compassionate care. *Journal of Advanced Nursing*, 70(8), 1738-1747. <https://doi.org/10.1111/jan.12322>

- Dewar, B., & Nolan, M. (2013). Caring about caring: Developing a model to implement compassionate relationship centred care in an older people care setting. *International journal of nursing studies*, 50(9), 1247-1258. <https://doi.org/10.1016/j.ijnurstu.2013.01.008>
- Duchscher, J. E. B. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of advanced nursing*, 65(5), 1103-1113. <https://doi.org/10.1111/j.1365-2648.2008.04898.x>
- Durkin, M., Beaumont, E., Martin, C. J. H., & Carson, J. (2016). A pilot study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life and wellbeing among UK community nurses. *Nurse education today*, 46, 109-114. <https://doi.org/10.1016/j.nedt.2016.08.030>
- Durkin, M., Gurbutt, R., & Carson, J. (2018). Qualities, teaching, and measurement of compassion in nursing: A systematic review. *Nurse education today*, 63, 50-58. <https://doi.org/10.1016/j.nedt.2018.01.025>
- Durkin, J., Usher, K., & Jackson, D. (2019). Embodying compassion: A systematic review of the views of nurses and patients. *Journal of clinical nursing*, 28, 9-10, 1380-1392. <https://doi.org/10.1111/jocn.14722>
- Elias, C. E., & Day, T. (2020). Experiences of Newly Qualified Nurses in Critical Care: A qualitative systematic review. *Journal of the Intensive Care Society*. <https://doi.org/10.1177/1751143720926794>
- Fenton, K., & Kidd, K. (2020). Reflective practice groups in a mental health inpatient setting. *Mental Health Practice*, 23(3). <https://doi.org/10.7748/mhp.2019.e1333>
- Fotaki, M. (2015). Why and how is compassion necessary to provide good quality healthcare? *International journal of health policy and management*, 4(4), 199. <https://doi.org/10.15171/ijhpm.2015.110>
- Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., Target, M., & Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of consulting and clinical psychology*, 64(1), 22. <https://doi.org/10.1037/0022-006X.64.1.22>
- Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary* (Vol. 947). The Stationery Office.
- Gale, C., Gilbert, P., Read, N., & Goss, K. (2014). An evaluation of the impact of introducing compassion focused therapy to a standard treatment programme

for people with eating disorders. *Clinical psychology & psychotherapy*, 21(1), 1-12. <https://doi.org/10.1002/cpp.1806>

Gardner, A., McCutcheon, H., & Fedoruk, M. (2012). Discovering constructivist grounded theory's fit and relevance to researching contemporary mental health nursing practice. *The Australian Journal of Advanced Nursing*, 30(2), 66-74. <https://search.informit.com.au/documentSummary;dn=089943908278207;res=IELAPA;type=pdf>

Gilbert, P. (2010). An introduction to compassion focused therapy in cognitive behavior therapy. *International Journal of Cognitive Therapy*, 3(2), 97-112. <https://doi.org/10.1521/ijct.2010.3.2.97>

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, 53(1), 6-41. <https://doi.org/10.1111/bjc.12043>

Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., Ceresatto, L., Duarte, J., Pinto-Gouveia, J., & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, 4, 4. <https://doi.org/10.1186/s40639-017-0033-3>

Glaser, B. G. (1978). *Theoretical sensitivity*. Sociological Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis*. Sociological Press.

Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: strategies for qualitative research*. Aldine.

Gray, D. E. (2006). *Doing research in the real world*. Sage.

Guest, G., Namey, E., Taylor, J., Eley, N., & McKenna, K. (2017). Comparing focus groups and individual interviews: findings from a randomized study. *International Journal of Social Research Methodology*, 20(6), 693-708. <https://doi.org/10.1080/13645579.2017.1281601>

Hale, C., & Griffiths, P. (2015). Ensuring the reporting quality of publications in nursing journals: A shared responsibility. *International Journal of Nursing Studies*, 52(6), 1025– 1028. <https://doi.org/10.1016/j.ijnurstu.2015.02.009>

Health Education England. (2017). *Stepping forward to 2020/21: The mental health workforce plan for England*. <http://hdl.voced.edu.au/10707/450168>

Heffernan, M., Quinn Griffin, M, T., McNulty, S. R & Fitzpatrick, J. J. (2010). Self-compassion and emotional intelligence in nurses. *International Journal of Nursing Practice*. 16, 366-373. <https://doi.org/10.1111/j.1440-172X.2010.01853.x>

- Heritage, B., Rees, C. S., & Hegney, D. G. (2018). The ProQOL-21: A revised version of the Professional Quality of Life (ProQOL) scale based on Rasch analysis. *PLoS one*, *13*, 2, e0193478. <https://doi.org/10.1371/journal.pone.0193478>
- Higgins, G., Spencer, R.L. & Kane, R. (2010) A systematic review of the experiences and perceptions of the newly qualified nurse in the United Kingdom. *Nurse Education Today*, *30*, 499–508. <https://doi.org/10.1016/j.nedt.2009.10.017>
- Hunter, D., McCallum, J., & Howes, J.D. (2018). Compassion in emergency departments. Part 1: nursing students' perspectives. *Emergency Nurse*, *26*(2), 25-30. <https://doi.org/10.7748/en.2018.e1774>
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Prentice-Hall.
- Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30-46. <https://doi.org/10.1177/0022167817722230>
- Jones, J., Winch, S., Strube, P., Mitchell, M., & Henderson, A. (2016). Delivering compassionate care in intensive care units: nurses' perceptions of enablers and barriers. *Journal of advanced nursing*, *72*(12), 3137-3146. <https://doi.org/10.1111/jan.13064>
- Kaiser, K. (2009). Protecting respondent confidentiality in qualitative research. *Qualitative health research*, *19*(11), 1632-1641. <https://doi.org/10.1177/1049732309350879>
- Kemper, K.J., Gascon, G., & Mahan, J.D. (2015). Two new scales for integrative medical education and research: confidence in providing calm, compassionate care scale (CCCS) and self-efficacy in providing non-drug therapies (SEND) to relieve common symptoms. *European Journal of Integrative Medicine*, *7*(4), 389–395. <https://doi.org/10.1016/j.eujim.2014.10.010>
- Kneafsey, R., Brown, S., Sein, K., Chamley, C., & Parsons, J. (2016). A qualitative study of key stakeholders' perspectives on compassion in healthcare and the development of a framework for compassionate interpersonal relations. *Journal of clinical nursing*, *25*, 70-79. <https://doi.org/10.1111/jocn.12964>
- Laschinger, H. K. S., Finegan, J., & Wilk, P. (2009). New graduate burnout: The impact of professional practice environment, workplace civility, and empowerment. *Nursing Economics*, *27*(6), 377-383. <https://search.proquest.com/docview/236965695?accountid=6724>
- Lavoie-Tremblay, M., Wright, D., Desforges, N., Gélinas, C., Marchionni, C., & Drevniok, U. (2008). Creating a healthy workplace for new-generation nurses. *Journal of Nursing Scholarship*, *40*(3), 290-297. <https://doi.org/10.1111/j.1547-5069.2008.00240.x>

- Lee, T. H. (2015). *An epidemic of empathy in healthcare: how to deliver compassionate, connected patient care that creates a competitive advantage*. McGraw Hill Professional.
- Lee, Y. & Seomun, G., (2016). Development and validation of an instrument to measure nurses' compassion competence. *Applied Nursing Research*, 30, 76–82. <https://doi.org/10.1016/j.apnr.2015.09.007>
- Lewin, K. (1948) *Resolving social conflicts*. Harper and Row
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Publications.
- Lown, B. A. (2015). Compassion is a necessity and an individual and collective responsibility: comment on "Why and how is compassion necessary to provide good quality healthcare?". *International Journal of Health Policy and Management*, 4(9), 613. <https://doi.org/10.15171/ijhpm.2015.110>
- McCaffrey, G. & McConnell, S. (2015). Compassion: A critical review of peer-reviewed literature. *Journal of Clinical Nursing*, 24(19-20), 3006-3015. <https://doi.org/10.1111/jocn.12924>
- Michalec, B., Diefenbeck, C., & Mahoney, M. (2013). The calm before the storm? Burnout and compassion fatigue among undergraduate nursing students. *Nurse education today*, 33(4), 314-320. <https://doi.org/10.1016/j.nedt.2013.01.026>
- Mor Barak, M. E. (2018). The practice & science of social good: Emerging paths to positive social impact. *Research on Social Work Practice*, 30(2), 139-150. <https://doi.org/10.1177/1049731517745600>
- Morse, J. M. (2004). Theoretical saturation. *Encyclopedia of social science research methods*, 3, 1122-23. Sage.
- Msiska, G., Smith, P., Fawcett, T., & Nyasulu, B. M. (2014). Emotional labour and compassionate care: What's the relationship?. *Nurse education today*, 34(9), 1246-1252. <https://doi.org/10.1016/j.nedt.2014.03.002>
- Naismith, I., Zarate Guerrero, S., & Feigenbaum, J. (2019). Abuse, invalidation, and lack of early warmth show distinct relationships with self-criticism, self-compassion, and fear of self-compassion in personality disorder. *Clinical psychology & psychotherapy*, 26(3), 350-361. <https://doi.org/10.1002/cpp.2357>
- Nathaniel, A. K., & Andrews, T. (2007). How grounded theory can improve nursing care quality. *Journal of Nursing Care Quality*, 22(4), 350-357. <https://doi.org/10.1097/01.NCQ.0000290417.27393.91>

- National Audit Office. (2020) *The NHS nursing workforce*. National Audit Office.
- Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. *American psychologist*, 58(6-7), 449.  
<https://doi.org/10.1037/0003-066X.58.6-7.449>
- NHS Digital (2018). *NHS Workforce Statistics*. <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics---march-2018-provisional-statistics>
- NHS England. (2016a). *Compassion in Practice: Evidencing the impact*.  
<https://www.england.nhs.uk/wp-content/uploads/2016/05/cip-yr-3.pdf>
- NHS England. (2016b). Leading change, adding value. *British Journal of Healthcare Assistants*, 10(6), 302-303. <https://doi.org/10.12968/bjha.2016.10.6.302>
- NHS Improvement (2019). *Interim NHS people plan*.  
[https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan\\_June2019.pdf](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf)
- Nuffield Trust. (2017). *The NHS is the world's fifth largest employer*.  
<https://www.nuffieldtrust.org.uk/chart/the-nhs-is-the-world-s-fifth-largest-employer>
- Nursing & Midwifery Council (NMC). (2018a) *Realising professionalism: Standards for education and training Part 2: Standards for student supervision and assessment*. Retrieved August 20, 2020, from  
<https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/standards-for-student-supervision-and-assessment/student-supervision-assessment.pdf>
- Nursing & Midwifery Council (NMC). (2018b) *Realising professionalism: Standards for education and training Part 3: Standards for pre-registration nursing programmes*. Retrieved December, 2020, from  
<https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/standards-for-pre-registration-nursing-programmes/programme-standards-nursing.pdf>
- Nursing & Midwifery Council (NMC). (2018c) *Realising professionalism: Standards for education and training Part 1: Standards framework for nursing and midwifery education*. Retrieved December, 2020, from  
<https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/standards-framework-for-nursing-and-midwifery-education/education-framework.pdf>

- Nursing & Midwifery Council (NMC). (2018d). *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. Retrieved March 30, 2020, from <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>
- Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage publications.
- Perez-Bret, E., Altisent, R. & Rocafort, J. (2016). Definition of compassion in healthcare: a systematic literature review. *International Journal of Palliative Nursing*, 22, 599–606.
- Premack, D., & Woodruff, G. (1978). Does the chimpanzee have a theory of mind? *Behavioral and brain sciences*, 1(4), 515-526. <https://doi.org/10.1017/S0140525X00076512>
- Reeve, K. L., Shumaker, C. J., Yearwood, E. L., Crowell, N. A., & Riley, J. B. (2013). Perceived stress and social support in undergraduate nursing students' educational experiences. *Nurse education today*, 33(4), 419-424. <https://doi.org/10.1016/j.nedt.2012.11.009>
- Sacco, T. L., & Copel, L. C. (2018). Compassion satisfaction: A concept analysis in nursing. *Nursing forum*, 53(1), 76-83. <https://doi.org/10.1111/nuf.12213>
- Scully, N. J. (2011). The theory-practice gap and skill acquisition: An issue for nursing education. *Collegian*, 18(2), 93-98. <https://doi.org/10.1016/j.colegn.2010.04.002>
- Senyuva, E., Kaya, H., Isik, B & Bodur, G. (2013). Relationship between self-compassion and emotional intelligence in nursing students. *International Journal of Nursing Practice*, 20(6), 588-596. <https://doi.org/10.1111/ijn.12204>
- Sheppard, K. (2015). Compassion fatigue among registered nurses: Connecting theory and research. *Applied Nursing Research*, 28(1), 57-59. <https://doi.org/10.1016/j.apnr.2014.10.007>
- Sinclair, S., Hack, T. F., Raffin-Bouchal, S., McClement, S., Stajduhar, K., Singh, P., Hagen, N. A., Sinnarajah, A., & Chochinov, H. M. (2018). What are healthcare providers' understandings and experiences of compassion? The healthcare compassion model: a grounded theory study of healthcare providers in Canada. *BMJ open*, 8, 3, e019701. <http://dx.doi.org/10.1136/bmjopen-2017-019701>
- Singh, P., Raffin-Bouchal, S., McClement, S., Hack, T. F., Stajduhar, K., Hagen, N. A., Sinnarajah, A., Chochinov, H. M., & Sinclair, S. (2018). Healthcare providers' perspectives on perceived barriers and facilitators of compassion: results from a

- grounded theory study. *Journal of clinical nursing*, 27(9-10), 2083-2097.  
<https://doi.org/10.1111/jocn.14357>
- Smith, G. D., Gelling, L., Haigh, C., Barnason, S., Allan, H. T., & Jackson, D. (2018). The position of reporting guidelines in qualitative nursing research. *Journal of clinical nursing*, 27(5-6), 889-891. <https://doi.org/10.1111/jocn.14213>
- Stamm, B.,H. (2009). *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. [https://www.proqol.org/uploads/ProQOL\\_5\\_English.pdf](https://www.proqol.org/uploads/ProQOL_5_English.pdf)
- Strauss, A. & Corbin, J. (1998). *Basics of Qualitative Research*. Sage Publications.
- Taylor, R. F. (2009). *Creating connections: an investigation into the first year experience of undergraduate nursing students* (Doctoral dissertation, Robert Gordon University). OpenAIR @ RGU. <https://rgu-repository.worktribe.com/output/247850>
- Taylor, R. (2012). Social capital and the nursing student experience. *Nurse Education Today*, 32(3), 250-254. <https://doi.org/10.1016/j.nedt.2011.05.006>
- ten Hoeve, Y., Castelein, S., Jansen, G., & Roodbol, P. (2017). Dreams and disappointments regarding nursing: Student nurses' reasons for attrition and retention. A qualitative study design. *Nurse education today*, 54, 28-36.  
<https://doi.org/10.1016/j.nedt.2017.04.013>
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32 item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19, 349 - 357. <https://doi.org/10.1093/intqhc/mzm042>
- Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative social work*, 11(1), 80-96. <https://doi.org/10.1177/1473325010368316>
- van Rooyen, D. R., Jordan, P. J., ten Ham-Baloyi, W., & Caka, E. M. (2018). A comprehensive literature review of guidelines facilitating transition of newly graduated nurses to professional nurses. *Nurse Education in Practice*, 30, 35-41.  
<https://doi.org/10.1016/j.nepr.2018.02.010>
- Vinales, J. J. (2015). The mentor as a role model and the importance of belongingness. *British Journal of Nursing*, 24(10), 532-535.  
<https://doi.org/10.12968/bjon.2015.24.10.532>
- Von Dietze, E., & Orb, A. (2000). Compassionate care: a moral dimension of nursing. *Nursing Inquiry*, 7(3), 166-174.  
<https://doi.org/10.1046/j.1440-1800.2000.00065.x>
- Vygotsky, L. (1962) *Thought and Language*. MIT Press.

- Weber, M. (1962). *Basic concepts in sociology*. Citadel Press.
- Wiener, C. L. (2007). Making teams work in conducting grounded theory. In A. Bryant, & K. Charmaz (Eds.). *The Sage handbook of grounded theory* (pp. 293-310). Sage.
- Williams, J. M. G., & Kabat-Zinn, J. (2013). *Mindfulness: Diverse perspectives on its meaning, origins and applications*. Routledge.
- Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-hill education (UK).
- Willis, J. W., Jost, M., & Nilakanta, R. (2007). *Foundations of qualitative research: Interpretive and critical approaches*. Sage
- Zhang, Y. P., Huang, X., Xu, S. Y., Xu, C. J., Feng, X. Q., & Jin, J. F. (2019). Can a one-on-one mentorship program reduce the turnover rate of new graduate nurses in China? A longitudinal study. *Nurse education in practice, 40*, 102616. <https://doi.org/10.1016/j.nepr.2019.08.010>
- Zhang, Y., Qian, Y., Wu, J., Wen, F., & Zhang, Y. (2016). The effectiveness and implementation of mentoring program for newly graduated nurses: A systematic review. *Nurse education today, 37*, 136-144. <https://doi.org/10.1016/j.nedt.2015.11.027>
- Zuroff, D. C., & Blatt, S. J. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology, 74*(1), 130–140. <https://doi.org/10.1037/0022-006X.74.1.130>

### Chapter 3: Reflective paper

Work/life off balance: A compassionate reflection on clinical psychology training

Overall chapter word count (at submission; excluding abstract, tables, figures and references): 3822

### 3.1 Introduction

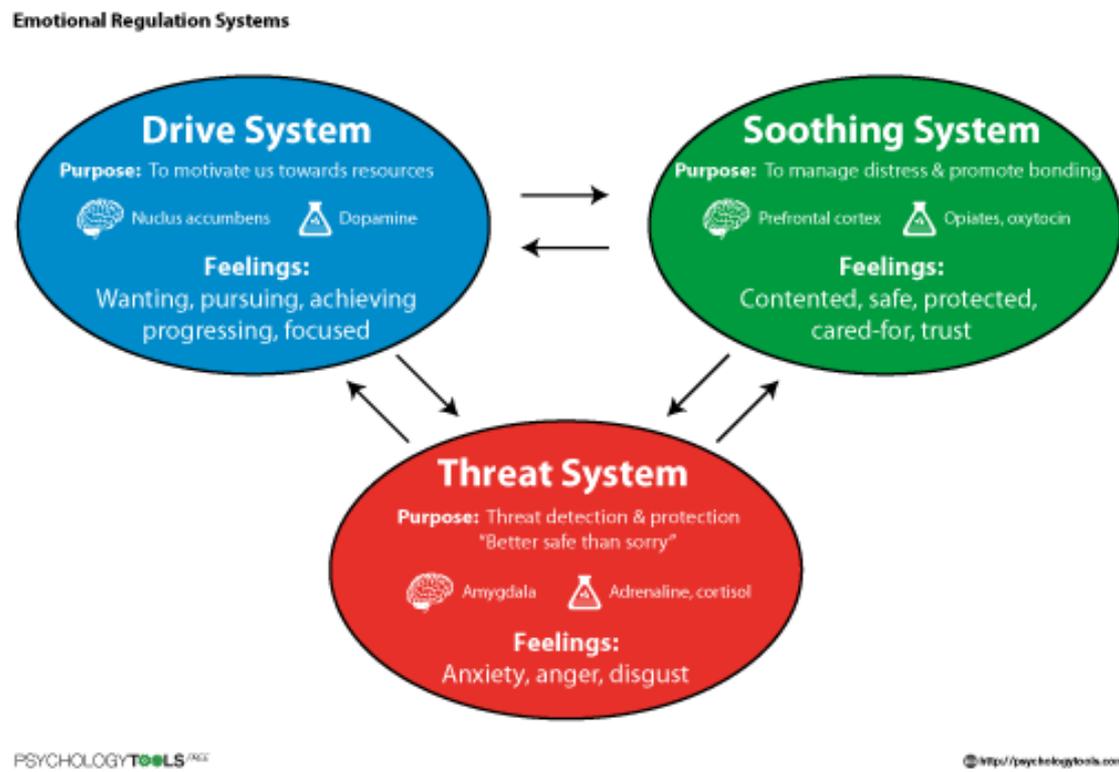
The standards for Doctoral programmes in Clinical Psychology (British Psychological Society [BPS], 2014) state Clinical Psychologists should be reflective scientist-practitioners. Trainees need to “monitor and review their own progress and develop skills in self-reflection and critical reflection on practice” (BPS, 2017, p. 40). I have used reflection throughout clinical placements on my doctorate journey for personal and professional development. Taking time to reflect has yielded insights that I was previously unaware of and led to helpful personal and professional changes. Engaging in reflexivity and reflection is important in qualitative research (D’Cruz et al., 2007), especially in Constructivist Grounded Theory (CGT) where the researcher is inherently connected to the final theoretical model.

This chapter details my reflections on the development, execution and writing of chapters one and two. I will introduce the three systems of emotion regulation from Gilbert (2009) and relate this to the process of completing my thesis. The chapter will continue with a description of how thesis writing activated my threat system, especially with the backdrop of the global health pandemic, corona virus disease 2019 (COVID-19), and my struggle to balance academic demands with my role as a parent. The chapter concludes with a focus on the future. The reflection process in this chapter has also been supported by compassion exercises from Gilbert (2010) and self-practice/self-reflection exercises in Kolts et al. (2018).

### 3.2 The three systems of emotion regulation

Gilbert (2009) introduces the three systems of emotion regulation, 'threat', 'drive' and 'safety/soothing'. The three systems explain every human being's motivations and emotions from an evolutionary perspective. Figure 3.1 shows a representation of the three systems.

Figure 3.1: The three emotion regulation systems (reproduced from <https://www.psychologytools.com>, based on Gilbert, 2005)



The threat, or self-protection system describes how humans are motivated towards keeping themselves (and others) safe by detecting and moving away from threat. Emotions in this system are anxiety, anger, fear and disgust and other emotions that motivate the detection of threat or movement away from it. In the threat system, attention and thinking are narrow and focused on whatever is threatening. The drive

system describes how humans are motivated towards achieving goals and feelings of reward for achieving resources or targets. The safeness/soothing system describes how humans soothe themselves from distress and is linked with bonding, nurturance and affiliation with others and feelings of contentment, safety, feeling cared-for, protection and trust. I will use this model to structure the reflections throughout this chapter. Figure 3.2 shows the personal emotion regulation systems at the start and middle of my thesis journey.

Figure 3.2: My personal emotion regulation systems at the start and middle of the thesis process



I used the self-practice/self-reflection prompts from Kolts et al. (2018) to reflect on my systems' diagram. At the start and middle of the thesis process, my threat and soothe systems were of similar size. With the drive system slightly smaller and the threat system very slightly overlapping the drive. The reason for this is that I was driven and motivated to use CGT as it not only suited the research question but also suited my epistemological and theoretical position. CGT felt like a methodology that brings

together elements of qualitative and quantitative styles, which Cupchik (2001) described as complementary in the analysis of social phenomena. The threat system would take charge whenever I was worried that I was 'doing it wrong' but I was able to recognise and manage this through checking the processes in Charmaz (2014) and reminding myself that it was a new methodology so it would take time to build confidence and competence. I was motivated by interviews, as they used similar skills of engagement, curiosity and were very active, which suited my 'activist' learning style (Honey & Mumford, 1982). I was also able to use new analysis skills gained from my research to offer more effective consultations to groups of social workers on my clinical placement. I was able to draw out similar themes in group supervision sessions, which enabled social workers to feel more connected to each other, with the impact of improving workplace wellbeing.

My soothe system was activated as I felt connected to participants who appeared to share my passion for compassion and this helped to drive my research forward and promoted bonding and contentment. I felt connected with my family, friends and placement supervisors. My soothe system was also activated due to a sense of commonality with my peers that we were sharing this doctorate journey. This feeling aligned with the category constructed as part of the theoretical model from chapter two, "*We're all in this together*", which describes the importance of connecting with peers for compassion. As the thesis progressed there were less 'active' activities to complete. The next stage of the thesis was writing and rewriting drafts. I struggled with this activity due to a number of personal and systemic factors. The impact on my emotional regulation systems is shown in Figure 3.3.

Figure 3.3: My personal emotion regulation systems during thesis writing

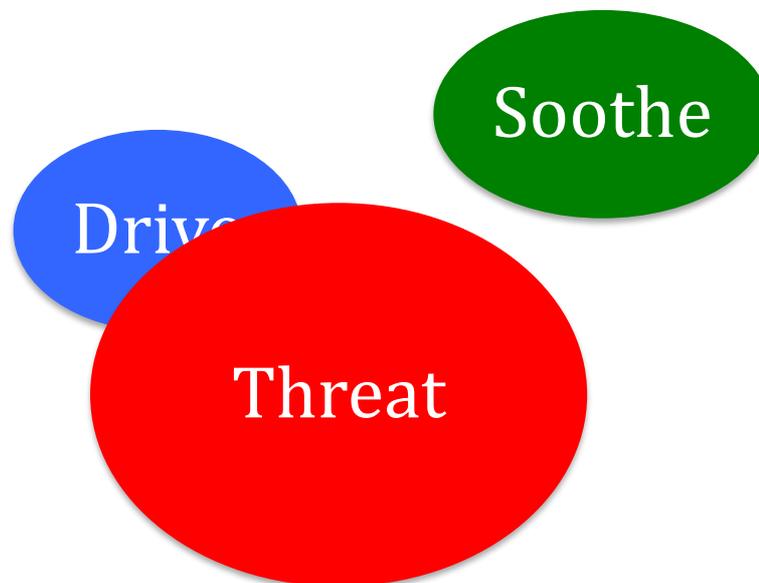


Figure 3.3 shows the relative sizes of my emotion regulation systems during the write up period of the thesis. The threat system was largest, followed by the soothe system, with the drive system the smallest. The diagram reflects recent life experiences, as I had been feeling anxious, scared and guilty and feeling ashamed for feeling so stressed when others were facing death, unemployment and poverty due to COVID-19. The threat system was blocking the drive system, inhibiting my motivation and ability to achieve my goals. The soothe system is separate from the threat and drive systems and is smaller than threat but larger than the drive system.

### 3.3 Activating the Threat System

A number of factors contributed to the activation of my threat system during the thesis writing stage. One challenge in the thesis writing process was engaging in research supervision and sending drafts to supervisors. Supervision meetings and feedback from

supervisors often activated my threat system due to a fear of being criticised, which had an inhibitory effect on my ability to work. The concern about being criticised by authority figures is something that I have worked on in self-reflection for a number of years. The fear of being criticised activates shame due to a fear of being seen as incompetent and cast out by others. Although this has slightly impacted my ability to engage in academic work in the past, it has never been debilitating, which led me to believe that there was something additional making this activity feel more threatening than similar situations. In previous academic situations where I was unsure about what to do, I have found comfort in reading assignment guidelines and reassured myself of the many assignments I had passed and done well in before. I have also reached out and connected with my peers who offered reassurance and support. As described above, the category "*We're all in this together*", previously rang true to offer support in times of distress. These actions historically gave me more confidence in my ability to do assignments and reduced the threat in order that I could get on with work. However, for the thesis, these strategies did not work. The guidelines were much less clear so this was less comforting. I have never carried out an assignment as large as this before so did not have the knowledge of doing well on previous papers to reassure me. Initially, I was still able to connect with my peers however, as time passed, the journey felt less shared and less like we were in the same boat, as others were nearing the end of their journey and I still felt out at sea. I was also unable to effectively connect with my supervision team, as my threat mindset was unfortunately deeming them part of the threat.

I have always used purposeful delay of academic work, preferring to work under pressure to meet deadlines. The pressure of deadlines has served to increase my external motivation. This strategy has typically increased my drive to complete assignments and resulted in positive academic outcomes. It has been a successful strategy for me to balance academic life with other responsibilities. Chun Chu and Choi (2015) describe this way of working as 'active procrastination' and suggest it is a positive type of procrastination corresponding with high academic performance and higher self-efficacy and confidence than passive procrastinators. Recent procrastination research has challenged the construct of active procrastination, asserting the terms 'purposeful delay' and 'arousal delay' are more appropriate descriptions (Chowdrury & Pychyl, 2019; Pinxten et al., 2019).

The purposeful delay strategy was not possible in the context of the thesis, for a number of reasons. Initially, the type of work activities needed to be completed at different stages, rather than in one go, as I would prefer to have worked. For example, ethics applications needed to be completed at the start of the process, with interviews, transcribing, memos and analysis throughout the process. Additionally, drafts needed to be sent to my supervision team, with reasonable notice. I previously have not completed drafts of work, especially to send to anyone else to review so this was something new that did not fit with my working style that I needed to adapt to.

The main factor that activated my threat system was the global COVID-19 pandemic and its impact on my family's life. Lockdown due to COVID-19 in the United Kingdom (UK) was announced in my second week of study leave, disabling my ability to utilise

previous strategies, and increasing the activation of my threat system. Throughout clinical training I have managed to balance the dual role of being a researcher and clinician with the additional role of being a parent. Being a parent is a large part of my self-identity and being a mother is extremely valued in my family culture. The majority perspective in my family system is that gender is seen as binary, with traditional feminine and masculine roles. Women are seen as providing nurturance and men providing economically; women are in charge of 'soothing' and men are in charge of the 'driving'. Women in my generation of the family have started to challenge the traditional family perspectives by returning to work after having children and promoting discussions about alternative perspectives to gender and equality. Despite these challenges to the family perspective, there is still a historical view of motherhood that I have internalized, where I view myself primarily as a mother. In my role as a mother, my view is that my children will always come first. This view feels similar to the category constructed in chapter two, *"Pure concern for other"*. In chapter two this related to Mental Health Nursing Students' (MHNSs') view that the patient comes first. *"Pure concern for other"* in my parenting role applies to my concern for my children. This self-view has impacted on my ability to complete the thesis in a number of ways. Throughout the last three years I have managed to organize myself in order that I can complete all assignments within the planned study time, without any impact on time with my children. This was not possible for the thesis where more time was needed to complete work. The main impact was on the planned study time, which, as stated earlier, was affected by school closures due to COVID-19. Instead of having two months of dedicated study time to finish the thesis write up, I was now faced with the challenge

of trying to write up my thesis alongside home-schooling two children, proving the dictum by Slaughter (2012) that “women still *can’t* have it all”.

Gilbert (2009) explains how, when the threat system is active, this emotional and motivational state organises our minds and experiences of the world. Figure 3.4 details the elements affected by a threat mindset.

Figure 3.4: How threat organises the mind (from Gilbert, 2009)



In order to explain these elements, I will describe the situation of trying to balance work and home life during the pandemic. The **thinking** I noticed were thoughts about my children’s safety, emotional wellbeing and education, thoughts about needing to complete drafts to send to supervisors, worries about the draft not being good enough, that I could not cope, that I did not know what I was doing, that I would not be able to cope with receiving criticism and having to make changes, that I may as well give up

and I was not capable of doing any more, that I should stop doing homeschooling and focus on work, that I was not getting either job right. The **behaviour** I noticed was flitting from task to task, struggling to concentrate, avoidance, procrastination and avoiding asking for help when needed. The **emotions** I noticed were fear, guilt, shame, anger and sadness. The **motivation** was to escape by walking away from the work and giving up the course. The **imagery** or scenarios that ran through my mind were images of the children struggling or being upset, images of people being ill, images of being criticised for getting it wrong, scenarios of having 'writer's block' and not being able to write anything and phantasies of giving up. My **attention** was narrowly focused on two distinct areas; my children's needs and my inability to do the thesis. Due to the dominance of my threat system, I no longer felt '*Safe to learn*' as described by MHNSs as their experience of their training.

Evolutionarily, it makes sense for a parent to offer soothing and safety to children in times of threat as this increases the likelihood of offspring survival (Darwin, 1896). Attachment theory also offers insights into how attachment behaviour can be activated in times of threat (Bowlby, 1969; 1973; 1980). In order to keep my children safe, my priority was to be their safe haven and secure base. The circle of security ([COS]; Cooper et al., 2005; Powell et al., 2009) explains how secure attachment is promoted through a caregiver supporting their child's exploration of the world alongside being a person of safety who protects, comforts, delights and organises their child's feelings. As COVID-19 made my children feel less safe, their threat system was activated, meaning I needed to be present to protect, comfort and support their emotions.

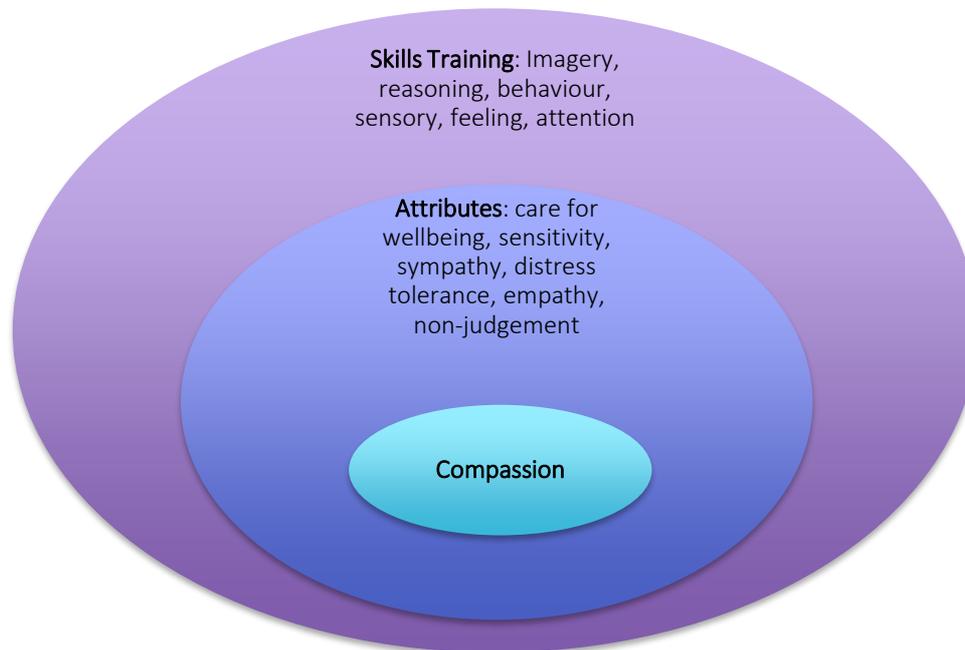
The consequence of prioritising my family's wellbeing at this stage of the course was that it was increasingly more difficult to focus on completing my thesis. What was already challenging for me had become even more of a challenge due to the extra strain of daily living, without opportunities to access additional support structures such as schools, sports clubs and wider family. Being a parent of young children appears to be one of the most important predictors of perceived effect of the pandemic (Collins et al., 2020) with women much more affected than men in heterosexual parenting couples (Collins et al., 2020). A reason for this may be due to societal and personal views of motherhood, with families attempting to respond to cultural ideal of the 'good mother' (Sutherland, 2010; Collins, 2020). In my role as a mother, I recognised a similarity with the category, '*Doing good, being good*' from chapter two as I was striving to be a 'good mother' in the same way that MHNSs were striving to be a 'good nurse'.

In relation to academic life, Raddon's (2002) discursive analysis of females who are mothers and academics suggested that women are situated within complex and often contradictory discourses around the 'successful academic' and the 'good mother'. Raddon suggests that the intersection of the two discourses creates conflicts for women and also offers opportunities for empowerment, should systems be willing to embrace the development of critical literacy. The conflict of attempting to fulfill these seemingly contradictory roles led to a continuation of my sense of threat; threat that I was being neither a 'good mother' nor a 'successful academic'.

### 3.4 Activating the Drive and Soothe Systems

In order to modify the situation activating my threat system, my supervision team suggested an extension to the hand in date of my thesis. I was initially distraught at the idea that I would hand in the thesis so much later than planned. However, it was the most compassionate decision from my supervision team. This decision activated my soothing system, leading to me feel understood, supported and soothed by my team even when I, clouded by my sense of threat, was struggling to understand myself. Being able to balance working on my thesis alongside childcare rather than feeling disabled by the need to choose between the two enabled my drive system to kick into gear, improving my motivation for academic work. The new deadline helped me to feel less threatened, empowering me to use self-reflection activities from Kolts et al. (2018) with an aim of developing compassion. I felt supervisors modified the style of their feedback to balance strengths and constructive criticism, enabling me to interpret this as less threatening. I shared my struggle and sought connection with family and friends and sought out other Trainee Clinical Psychologists who were in the same position. Figure 3.5 details Gilbert's (2009) two 'psychologies' of compassion. I used knowledge of attributes and skills training in self-reflection to cultivate my compassionate mind.

Figure 3.5: Two 'psychologies' of compassion: Compassionate attributes and skills training (Gilbert, 2009; Kolts et al., 2018)



Compassion is in the centre of Figure 3.5. In order to reach a compassion state, Gilbert (2009) proposes that struggles need to be engaged with, through using specific attributes. Following commitment to engage with suffering, skills training can be used to alleviate and prevent suffering. The attributes include care for wellbeing, sensitivity, sympathy, distress tolerance, empathy, non-judgement. Care for wellbeing describes the ability to connect with suffering. Sensitivity describes how one is able to recognise suffering in oneself or others. Sympathy in this model considers how moved one is by the suffering. Distress tolerance describes the ability to cope in the face of suffering without avoiding or escaping the problem. Empathy describes the ability to recognise and understand one's emotions or the emotions of others. Non-judgement relates to being able to abstain from criticism of oneself or others in the face of suffering. The skills training elements are imagery, reasoning, behaviour, sensory, feeling, attention. Skills training encompasses a wide range of strategies such as 'compassionate self' and

'compassionate other' imagery, creating soothing sensory boxes, reframing thoughts to focus on what is most helpful, mindfulness and values-based behaviour change. The purpose of skills training is to help rebalance the emotion motivation systems, typically aiming to increase the soothing system and reduce the threat system.

### **3.5 Developing a compassionate mind**

Through self-reflection I was able to recognise the attribute areas that I struggled with and use skills training to develop a compassionate mind rather than a mind organised by threat. For example, I used a compassionate imagery exercise from Kolts et al. (2018), which highlighted to me the importance, not only of self-kindness but also the importance of being wise and courageous. I reflected that I have previously used a guise of kindness to be avoidant of difficulties. Reflecting on the attribute of distress tolerance, it was clear to me that the thesis needed courage and an ability to tolerate and stick with the struggle rather than trying to avoid or escape it. Learning to sit with the struggles of worrying about balancing work/life commitments and the fear of criticism was wise and courageous. Being able to tolerate the distress enabled me to move on from a situation of paralysis and to move forward with work. Figure 3.6 and the following description details how engaging in compassion helped to organise my mind.

Figure 3.6: How compassion organises the mind (from Gilbert, 2009)



The situation described below was preparing a draft for supervisors to read. The **thinking** that I noticed changed from ‘shame-based self-attacking’ to ‘compassionate self-correction’ thoughts. The focus of each type of thinking is detailed in Table 3.1

Table 3.1: Shame-based self-attacking and failure focused to compassionate self-correction thoughts (reproduced from Gilbert, 2010)

Compassionate Self-Correction is Focused on	Shame Based Self-Attacking is Focused on
<ul style="list-style-type: none"> <li>- The desire to improve</li> <li>- Growth and enhancement</li> <li>- Forward-looking</li> <li>- Giving with encouragement, support and kindness</li> <li>- Building on positives (e.g. seeing what one did well and then considering learning points)</li> <li>- Focusing on attributes and specific qualities of self</li> <li>- Focusing and hope for success</li> </ul>	<ul style="list-style-type: none"> <li>- The desire to condemn and punish</li> <li>- Punishing past errors and often backward looking</li> <li>- Giving with anger, frustration, contempt and disappointment</li> <li>- Focusing on deficits and fear of exposure</li> <li>- Focusing on self as a global sense of self</li> <li>- Focusing on high fear of failure</li> <li>- Increasing chances of avoidance and withdrawal</li> </ul>

Specific thoughts included taking one step at a time and how sending drafts gave supervisors opportunities to comment and this would help me progress. I also noted self-talk about completing the thesis, as this was best in the long-term for my children. I am aware that this fits with the category '*Care for self for others*' from my empirical study. The category '*Care for self for others*' described how MHNSs were motivated to care for themselves if it was beneficial to their patients. My thoughts followed the same pattern, perhaps more accurately described as 'work for self for others', as I was more motivated to work when I thought about the long-term benefit for my children. This cognitive reinterpreting fits with what Pedersen (2016) describes as "postfeminist refashioning of the admission of mothering failures as part of being a good mother" (p. 28). Pedersen (2016) described that middle-class mothers would reframe 'selfish' acts (working, self-care, gaining support with childcare) as part of the new 'good mother' ideal, possibly in an attempt to ease motherly guilt.

The **behaviour** I noticed was an ability to start writing, to use time more effectively, to send work rather than avoid it alongside finding more quality time with my children. The **emotions** I noticed were hope and a feeling of calm. The **motivation** was to organise myself and to start working. The **imagery** or scenarios that ran through my mind were images of being in a marathon and how each submitted draft was like running a kilometre to get nearer to the end. My **attention** was broadly focused on all of my life commitments with an ability to focus on specific tasks when needed. There were definitely times when the threat mindset returned throughout the writing period. In these times I tried to cultivate compassion through engagement with the struggle and skills to alleviate the suffering.

### 3.6 The future

Reflection on my thesis journey has given me insights into personal and professional development opportunities. My passion for parenthood influenced the topic in chapter one and has also led me to be successful in securing a role as a Specialist Perinatal Clinical Psychologist following training. Part of my role will be setting up a new service. I hope to bring critical skills learned as a researcher such as analysing evidence to support best practice and specific knowledge about compassion interventions for parents to this role. Regarding research, my personal journey fits with many of the categories from the theoretical model from chapter two. What was noticeable for me was that times where I was not connecting, for example, with training or with my peers, were times where I felt most distressed. Therefore, it would be interesting to see whether the model translates to clinical psychology training.

In terms of reflective practice, I will definitely continue to use compassion skills training to further develop my ability to be courageous in the face of adversity. I hope that continuing to use self-reflection exercises will build my resilience, understood as “the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma” (Windle, 2011, p. 163). Reflecting on my journey has also highlighted the importance of teaching these skills to my children and clients. I am hopeful that in future situations I find difficult, I will have courage to share my struggles with others rather than trying to cope alone.

In summary, although Slaughter (2012) may be right that women *can't* have it all, we can be kind, wise and courageous, and that is good enough for me.

### 3.7 References

- British Psychological Society (BPS). (2014). *Standards for Doctoral programmes in Clinical Psychology*. Retrieved August 03, 2020, from: [http://cedar.exeter.ac.uk/media/universityofexeter/schoolofpsychology/cedar/documents/dclinpsy2014/dclinpsy\\_standards\\_approved\\_may\\_2014.pdf](http://cedar.exeter.ac.uk/media/universityofexeter/schoolofpsychology/cedar/documents/dclinpsy2014/dclinpsy_standards_approved_may_2014.pdf)
- British Psychological Society (BPS). (2017) *Standards for the accreditation of Doctoral programmes in clinical psychology*. Retrieved August 03, 2020, from: [https://www.bps.org.uk/sites/bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%20\(2017\).pdf](https://www.bps.org.uk/sites/bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%20(2017).pdf)
- Bowlby, J. (1969). *Attachment: Attachment and loss*. Basic.
- Bowlby, J. (1973). *Attachment and Loss: Volume II: Separation, Anxiety and Anger*. Hogarth Press and the Institute of Psycho-Analysis.
- Bowlby, J. (1980). *Attachment and loss: Volume III: Loss*. Hogarth Press and the Institute of Psycho-Analysis.
- Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative analysis, second edition*. Sage.
- Chowdhury, S. F., & Pychyl, T. A. (2018). A critique of the construct validity of active procrastination. *Personality and Individual Differences, 120*, 7-12. <https://doi.org/10.1016/j.paid.2017.08.016>
- Collins, C. (2020). Is maternal guilt a cross-national experience? *Qualitative Sociology*. <https://doi.org/10.1007/s11133-020-09451-2>
- Collins, C., Landivar, L. C., Ruppner, L., & Scarborough, W. J. (2020). COVID-19 and the gender gap in work hours. *Gender, Work & Organization*. <https://doi.org/10.1111/gwao.12506>
- Cooper, G., Hoffman, K., Powell, B., Marvin, R., (2005). The circle of security intervention. In L. J. Berlin, Y. Ziv, L. M. Amaya-Jackson & M. T. & Greenberg. *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 127-151). Guilford.
- Cupchik, G. (2001) Constructivist realism: An ontology that encompasses positivist and constructivist approaches to the social sciences. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 2*(1), 7. <http://dx.doi.org/10.17169/fqs-2.1.968>
- Darwin, C. (1896). *The descent of man and selection in relation to sex* (Vol. 1). D. Appleton.

- D'cruz, H., Gillingham, P., & Melendez, S. (2007). Reflexivity, its meanings and relevance for social work: A critical review of the literature. *The British Journal of Social Work*, 37(1), 73-90. <https://doi.org/10.1093/bjsw/bcl001>
- Gilbert, P. (Ed.). (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. Routledge.
- Gilbert, P. (2009). *The compassionate mind*. Robinson.
- Gilbert, P. (2010). *Training our minds in, with and for compassion. An introduction to concepts and compassion-focused exercises*. <https://www.getselfhelp.co.uk/docs/GILBERT-COMPASSION-HANDOUT.pdf>
- Honey, P. & Mumford, A. (1982). *Manual of Learning Styles*. Peter Honey Associates.
- Howell, K. (2013). *An Introduction to the Philosophy of Methodology*. SAGE.
- Kolts, R. L., Bell, T., Bennett-Levy, J., & Irons, C. (2018). *Experiencing compassion-focused therapy from the inside out: A self-practice/self-reflection workbook for therapists*. Guilford Publications
- Pedersen, S. (2016). The good, the bad and the 'good enough' mother on the UK parenting forum Mumsnet. *Women's studies international forum*, 59, 32-38. <https://doi.org/10.1016/j.wsif.2016.09.004>
- Pinxten, M., De Laet, T., Van Soom, C., Peeters, C., & Langie, G. (2019). Purposeful delay and academic achievement. A critical review of the Active Procrastination Scale. *Learning and Individual Differences*, 73, 42-51. <https://doi.org/10.1016/j.lindif.2019.04.010>
- Powell, B., Cooper, G., Hoffman, K., & Marvin, R. S. (2009). The circle of security. In C. H. Zeanah Jr. (Ed.) *Handbook of infant mental health* (3<sup>rd</sup> ed.), (pp. 450-467). The Guildford Press.
- Raddon, A. (2002). Mothers in the Academy: positioned and positioning within discourses of the 'successful academic' and the 'good mother'. *Studies in Higher Education*, 27(4), 387-403. <https://doi.org/10.1080/0307507022000011516>
- Slaughter, A. M. (2012, July/August). Why women still can't have it all, *The Atlantic*. <https://www.theatlantic.com/magazine/archive/2012/07/why-women-still-cant-have-it-all/309020/>
- Sutherland, J-A. (2010). Mothering, guilt and shame. *Sociology Compass*, 4, 310-321. <https://doi.org/10.1111/j.1751-9020.2010.00283.x>

Windle, G. (2011). What is resilience? A review and concept analysis. *Reviews in clinical gerontology*, 21(2), 152.

<https://www.doi.org/10.1017/S0959259810000420>

## Appendices

### Appendix A: *Parenting: Science and Practice* Instructions for Authors

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## **Certificate of Ethical Approval**

Applicant:

Lara Griffin

Project Title:

Compassion-based interventions for current and future parents: A systematic review

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

05 March 2020

Project Reference Number:

P103461

## Appendix C: Details of Quality Assessment Tools (QAT)

Caldwell et al.'s (2005) QAT can be used for both qualitative and quantitative methodology (Caldwell et al., 2011), which suits this review, as both qualitative and quantitative methodology is included. In order to take into account studies using mixed-methods, three questions regarding mixed method study design and findings from Pluye et al. (2009) were also included (see table below).

Caldwell et al. (2005) contains 11 generic questions and seven additional questions depending on whether studies use quantitative or qualitative methodology. For quantitative and qualitative studies, the total of 18 questions was given a score of 0 if a criterion was not met or it could not be determined from the information reported, a score of 1 if the criterion was partially met and a score of 2 if it was fully met. A total score of 36 could be achieved which is reported using a percentage to enable comparison with mixed-method studies. When assessing quality of mixed-methods studies, three additional questions from Pluye et al. (2009) were rated in addition to all quantitative and qualitative questions from Caldwell et al. (2011), totaling a possible maximum score of 56 if all questions were applicable. As all questions for mixed-methods studies may not be applicable, a quality percentage was derived. For example, if 28 questions were relevant then the maximum total would be 28 (questions) x 2 (item quality fully met) giving 56. If the study scored 56/56, it was reported as 100%. It was planned that studies achieving less than 50% would be excluded due to a lack of quality. No studies were excluded due to poor quality.

<b>Quality Assessment Criteria</b>	
1	Does the title reflect the content? <sup>[1-1]</sup> <sub>[SEP]</sub>
2	Are the authors credible? <sup>[1-1]</sup> <sub>[SEP]</sub>
3	Does the abstract summarize the key components? <sup>[1-1]</sup> <sub>[SEP]</sub>
4	Is the rationale for undertaking the research clearly outlined? <sup>[1-1]</sup> <sub>[SEP]</sub>
5	Is the literature review comprehensive and up-to-date? <sup>[1-1]</sup> <sub>[SEP]</sub>
6	Is the aim of the research clearly stated? <sup>[1-1]</sup> <sub>[SEP]</sub>
7	Are all ethical issues identified and addressed? <sup>[1-1]</sup> <sub>[SEP]</sub>
8	Is the methodology identified and justified?
9	Are the results presented in a way that is appropriate and clear?
10	<sup>[1-1]</sup> <sub>[SEP]</sub> Is the discussion comprehensive?
11	Is the conclusion comprehensive? <sup>[1-1]</sup> <sub>[SEP]</sub>
<b>Sub Total: /22</b>	
<b>Qualitative only:</b>	
12	Are the philosophical background and study design identified and the rationale for choice evident?
13	Are the major concepts identified? <sup>[1-1]</sup> <sub>[SEP]</sub>
14	Is the context of the study outlined?
15	Is the selection of participants described and sampling method identified? <sup>[1-1]</sup> <sub>[SEP]</sub>
16	Is the method of data collection auditable?
17	<sup>[1-1]</sup> <sub>[SEP]</sub> Is the method of data analysis credible and confirmable?
18	Are the results transferable?
<b>Quantitative only:</b>	
19	Is the study design clearly identified and rationale for choice of design evident?
20	Is there an experimental hypothesis clearly stated?
21	Is the population identified?
22	Is the sample adequately described and reflective of the population?
23	Is the method of data collection valid and reliable?
24	Is the method of data analysis valid and reliable?
25	Are the results generalisable?
<b>Mixed Method only:</b>	
26	Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?
27	Is the integration of qualitative and quantitative data (or results) relevant to address the research question (objective)?
28	Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results)?
<b>Total /36 or /56</b>	

#### **Appendix D: Details of Mixed Studies Result-based Convergent Synthesis Design**

The aim of mixed studies result-based convergent synthesis design is to combine and interpret qualitative and quantitative data in order to provide in-depth answers to reviews with aims addressing complex clinical problems (Hong et al., 2019). This type of analysis is suitable for analysing quantitative, qualitative and mixed-method studies together due to the emphasis on combining results to create a coherent narrative (Pluye & Hong, 2014). This strategy suits the aims of this review as evaluation of effectiveness will be achieved using quantitative synthesis and results, examination of the main themes emerging will be completed using qualitative synthesis and results and combined synthesis will enable the third aim, integration of quantitative and qualitative knowledge on the topic, to be fulfilled. Mixed studies result-based convergent synthesis design has been used in a systematic review with similar multiple aims to this review (Campbell et al., 2011). Campbell et al. (2011) aimed to review studies to ascertain the effectiveness of dietary and physical interventions for pregnant women to reduce pregnancy weight gain alongside reviewing pregnant women's views about these interventions. Combined synthesis of quantitative and qualitative data enabled explanation of the success or failure of the intervention.

The process of this type of analysis is detailed in Chapter one, Figure 1.2. Once searches were completed, quantitative and qualitative data were separated and synthesised separately. Following synthesis, quantitative and qualitative results are reported separately and then combined to produce integrated results. Meta-analysis of quantitative data was considered, however a statistician's input confirmed that due to the heterogeneity of studies this analysis method was not feasible. Narrative methods

are useful for investigating heterogeneity across primary studies (Popay et al., 2006)

therefore narrative synthesis was utilised for synthesising data.

## **Appendix E: Characteristics of Included Studies**

### **Study Year and Author**

The publication year of the studies ranged from 2018 to 2020. One author (Kirby) was named in three studies. All authors were employed in credible institutions such as psychology and human development departments of universities and health services, though information about their job roles was limited.

### **Country of Study**

Three studies were carried out in Australia with one spanning Australia and New Zealand (Kirby & Baldwin, 2018; Kirby et al., 2019; Mitchell et al., 2018). Two studies were carried out in the United States of America (USA; Fernandez-Carriba et al., 2019; Poehlmann-Tynan et al., 2020), two in the United Kingdom (UK; Gammer et al., 2020; Sirois et al., 2019) and one study in Sweden (Bratt et al., 2019). One study took place in China (Guo et al., 2020) and one in Iran (Navab et al., 2019).

### **Study Aims**

There was some overlap in study aims. The qualitative study (Bratt et al., 2019) aimed to describe the lived experience of participating in compassion-based interventions, whereas the quantitative studies aimed to explore efficacy of CBIs (Fernandez-Carriba et al., 2019; Guo et al., 2020; Kirby & Baldwin, 2018; Kirby et al., 2019; Mitchell et al., 2018; Navab et al., 2019; Poehlmann et al., 2020; Sirois et al., 2019), feasibility of CBIs (Fernandez-Cariba et al., 2019) and accessibility and acceptability of the interventions (Gammer et al., 2020; Guo et al., 2020; Kirby and Baldwin, 2018; Mitchell et al., 2018).

## **Study Designs**

One study used a qualitative design (Bratt et al., 2019), one used a mixed-method design (Fernandez-Cariba et al., 2019) and the remaining eight studies used a quantitative methodology with Randomised Controlled Trial (RCT) design (Gammer et al., 2020; Guo et al., 2020; Poehlmann et al., 2020); experimental micro-trial design (Kirby & Baldwin, 2018); experimental design with random allocation (Kirby et al., 2019); repeated measures with no control (Mitchell et al., 2018); a quasi-experimental pre-test / post-test design with control (Navab et al., 2019) or a quasi-experimental between groups design with randomisation (Sirois et al., 2019).

## **Participants**

Participants in the majority of studies were 100% female (Fernandez-Carriba et al., 2019; Gammer et al., 2020; Guo et al., 2020; Kirby et al., 2019; Mitchell et al., 2018; Navab et al., 2019) or predominantly female with rates between 55% (Bratt et al., 2019) and 86.7% female (Poehlmann-Tynan et al., 2020).

Ethnicity was not reported in four studies (Bratt et al., 2019; Guo et al., 2020; Kirby et al., 2019; Navab et al., 2019). In the studies reporting ethnicity, the majority of participants were White with the exception of Fernandez-Carriba et al. (2019) who reported 50% of the sample as African American, Asian or Hispanic. Six studies reported relationship status; with four studies describing their samples as having a majority status as married (Guo et al., 2020; Kirby & Baldwin, 2018; Mitchell et al., 2018 and Poehlmann-Tynan et al., 2020), one study reporting 20% single parent households

(Fernandez-Carriba et al., 2019) and Bratt et al. (2019) stating 55% of participants were divorced parents.

The highest mean age of participants was 45 years (Fernandez-Carriba et al., 2019) and the lowest mean age was 30.6 years (Guo et al., 2020). Ages of children ranged from unborn (Guo et al., 2020) to 12-17 years old (Bratt et al., 2019). All but Bratt et al. (2019) focused on parents of children younger than 13. Parent educational level, when stated, was high, with the lowest reported educational level 55.41% with higher education and above (Guo et al., 2020) to 100% of the sample having degree level education or above (Poehlmann-Tynan et al., 2020). Sample sizes were small, ranging from 11 (Bratt et al., 2019) to 354 (Guo et al., 2020). Only Guo et al. (2020) used a clinical sample.

### **Interventions**

Of the ten studies, there were variations in the type of compassion-based intervention used. These included group based Compassion Focused Therapy (CFT; Bratt et al., 2019; Navab et al., 2019), online CFT resources (Mitchell et al., 2018), Cognitively Based Compassion Therapy (CBCT; Fernandez-Carriba et al., 2019; Poehlmann-Tynan et al., 2020), online antenatal Mindful self-compassion program (MBSP; Guo et al., 2020), Kindness For Mums Online (KFMO; Gammer et al., 2020), Loving Kindness Meditation (LKM; Kirby & Baldwin, 2018) and a one-off compassion intervention (Kirby et al., 2019; Sirois et al., 2019).

## Measures

Qualitative methods of data collection were interview (Bratt et al., 2019) and open comment via e-mail (Fernandez-Carriba et al., 2019). A wide variety of self-report measures were used in the quantitative studies to evaluate compassion, self-compassion, anxiety, depression, stress, psychological distress, shame and wellbeing.

## Analysis

Bratt et al. (2019) used Reflective Lifeworld Research (RLR; Dahlberg, Dahlberg & Nyström, 2008) to analyse their data. Fernandez-Carriba et al. (2019) did not report their qualitative analysis method. Quantitative data was analysed using paired *t*-tests (Fernandez-Carriba et al., 2019; Guo et al., 2020; Mitchell et al., 2019); Wilcoxon (Navab et al., 2019); Mann-Whitney *U* (Gammer et al., 2019; Navab et al., 2019); independent *t*-tests (Gammer et al., 2019; Kirby & Baldwin, 2018); Chi-square tests (Guo et al., 2019); ANOVA with post hoc tests (Guo et al., 2019; Kirby et al., 2019); ANCOVA (Poelmann-Tynan et al., 2020; Sirois et al., 2019) or MANOVA (Kirby & Baldwin, 2018; Sirois et al., 2019).

Studies calculated effect sizes using Cohen's *d* (Fernandez-Carriba et al., 2019; Mitchell et al., 2018); Rosenthal's *r* (Gammer et al., 2020) or partial eta squared (Sirois et al., 2019). Cohen's *d* effect sizes were calculated by the author for studies with parametric data available (Gammer et al., 2020; Guo et al., 2020; Kirby & Baldwin, 2018; Kirby et al., 2019; Navab et al., 2019) in order to support quantitative synthesis. Cohen (1988) categorises effect sizes as small (0.2 standard deviations), medium (0.5 standard deviations) or large (0.8 standard deviations).

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3. [MANUSCRIPT CATEGORIES AND REQUIREMENTS](#)
4. [PREPARING YOUR SUBMISSION](#)
5. [EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS](#)
6. [AUTHOR LICENSING](#)
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## **How Do Mental Health Nursing Students Understand Compassion?**

### **PARTICIPANT INFORMATION SHEET**

You are being invited to take part in a research study exploring understanding of compassion in Mental Health Nursing Students. Lara Griffin, Trainee Clinical Psychologist at Coventry University is leading this research. Before you decide to take part it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

#### **What is the purpose of the study?**

The purpose of the study is to gain a better understanding of the concept of compassion from the perspective of Mental Health Nursing Students. The aim is to create a model or theory grounded in the data that answers the question, "How do Mental Health Nursing Students understand compassion?".

#### **Why have I been chosen to take part?**

You have been invited to participate in this study because you are currently registered on a Mental Health Nursing BSc (Hons) course.

#### **What are the benefits of taking part?**

By sharing your experiences with us, you will be helping Lara Griffin and Coventry University to better understand Mental Health Nursing students' understanding of compassion. It is hoped that this research can inform Mental Health Nurse training on the concept of compassion in order to promote the development of compassion throughout Nursing.

#### **Are there any risks associated with taking part?**

This study has been reviewed and approved through Coventry University Ethics Committee. I will be asking you about your personal views about compassion. Should you become distressed during the interview, you could choose to stop the interview or have a break and re-start. I will give you written information about support services if you require further support.

If you disclose any risks of harm to yourself or others, I have a duty to acknowledge and act upon this disclosure in line with relevant policies.

#### **Do I have to take part?**

No – it is entirely up to you.

If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. Please note down your participant number (which is on the Consent Form) and provide this to the lead researcher if you seek to withdraw from the study at a later date. You are free to withdraw your

information from the project data set at any time until the data are anonymised in our records on 01.03.2020.

Your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the lead researcher (contact details are provided below). Please also contact Samantha Trow, Research Support Administrator, Health and Life Sciences Research Support Office ([ethics.hls@coventry.ac.uk](mailto:ethics.hls@coventry.ac.uk); 02477 657 688) so that your request can be dealt with promptly in the event of the lead researcher's absence. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you in any way.

### **What will happen if I decide to take part?**

You will be invited to complete an individual interview with me where I will ask a number of questions regarding your understanding of compassion. The interview will take place in a quiet private room at university at a time that is convenient to you. I will audio record your responses (and will require your consent for this). The interview should take around 30-60 minutes to complete. I will contact you via telephone or e-mail following the interview for you to check the accuracy of the data and in order that you can choose to remove information if you wish to do so. I may contact you within 2 weeks of your interview via telephone or e-mail with further questions following initial data analysis.

### **Data Protection and Confidentiality**

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. All information collected about you will be kept strictly confidential. Your data will be anonymised as far as is possible and you can choose a pseudonym for your data for reporting purposes. All audio recordings will be destroyed once they have been transcribed. Your anonymised data will only be viewed by the researcher and the research team (Ms. Jo Kucharska, Clinical Director/Senior Lecturer; Dr Magdalena Marczak, Lecturer in Clinical Psychology and Dr Hannah Andrews, Mental Health Co-ordinator/RMN). All electronic data will be stored on a password-protected computer file at the researcher's home. All paper records will be stored in a locked filing cabinet at the researcher's home or at Coventry University. Your consent information will be kept separately from your responses in order to minimise risk in the event of a data breach. Coventry University will take responsibility for data destruction and all collected data will be destroyed on or before 22/02/2024.

### **Data Protection Rights**

Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation and the Data Protection Act 2018. You also have other rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit [www.ico.org.uk](http://www.ico.org.uk). Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer - [enquiry.ipu@coventry.ac.uk](mailto:enquiry.ipu@coventry.ac.uk)

### **What will happen with the results of this study?**

The results of this study may be summarised in published articles, reports and presentations. Quotes or key findings will always be made anonymous in any formal outputs unless we have your prior and explicit written permission to attribute them to you by name.

### **Making a Complaint**

If you are unhappy with any aspect of this research, please first contact the lead researcher:

**Lara Griffin**, Trainee Clinical Psychologist

Clinical Psychology Doctorate

Charles Ward Building

Coventry University

Coventry

CV1 5FB

E-mail: [griff185@uni.coventry.ac.uk](mailto:griff185@uni.coventry.ac.uk)

If you still have concerns and wish to make a formal complaint, please write to one of the following:

**Dr Jo Kucharska**

Clinical Director / Senior Lecturer

Clinical Psychology Doctorate

Charles Ward Building

Coventry University

Coventry

CV1 5FB

E-mail: [aa3539@coventry.ac.uk](mailto:aa3539@coventry.ac.uk)

**Dr Magdalena Marczak**

Lecturer in Clinical Psychology

Clinical Psychology Doctorate

Charles Ward Building

Coventry University

Coventry

CV1 5FB

Email: [Magdalena.Marczak@coventry.ac.uk](mailto:Magdalena.Marczak@coventry.ac.uk)

**Dr Hannah Andrews**

Mental Health Co-ordinator/RMN

Mental Health Team

Senate House

University of Warwick

CV4 7AL

E-mail: [H.Andrews@warwick.ac.uk](mailto:H.Andrews@warwick.ac.uk)

In your letter please provide information about the research project, specify the name of the researcher and detail the nature of your complaint.

Appendix H: Initial Interview Schedule and Guide

**Interview Schedule**

**Project Title: How do Mental Health Nursing Students Understand Compassion?**

**Initial Questions**

**Age:** 18-21 / 22-25 / 26-29 / 30-34 / 35-39 / 40-44 / 45-49 / 50-54 / 55-59 / 60+

**Gender:** Female / Male / Transgender / Prefer not to say

**Ethnic Group**

<b>White</b>	1. English/Welsh/Scottish/Northern Irish/British 2. Irish 3. Gypsy or Irish Traveller 4. Any other White background, please describe
<b>Mixed/Multiple ethnic groups</b>	5. White and Black Caribbean 6. White and Black African 7. White and Asian 8. Any other Mixed/Multiple ethnic background, please describe
<b>Asian/Asian British</b>	9. Indian 10. Pakistani 11. Bangladeshi 12. Chinese 13. Any other Asian background, please describe
<b>Black/African/Caribbean/Black British</b>	14. African 15. Caribbean 16. Any other Black/African/Caribbean background, please describe
<b>Other ethnic group</b>	17. Arab 18. Any other ethnic group, please describe

**Type of Student:** UK / EU / International

**Year of Study:** 1 / 2 / 3

**Pseudonym Chosen:**

**Would you like to see the transcript of the interview?** Yes / No

**Would you like to see the research when it is finished?** Yes / No

## **Interview Guide**

This initial interview schedule will be used as a set of prompts to guide the conversation rather than used as a script. It may be subject to change following interviews in line with Constructivist Grounded Theory methodology (Charmaz, 2006).

- What do you understand by the term 'compassion'?  
Prompts
  - to self
  - to others
  - from others
  
- What examples of compassion do you have since you started training?  
Prompts
  - to self
  - from course staff, cohort, colleagues
  - to cohort, colleagues, course staff, patients
  
- Who or what makes compassion more likely?
  
- Who or what makes compassion less likely?
  
- How, if at all, has your understanding of compassion changed since before training?
  - What has made this change happen?
  
- What would help you develop your understanding of compassion further?
  
- Do you have any other comments you would like to share today?
  
- Do you have any further questions about the interview today / project in general?

**Thank you for taking part in the interview today; your participation is greatly appreciated.**

## Appendix I: Final Interview Guide

### Interview Guide

This initial interview schedule will be used as a set of prompts to guide the conversation rather than used as a script. It may be subject to change following interviews in line with Constructivist Grounded Theory methodology (Charmaz, 2006).

- What do you understand by the term 'compassion'?  
Prompts - to self, to others, from others
- How do you know when compassion is needed?
- Who or what makes compassion more likely?
- Who or what makes compassion less likely / what barriers have you noticed?
- How would you describe compassion with your course mates compared to compassion with others?
- How would you describe the role of the mentor in relation to compassion?
- How does it feel to give / receive compassion?
- Does compassion look the same for everyone?
- How would you describe the relationship between compassion and gender?
- How, if at all, is compassion related to your role as a MHNS?
- What have you noticed in terms of compassion and other work roles?
- How much do you feel that compassion can be taught?
- How, if at all, has your understanding of compassion changed since before training? What has made this change happen?
- What would help you develop your understanding of compassion further?
- Do you have any other comments you would like to share today?
- Do you have any further questions about the interview today / project in general?

**Thank you for taking part in the interview today; your participation is greatly appreciated.**

**INFORMED CONSENT FORM:  
How Do Mental Health Nursing Students Understand  
Compassion?**

You are invited to take part in this research study for the purpose of collecting data on how Mental Health Nursing Students understand compassion.

Before you decide to take part, please ensure you have **read the accompanying Participant Information Sheet.**

Please do not hesitate to ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

If you are happy to participate, please confirm your consent by circling YES against each of the below statements and then signing and dating the form as participant.

1	I confirm that I have read and understood the <b><u>Participant Information Sheet</u></b> for the above study and have had the opportunity to ask questions	YES	NO
2	I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Research Support Office <b><u>at any time</u></b> until the date specified in the Participant Information Sheet	YES	NO
3	I have noted down my participant number (top left of this Consent Form) which may be required by the lead researcher if I wish to withdraw from the study	YES	NO
4	I understand that all the information I provide will be held securely and treated confidentially	YES	NO
5	I am happy for the information I provide to be used (anonymously) in academic papers and other formal outputs	YES	NO
6	I am happy for the interview to be <b><u>audio recorded</u></b>	YES	NO
7	I agree to take part in the above study	YES	NO
8	I wish to see the transcript of the interview	YES	NO
9	I agree to be contacted via telephone and/or e-mail following initial data analysis to answer further questions, if necessary within 2 weeks of the original interview	YES	NO
10	I wish to see the findings on completion of the study	YES	NO

**Thank you for your participation in this study. Your help is very much appreciated.**

<b>Participant's Name</b>	<b>Date</b>	<b>Signature</b>
<b>Researcher</b>	<b>Date</b>	<b>Signature</b>



**How Do Mental Health Nursing Students Understand Compassion?**

**Lead Researcher: Lara Griffin, Trainee Clinical Psychologist**

**DEBRIEF SHEET**

Thank you for taking part in the study today. I really appreciate your participation.

I hope that the interview has not caused you any distress. In the event that you are feeling distressed, I advise you to contact one of the following services:

**University-Based Support**

**Your Personal Tutor at Coventry University**

**The Coventry University Student Support Service**

Telephone: 02477 658 029 or e-mail: [counsell.ss@coventry.ac.uk](mailto:counsell.ss@coventry.ac.uk)

**External Support**

**Your General Practitioner (GP/Family Doctor)**

**Mental Health Matters**

Telephone: 0800 616 171 or webchat: <https://www.mhm.org.uk>

**Samaritans**

Telephone: 116 123, e-mail: [jo@samaritans.org](mailto:jo@samaritans.org), Samaritans, 57 Moor Street, Earlsdon, Coventry, CV5 6ER

Appendix L: Certificate of Ethical Approval from Coventry University for Chapter 2:  
Empirical Paper



## Certificate of Ethical Approval

Applicant:

Lara Griffin

Project Title:

How do Mental Health Nursing Students Understand Compassion?: A Constructivist  
Grounded Theory Approach

This is to certify that the above named applicant has completed the Coventry  
University Ethical Approval process and their project has been confirmed and  
approved as Medium Risk

Date of approval:

16 May 2019

Project Reference Number:

P88244

## **Appendix M: Research Design Details**

### **Social constructivism**

Social constructivism posits reality is not 'objective truth' but a construction by multiple individuals from their interactions with the world. The limited existing literature led to the theoretical perspective of interpretivism.

### **Interpretivism**

Interpretivist research uses qualitative methods to gather insights from multiple individuals about their experiences, perspectives and understanding to gain 'meaningful understanding' (Willis et al., 2007; Weber, 1962).

### **Constructivist Grounded Theory (CGT)**

CGT is a qualitative methodology with systematic, flexible guidelines for gathering and analysing data to construct theories directly from the collected data (Charmaz, 2006). CGT lies within the interpretative approach, with its goal of interpreting how individuals construct meaning of their experiences. CGT fits with social constructivism, focusing on how individuals and researchers co-construct a shared reality through interaction and language. CGT involves concurrent gathering of data, constant comparison, analysis and development of theories (Charmaz, 2014). The theories derived often have explanatory outcome.

### **CGT, Nursing and Compassion**

CGT is valuable for research in nursing as can capture meaning and the intricacies of the interactions between nursing students and others. CGT affiliates with Symbolic

Interactionism, a viewpoint stating human actions construct themselves, others and society through interpersonal exchanges (Charmaz, 2014; Blumer, 1969). CGT aligns with social constructivists such as Vygotsky (1962), who recognise the importance of research investigating social psychology or social structure, so is a suited to investigating nursing, an inherently social profession. CGT is appropriate for Mental Health Nursing practice (Gardner et al., 2012). It is a good fit for compassion, which is hypothesised as psychological and can be social in nature. An additional benefit of CGT is that it can generate a theory helpful for mental health nursing recruitment and education and improve the quality of patient care (Nathaniel & Andrews, 2007).

## Appendix N: Examples of initial codes and coding process

Really listening	"It's not really my opinion"
Being non-judgmental	Doing the right thing
Making time to connect	Respecting the other person
Understanding their feelings	Feeling selfish
Being with them	Doing something for another person
"Having to be very compassionate"	Doing something good
Constantly reassuring	Being non-transactional
Making him feel better	Helping each other
Comparing compassion	Minimising own distress
Questioning the compassion of others	Struggling to think about self
Developing compassion	"Everything feels a little more doable"
Trying to give time	Feeling cared for
Not understanding self-compassion	Having a good reason
Keeping work and 'life' separate	Enabling you to do your job
Connecting with people	Entering into their world
Keeping things to yourself	Doing everything we can
Being attacked	Not being dismissive
Learning from experience	Gaining knowledge and experience
Needing an issue	Increasing awareness
Getting to know them	Having similar values
Observing people	Possessing compassion
Really noticing people	Being part of Humanity
Being different for everyone	Understanding narratives
Being deserving of help	Recognising pain
Being a compassionate person	"part of it is intrinsic"
Meeting individual needs	Being a nice person
Getting through	Sacrificing your needs
Struggling	Guessing what they need
Doing it together	Not about a process
Doing the best you can	Not doing it for the money
Offering hope	Making you feel good
Needing connection	Enjoying the job
"Give them all your time"	Getting to know people
Caring	Developing a relationship
Wanting to change it	Regarding the whole person
Experiencing neglect	Fulfilling a purpose
Hearing people's stories	Failing as a human
Wanting to help	Getting a connection
Crossing the line	Feeling supported
"I feel how they feel"	Forming an attachment
Trying to imagine how they feel	Recognising injustice
Alleviating distress	Feeling overwhelmed
"In any way that you can"	Coming from the person

## Initial coding process

Excerpt from interview with Joe	Initial codes
<p>I mean with, it's something that we've discussed quite a bit, like jokingly, as a cohort, which despite talking about all that practice thing, there's an element of like, there's almost like you have a, a limited amount of compassion and you're really, really compassionate at work and you make all those allowances for very good reasons as to behaviours that perhaps if one of your friends spoke to you that way you absolutely wouldn't accept it and that you have all this time, long shifts and long days even just the way you have to write an essay when we're at uni, you have all that compassion time, rather than that practice making you necessarily more compassionate outside of the healthcare side, it's like you can use it all up.</p>	<p>Having discussions            Joking with cohort            Sharing experiences              Having a limited amount of compassion            Being extremely compassionate            Making allowances            Understanding narratives            Comparing patients and friends            Not accepting behaviour            Working long hours            Having academic demands              Being more/less compassionate              'It's like you can use it all up'</p>

## Appendix O: Example of Focused Coding

Person speaking	Transcript Content	Focused codes
Interviewer	I'm interested about how your compassion has developed over the time that you have been doing your training?	
Sally	I think it has massively because I didn't work in care before I started this course, so obviously it's something that I've had to kind of build up from the bottom. Erm, some of it is kind of using things that you've learnt throughout your life, I think, so I've kind of been able to use generic kind of compassionate behaviours urm but also I think tailor them to the individuals so not necessarily treat everybody the same way, it's kind of, recognising the behaviours and all that kind of thing and thinking where your kind of skills are needed in those particular moments. I think I've got kind of better at that toning, toning? Honing in on what the individual might need.	<p>Building compassion</p> <p>Using life skills</p> <p>Respecting the individual</p> <p>Accepting and understanding people</p>
Interviewer	Yeah?	
Sally	Yeah	
Interviewer	So it might be different for each person?	
Sally	Yeah, I think just to come across as positive and that kind of thing is across the board but like I said with everyone, everyone's got an individual history, individual behaviours and it's getting to know the person, getting to know their, like their personality traits, what they've been through, how their illness presents and that kind of	<p>Respecting the individual</p> <p>Developing an understanding of the person</p>

Interviewer	<p>thing that can then influence how we care for them.</p>	
	<p>What do you think it is that made you interested in being compassionate to other people?</p>	
Sally	<p>Urm, that's a hard question! Urm, I don't know! I think I've always kind of been a caring person so always been a person that wants to look after other people whether that be siblings, cousins, friends, that's just kind of in my nature. Urm, so I think that helps in a professional sense, the fact that it's kind of ingrained in me to want to help other people.</p>	<p>Seeing herself as a caring person</p> <p>Compassion is in her nature</p>



## Appendix Q: Example of a Memo

### 01.10.2019 – Difficulty describing emotion

I've noticed there is a real difficulty in participants' ability to describe the emotions they are feeling, especially when asked about anything to do with their own needs or self-compassion. So far people I've noticed a few ways that this has come across:

- saying 'you' or 'we' instead of 'I' – making the sentences become less personal – is this a way of taking less responsibility or reducing guilt for thinking about themselves?
- using humour – is this to distract from further questions or minimize their own needs?
- trying but not being able to word their feelings
- using vague terminology such as feeling 'good'

It's hard to know if this is because people have never thought about it before so haven't got the words, or they can't recognise their own feelings and needs.

I wonder if they are aware that they are doing it? It felt very genuine that they couldn't describe how they were feeling or unconsciously used humour to deflect – it didn't seem like a conscious choice not to explain things.

Maybe there's something protective about it? Or something related to the role of a MHNS?

It reminds me about that research I read about midwives who were more in touch with their feelings having more secondary traumatic stress – perhaps it stops people from suffering as much from others' distress?

I guess it could also be linked to my interpretation from a psychologist's perspective. That being that I may have high expectations of others' ability to recognise and describe their feelings. Maybe this is nothing to do with MHNSs at all and is just typical of people in general?

It's definitely worth asking more participants about and comparing data from earlier and later interviews and see if it holds as a code/category.

## Appendix R: Details of Reflexivity

The researcher was new to qualitative research methodology. She is a female Trainee Clinical Psychologist who has worked alongside MHNSs in clinical settings and used Compassion Focused Therapy (CFT; Gilbert, 2010) with clients in distress. Prior views about compassion and MHNSs were acknowledged. Before commencement of interviews a bracketing interview was completed. There is disagreement amongst researchers on the optimum timing of bracketing interviews. In Grounded Theory, Glaser (1978, 1992) advocates developing an awareness of preconceptions at the start of research. Bracketing interviews are used in order to mitigate potential effects of researcher preconceptions that may influence the research (Charmaz, 2006) and can enable the researcher to access deeper layers of reflection (Tufford & Newman, 2012). Supervisor feedback from the interview was that the researcher's views appeared closely aligned to Gilbert (2014). Gilbert (2014) describes compassion as having sensitivity to suffering in one's self and others alongside desire to alleviate and prevent it. Compassion in Gilbert's (2014) definition has three 'flows'; towards one's self, to another and from another. The researcher reflected on the feedback and took care to be aware of this bias when conducting interviews with participants.

Appendix S: Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007)

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?
2.	Credentials	What were the researcher's credentials? E.g. PhD, MD
3.	Occupation	What was their occupation at the time of the study?
4.	Gender	Was the researcher male or female?
5.	Experience and training	What experience or training did the researcher have?
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement?
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic
Domain 2: study design		

No	Item	Guide questions/description
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis
Participant selection		
10.	Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball
11.	Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email
12.	Sample size	How many participants were in the study?
13.	Non-participation	How many people refused to participate or dropped out? Reasons?
Setting		
14.	Setting of data collection	Where was the data collected? e.g. home, clinic, workplace
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?
16.	Description of sample	What are the important characteristics of the sample? e.g. demographic data, date
Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?

No	Item	Guide questions/description
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?
20.	Field notes	Were field notes made during and/or after the interview or focus group?
21.	Duration	What was the duration of the interviews or focus group?
22.	Data saturation	Was data saturation discussed?
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?
Domain 3: analysis and findingsz		
Data analysis		
24.	Number of data coders	How many data coders coded the data?
25.	Description of the coding tree	Did authors provide a description of the coding tree?
26.	Derivation of themes	Were themes identified in advance or derived from the data?
27.	Software	What software, if applicable, was used to manage the data?
28.	Participant checking	Did participants provide feedback on the findings?
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number
30.	Data and findings consistent	Was there consistency between the data presented and the findings?

No	Item	Guide questions/description
31.	Clarity of major themes	Were major themes clearly presented in the findings?
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?

Appendix T: Participant contribution to categories

	“Pure concern for other”	Doing good, being good	Safe to learn	“We’re all in this together”	Care for self for others
Jade	✓	✓	✓		
Phoebe	✓	✓		✓	✓
Sally	✓	✓	✓	✓	✓
Leah	✓	✓	✓		✓
Courtney	✓	✓	✓		✓
John	✓	✓	✓		✓
Sarah	✓	✓		✓	✓
Joe	✓	✓	✓	✓	✓
Lauren	✓	✓	✓	✓	✓