Compassion Focused Approaches to

Nurse Mentoring

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by

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Declaration

I can confirm that the literature review and research contained within this thesis are my own work and have not been submitted for any other degree or to any other institution.

Compassion Focused Approaches to Nurse Mentoring

By Joanna Kucharska

Thesis Abstract

This thesis explored the delivery of Compassion Focused Approaches (CFA) and Mindfulness Based Interventions (MBIs) to support the training of healthcare professionals. Preliminary information from existing narrative reviews regarding the implementation of MBIs for Trainee Psychological Therapists (TPTs) have demonstrated potential benefits for TPTs. The systematic review aimed to identify specific areas of improvement for TPTs following their participation in MBIs. Nineteen studies of medium to high quality met the inclusion criteria. The review highlighted that MBIs have a positive impact on some areas of TPTs' psychological wellbeing, specifically on anxiety. Further, TPTs' therapeutic skills such as empathy, self-compassion, mindfulness skills and TPTs' perceived 'therapist self-efficacy' improved. Factors influencing fidelity in the delivery of the MBI amongst other issues may have influenced the outcomes.

Enhancing the underexplored nurse mentor-mentee relationship may improve the retention of pre-registration nurses. The empirical study investigated the impact of a Compassion Focused Approaches to Nurse Mentoring Programme (CFA-MP) on nurse mentors and their mentoring practice. A repeated measures mixed methods empirical study investigated the application of CFA-MP. Emergent qualitative evidence suggested that CFA-MP is helpful in facilitating the mentoring processes and that its positive impact remained over a period of at least at the 12 months follow-up. The lack of statistical power and significant gaps in participants' responses led to the quantitative analyses being unable to detect, any measureable impact of CFA-MP on nurse mentors. A qualitative service evaluation of a CFA-MP aimed to identify the key concepts in CFA that can be applied to and assist with the nurse mentoring process. Three themes emerged from the thematic analysis: 'Utility of the Model' 'Receptiveness' and 'Learning'. More research is necessary to investigate whether CFA-MP would strengthen the mentor-mentee relationship.

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Thesis Abstract	284
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Critical Appraisal	3857
Service Evaluation	5961
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Literature Review

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List of Abbreviations

FA	Compassion Focused Approaches
MBI	Mindfulness Based Intervention
TPT	Trainee Psychological Therapist
CFA-MP	Compassion Focused Approaches to Nurse Mentoring Programme
MBSR	Mindfulness Based Stress Reduction
DBT	Dialectical Behaviour Therapy
MBCT	Mindfulness Based Cognitive Therapy
ACT	Acceptance and Commitment Therapy
CFT	Compassion Focused Therapy
IAPT	Improving Access to Psychological Therapies
CINAHL	Cumulative Index of Nursing and Allied Health Literature
AMED	Allied and Complementary Medicine Database
PRISMA	Preferred Reporting Items for Systematic Review and Meta-analysis
CCAT	Crowe Critical Appraisal Tool
USA	United States of America
UK	United Kingdom
SCS	Self-Compassion Scale
IRI	Interpersonal Reactivity Index
FFMQ	Five Facet Mindfulness Questionnaire
COSE	Counseling Self-Estimate Inventory
PSS	Perceived Stress Scale
MAAS	Mindfulness Attention Awareness Scale
MLQ	Meaning in Life Questionnaire
SCS-R	Social Connectedness Scale-Revised
SREIT	Self-Report of Emotional Intelligence
BAI	Beck Anxiety Inventory
CESD	Centre for Epidemiological Studies-Depression

FMI	Freiburg Mindfulness Inventory
SWLS	Satisfaction With Life Scale
PANAS	Positive and Negative Affect Schedule
DERS	Difficulties in Emotion Regulation Scale
DASS21	Depression Anxiety and Stress Scales
AHI	Authentic Happiness Inventory
STEP	Questionnaire for General and Differential Individual Psychotherapy
SCL-90R	Symptom Checklist
VEV	Questionnaire of Changes in Experience and Behavior
SRS	Session Rating Scale
TPI-C	TPI-C Therapist Presence Inventory—Client Form
ASS	Affective Sensitivity Scale
TEI	The Experience Inquiry
POI	Personal Orientation Inventory
KIMS	Kentucky Inventory of Mindfulness Skills
MHPSS	Mental Health Professional Stress Scale
ASHS	Counselor Activity Self-Efficacy Scales Helping Skills
WAI-SF	Working Alliance Inventory-Short Form
AAQ	Acceptance and Action Questionnaire
WBSI	White Bear Suppression Inventory
VLQ	Valued Living Questionnaire
RRQ	Rumination-Reflection Questionnaire
HADS	Hospital Anxiety and Depression Scale
STAI	State-Trait Anxiety Inventory
STAXi-2	State-Trait Anger Expression Inventory-2
BDI	Beck Depression Inventory
MAAS	Mindful Attention Awareness Scale
CPT	Continuous Performance Test
ANOVA	Analyses of Variance
MANOVA	Multivariate Analysis of Variance

GHQ-28	General Health Questionnaire-28
CASES	Counselor Activity Self-Efficacy Scales-Helping Skills Scale
TMS	Toronto Mindfulness Scale
TPI-T	Therapist Presence Inventory–Therapist form
T1	Pre-intervention
T2	Post five day psychoeducation programme
T3	End of the tenth supervision session
T4	Two months follow-up
NHS	National Health Service
NMC	Nursing and Midwifery Council
BPS	British Psychological Society
CEAS	Compassionate Engagement and Action Scales
CSE	Compassion for Self Engagement
CSA	Compassion for Self Actions
CTOE	Compassion To Others Engagement
CTOA	Compassion To Others Actions
CFOA	Compassion From Others Engagement
GHQ-12	General Health Questionnaire-12
SS	Stress Subscale of the Depression, Anxiety and Stress Scale
ProQOL V	Professional Quality of Life Scale
CSS	Compassion Satisfaction Scale
BS	Burnout subscale
STSS	Secondary Traumatic Stress Subscale
V1	Vignette 1
V2	Vignette 2
V3	Vignette 3
V4	Vignette 4
RMN	Registered Mental Nurse
RLDN	Registered Learning Disability Nurse
RGN	Registered General Nurse
IQR	Inter Quartile Range

PS-S	Practical Self-Soothing
SB	Safe Place Imagery
SPI	Compassionate Imagery: Me at My Best
CIMMB	Compassionate Imagery: Me at My Best
CICC	Compassionate Imagery: Compassionate Companion
AOCM	Allowing Others to be Compassionate to Me
BCO	Behaving Compassionately to Others
BCM	Behaving Compassionately to Myself
HOC	Higher Order Category
LOC	Lower Order Category
BABCP	British Association of Behavioural and Cognitive Therapies
CU	Coventry University
RCN	Royal College of Nursing
SRN	State Registered Nurses

Literature Review

Mindfulness Based Interventions for Trainee Psychological Therapists:

A Systematic Review

By Joanna Kucharska

Target Journal: British Journal of Clinical Psychology

Mindfulness Based Interventions for Trainee Psychological Therapists: A Systematic Review

Abstract

Objectives: Existing narrative reviews have demonstrated the potential benefits for Trainee Psychological Therapists (TPTs) participating in Mindfulness Based Interventions (MBIs). This systematic review aimed to identify areas of improvement in TPTs' wellbeing, therapeutic skills, and their development of MBI skills, academic learning and improvements in their therapeutic outcomes following their participation in MBIs.

Methods: A systematic search of seven electronic databases and the examination of relevant studies' reference lists resulted in 19 studies for review. The Crowe Critical Appraisal Tool (Crowe, 2013) was used to assess the quality of studies and inform the analysis and critique of the studies.

Results: Improvements were found in TPTs' wellbeing specifically: Anxiety and therapeutic skills such as empathy; self-compassion; mindfulness skills; and TPTs' perceived 'therapist self-efficacy'. There was limited evidence of decreased client distress post MBIs for TPTs.

Conclusions: MBIs have a positive impact on areas of TPTs' psychological wellbeing and therapeutic skills. Factors influencing fidelity in the delivery of the MBI amongst other issues may have influenced outcomes.

Practitioner Points

Implications for education and practice

- There is growing evidence to support the integration of MBIs into TPTs' training programmes.

Limitations

- The diverse range of TPTs and the differing demands of their training programmes may have compromised the outcomes of this review.
- TPTs' qualitative views on the benefits and the difficulties that MBIs may present were excluded.
- There is the potential for publication and selection biases as non-peer reviewed studies were excluded.

1.1 Introduction

Research in the area of Mindfulness Based Interventions (MBIs) has grown rapidly over the last thirty years, despite there being no clear definition for MBIs (Cheisa, 2013). MBI research encompasses third wave cognitive behavioural approaches[1], Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 2005), and traditional interventions including Zen and Vipassana meditations. The clinical applications of MBIs have been extensively reviewed including anxiety and depression (Hofmann, Sawyer, Witt, & Oh, 2010) and aggression (Fix & Fix, 2013). Further, reviews have focused on MBIs for staff wellbeing within the general workforce (Luken & Sammons, 2016); and healthcare staff (Lomas, Medina, Ivtzan, Rupprecht, & Eiroa-Orosa, 2018). The present review aimed to examine research where a specific population of healthcare professionals in training, namely Trainee Psychological Therapists (TPTs) participated in MBIs. This involved recognising and summarising areas of improvement for TPTs following the delivery of the MBIs.

1.1.1 Previous research and literature reviews in health care: An overview

1.1.1.1 Health and wellbeing in healthcare

The deleterious effect of the National Health Service's (NHS) working cultures on staff health and psychological wellbeing, patient care alongside intra and inter professional relationships has previously been highlighted by Boorman (2009; 2010) and Francis (2013). Specifically these authors raised concerns such as bullying, harassment, increased workloads and target driven services. Despite, the implementation of Department of Health's (2009a; 2009b; 2011) and Department for Work and Pensions'

[1] Dialectical Behaviour Therapy (DBT; Linehan, 2015), Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2012), Acceptance and Commitment Therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006), and Compassion Focused Therapy (CFT; Gilbert, 2014)

(2009) strategies to improve these working cultures and improve staff mental health increased workloads and limited resources continue to affect healthcare professionals' wellbeing (Dudman, Isaac, & Johnson, 2015). Importantly, organisations that prioritise staff wellbeing have demonstrated improvements in the delivery of patient care and in staff sickness rates (Boorman, 2009).

Although organisational change has been considered crucial in improving staff wellbeing, there is recognition that such change can be slow (The National Workforce Skills Development Unit, 2019). Further, Nelson and Quick (2013) highlight overall change in an organisation occurs when it is addressed at organisational and individual levels. The NHS Staff and Learners' Mental Wellbeing Commission (2019) reinforced this assertion by emphasising for example, the need for individual self-care in qualified and trainee healthcare professionals in addition to organisational change.

1.1.1.2 MBIs for healthcare professionals

Recent reviews have demonstrated how healthcare professionals' wellbeing benefits from their participation in MBIs. Particularly, reductions were found in stress, anxiety, depression, burnout, and increased levels of empathy, general wellbeing and coping (Lamothe, Rondeau, Malboeuf-Hurtubise, Duval, & Sultan, 2016; Lomas et al., 2018). MBI research has expanded to include those in training with similar improvements demonstrated in systematic reviews for uni-professional groups for example the medical and the nursing professions (Guillauime, Boiral & Champagne, 2017; Regehr, Glancy, Pitts, & LeBlanc, 2014).

1.1.1.3 MBIs in healthcare professionals in training

Academic stresses (including assignments and issues with academic staff) and clinical practice pressures (such as the challenging clinical environment, the clinical work itself

and tensions with clinical supervisors) have been identified as key stressors for healthcare professionals in training. This has been found in many professional groups including dental, nursing/midwifery, and medical students (Alzahem, van der Molen, Alaujan, Schmidt & Zamakhshary, 2011; Gold, Johnson, Leydon, Rohrbaugh & Wilkins, 2015; McCarthy et al., 2018). Consequently, studies exploring how interventions including MBIs could support healthcare professionals in training have increased (Stillwell, Vermeesch & Scott, 2017). Specifically, in practitioner training, research has focused on the impact of student wellbeing, student stress, the development of clinical skills, and enhanced learning. A range of benefits have been reported for medical, nursing/midwifery and social work students including reduced stress and suggested increase in academic success (Daya & Heath Hearn, 2018; Manocchi, 2017; McCarthy et al., 2018; Trowbridge & Mische Lawson, 2016).

1.1.2 TPTs

A range of psychological therapists working in healthcare settings. These include counsellors, cognitive behavioural therapists, clinical psychologists, and counselling psychologists (Health Education England, 2018). The inception of initiatives such as Improving Access to Psychological Therapies (IAPT; NHS England, 2018) has broadened and increased the numbers of these professions and TPTs. The stressors affecting healthcare professionals in training were noted in the training of TPTs such as trainee clinical psychologists (Cushway, 1992). Further, since 2014 the New Savoy Partnership has assessed the wellbeing of psychological therapist working in IAPT services and consistently demonstrated over 40% of staff felt depressed, above 70% were concerned about low staffing numbers and approximately a quarter of staff were considering leaving the NHS (Marzouk, 2019). Opportunities for TPTs to engage in

personal therapy during their training have been considered beneficial in supporting TPTs, not only to safeguard clients (by enhancing TPTs' self-awareness, understanding of interpersonal dynamics and improving clinical effectiveness), but in maintaining TPTs' wellbeing through enhanced emotional resilience (Murphy, Irfan, Barnett, Castledine & Enescu, 2018). However, there is variability within the psychological therapy professions regarding mandatory personal therapy during training (Malikiosi-Loizos, 2013). Recently, research has indicated that although mandatory personal therapy can be of benefit to TPTs, it can increase TPTs' distress (Murphy et al., 2018). Therefore, alternatives to improve TPTs' wellbeing should be considered.

1.1.3 TPTs and MBIs

Increasingly MBI research has focused on TPT participant groups. For example, cultivating self-care and compassion in trainee cognitive-behavioural therapists, exploring changes in perceived stress and self-care for counselling students, and investigating self-care and professional development for trainee clinical psychologists (Boellinghaus, Jones & Hutton, 2013; Felton, Coates & Christopher, 2013; Hemanth & Fisher, 2015a). MBIs are considered helpful for TPTs so they can acquire specific MBI therapeutic skills through direct personal experience (Boellinghaus, Jones & Hutton, 2013; Bohecker & Doughty Horn, 2016; Rimes & Wingrove, 2011). This form of learning is aligned with the Declarative-Procedural-Reflective model, which has highlighted the benefit of TPTs' experiential learning of an intervention (Bennett-Levy, 2006).

Christopher & Maris' (2010) narrative review of qualitative research in counsellor training reported that MBIs improve self-care and reduce burnout, compassion fatigue and vicarious trauma. A later narrative review of seven MBI research studies by

Hemanth and Fisher (2015b) included quantitative, mixed method and qualitative studies. The qualitative data indicated that MBIs increased TPTs' self-awareness in therapy sessions. The authors suggested that such self-awareness enabled TPTs to tolerate their own and their clients' affect as well as improve how TPTs managed countertransference. In addition, MBIs improved TPTs' attention skills, empathy and compassion towards clients. The quantitative data demonstrated improvements for TPTs in a variety of areas including perceived stress, rumination, self-compassion, attention skills, positive affect, life satisfaction, and therapeutic outcomes.

1.1.4 Summary and rationale for conducting the present review

Organisational cultures in healthcare such as the NHS directly affect the health and wellbeing of staff and, ultimately patient care. Whilst organisational change to improve working cultures in these services is vital, consideration of interventions that support the individual to improve their health and wellbeing is also warranted. There have been a number of systematic reviews focused on the use of MBI's with healthcare professionals in training, such as social work students and their qualified colleagues and medical students (Trowbridge & Mische Lawson, 2016; Daya & Heath Hearn, 2018). However, there have been no systematic reviews focused on the use of MBIs with TPTs. The existing narrative reviews with TPTs have highlighted that MBIs improve emotional wellbeing, life satisfaction, therapeutic skills and therapeutic outcomes. Whilst these reviews have provided useful preliminary information regarding the implementation of MBIs with TPTs, a more systematic review of this literature is required. Further, no review has explored changes in TPTs' learning post MBI. Therefore, a systematic review was undertaken to examine existing peer

reviewed quantitative MBI research for TPTs and investigate the effect of MBIs for TPTs.

1.1.5 Aims

The overall purpose of this review was to add to growing body of systematic reviews for the healthcare professionals in training population, to consolidate the research of MBIs for TPTs, and to identify and summarise specific areas of change for TPTs following their participation in MBIs. The first specific aim was to examine whether results of reviewed studies demonstrated improvements in TPTs' wellbeing. Previous research has defined subjective wellbeing as a combination of positive and negative affect and life satisfaction (Brown & Ryan, 2003; Collard, Anvy & Boniwell, 2008). For the purpose of this review, this definition of wellbeing was been extended to include psychological distress (general mental health, stress, anxiety, rumination, depression, affect, anger, eudaimonic happiness[2]) social connectedness and life satisfaction. The second specific aim was to explore the evidence regarding changes in TPT learning post MBI. These would include TPTs' therapeutic skills, development of MBI skills and academic learning. Finally, the third specific aim was to examine what changes in therapeutic outcome have been reported for TPTs post MBI, including changes in client distress and the effect of MBIs on the client and TPT's experience of therapy.

1.2 Method

For the purposes of this review, TPTs were defined as those training to be counsellors, clinical psychologists, counselling psychologists, and other related graduates of applied psychology programmes including health psychologists, cognitive behavioural

[2] Kashdan, Biswas-Diener and King (2008) describe eudiamonic happiness as resulting from individuals living with meaning and purpose through for example virtuous activities, ethical living and friendships as opposed to the experience of pleasure itself.

therapists, and psychotherapists including psychiatrists specifically training in this area.

1.2.1 Inclusion/exclusion criteria

In keeping with the broad aims of this literature review, no restriction in date was applied to the search (other than the dates of the search itself). Studies were screened via titles, abstract or main text to assess for their eligibility to be included in this review (see Table 1.1 for inclusion/exclusion criteria). Primarily studies were included if they were peer reviewed, written in English and had quantitative or mixed methodologies, delivered a MBI, and where participants were TPTs.

Table 1.1. Inclusion/Exclusion Criteria

Criteria	Inclusion	Exclusion
Language	English	Non-English
Peer Reviewed	Peer Reviewed	Unpublished/not peer reviewed
Methodology	Quantitative or Mixed Methods with extractable quantitative data element	Qualitative
Participants	Trainee Psychological Therapists (i.e. Trainee: Psychologists, Counsellors, Psychotherapists, Cognitive Behaviour Psychotherapists, and Psychiatrists).	Other trainee health and social care professions Combined qualified and trainee psychological therapists were data could not be separated
Focus	MBI delivered to Trainee Psychological Therapists	MBI not delivered to Trainee Psychological Therapists

1.2.2 Search overview

A systematic search of the literature was completed for quantitative research investigating MBIs for TPTs. The researcher alongside the subject librarian refined search terms prior to the search to ensure relevant subject headings, synonyms, wildcards and appropriate adjacency terms were used in conjunction with Boolean operators “AND” and “OR” (see Table 1.2).

Table 1.2. Search terms used for literature review

Concept	Data base	Terms		Location
Trainee Psychological Therapist **AND**	PsychInfo; CINAHL; AMED; Academic Search Complete	train* N2 therapist* **OR** train* N3 "clinical psychologist" **OR** train* N2 counsel* **OR** train* N2 psychiatr* **OR** train* N2 psychother*		Title Abstract Main Text
	Scopus	train* W/2 therapist* **OR** train* W/3 "clinical psychologist" **OR** train* W/2 counsel* **OR** train* W/2 psychiatr* **OR** train* W/2 psychother*		
	Web of Science	train* NEAR/2 therapist* **OR** train* NEAR/3 "clinical psychologist" **OR** train* NEAR/2 counsel* **OR** train* NEAR/2 psychiatr* **OR** train* NEAR/2 psychother*		
	Medline	train* ADJ2 therapist* **OR** train* ADJ 3 clinical psychologist **OR** train* ADJ 2 counsel* **OR** train* ADJ2 psychiatr* **OR** train* ADJ 2 psychother*		
Mindfulness Based Intervention	PsychInfo	Subject Headings	Mindfulness **OR** Acceptance and Commitment Therapy **OR** Dialectical Behavior Therapy **OR** Meditation	Title Abstract Main text
	CINAHL		Acceptance and Commitment Therapy **OR** Mindfulness **OR** Meditation	
	AMED		Mindfulness **OR** Mindfulness-based stress reduction **OR** Meditation	
	Academic Search Complete		Acceptance & commitment therapy **OR** Mindfulness-based cognitive therapy **OR** Mindfulness (Psychology) **OR** Meditation **OR** Dialectical behavior therapy	
	Medline		MINDFULNESS/ or Meditation **OR** "acceptance and commitment therapy"/ or mindfulness/ OR MEDITATION/	
	All	Keywords	Mindful* **OR** Meditation OR Acceptance Commitment Therapy OR ACT OR DBT	
	PsychInfo; CINAHL; AMED; Academic Search Complete: Scopus; Medline	Wildcards	Dialectical Behavio?r Therapy	
	Web of Science		Dialectical Behavio$r Therapy	

1.2.3 Study selection

The search was completed between 01.05.18 and 08.06.18 using PsychInfo, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Allied and Complementary Medicine Database (AMED), Academic Search Complete, Scopus, Web of Science and Medline databases. Articles were selected according to the 'Preferred Reporting Items for Systematic Review and Meta-analysis' (PRISMA) diagram (Moher, Liberati, Tetzlaff & Altman, 2009) shown in Figure 1.1. A total of 2039 articles were originally generated through the database searches and additional records. Following the removal of 114 duplicates, an additional 1,848 studies were excluded at the title/abstract phase for either being a MBI directed towards specific clinical populations, unrelated medical interventions and guidelines, or combined qualified professionals with trainee health and social care workers. This reduced the total to 77 articles. A full text screening of the remaining studies excluded a further 58 papers which did not meet the inclusion criteria leaving 19 papers in total that met the inclusion criteria.

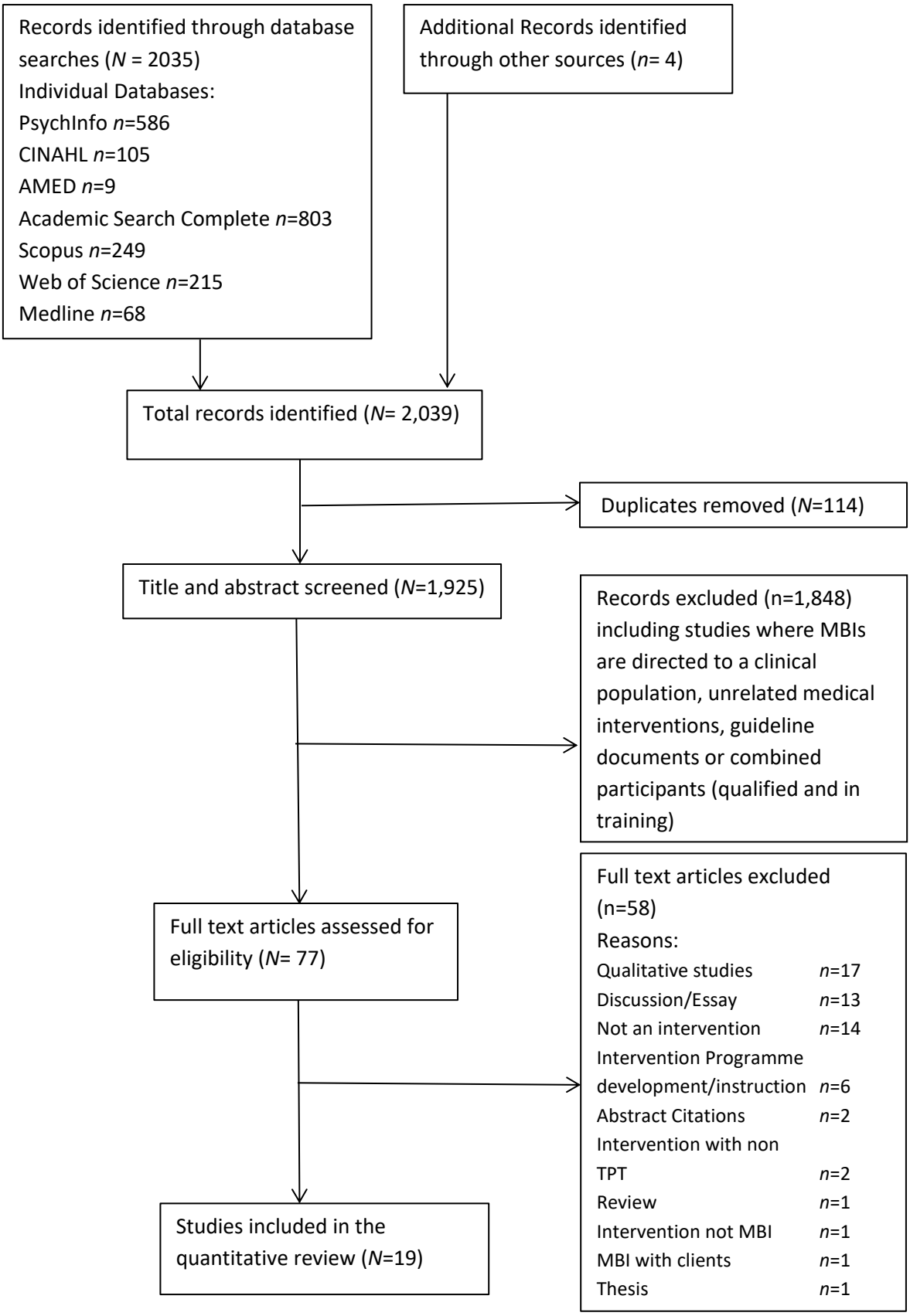

Figure 1.1. PRISMA Flow diagram (Moher et al., 2009)

1.2.4 Assessment of methodological quality

The reviewed studies varied in their methodological design, therefore the Crowe Critical Appraisal Tool (CCAT; Crowe, 2013) was selected as a quality assessment tool. The CCAT was specifically developed for a diverse range of methodologies and was subjected to reliability analysis using intraclass correlation coefficients and generalisability theory (Crowe, Sheppard & Campbell, 2013). Their analyses indicated acceptable to good consistency coefficients of 0.72 and 0.91 for all designs except Descriptive, Exploratory, Observational designs (0.64).

To improve reliability all 19 papers were quality assessed by an independent researcher. Kappa coefficients (Cohen, 1960) were calculated to check inter-rater reliability, with an overall reliability score *K*=0.84 suggesting a 'very good' overall strength of agreement (Altman, 1999). All Kappa coefficients were above .74 except one quality assessment that still achieved a moderate strength of agreement of .62. A summary of the individual studies quality assessment can be seen in Appendix A. Thirteen (68%) studies were considered of high quality with scores of 70% or above. Four (21%) studies scored between 60-70% and two (11%) studies scored between 50-60%. All of the quality assessed studies were included in the review.

1.2.5 Data Extraction

To address the aims of the review the same information was extracted from each of the research papers. This included the authors, date of publication, country of origin, quality rating, aims and hypotheses, design and sampling method, method of analysis, standardised measured used, the type of MBI, number of sessions TPTs attended, the experience of facilitator, participant information (type of TPT, sample size, demographic information), and the key findings. There was a lack of homogeneity of

studies therefore a meta-analysis was not appropriate and a systematic review of the data was conducted.

1.3 Results

This section briefly outlines the characteristics of studies included in the review (summarised in Table 1.3).

1.3.1 Characteristics of Studies

Eight studies were from United States of America (USA; Bohecker & Doughty Horn, 2016; Cohen & Miler, 2009; Ivanovic, Swift, Callahan & Dunn, 2015; Leppma & Young, 2016; Lesh, 1970; Schomaker & Ricard, 2015; Shapiro, Brown & Biegel, 2007; Swift, Callahan, Dunn, Brecht, & Ivanovic, 2017). Four were Australian (Finaly-Jones, Kane & Rees, 2016; Hopkins and Proeve, 2013; Pakenham, 2015; Stafford-Brown & Pakenham, 2012). Four were from the United Kingdom (UK; Beaumont, Rayner, Durkin & Bowling, 2017; Collard, Avny & Boniwell, 2008; Moore, 2008; Rimes & Wingrove, 2011). Two studies were from Germany (Grepmair et al., 2007a; Grepmair, Mitterlehner, Loew, & Nickel 2007b). One study was from Spain (Rodriguez Vega et al., 2014). All but three of the studies employed repeated measures designs. Bohecker and Doughty Horn (2016) used a Solomon four group design[3], Schomaker and Ricard (2015) used an A-B Single-Case Experimental Design, and Shapiro et al. (2007) used a prospective, nonrandomized, cohort-controlled design. Sample sizes ranged from 5 (Schomaker & Ricard, 2015) to 103 (Leppma & Young, 2016). The mean age of participants ranged

[3] The Solomon four-group design where participants are randomly assigned to one of four conditions: Condition 1 receives a pre-test and experimental and posttest; Condition 2 receives no pretest, and receives the experimental intervention with posttest; Condition 3 receives pretest and posttest but not the experimental intervention; Condition4 receives posttest only (Rosnow & Rosenthal, 2005).

from 26 years (Cohen & Miller, 2009) to 40.2 years (Schomaker & Ricard, 2015) with the majority being female (ranging from 70% to 100%). Participants were from either a discrete psychological profession or combinations of psychological therapy trainees. Within these professions, there were some differences in the level of academic study (as shown in Table 1.3). A brief summary of types of MBI, the protocol used and the delivery of the MBIs can be seen in Appendix B. The MBI facilitators' experience and additional supervision information is summarised in Appendix C. More comprehensive details are summarised in Table 1.3.

Table 1.3. Characteristics of studies

Quality Rating (QR) (%) **Kappa Rating**	**Authors** **Date** **Country of origin**	**Aims** **Hypotheses (where stated)**	**Design and sampling method (where mixed methods only quantitative aspect of design is extracted)**	**Method of Analysis** **Measured Used**	**Type of Mindfulness Based Intervention (MBI)** **Where stated how many sessions participants attended;** **if MBI was facilitated: Experience of facilitator**	**Participants** **Type of Trainee Psychological Therapist (TPT)** **Sample Size (*N*)** **Demographics:** **Where stated: gender; age; ethnicity; religion; socio-economic status; previous mediation practice**	**Key Findings**
QR=50% *K*=.81	Beaumont, Rayner, Durkin and Bowling 2017 UK	To explore whether CMT would increase self-compassion, compassion for others, dispositional empathy and reduce self-critical judgement	Mixed Methods: Quantitative: Repeated measures Convenience sampling	Paired sampled t-tests **Measures:** Self-Compassion Scale (SCS; Neff, 2003b) Compassion for Others Scale (Pommier, 2011) The Interpersonal Reactivity Index	6 sessions of Compassionate Mind Training based on Gilbert's (2009, 2014) model	Post Graduate Diploma in Cognitive Behavioural Psychotherapy *N*=21 (19 women; 90%)	**Self-Compassion and Critical Judgement: SCS** A significant increase in Self-Compassion post training, $t(20)=-2.47$, $p=.022$ A significant decrease in Self-critical judgement post training, $t(20)=-2.78$, $p=.012$ **Compassion for Others Scale** Increased scores on this scale did not reach statistical significance post training $t(17)=-1.56$, $p=.139$ **Empathy: IRI** No differences pre to post training for

				(IRI; Davis, 1980)			Empathic concern, *t*(19)=−4.67, *p*>.05 Fantasy scale, *t*(20)=−3.23, *p*>.05 Perspective taking, *t*(20)=1.63, *p*>.05 Personal distress, *t*(20)=1.55, *p*>.05
QR=70% *K*=1.00	Bohecker and Doughty Horn 2016 USA	To provide a further understanding of the relationship between the Mindfulness Experiential Small Group (MESG) and demonstrate an increase in mindfulness skills, empathy, counseling self-efficacy and a decrease in stress	Solomon four-group Purposeful sampling	Independent groups t-test **Measures:** Five Facet Mindfulness Questionnaire (FFMQ**;** Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) The Interpersonal Reactivity Index (IRI; Davis, 1980), The Counseling Self-Estimate Inventory (COSE; Larson et al., 1992),	The Mindfulness Experiential Small Group (MESG) curriculum (Bohecker, Wathen, Wells, Salazar & Vereen, 2014) Facilitators: Doctoral level students with intensive training in the MESG curriculum and supervision from first author	Master's Counsellor students *N*=22 (16 women; 72.7%) Mean age= 28.7 years (*SD*=9.4) Ethnicity: 90.9% (*n*=20) White/Caucasian; 4.5% (*n*=1) biracial (Black/Africa American-White/Caucasian); 4.5% (*n*=1) Hawaiian/Pacific Islander Religion: 27.3% (*n*=6) Christian 22.7% (*n*=5) LDS 18.2% (*n*=4) Spiritual, Unaffiliated 9.1% (*n*=2) Catholic Orthodox 4.5% (*n*=1) Christian	Significant improvements were shown for the MESG group post intervention for **Mindfulness:** **FFMQ** All but one subscale for MESG group: Observing: *t*(2)=2.13, *p*=.046 Describing: *t*(20)=2.19, *p*=.040 Awareness: *t*(20)=2.25, *p*=.036 Non-judging: *t*(20)=1.74, *p*>.05 Total: *t*(20)=2.46, *p*=.023 **Empathy: IRI** Increased empathy levels, *t*(20)=3.01, *p*=.007 **Self-Efficay: COSE** Total score: *t*(20)=2.42, *p*=.025 Process subscale: *t*(20)=2.85, *p*=.010 **Stress: PSS**

				The Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983).		4.5% (*n*=1)Religious Affiliated 4.5% (*n*=1) Atheist 4.5% (*n*=1) Questioning. Socio economic status: 50.0% (*n*=11) Middle household income level 4.5% (*n*=1) Upper 9.1% (*n*=2) Upper Middle 27.3% (*n*=6) Lower Middle 9.1% (*n*=2) Very Low	No significant change: *t*(20)=-.10, *p*=.925
QR=67.5% *K*=.82	Cohen and Miller 2009 USA	To expand on preliminary research supporting the feasibility and helpfulness of mindfulness interventions for graduate students in psychology. To investigate the feasibility and helpfulness of a novel adaptation of MBSR (Mindfulness	Repeated Measures (Pre-Post Intervention with no control) Convenience sampling	Repeated Measures Analysis of Variance (ANOVA) Effect sizes with Cohen's *d* **Measures:** Mindfulness Attention Awareness Scale (MAAS; Brown & Ryan, 2003) Perceived Stress Scale (PSS; Cohen,	Interpersonal Mindfulness Training (IMT) modelled after manualised Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 2005) with an added emphasis placed on relational awareness: 6 weeks for 90 mins All participants attended at least 5 of the 6 sessions	Psychology master's level (*n*=20) Doctoral clinical psychology student (*n*=1) *N*=21 95% (*n*=20) women Age range 22-46 years Mean Age=26 (Median=24 years) Ethnicity *N*=20 66.7% (*n*=14) White-non-Latino; 8% (*n*=1 4)African American; 4.8% (*n*=1) Asian;	**Significant change posttest for:** **Mindfulness: MAAS** Increased mindfulness *F*(*)=10.04 *p*=.005) *d*=.49 **Stress: PSS** Decreased stress, *F*(*)==14.96, *p*=.001, *d*=.55 **Life Satisfaction: SWLS** Increased satisfaction *F*(*)=4.93, *p*<.01, *d*=.45 **Emotional Intelligence: SREIT** Increased reported emotional intelligence, *F*(*)=6.40, *p*<.05, *d*=.40 **Anxiety: BAI**

* Not provided

		Based Stress Reduction) that stresses relational awareness.		Kamarck & Mermelstein 1983) Meaning in Life Questionnaire (MLQ; Steger, Frazier, Oishi & Kaler 2006) Satisfaction With Life Scale (SWLSa; Pavot & Diener 1993) Social Connectedness Scale-Revised (SCS-R; Lee, Draper & Lee, 2001) Self-Report of Emotional Intelligence (SREIT; Shutte et al 1998) Beck Anxiety Inventory (BAI; Beck 1990) Centre for Epidemiological	The facilitator was an "experienced Mediation Teacher" (Cohen & Miller, 2009, p.2763)	4.8% (*n*=1) mixed White/Latino; 4.8% (*n*=1) Spanish/Mexican; 4.8% (*n*=1) Indian American Previous meditation practice *n*=20 55% (*n*=11) none; 35% (n=7) monthly; 9.6% (n=2) several times/week or daily	Decreased Anxiety, *F*(*)=5.73, *p*<.05, *d*=.47 **Social Connectedness: SCS-R** Increased Social Connectedness *F*(*)=16.02, *p<.002*, *d*=.59 **No significant change post-test for:** **Depression: CESD** *F*(*)=.53, *p=.47*, *d*=.12 **Quality of Life: MLQ - Presence** *F*(*)=.363, *p=.54*, *d*=.12 **Quality of Life: MLQ - Searching** *F*(*)=3.71, *p=.07*, *d*=.36

				Studies-Depression (CESD; Radloff, 1977)			
QR=73% *K*=.82	Collard, Avny and Boniwell 2008 UK	Participants' level of Mindfulness will increase following Mindfulness Based Cognitive Therapy (MBCT) programme. Participants' Satisfaction with Life will increase following MBCT. Participants' level of Negative Affect will decrease while level of Positive Affect will remain unchanged following MBCT. Longer weekly practice time of Mindfulness during the MBCT programme will	Repeated Measures (Test–Retest) within participants design Convenience sampling	Dependent t-tests, Pearson Correlation **Measures:** Freiburg Mindfulness Inventory (FMI; Walach, Buchheld, Buttenmuller, Kleinknecht, & Schmidt, 2006) Satisfaction With Life Scale (SWLSb; Diener, Emmons, Larsen & Griffin, 1985) Positive and Negative Affect Schedule (PANAS; Watson, Clark & Tellegen, 1988).	8 week Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002) Participant session attendance not stated Facilitator has only done short introductions to MBCT in previous years	Diploma of Integrative Counselling and Psychotherapy *N*=16 (14 women, 87.5%) but only 15 sets of data analysed Age 24-56 (no mean provided)	**Levels of Mindfulness: FMI** A significant increase in mindfulness post-test, $t(14)=-1.97$, $p<.05$, r=.47 **Life Satisfaction: SWLS** Posttest, no significant differences $t(14)=1.74$, $p=.052$ **Changes in affect: PANAS** **Positive Affect:** Post-test no significant change in $t(14)=.64$, $p=.267$; **Negative Affect:** Post-test a significant decrease $t(14)=2.40$, $p<.05$, $r=.54$ **Pearson's Correlations** A significant correlation between Mindfulness and Negative Affect $r=-.572$, $p<.05$. **Duration of Practice:** **L**onger weekly Mindfulness practice during the course was significantly associated with a higher level of Mindfulness by the end of the MBCT programme, $r=.46$, $p<.05$

		be associated with a higher level of Mindfulness at the end of the programme					
QR=77.5% *K*=.81	Finaly-Jones, Kane and Rees 2016 Australia	To conduct a preliminary investigation of the feasibility and effectiveness of the Self-Compassion Cultivation Online (SCO) programme for increasing self-compassion, and reducing symptoms of psychological distress, including perceived stress, emotion regulation difficulties, and symptoms of depression, anxiety, and stress.	Repeated measures Purposeful sampling	Multilevel mixed effects linear regression Cohen's d for effect sizes **Measures:** Self-Compassion Scale (SCS; Neff, 2003) Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983) Emotion Regulation Scale (Difficulties in Emotion Regulation Scale, [DERS],	6 week self-compassion Cultivation Online (SCO) cultivation programme developed from compassion-focused therapy (Gilbert, 2010), and Mindfulness and Acceptance-Based (MAB) interventions (Roemer & Orsillo, 2009)	Post Graduate psychology trainees *N*=37 21.62% (*n*=8) postgraduate counselling psychology program; 78.38% (*n*=29) postgraduate clinical psychology program 89% women Mean age= 32.61 years	**Self-Compassion: SCS** Significant positive change (Bonferroni-corrected alpha level of .008)of *F*(2,65)=28.51, *p*<.001 post-test,*d*=.86, maintained at follow-up, *d*=1.15 **Stress: PSS** Significant decrease post-test *F*(2,66)=4.97, *p*=.002, *d*=.52,maintained at follow-up *d*=.48 **Emotional Regulation: DERS** Post-test: a significant reduction in emotional regulation difficulties (Bonferroni-corrected alpha level of .008) of *F*(2,65)=17.01, *p*<.001, *d*=.62, maintained at follow-up, *d*=.52 **Depression, Anxiety, and Stress DASS-21** Bonferroni-corrected alpha level of .017: **Depression** *F*(2,67)=5.37, *p*=.007 Pre- to post-test scores showed a significant decrease (*p*=.002,

		To examine the effect of the SCO program on eudaimonic happiness		Gratz & Roemer, 2004) Depression Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995) Authentic Happiness Inventory (AHI; Peterson & Park, 2008)			*d*=.54, maintained at follow up, *d*=.31 **Anxiety** *F*(2,65)=7.92, *p*=.001 with a significant decrease shown only between pre-test and follow-up, *p*=.003, =.52 **Stress** *F*(2,67)=14.60, *p*<.001 Pre- to post-test scores showed a significant decrease, *p*<.001,(*d*=.85, maintained at follow up, *d*=.46 **Eudaimonic Happiness: AHI** Significant positive change, *F*(2,67)=6.75, *p*=.002, at post-test of *p*<.001, *d*=.59 and maintained at follow up, *d*=.23
QR=83% *K*=.62	Grepmair et al. 2007a, Germany	To assess whether the promotion of mindfulness, through daily Zen meditation, in psychotherapists in training influences the treatment results of their patients.	Randomised Double-Blind controlled Study Convenience sampling	Linear mixed-effects model **All Measures completed by clients:** Session Questionnaire for General and Differential Individual Psychotherapy	9 weeks of daily Zen mediation practice (Monday-Friday) for one hour Japanese Zen master (Nakagawa 1997) facilitated the intervention (blind to study)	Psychotherapists in Training all completing the same course of university studies to qualify as psychologists at the same level of training *N*=18 Meditation Group (MED) Therapists *n*=9 (all women) Age Mean=29.3±3.2 years Clients *n*=63	**Therapy Session Improvements: STEP subscales:** **Clarification Perspective** Significant treatment by-time interaction effects: Initial MED Mean=46.7±12.4; Initial noMED Mean= 48.6±7.9; Final MED Mean=70.8±11.5; Final noMED Mean= 55.8±10.1; *p*<.01 **Problem Solving Perspective**

				(STEP; Krampen, 2002), after each of their inpatient treatment Symptom Checklist (SCL-90-R; Franke, 2002) at admission and prior to discharge Questionnaire of Changes in Experience and Behavior (VEV; Zielke & Kopf-Mehnert, 1978) once		Control Group (noMED) Therapists *n*=9 (all women) Age Mean=30.4±2.9 yearsClients MED *n*=63 Age Mean=38.9±10.9 Previous Treatment with 2 years: 31.7% (*n*=20) Outpatient psychotherapy 77.8% (*n*=49) Psychopharmacology 9.5% (*n*=6) Inpatient psychiatry/psychotherapy Diagnosis: 47.6% (*n*=30) Stress/Adjustment disorder 38.1% (*n*=24) Mood Disorder 22.2% (*n*=14) Personality Disorders 17.5% (*n*=11) Somatoform Disorders 15.9% (n=10) Anxiety Disorders 6.3% (*n*=) Substance abuse 2% (*n*=2)Obsessive-compulsive disorders NoMED *n*=61	Significant treatment by-time interaction effects: Initial MED Mean=44.3±13.4; Initial noMED Mean=46.4±9.8 Final MED Mean=70.7±13.0; Final noMED Mean=57.0±10.0; *p*<.01 **Relationship Perspective** Non-significant treatment by-time interaction effects: Initial MED Mean=53.0±18.4; Initial noMED Mean=54.2±4.7 Final MED Mean=72.2±14.0; Final noMED Mean=66.6±13.2; *p*=.091 **Changes in Distress: SCL-90-R** Significant treatment by-time interaction effects were identified on MED group compared to noMED group on all subscales *p*<.01 except Phobic anxiety, p=0.048 and Paranoid Thinking, *p*=.16 **Changes in Therapist Behaviour: VEV** Significant treatment by-time interaction effects were identified MED Mean=24.9±34.9; noMED Mean=209.3±23.8; *p*<.01

						Age Mean=39.8±12.3 Previous Treatment with 2 years: 34.9% (*n*=22) Outpatient psychotherapy 77.0% (*n*=47) Psychopharmacology 11.5% (*n*=7) Inpatient psychiatry/psychotherapy 45.9% (*n*=28) Stress/Adjustment disorder 40.9% (*n*=25) Mood Disorder 21.3% (*n*=13) Personality Disorders 19.7% (*n*=12)Somatoform Disorders 14.7% (*n*=9)Anxiety Disorders 8.1% (*n*=5)Substance abuse 3.3% (*n*=2)Obsessive-compulsive disorders	
QR=62.5% *K*=.74	Grepmair Mitterlehner, Loew, and Nickel 2007b Germany	To assess whether there are indications that the promotion of mindfulness, through daily Zen meditation, in psychotherapists	Pre-post with historical control group and double-blind Convenience sampling	Linear mixed-effects model **All measures completed by clients:** Session Questionnaire for General and	9 weeks of daily Zen mediation (Ma & Teasdale 2004) practice (Monday-Friday) for one hour Japanese Zen master (facilitated	Psychology Trainees all with equivalent bachelor's degree in psychology Meditation Group (MFG) Therapist *N*=9 83.6% (*n*=46) women Clients *N*=58	**Therapy Session Improvements: STEP subscales: Clarification Perspective** Significant treatment by-time interaction effects: Initial MFG Mean=47.3±11.5; Initial CG Mean=48.4 ± 10.1; Final MFG Mean=71.9±10.2; Final CG Mean=57.9±9.5; *p*<0.01

		in training influences the treatment results of their patients.		Differential Individual Psychotherapy (STEP; Krampen, 2002), after each of their inpatient treatment Symptom Checklist (SCL-90-R; Franke 2002) at admission and prior to discharge Questionnaire of Changes in Experience and Behavior (VEV; Zielke & Kopf-Mehnert, 1978) once	the intervention blind to study)	Mean age=38.1±9.7 Treatment within the past two years 55.2% (*n*=32) Psychopharmacology 13.8% (*n*=8) Inpatient psychiatry/psychotherapy Historical Control Group (CG) Therapist *N*=9 84.5% (*n*=49) women Clients *N*=55 Mean age=39.5±9.1 Treatment within the past two years 56.4% (*n*=31) Psychopharmacology 16.4% (*n*=9) Inpatient psychiatry/psychotherapy	**Problem Solving Perspective** Significant treatment by-time interaction effects: Initial MFG Mean=44.5±12.4; Initial CG Mean=46.3±11.2; Final MFG Mean=71.3±10.5; Final CG Mean= 57.1 ±9.8; *p*=.044 **Relationship Perspective** Non-significant treatment by-time interaction effects: Initial MFG Mean=52.2±15.2; Initial CG Mean=53.9±15.7; Final MFG Mean=72.6±10.7; Final CG Mean=63.1±10.9; *p*=.51 **Changes in Distress: SCL-90-R** Significant treatment by-time interaction effects were identified on MFG group compared to noMED group on subscales of Somatization; Obsessiveness; Global Severity Scale *p*<.01; Anxiety; Hostility; Phobic Anxiety; Psychoticism *p*<.05, except Insecurity in Social Contact *p*>.05 and Paranoid Thinking *p*>.05 **Changes in Therapist Behaviour: VEV**

							A significant difference between MFG *M*=230; CG *M*=210; *p*<.001
QR=72.5% *K*=.80	Hopkins and Proeve 2013 Australia	To investigate the experiences of trainee psychologists undergoing a structured mindfulness-training programme and its impact on their well-being and therapeutic practice.	Mixed Methods Quantitative: Repeated Measures Convenience sampling	Friedman's analysis of variance **Measures:** Perceived Stress Scale (PSS14; Cohen, Kamarck, & Mermelstein, 1983). The Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) The Interpersonal Reactivity Index (IRI; Davis, 1983)	Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002) On average participants attended 6.3 classes out of a possible eight. Both facilitators had completed training in MBCT and received supervision from an experienced mindfulness instructor during the study to ensure MBCT programme adherence	Clinical Psychology Trainees *N*=11 90.9% (*n*=10) women Mean age=33.6 years (range 24–55 years). Meditation experience: excluded if had participated in mindfulness programmes in the past or if they currently practiced meditation or yoga more than twice a week	**Well-being: PSS14** No significant differences were found **Mindfulness: FFMQ** A statistically significant difference between pre to post to follow-up for subscales: **Observe**: $\chi 2(2, N=11)=6.05$, $p<.05$ **Non-judge**: $\chi 2(2, N=11)=12.38$, $p<.01$ **Non-react:** $\chi 2(2, N=11)=9.80$, $p<.01$. **Empathy: IRI** A statistically significant difference between pre to post to follow-up for Fantasy sub-scale, $\chi 2(2, N=11)=9.27$, $p<.01$
QR=70% *K*=.83	Ivanovic, Swift, Callahan and Dunn 2015	To extend the findings from previous studies by providing a test of mindfulness	Multisite Repeated Measures - Pre-Post Study	Hierarchical linear modelling **All measures completed by clients:**	5-week, 20 minute manualized mindfulness training developed by authors	Graduate students on doctoral programmes in (*n*=23): Clinical Psychology, Clinical Health Psychology and Behavioral Medicine	**Client ratings of therapy session: SRS** A significant difference client scores from pre to post brief mindfulness training, $t(170.91)=2.63$, $p=.01$, $d=.30$

	USA	training in a student-training context.
		
		To clarify findings from the previous studies by examining within-session impacts of mindfulness training, rather than end point treatment outcomes.
		
		Hypothesis: Therapists would be rated by their clients as more present and their sessions as more effective after they participate in a brief mindfulness training programme.
			Convenience sampling	The Session Rating Scale (SRS; Johnson, Miller & Duncan, 2000)
				
				Therapist Presence Inventory—Client Form. (TPI-C; Geller, Greenberg & Watson, 2010)
						[accredited as Clinical], and Psychotherapy Psychology)
						
						Graduates on master's programme in Clinical Psychology (*n*=8)
						
						N=31
						
						71%women
						Age range: 22 to 34 years old
						Mean age=26.45 (*SD*=2.92) years
						
						Ethnicity:
						67.7% white;
						n=4 Hispanic;
						n=5 Asian American;
						n=1 Native American;
						n=4 bi/multiracial or other
						
						Clients: No demographic information obtained as secondary participants
							Therapist Presence: TPI-C
							No significant difference between client scores from pre- to post- brief mindfulness training
							t(12.42)=.58, *p*=.57, *d*=.13

QR=72.5% *K*=.83	Leppma and Young 2016	To examine whether Loving Kindness Meditation (LKM) would	Quasi-experimental design, repeated measures	Mixed-model multivariate analysis of variance.	6 weekly, 60 minute group sessions Loving Kindness Meditation (LKM -	Master's level counsellor students *N*=103	**Empathy: IRI** **Subscales:** **Empathic Concern:** Statistically significant increase for the treatment group

	USA	have a positive effect on counseling students' levels of empathy. To investigate whether there a relationship between the amount of time spent in meditation and empathy	with randomly assigned no matched control group Purposeful sampling	Spearman correlation coefficient **Measures:** Interpersonal Reactivity Index (IRI; Davis, 1980) Weekly mediation logs: time on daily formal meditation practice between group sessions Questionnaire designed authors to assess mediation practice; self-rated level of participation; satisfaction with Loving Kindness Meditation	adapted from Salzberg , 2005; Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Mindfulness Awareness Research Center (n.d.); Weibel, 2007) *N*=63 (64%) participants attended six sessions *n*=23 (23%) attended five sessions, *n*=9 (9%) attended four sessions, *n*=3 (3%) attended three sessions, *n*=0 (0%) attended two sessions, *n*=1 one (1%) attended one session. Experience of facilitator not stated	87.4% (*n*=90) women Age range=20–57 Mean age=27.5 years (*SD*=8.2, with a modal age of 23 years) Ethnicity 75% (*n*=80) Caucasian 11% (*n*=12) Hispanic 4% (*n*=4) Black 2% (*n*=2) Asian 8% (n=9) other or biracial Previous meditation experience 51% (*n*=56) tried meditating in the past 12% (*n*=13) currently meditated.	*F*(1,101)=8.21, *p*=.006, *η2*=.12 with a large (Sink & Stroh, 2006) relationship between the LKM treatment and the increase scores accounting for 11.5% of the variance scores in the treatment group. There was no significant change the control group, *F*(1,38)=1.08, *p*=.306, *η2*=.03. **Personal Distress:** Non-significant decrease for the treatment group *F*(1,63)=6.11, *p*=.016, *η2*=.09 and no significant change for the control group *F*(1,38)=3.29, *p*=.078, *η2*=.08 **Perspective Taking** A statistically significant Time ×Treatment interaction effect: *F*(1,101)=13.18, *p*=.000, *η2*=.21, and no significant change scores in the control group, *F*(1,38)=.232, *p*=<.05, *η2*=.01. A large (Sink & Stroh, 2006) relationship between the LKM treatment and the increase in scores was indicated and LKM treatment accounted for 21.3% of the variance in scores in the treatment group.

							Fantasy Statistically significant Time ×Treatment interaction effect: $F(1,63)=13.18$, $p=.001$, $\eta 2= 17$. With no significant change in scores in the control group, $F(1,38)=1.27$, $p=.273$, $\eta 2=.03$. A large (Sink & Stroh, 2006) relationship between the LKM treatment and the increase in scores in the LKM treatment group accounted for 17.3% of the variance in scores. **Relationship between amount of time spent in meditation and empathy** No significant relationship was indicated for subscales of Empathic Concern; Personal Distress or Fantasy. A medium positive correlation between meditation time and the cognitive empathy subscale for **Perspective Taking** ($rs=.292$, $n=96$, $p=.004$), with higher meditation times correlated with higher scores.
QR=65% *K*=.81	Lesh 1970 USA	**Hypotheses:** Counselors who practice Zen meditation (zazen) regularly over a	Repeated Measures: Pretest-posttest with a control group	Analysis of covariance **Measures:** Affective Sensitivity Scale	4 weekly 30 minute Zen Meditation exercises on a pre-recorded tape	Group 1: Master's degree program in counselling psychology Group 2:	**Empathy:** Demonstrated the experimental group to have a significantly higher degree of empathy post intervention: Group 1: $t(35)=7.23$, $p<.01$

		prescribed length of time will develop a higher degree of empathy as measured by the Affective Sensitivity Scale than counselors who do not practice zazen over the same time span. There will be a positive correlation between the individual response to meditation and scores on the Affective Sensitivity Scale. There will be positive correlation between individual response to mediation and openness to experience as	Convenience sampling	(ASS; Kagan, Krathwohl, & Farquhar 1965; Kagan et al., 1967) The Experience Inquiry (TEI; Fitzgerald, 1966) Personal Orientation Inventory (POI; Shostrom, 1966)	Participant session attendance not stated	Master's degree students taking counselling courses Group 3: Master's degree students taking counselling courses who did not wish to participate in the meditation *N*=39 Group 1: Experimental Group *n*=16 Group 2: Control *n*=12 Group 3; Control *n*=11	Group 2: *t*(35)=0.29, *p*>.05 Group 3: *t*(35)=-1.82, *p*>.05 No supported positive correlation between Individual Response to meditation and empathy using Kendall's Tau pretest *Tau*=.03 and post-test *Tau*=.09 *p*>.05 Openness to experience: A positive correlation between individual response to meditation and openness to experience using Kendall's Tau pretest *Tau*=.56, *p*=.01 and post-test *Tau*=.412, *p*=.05 Openness to experience and empathy were positively correlated *z*=3.88, *p*<.001 pre-test and *z*=3.99, *p*<.001 post-test **Empathy and Self-Fulfilment/Actualisation (POI):** A significant positive correlation between those scoring highly on empathy and Self-Fulfilment/Actualisation *z*=2.63, *p*>.05 pre-test and *z*=3.37, *p*<.001 post-test

		measured by The Experience Inquiry. Individual scores in openness to experience will be positively correlated with individual scores in affective sensitivity (from low to high). Individuals scoring high in affective sensitivity will score high in each of 12 categories of the Personal Orientation Inventory (POI) (Shostrom, 1966)					
QR=72.5% *K*=.81	Moore 2008 UK	To investigate whether a short course of brief mindfulness exercises could facilitate the development of personal	Mixed Methods Quantitative: Repeated Measures Convenience sampling	Wilcoxon signed ranks test **Measures:** Kentucky Inventory of	14 sessions of 10 minutes with short scripted meditations read by a different participant each time structured on	Doctorate Trainee Clinical Psychologists *N*=10 90% (*n*=9) women	**Mindfulness: KIMS** A significant increase in mindfulness abilities reported on the KIMS *z*=1.74, *N-Ties*=10, *p*=.04, one tailed Specifically the subscale Observe *z*=2.60, *N-Ties*=10, *p*<.01, one tailed)

		understandings of mindfulness without requiring a significant time commitment that might impinge upon participants' ability to take part. **Hypothesis:** Increases in measures of constructs related to mindfulness and self-compassion, and a decrease in perceived stress would be found when comparing post-course to pre-course self-report measures.		Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004) The Neff Compassion Scale (SCS; Neff, 2003) Perceived Stress Scale (PSS14; Cohen, Kamarck, & Mermelstein, 1983)	Vipassana insight meditation Participants attended a minimum of 8 sessions No previous meditation experience stated		**Self-Compassion: SCS** A significant difference was found on the Self-kindness subscale z=1.99, *N-Ties*=8, p=.02, one tailed) **Perceived Stress: PSS14** No significant differences were found from pre to post course.[†]
QR=65% *K*=.84	Pakenham 2015 Australia	To examine the effects of training Clinical Psychology Trainees (CPTs)	Repeated Measures Convenience sampling	Pairwise t-tests Correlations (but not stated type)	12 weekly sessions of 2 hours of Acceptance and Commitment	Post Graduate Clinical Psychology Trainees: 94% full time 38.56%: 2 year master's degree	**Stress:** **Mental Health Professional Stress Scale** There were no significant changes in scores on this

[†] No statistics provided

		in Acceptance and Commitment Therapy (ACT) within a clinical psychology training programme. Hypothesis: CPTs would report improvement on three sets of variables: stress, therapist skills and attributes (counselling self-efficacy, client–therapist alliance and self-compassion), and the ACT processes (acceptance, cognitive defusion [Thought suppression], mindfulness and values). It was predicted that higher		**Measures:** **Stress:** Mental Health Professional Stress Scale (MHPSS; Cushway, Tyler, & Nolan, 1996) General Health Questionnaire (GHQ-28; Goldberg, 1978) **Therapist Skills:** Counselor Activity Self-Efficacy Scales Helping Skills (ASHS; Lent, Hill, & Hoffman, 2003) Working Alliance Inventory-Short Form (WAI-SF; Tracey & Kokotovic, 1989) Self-Compassion	Therapy (ACT) training Participant session attendance not stated Experience of facilitators not stated	56%: 3year doctorate 3%: 4 year Ph.D *N*=32 88% (*n*=28) women Mean Age=27.66 years (*SD*=6.62) No Previous ACT training	measure from pre-test to post-test with an overall the stress score $t(30)=-1.28$, $p>.05$ and on subscales of Professional Self-doubt $t(30)=-.04$, $p>.05$; Workload $t(30)=-1.64$, $p>.05$; Home-work conflict $t(30)=-1.22$, $p>.05$ but a significant on the subscale Client-Related Difficulties $t(30)=-1.87$, $p=.08$ **GHQ-28** There were no significant changes in scores on this measure from pre-test to post-test $t(27)=1.15$, $p>.05$ **Therapist Skills:** **Self-efficacy: Counselor Activity Self-Efficacy Scales Helping Skills** Overall, a significant increase in scores on this scale $t(28)=-2.73$, $p<.05$ and on subscales: Exploration Skills $t(30)=-2.99$, $p<.01$; Action Skills $t(29)=-3.77$, $p<.001$ **Therapist Alliance: Working Alliance Inventory-Short Form** A significant increased score for Client therapist Alliance $t(29)=-$

		levels of the ACT processes would be related to lower stress and increases in therapist skills and attributes.		Scale (SCS; Neff, 2003) **ACT Processes** Acceptance and Action Questionnaire (AAQ; Bond & Bunce, 2003) The White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994) Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006) Valued Living Questionnaire (VLQ; Wilson, Sandoz, Kitchens & Roberts, 2010)			2.21, *p*<.05 and Goal subscale *t*(29)=-2.20 *p*<.05 **Self-Compassion: SCS** No significant increase in the overall score but a significant increase in subscale Self-Kindness *t*(30)=-2.01, *p*<.05 **ACT Processes** **Acceptance: Acceptance and Action Questionnaire** A significant change in score *t*(30)=11.0, *p*<.001 **Cognitive Defusion: WBSI** Significant improvement was reported *t*(30)=4.31, *p*<.001 **Mindfulness: FFMQ** Significant changes in overall Mindfulness, *t*(28)=-4.42, *p*<.001 and subscales: Observing *t*(30)=-2.08, *p*<.05; Describing *t*(29)=-2.13, *p*<.05 Non-judging *t*(29)=-3.91, *p*<.001; Non-reactivity *t*(30)=-2.47, *p*<.05 **Values: Valued Living Questionnaire** Significant improvements were reported *t*(30)=-4.46, *p*<.001 **Correlations** Significant correlations were noted for the following:

							ACT Processes and General Mental Health: Acceptance: *r*=-.44, *p*<.05 Cognitive Defusion [Thought Suppression]: *r*=.70, *p*<0.001 Mindfulness: *r*=-.52, *p*<.01 **ACT Processes and Work-Related Stress:** Acceptance: *r*=-.43, *p*<.05 Cognitive Defusion [Thought Suppression]: *r*=.43, *p*<.05 Mindfulness: *r*=-.48, *p*<.01 **ACT Processes and Counselling Self-Efficacy** Cognitive Defusion [Thought Suppression]: *r*=-.34, *p*<.05 Mindfulness: *r*=.39, *p*<.05 Values: *r*=.40, *p*<.05 **ACT Processes and Client-Therapist Alliance** Acceptance: *r*=.52, *p*<.01 Cognitive Defusion [Thought Suppression]: *r*=-.37, *p*<.05 Mindfulness: *r*=.43, *p*<.05 **ACT Processes and Self-Compassion** Acceptance: *r*=.58, *p*<.001 Cognitive Defusion [Thought Suppression]:

							r=-.68, *p*<.01 Mindfulness: *r*=.77, *p*<.001 Values: *r*=.43, *p*<.05
QR=52.5% *K*=.83	Rimes and Wingrove 2011 UK	To investigate whether the practice of mindfulness contributes to the development of trainees skills of self-awareness and reflection, and makes a positive contribution to their training as therapists. To see if Mindfulness Based Cognitive Therapy (MBCT) acts as a stress-management intervention. To investigate any indication of a differential impact depending on the stage of training	Mixed Methods Quantitative: Repeated Measures Convenience sampling	Paired t-tests Independent t-tests Pearson's correlations **Measures:** **Therapist Skills** The Interpersonal Reactivity Index (IRI; Davis, 1983). Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer & Toney, 2006) **Psychological Distress:** Rumination-Reflection Questionnaire (RRQ; Trapnell & Campbell, 1999)	8-week Mindfulness Based Cognitive Therapy (MBCT) course was based on Segal et al. (2002) *n*=7 attended all eight sessions *n*=6 attended seven sessions *n*=5 attended six *n*=2 attended five sessions The facilitators were undertaking a post-graduate certificate/diploma in mindfulness-based approaches at Bangor University.	Doctorate Clinical Psychology Trainees *n*=9 1st year *n*=6 2nd year *n*=5 3rd year *N*=20 100% women	**Therapist Skills:** There were no significant changes reported pretest-post test for **Empathy: IRI**† **Mindfulness: FFMQ** A significant increase in mindfulness *t*(*)=3.0, *p*=.0008 **Psychological Distress** **Stress:** Significant positive changes in: **Rumination: RRQ** *t*(*)=4.9, *p*<.0005 **Self-Compassion: SCS** *t*(*)=3.1, *p*=.016 There were no significant changes reported pretest-post test for: **Stress PSS; Anxiety and Depression: HADS**† **Correlations:** Significant correlations were noted for the following: **Reductions in Stress with:** **Reductions in Rumination:** *r*(19)=0.63, *p*=.004

				The Self-Compassion Scale (SCS; Neff, 2003) Perceived Stress Scale (PSS; Cohen, Kamarck & Mermelstein, 1983), Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983)			**Reductions in Anxiety:** *r*(19)=0.53, *p*=.020 **Increased Empathic Concern:** *r*(19)=−0.55, *p*=.015 **Greater duration of home practice:** **Reductions in rumination:** *r*(20)=−0.49, *p*=.039 **Increased empathic concern:** *r*(20)=0.484, *p*=.042 **More days per week practice and decreases in:** **Stress:** *r*(19)=−0.557, *p*=.013 **Rumination:** *r*(20)=−0.650, *p*=.002 **Anxiety:** *r*(20)=−0.602, *p*=.005 **Increased empathic concern:** *r*(20)=0.511, *p*=.021 **Year of training:** First years showed a significantly larger increase in self-compassion than other years *t*(19)=2.4, *p*=.025. Further, first years had a significant decrease in stress *t*(8)=2.7, *p*=.028
QR=72.5% *K*=.80	Rodriguez Vega et al.	To analyse the effect of mindfulness	Pretest-Posttest Repeated	Mixed Model Analysis, one repeated	Mindfulness Based 8 weekly 2.5 hour classes	*N*=101 Experimental Group *n*=58	**Emotional Measures:** **State Anxiety:**

	2014 Spain	training via a structured Mindfulness Based Stress Reduction (MBSR)-based program (Kabat-Zinn, 1990) on emotional variables (anxiety, sadness, and anger), attentional variables (performance tests of sustained attention and attentional control), and state of mindfulness in a group of resident clinical psychologists and resident psychiatrists within the Spanish National Health System. **Hypotheses:**	Measures with a control group Convenience sampling	measure with post-hoc analyses for all measures and adjusted the p-values for multiple comparisons using the Bonferroni method **Measures:** **Emotional Measures:** State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch & Lushene, 1982; translated into Spanish by Seisdedos, 1988) State-Trait Anger Expression Inventory-2 (STAXI-2; Spielberger, 1999 Spanish translation by	Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 1990) Excluded if >2 absences from programme The facilitator personally practiced mindfulness and had training in the Tibetan tradition, and attended the MBSR 8-week Practicum at the Center for Mindfulness in Medicine (UMass)	*n*=33 Resident Psychiatrists *n*=25 Resident Clinical Psychologists Mean Age=29.6±5.6 years 72.41% (*n*=42) women Control Group *n*=43 *n*=24 Resident Psychiatrists *n*=19 Resident Clinical Psychologists Mean Age=28.4±4.02 years Ratio female/male=33/10 None had prior experience with any form of meditation, yoga, tai chi, or Qigong. They were asked not to engage in other forms of meditation during the study	A significant Time x Group interaction $F(1, 83.292)=12.02$, $p=.001$ with a significant decrease posttest for the experimental group ($p=.002$) **Trait Anxiety:** No significant Time x Group interaction observed $F(*)=2.74$, $p=.10$ for the experimental group. **Anger: STAXI-2** **State Anger** No significant Time x Group interaction observed $F(*)=1.22$, $p=.28$ for the experimental group. **Trait Anger:** A significant Time x Group interaction $F(1,81.405)=7.79$, $p=.007$ There were no significant changes on any other subscales except: **Angry Reaction:** A significant Time x Group interaction $F(1,83.733)=9.72$, $p=.002$ with a significant decrease posttest for the experimental group ($p=.001$) **Depression: BDI** A significant Time x Group interaction $F(1,81.213)=6.33$, $p=.014$ with a significant

		Scores of anxiety, anger, and depression would decrease after MBSR training and scores of mindfulness state would increase. Participants who received MBSR training would show greater attentional control than the control group, as reflected by fewer errors and perseverations in the Stroop task and less variability in reaction time consistency in the continuous performance test.		Miguel-Tobal, Casado, Cano-Vindel, & Spielberger, 2001) Beck Depression Inventory (BDI; Beck & Steer, 1993 Spanish version: Sanz & Vazquez, 1998). **Mindfulness Attitude:** Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003 Spanish version: Soler, et al., 2012) **Attentional Measures:** Stroop task (Stroop, 1935) Continuous Performance Test (CPT; Rosvold,			decrease posttest for the experimental group (p=.029) **Mindfulness State:** **MAAS** A significant Time x Group interaction F(1,83.107)=26.24, p<.001 with a significant group difference posttest (p<.001) with scores from Experimental Group significantly increased from pretest to posttest (p<.001) **Attentional Measures** **Attentional Control:** **Stroop task** The control group provided more errors as demonstrated by the following: A significant Time x Group interaction for: **Variable Errors** F(1,82.613)=7.48, p=.008 with significant changes in the number of errors pretest-posttest for the Experimental Group (p=.023) **Perseverations** F(1,70.681)=6.05, p=.016 with a significant increase in perseverations in the control group (p=.046).

				Mirsky, Sarason, Bransome & Beck, 1956)			**Attentional Control: Stroop task Errors and Perseverations:** The control group provided more errors as demonstrated by the significant Time x Group interaction for: **Variable Errors** *F*(1,82.613)=7.48, *p*=.008 with significant changes in the number of errors pretest-posttest for the Experimental Group (*p*=.023) **Perseverations** *F*(1,70.681)=6.05, *p*=.016 with a significant increase in perseverations in the control group (*p*=.046). **Reaction Times:** The control group showed lower reaction times as demonstrated: **Word:** *F* (1,83.976)=9.69, *p*=.003 with a significant decrease for the control group posttest *p*=.002 **Congruent:** *F* (1,88.617)=9.9, *p*=.002 with a significant increase for the experimental group posttest *p*=.001 **Neutral:** *F*(1,86.369)=10.23, *p*=.002 with a significant decrease for the control group posttest *p*=.005

							Attentional Control: CPT No significant Time x Group interactions reported on all variables which suggests no effects on sustaining attention: Percentage Omissions *F*(*)=.02, *p*=.89 Percentage Commissions *F*(*)=2.48, *p*=.12 Reaction time *F*(*)=1.085 *p*=.30 Detection and decision making (d')*F*(*)=0.98, *p*=.324 Beta *F*(*)=0.76, *p*=.39 SE of the predicted RT by sub-block *F*(*)=0.44, *p*=.51 SE of the predicted RT by ISI *F*(*)=0.71, *p*=.40
QR=70% *K*=.74	Schomaker and Ricard 2015 USA	To evaluate the degree of treatment effect associated with a mindfulness-based intervention (MI) on the dynamics of counselor–client attunement with counselor trainees.	A-B single-case research designs Convenience sampling	Median calculated for visual analysis, Percentage exceeding the mean (PEM) with effect sizes (Scruggs & Mastropieri 1998), Relative Success Rate **Measures:** Session Rating Scale Version 3	6 week training (9 hours in total) from a manualized protocol (Schomaker 2013 based on MBSR Kabat-Zinn, 1994; McCown, Reibel, & Micozzi, 2011) and interpersonal practices (Morgan & Morgan, 2005; Shapiro & Izett, 2008)	Master's level counsellors in training MI Group *N*=5; all women 40% (*n*=2)in practicum 40% (*n*=2) Internship 1 20% (*n*=1) Internship 2 Mean age=40.2 years (*SD*=31.1) Ethnicity: 40% (*n*=2) Caucasian 40% (*n*=2) Hispanic/Latino 20% (*n*=1) Asian	**SRS** Improvement in attunement scores were noted in the majority of cases i.e.: 'very effective treatment effect' for **two cases**; A 'large effect' or **one case**; Improvement but not clear effect for **one case**; Variability in **one case**.

		Hypothesis: functional relationship between an MI and enhanced counselor–client attunement with counselors-in-training (CITs) over time, in which CITs receiving an MI would achieve reliably higher levels of attunement with their clients than a comparison group over time.		(SRS Duncan et al., 2003)	Participant session attendance not stated Facilitators were mindfulness practitioners, with the primary instructor having completed 1 year of mindfulness study and practice and the advisory instructor having been trained in mindfulness-based cognitive therapy and completing over 4 years of practice	Comparison group *N*=4; 100%: Internship 2 25% women Mean age= 43.5 years (*SD*=16.8) Ethnicity 50% (*n*=2) Caucasian 50% (*n*=2) Hispanic/Latino	
QR=75% *K*=1.00	Shapiro, Brown and Biegel 2007 USA	To examine associations between the type and amount of mindfulness practice performed and the well-being-related outcomes of the Mindfulness Based Stress Reduction	Prospective, non – randomised cohort-controlled design Convenience sampling	Mixed factorial analyses of variance (ANOVAs) **Measures:** **Wellbeing:** Positive and Negative Affectivity Schedule (PANAS; Watson, Clark,	10 weekly classes, 3 hours per week, first 2 weeks psychoeducation on stress and stress management techniques (non-mindfulness and students not instructed to practice these techniques) Mindfulness Based	Master's level counselling psychology program 56.9%: first year 29.4%: second year 11.8%: third year 2%: fourth year *N*=64 with attrition *N*=54 Mean Age=29.2 years (*SD*=9.07) Ethnicity: 76.9%: Caucasian 7.7%: Latina/Latino	**Wellbeing:** Significant improvements were shown on all measures for the experimental group relative to the control group: **Affect: PANAS** **Positive affect** *p*=.0002 **Negative affect** *p*=.04 **Stress: PSS** *p*=.0001

		(MBSR) programme.		& Tellegen, 1988) Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983) State/Trait Anxiety Inventory (STAI; Spielberger, 1983) Reflection Rumination Questionnaire (RRQ; Trapnell & Campbell, 1999) Self-Compassion Scale (SCS; Neff, 2003) **Mindfulness:** The Mindful Attention Awareness Scale (MAAS;	Stress Reduction (MBSR; adapted from Kabat-Zinn, 1982) started in week 3.	5.8%: Asian 3.8%: Filipino 1.9%: African American 1.9%: Portuguese 1.9%: Persian 3.8%: declined to indicate their race or ethnicity. Experimental Group *n*=22 Control Pre *n*=42 and post *n*=32	**Anxiety: STAI** **State Anxiety** *p*=.0005 **Trait Anxiety** *p*=.0002 **Rumination: RRQ** *p*=.0006 **Self-Compassion: SCS** *p*=.0001 Several main effects for age were found, with older students showing lower levels of negative affect, trait anxiety, rumination, perceived stress, and higher self-compassion.† **Mindfulness:** Significant improvements were shown on the measure for the experimental group relative to the control group: **MAAS** *p*=.006 **Simple Regression of pre to post intervention indicated** significant relations where an increase in mindful awareness and attention predicted a reduction in: **Rumination**

				Brown & Ryan, 2003) Daily mindfulness practice diaries for the entire 8-week intervention so as to examine the effects of practice on the study outcomes			Pre *β*=-.56, *SE*=.18, Post *β*=-.57; *p*<.01 **Trait anxiety** Pre *β*=-.79, *SE*=.29, Post *β*=-.52; *p*<.01 **Perceived Stress** Pre *β*=-5.56, *SE*=1.49, Post *β*=-.65; *p*<.001 An increase in: **Self-Compassion** Pre *β*=2.95, *SE*=.94, Post *β*=.58; *p*<.01
QR=75% *K*=.80	Stafford-Brown and Pakenham 2012 Australia	To evaluate the effectiveness of a group Acceptance and Commitment Therapy (ACT) stress management intervention for postgraduate clinical psychology trainees. To examine the mediating role of ACT processes. **Hypotheses:** Relative to a control group,	Repeated Measures Cohort controlled Convenience sampling	Chi –Square and Fisher Analysis of variance (ANOVA) Multivariate Analysis of Variance (MANOVA) Pairwise t-tests **Measures:** Mental Health Professional Stress Scale (MHPSS; Cushway, Tyler, & Nolan, 1996) The General Health	A group protocol of standard Acceptance and Commitment Therapy (ACT) concepts, exercises, and interventions was delivered via one 3-hour session per week for 4 consecutive weeks No session had more than 11 or fewer than 5 participants. The facilitator had extensive training and clinical experience in ACT	Clinical Psychology Trainees *N*=56 Experimental Group *n*=28 50% (*n*=14) Master's 39.3% (*n*=11) Doctorate 10.7% (*n*=3) PhD 100% (*n*=28) Full time 89.3% (*n*=25) women Mean age=28.79 (*SD*=8.99); range 21-52 Control Group *n*=28 64.2% (*n*=18) Master's 17.9% (*n*=5) Doctorate 17.9% (*n*=5) PhD	**Pre to Post group Comparisons** Significant time × group interactions were noted in the following areas: **1) Adjustment outcomes:** A significant decrease for Experimental group and an increase for the control group for: **Mental Health Professional Stress Scale Subscale: Professional Self-doubt** Wilks's *Λ*=.93, *F*(1,54)=4.38, *p*<.05, *η2*=.08 **General Mental Health: GHQ-28** Wilks's *Λ*=.93, *F*(1,54)=4.18, *p*<.05, *η2*=.07 There was also a reduction in caseness in the Experimental group which was maintained at follow up. There was minimal

		ACT stress management intervention participants would report better adjustment outcomes (lower work-related stress and psychological distress and greater life satisfaction), enhanced positive therapist qualities (self-compassion and self-efficacy) and therapeutic alliance, and greater improvements in the ACT process variables (acceptance and action, mindfulness, valued living, and cognitive defusion [thought suppression-		Questionnaire-28 (GHQ-28; Goldberg, 1978) The Satisfaction With Life Scale (SWLSb; Diener, Emmons, Larsen, & Griffin, 1985) Self-Compassion Scale (SCS; Neff, 2003) Counselor Activity Self-Efficacy Scales-Helping Skills Scale (CASES; Lent, Hill, & Hoffman, 2003) Working Alliance Inventory-Short Form (WAI-SF; Tracey & Kokotovic, 1989). Acceptance and Action	and who received peer supervision from an experienced ACT therapist while undertaking the intervention.	94.6% (*n*=25) Full time 10.7% (*n*=3) part time 87.5% (*n*=24)women Mean age=28.11 (*SD*=7.59); range 22-50	change in caseness for the control group **Life Satisfaction: SWLS** No significant change $F(1,54)=2.40$, $p>.05$, $\eta 2=.04$ **2) Therapist Qualities** **Self-Compassion: SCS** A significant main effect of time on total self-compassion indicated that both groups improved on this measure, Wilks's $\Lambda=.76$, $F(1,54)=16.81$, $p<.001$, $\eta 2=.24$ **Overidentification subscale** A univariate test indicated that scores increased more for the treatment group than for the control group $F(1,54)=4.02$, $p<.05$, $\eta 2=.07$ **Self-Efficacy: Counselor Activity Self-Efficacy Scales-Helping Skills Scale** Significant improvement for the experimental group more than the control group, Wilks's $\Lambda=.90$, $F(1,54)=6.10$, $p<.05$, $\eta 2=.10$ **Therapeutic Alliance Working Alliance Inventory-Short Form Subscale: Bond** The experimental group reported a stronger bond (Mean=23.72, *SD*=2.40) than the

		which is the reverse process]). Changes in adjustment outcomes and therapist qualities would be mediated by changes in some or all of the ACT processes.		Questionnaire (AAQ; Bond & Bunce, 2003) The White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994) Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietmeyer, & Toney, 2006) The Valued Living Questionnaire (VLQ; Wilson, Sandoz, Kitchens, & Roberts, 2010)			control group (Mean=21.35, *SD*=4.14) and this was significantly different *F*(1,33)=4.36, *p*<.05 *η2*=.117 **3) ACT Processes** Experimental group reported greater improvements than the control group on **Acceptance: Acceptance and Action Questionnaire** Wilks's *Λ*=.93, *F*(1,54)=4.32, *p*<.05, *η2*=.07 **Cognitive Defusion: WBSI** [Thought suppression] Wilks's *Λ*=.90, *F*(1,54 =5.72, *p*<.05, *η2*=.10 **Mindfulness: FFMQ** Mindfulness, Wilks's *Λ*=.80, *F*(1,54)=13.55, *p*<.001, *η2*=.20 **Values: The valued living questionnaire** valued living, Wilks's *Λ*=77, *F*(1,54)=16.31, *p*<.001, *η2*=.23 **Treatment effects were maintained at follow-up** **Mediational Analyses** **General Mental Health (GHQ-28)** The four ACT process measures (Acceptance and Action; Mindfulness; Cognitive Defusion

							[Thought suppression]; Valued Living) mediated the relationship between intervention and general mental health (significant, with a point estimate of −4.54 and a 95% *BCa CI* of −9.161 to −1.033). **Self-Compassion (SCS): Overidentification subscale:** Acceptance and Action was a mediator with a point estimate of .09 and a 95% *BCa CI* of .0123 to .2535. **Self-Efficacy (Counselor Activity Self-Efficacy Scales-Helping Skills Scale)** Acceptance and action was a mediator with a point estimate of 1.77 and a 95% *BCa CI* of .2245 to 6.232 Mindfulness was a mediator with a point estimate of 4.30 and a 95% *BCa CI* of 1.451 to 9.393. There were no significant indirect effects of the ACT processes for the posttreatment changes in **Mental Health Professional Stress Scale Subscale: Professional Self-Doubt or Working Alliance Inventory-Short Form Subscale: Bond**

QR=75% *K*=.80	Swift, Callahan, Dunn, Brecht, and Ivanovic 2017 USA	To test whether a brief mindfulness training program for students could result in session benefits for clients using a randomized-controlled design. **Hypotheses:** Students would report greater improvements in trait and state mindfulness over the course of the training program compared to changes seen in psychotherapists assigned to a control group. Students would report greater levels of presence in the compared to the sessions	A Randomised-Controlled Crossover Trial Convenience sampling	Hierarchical Linear Modeling **Measures:** **Therapist Completed:** Toronto Mindfulness Scale (TMS; Lau et al., 2006) Five-Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). Therapist Presence Inventory–Therapist form (TPI-T; Geller, Greenberg, & Watson, 2010) at the end of these sessions.	Mindfulness Programme (Ivanovic, Swift, Callahan & Dunn, 2015) 5 sessions of 30 minutes. Students rated their knowledge and experience with mindfulness on a 7-point scale, ranging from 1 (none whatsoever) to 7 (deep and rich theoretical and practical understanding/ years of experience and daily practice). Mean for prior mindfulness knowledge = 3.73, SD= 1.11 Mean mindfulness experience = 2.95, SD= 1.18 Attendance	Graduate student psychotherapists *n*=10 Clinical Psychology Master's *n*=10 Clinical-Community Psychology PhD program *n*=7 Clinical Psychology PhD program *n*=8 Counselling Psychology PhD program *n*=5 Clinical Health Psychology PhD 45%: third year 32.5%: second year 17.5%: first year *N*=40 70% Women Mean age = 27.5 years (*SD*=6.20) range 23-54 years 75%: Caucasian 10%: Latino/a American 7.5%: Asian American 7.5%: bi/multiracial American. Clients *N*=131	**Results from therapists:** **Mindfulness:** **1) TMS** Examining the mean score from the first to last training session a significant linear trend was noted $t(141.32)=2.07$, $p<.05$ **2) FFMQ** Comparing mean scores during the control to intervention periods a significant time-by-condition interaction was observed, $t(48.90)=5.23$, $p<.001$, specifically post-intervention/post-wait $t(14.53)=5.46$, $p<.001$ with participants expected to have higher score post intervention **Presence in sessions:** **TPI-T** Comparing mean scores during the control to intervention periods significant time (pretraining/wait vs. posttraining/wait) by condition (mindfulness vs. control) interaction, $t(174.10)=4.55$, $p<.001$ with trainees expected to rate themselves more highly

		conducted by psychotherapists in the control group Clients would report higher levels of session effectiveness and possibly psychotherapist presence in the sessions conducted by psychotherapists who had attended the mindfulness training compared to sessions conducted by the control group.		**Client Completed:** Therapist Presence Inventory–Client form (TPI-C; Geller, Greenberg, & Watson, 2010) Session Rating Scale (SRS; Johnson, Miller, & Duncan, 2000)	n=3 attended 2 sessions n=4 attended 3 sessions n=3 attended 4 sessions Three researchers led the different groups each with personal experience with mindfulness practice	Age Mean=33.32 year (*SD*=12.14) range 19-65 years 61.97% Female Ethnicity: 70.15% Caucasian 11.94% African American 8.96%Latino/a 2.9% Asian American 2.9% American Indian/ Alaska Native 2.9% bi/multiracial American 50.75% were college students Presenting concerns: 32.86% depression 22.86% adjustment problems 15.71% anxiety 12.86% relationship difficulties 4.29% trauma 2.86% anger management 2.86% bipolar disorder 1.43% alcohol use 1.43% bereavement 1.43% gender dysphoria	post-intervention compared to the wait period. **Results from clients:** **Therapist Presence: TPI-C** Comparing mean scores during the control to intervention periods no significant time by condition interaction on clients' ratings of the trainees' session-level presence $t(183.39)=1.62$, $p=.11$. **Session Effectiveness: SRS** Comparing mean scores during the control to intervention periods a significant time-by-condition interaction in clients' ratings was indicated, $t(177.99)=3.25$, $p<.001$, this interaction was due to differences between the conditions at baseline, $t(64.57)=2.35$, $p<.05$, rather than at posttraining/postwait, $t(73.27)=1.14$, $p>.05$

1.3.2 Overview of areas of change for TPTs following their participation in MBIs

Fourteen of the reviewed studies investigated areas of change relating directly to TPTs following their participation in MBIs (Beaumont et al., 2017; Bohecker & Doughty Horn, 2016; Cohen & Miller, 2009; Collard et al., 2008; Finaly-Jones et al., 2016; Hopkins & Proeve, 2013; Leppma & Young, 2016; Lesh, 1970; Moore, 2008; Pakenham 2015; Rimes & Wingrove, 2011; Rodriguez Vega et al., 2014; Shaprio et al., 2007; Stafford-Brown & Pakenham, 2012). These are reported here in relation to the aims, incorporating: TPTs' wellbeing, learning and the specific effect of ACT MBIs for TPTs. Four studies, three of high quality and one of good quality investigated the effect of MBIs on the client experience i.e. therapeutic outcome (Grepmair et al., 2007a; 2007b; Ivanovic et al., 2015; Schomaker & Ricard, 2015). Finally, one high quality study investigated the changes in client and TPT experience following a MBI (Swift et al., 2017). These findings are summarised below in relation to the specific aims of the review.

1.3.3 Aim 1: Improvements in TPTs' wellbeing

This section relates to two areas of TPT wellbeing: 'Psychological distress' and 'social connectedness', and 'life satisfaction' with further information[4] summarised in Appendix D.

[4] The specific measures used, the type of MBI, percentage of studies indicating change, level of significance (where applicable) and the quality of the study.

1.3.3.1 TPTs' 'Psychological Distress' and 'Social Connectedness'

1.3.3.1.1 'Psychological distress'

Changes in psychological distress for TPTs post MBI was assessed in eight different areas. These were general mental health, stress, anxiety, rumination, depression, affect, anger and eudaimonic happiness.

Two studies used the same measure of 'general mental health' (Pakenham, 2015; Stafford-Brown & Pakenham, 2012). Only Stafford-Brown and Pakenham (2012) reported a reduction in 'general mental health' post MBI (maintained at ten weeks follow-up).

Five measures of 'stress' were used in seven studies (Finaly-Jones et al., 2016; Hopkins & Proeve, 2013; Moore, 2008; Pakenham 2015; Rimes & Wingrove, 2011; Shaprio et al., 2007; Stafford-Brown & Pakenham, 2012). A small majority demonstrated no change in 'perceived stress'. However, when examining the year of training, one study showed significant decreases in 'stress' post MBI for first year TPTs (Rimes & Wingrove, 2011). One study demonstrated significant improvements on two measures of 'stress' (Finlay-Jones et al., 2016). Further where associations between MBI processes and general mental health were investigated, all ACT processes ('Acceptance', 'Mindfulness', 'Cognitive Defusion', and 'Values'[5]) were reported to mediate the relationship between the MBI and reductions in 'general mental health' (Stafford-Brown & Pakenham, 2012). Additionally, significant correlations between improvements in three ACT processes ('Acceptance',

[5] 'Acceptance' (embracing internal experiences without any attempt to change them), 'Cognitive Defusion' (observing thoughts rather than taking them literally), 'Values' (being consistent with one's personal values)

'Defusion' and 'Mindfulness') and decreased 'general mental health' were reported (Pakenham, 2015).

Stafford-Brown and Pakenham (2012) demonstrated significant improvement on the 'Professional Self-doubt' subscale of the Mental Health Professional Stress Scale (MHPSS; Cushway, Tyler, & Nolan, 1996). This finding was not replicated by Pakenham (2015); however, improvements in three ACT processes ('Acceptance', 'Defusion' and 'Mindfulness') were significantly correlated with reduced 'work stress' (Pakenham, 2015).

Four measures of anxiety were used in five studies. Two high quality studies reported a significant decrease post-intervention for 'State Anxiety' (Rodriguez Vega et al., 2014; Shapiro et al., 2007). Shapiro et al. (2007) demonstrated significant improvement with 'Trait Anxiety'. A further two high quality studies demonstrated improvements in generic anxiety measures (Cohen & Miller, 2009; Finlay-Jones et al., 2016). One study demonstrated no change (Rimes & Wingrove, 2011). Further, two studies using the same measure for 'rumination', indicated a significant improvements post MBI (Rimes & Wingrove, 2011; Shapiro et al., 2007). Finally, Rimes and Wingrove (2011) reported that decreased scores for 'stress', 'anxiety' and 'rumination' were significantly associated with the increased number of days TPTs practiced mindfulness.

Four studies focused on 'depression'. Each used different measures of depression. Two high quality studies demonstrated a significant decrease in 'depression' scores post MBI (Finlay-Jones et al, 2016; Rodriguez Vega et al., 2014). Two studies reported no significant changes (Cohen & Miller, 2009: Rimes & Wingrove, 2011). Further, two high quality studies utilising the same Affect scale showed a significant

decrease in 'negative affect' (Collard et al., 2008; Shaprio et al., 2007). One study showed a significant increase in 'positive affect' (Shaprio et al., 2007).

For 'Trait Anger', a significant decrease post MBI was indicated in one high quality study (Rodriguez Vega et al., 2014). Finaly-Jones et al. (2016) reported a significant improvement in 'happiness' post MBI (maintained at twelve weeks follow-up).

1.3.3.1.2 'Social connectedness'

A significant improvement in 'social connectedness' (belonging) was demonstrated in a study by Cohen & Miller (2009).

1.3.3.2 TPTs' 'life satisfaction'

Four measures of 'life satisfaction' were used in three studies (Cohen & Miller, 2009; Collard et al., 2008; Stafford-Brown & Pakenham, 2012). None of the studies demonstrated significant improvements in 'life satisfaction' post MBIs.

1.3.4 Aim 2: To explore the evidence regarding changes in TPT learning post MBI including TPTs' therapeutic skills, their development of MBI skills and their academic learning.

This section relates to three areas of change: TPTs' therapeutic skills, the development of MBI skills (specifically mindfulness and particular ACT skills) and academic learning, with further information[6] summarised in Appendix E.

1.3.4.1 TPTs' therapeutic skills

a. 'Emotional Connection'

The reviewed studies investigated a number of areas relating to the TPTs' therapeutic skills specifically their ability to connect with and manage emotions.

[6] The specific measures used, the type of MBI, percentage of studies indicating change, level of significance (where applicable) and the quality of the study.

Two studies demonstrated overall improvements in measures of 'empathy' post MBI (Bohecker & Doughty Horn, 2016; Lesh, 1970). Two further studies showed improvements in one empathy subscale (Hopkins & Proeve, 2013; Leppma & Young, 2016). Finally, three studies explored the relationship between the duration of TPTs' mindfulness practice and changes in empathy (Rimes & Wingrove, 2011; Leppma & Young, 2016; Collard et al., 2008). These yielded positive correlations for the Interpersonal Reactivity Index (IRI; Davis, 1980). More specifically, these were between the amount of meditation and increased scores on the IRI subscales of 'Empathic Concern' and 'Perspective Taking'.

Six studies reported significant improvements in 'self- compassion' post MBI (Beaumont, Rayner, Durkin & Bowling, 2017; Finaly-Jones, Kane and Rees, 2016; Moore, 2008; Rimes and Wingrove, 2011; Shaprio, Brown & Biegel, 2007; Stafford-Brown and Pakenham, 2012). One study found significant improvement in one subscale only (Pakenham, 2015). Further, Pakenham (2015) demonstrated a positive and significant correlation between improvements in all ACT processes and 'self-compassion'. One study showed no significant changes for 'compassion to others' (Beaumont et al., 2017). Finally, when the TPTs' year of training was incorporated into the analyses, significantly larger increases in 'self-compassion' were found for first year TPTs post MBI (Rimes & Wingrove, 2011).

Significant improvements in 'emotional intelligence' (an ability to understand and read emotions) were revealed post MBI (Cohen & Miller, 2009). Further, TPTs' ability to regulate emotions was significantly improved post MBI and maintained at twelve weeks follow-up (Finaly-Jones et al., 2016). Finally, a positive correlation

between TPTs valuing meditation and being more 'open to experience' post MBIs was demonstrated (Lesh, 1970).

b. TFTs' efficacy, attention and therapeutic alliance

Four studies investigated three areas of therapist competence (Bohecker & Doughty Horn, 2016; Pakenham, 2015; Rodriguez Vega et al., 2014; Stafford-Brown & Pakenham, 2012). Firstly, for TPTs' 'perceived therapeutic efficacy', three studies demonstrated significant increases post MBIs (Bohecker & Doughty Horn, 2016; Pakenham, 2015; Stafford-Brown & Pakenham, 2012). Secondly, Rodriguez Vega et al. (2014) investigated changes in TPTs' attentional control and showed some improvements post MBIs for TPTs as they made fewer mistakes and had quicker reaction times on attention tasks than the control group. Finally, the influence of MBIs on 'therapeutic alliance' was examined (Pakenham, 2015; Stafford-Brown & Pakenham, 2012). Here the overall scores on the Working Alliance Inventory indicated no significant improvement (with significant improvements on discrete subscales only). Lastly, Pakenham (2015) demonstrated positive and significant correlations between improvements in ACT processes and both therapeutic skills of 'perceived therapist self-efficacy', and 'therapeutic alliance'.

1.3.4.2 The development of TPTs' MBI Skills

Developments in TPTs' MBI skills post interventions were investigated for Mindfulness, and the additional ACT skills ('Acceptance', 'Cognitive Defusion' and 'Values').

a. Mindfulness

Nine studies demonstrated significant improvements in Mindfulness measures post MBIs (Bohecker & Doughty Horn, 2016; Cohen & Miller, 2009; Collard et al., 2008;

Moore, 2008; Pakenham, 2015; Rimes & Wingrove , 2011; Rodriguez Vega et al., 2014; Shaprio et al., 2007; Swift et al., 2017). A further study demonstrated significant improvements on three mindfulness subscales (Hopkins & Proeve, 2013).

b. ACT skills

Regarding specific ACT skills, two studies investigated changes in 'Acceptance', 'Cognitive Defusion' and 'Values' (Pakenham 2015; Stafford-Brown & Pakenham, 2012). Significant improvements were demonstrated for all three areas. Stafford-Brown and Pakenham, (2012) showed that improvements were maintained at ten weeks follow-up in all three ACT skills.

1.3.4.3 Academic Learning

None of the studies investigated improvements in TPTs' academic learning post MBI.

1.3.5 Aim 3: To examine what changes in therapeutic outcome have been reported for TPTs post MBI including changes in client distress and the effect of MBIs on the clients' and TPTs' experience of therapy

For clarity, the findings of the four studies have been divided into three sections (Grepmair et al., 2007a; 2007b; Ivanovic et al., 2015; Schomaker & Ricard, 2015) which are outlined below.

1.3.5.1 Changes in client distress for MBI groups

Grepmair et al. (2007a) reported significant improvements for clients on all subscales of the SCL-90-R except 'Phobic Anxiety' and 'Paranoid Thinking'. Similarly, Grepmair et al. (2007b) reported significant improvements for clients on all subscales ('Global Severity Scale'; 'Anxiety'; 'Hostility'; 'Phobic Anxiety'; 'Psychoticism') except 'Social Contact' and 'Paranoid Thinking'.

1.3.5.2 Changes in clients' experience of TPTs

Two studies reported significant improvements in therapist behaviour for the MBI group (Grepmair et al., 2007a; 2007b). Specifically, clients rated improvements on the 'Problem Solving Perspective' subscale (Grepmair et al., 2007a; 2007b)[7].

In contrast, Ivanovic, et al. (2015) reported no significant change in client's ratings of 'therapist presence' post MBI.

1.3.5.3 Changes in client and TPT experience of therapy

One high quality Randomised Control Crossover trial investigated changes in client and TPT experience of therapy (Swift et al., 2017). TPTs rated their 'therapist presence' more strongly during the intervention period as opposed to the control period. This was not supported by the clients' ratings of 'therapist presence'. No significant improvements were noted post MBI by clients on the Session Rating Scale. Conversely, Ivanovic, et al. (2015) demonstrated overall improvements in the client's perception of the effectiveness of therapeutic sessions post MBI. Further, Schomaker and Ricard (2015) showed improvement in session effectiveness on one subscale ('attunement') in the majority of single-cases.

1.3.6 Critique of studies[8]

1.3.6.1 Fidelity of MBI

Irrespective of quality, the facilitated MBI studies lacked quantifiable information regarding the facilitators' experience with the MBI under investigation. For example, four papers of moderate to high quality reported the level of training received by the

[7] Neither study provided an explicit explanation of what each subscales of the STEP measures including the Problem Solving Perspective subscale.

[8] As concerns relating to sample size have been previously raised within the text, they will not be discussed further within this section.

facilitators (Grepmair et al., 2007a; Grepmair et al., 2007b; Rimes & Wingrove, 2011; Rodriguez Vega et al., 2014). Further, three high quality studies provided both the facilitators' and their supervisor's experience/training in MBIs (Hopkins & Proeve, 2013; Schomaker & Ricard, 2015; Stafford-Brown & Pakenham, 2012). The fidelity to the specific MBIs of the remaining nine facilitated studies was unclear. Three studies adapted the specific MBI protocol (Cohen & Miller 2009; Schomaker & Ricard, 2015; Shapiro et al., 2007). Six studies produced bespoke MBIs (Beaumont et al., 2017; Bohecker & Doughty Horn 2017; Finaly-Jones et al., 2016, Ivanovic et al., 2015; Leppma & Young 2016; Swift et al., 2017). These adaptations compromised MBI fidelity and may have led to problems regarding the replication and generalisability of the research.

1.3.6.2 Previous participant mindfulness experience

Two studies excluded participants with previous meditation practice (Hopkins & Proeve, 2013; Rodriguez Vega et al., 2014). Three studies included participants with previous and/or current meditation practice (Cohen & Miller, 2009; Leppma & Young, 2016; Swift et al., 2017).The remaining studies did not report participants' current or previous meditation practice. The contribution of current/previous meditation practice to outcome data, therefore, is unclear.

1.3.6.3 Variability in TPT training

Each psychological therapy training programme has differing educational requirements (e.g., level of academic qualification, length of training) and experience (e.g., clinical contact hours, personal therapy during training, pre-training course clinical experience). Only one study compared the year of training to their outcome measures acknowledging that the specific year of training might produce specific pressures (Rimes & Wingrove, 2011). None of the studies stated whether TPTs were simultaneously

undertaking mandatory psychotherapy. These differences may account for some of the variability in outcomes across studies.

1.3.6.4 Participant attendance

Stafford-Brown and Pakenham (2012) stated the range of participant attendance per session. Leppma and Young (2016) highlighted a minimum attendance of one of six sessions, whilst Swift et al. (2017) stated a minimum of two of five sessions. The average number of sessions attended was provided by Hopkins and Proeve (2013). The remaining studies did not state the participants' level of attendance. Such variability in attendance may have contributed to the mixed outcomes.

1.3.6.5 Research bias

Two studies stated that the facilitator was unaware of the research process at the point of facilitating the groups (Grepmair et al., 2007a; 2007b). In the remaining studies the facilitators were either part of the research team or their relationship to the research process was not stated. Depending on the relationship of facilitator with participants, any dual roles may have affected how participants rated any outcomes measures.

1.3.6.6 Gender

The majority of participants were female, which is representative of the workforce (Morison et al., 2014). Importantly, any positive outcomes may be skewed as females are more likely to benefit from MBIs than males (O'Driscoll et al., 2017).

1.3.6.7 Follow-up data

Four studies included follow-up data (Finlay-Jones et al., 2016; Hopkins & Proeve, 2013; Stafford-Brown & Pakenham, 2011; Swift et al., 2017). Finlay-Jones et al. (2016) had the longest period of twelve weeks post intervention. Therefore, there is limited information of the longer-term outcomes of MBI for TPTs.

1.4 Discussion

1.4.1 Overall summary

The reviewed studies were of moderate to high quality with the main concern being low participant numbers (*N*=5 to *N*=103) and limited reporting of effect sizes. Only two studies conducted power calculations (Finlay-Jones, Kane & Rees, 2016 Leppma & Young, 2016).

There were three areas where significant improvements were clearly noted for TPTs' wellbeing post MBIs. These included 'anxiety' and 'rumination' (from moderate to high quality studies) and 'positive affect' (from high quality studies). High quality studies also demonstrated significant improvements for 'trait anger', 'happiness' and 'social connectedness'. However for TPTs' 'perceived stress', the results were inconclusive, with relatively equal numbers of high quality studies indicating either significant improvement or no significant change post MBI. Further, one high quality study demonstrated significant change for 'general mental health', in contrast to one good quality study showing no change. This variability may have been compounded by limitations such as MBI fidelity, varying participant attendance, the inclusion of participants with previous/current meditation practice and the variability in training. Further none of the reviewed studies considered the organisational cultures where TPTs were practicing. Boorman (2009; 2010) highlighted variance in healthcare services, with those addressing staff welfare demonstrating improved staff health and wellbeing. Therefore TPTs' working environments may also have accounted for some the variability of these outcomes.

Initial improvements in TPTs' therapeutic skills were noted for emotional regulation (a high quality study), 'emotional intelligence' (a good quality study), perceived 'self-

efficacy' and 'therapeutic efficacy' (good to high quality studies). Only one high quality paper (from a range of six high quality, two good quality and a moderate quality paper) failed to demonstrate significant improvement in the MBI skill 'mindfulness'. All ACT process demonstrated significant improvement post MBI in good and high quality studies. The longevity of any outcomes was uncertain given the limited follow-up data. None of the studies investigated the impact of MBIs on TPTs' academic learning or academic performance.

Significant improvements in client distress were demonstrated in two studies (of high and medium quality). These studies did not appear to account for potential confounding variables that may have influenced these findings such as changes client's social, economic, health or other personal circumstances. However, improvement in clients' perceptions of TPTs' behaviour in sessions and the effectiveness of therapy sessions was less evident. Two areas of improvement were reported in one medium quality and two high quality studies ('problem solving perspective' and 'attunement'). Further, perceptions of 'therapist presence' post MBIs differed between TPTs and clients. High quality studies reported that TPTs rated significant improvements in 'therapist presence' whereas clients reported no change.

The MBIs fell into two categories, facilitated and non-facilitated, with all but one online intervention (Finlay-Jones et al., 2016) being group interventions. There was no clear evidence of one MBI being more beneficial than another for TPTs with potential improvements in: 'Stress' and 'anxiety' (MBSR; Compassionate Mind Training [CMT]), 'empathy' (Mindfulness Experiential Small Group [MESG]; Zen), 'self-compassion' (Mindfulness Based Cognitive Therapy [MBCT]; MBSR; CMT; Vispassana), 'mindfulness' (MESG; ACT; MBSR; MBCT; Vipassana), 'perceived therapist self-efficacy' (MESG; ACT),

and decreases in 'client distress' (Zen). The findings will be discussed in relation to the previous literature below.

1.4.2 Improvements in TPTs' wellbeing following their participation in MBIs

Consistent with MBIs for medical students and the limited findings for nursing/midwifery students this review found equivocal results regarding 'perceived stress' (Daya & Heath Hern, 2018; McCarthy et al, 2018). This is in contrast to research with healthcare professionals and healthcare professionals in training where reductions in reported stress were more evident (Lomas et al., 2018; McConville et al., 2017; O'Driscoll et al., 2017). This may have reflected the demands of differing training programmes, the year of training (Rimes & Wingrove, 2011) or the types of MBIs investigated. For example, the majority of MBIs were either MBSR or MBSR adaptations for healthcare professionals in training reviews (McConville et al., 2017 and O'Driscoll et al., 2017). Further, some of the measures selected for 'perceived stress' (i.e. Perceived Stress Scale; Cohen, Kamarck, & Mermelstein, 1983) may lack appropriate sensitivity to change and therefore compromise outcomes (Bohecker & Doughty Horn, 2016). The lack of significant change shown in TPTs' life satisfaction ('professional stress' and 'quality of life') matched previous findings for healthcare professionals (Lomas et al., 2018). Significant improvements were demonstrated post MBIs across studies in relation to 'state anxiety' and 'rumination' which matched previous findings for healthcare professionals and healthcare professionals in training (Lomas et al., 2018; McConville et al., 2017). One study demonstrated reductions in 'state anger' for TPT's, which was consistent with improvements in aggression found in a clinical population (Fix & Fix, 2013). The significant reductions in 'negative affect' were congruent with previous findings of MBIs improving mood for healthcare professionals in training

(McConville et al., 2017). Outcomes were far more inconclusive in relation to decreased TPT depression. Finlay-Jones et al. (2016) suggested that this might be related to the sensitivity of measures used in the studies, for instance, the Depression Anxiety and Stress Scales (Lovibond & Lovibond, 1995).

1.4.3 Changes in TPT learning (therapeutic skills, and MBIs skill development) post MBI

TPTs appeared to score more highly than the norm on measures of 'empathy' and 'compassion for others' pre-MBI (Beaumont et al., 2017). This may account for some of the variance in results relating to TPTs' empathy and a lack significant change demonstrated on the 'compassion for others' measure. Significant improvements in TPTs' skills including mindfulness and ACT processes were demonstrated across studies. This was consistent with improvements in mindfulness in healthcare professionals and healthcare professionals in training and self-compassion (Lomas et al., 2018; McConville et al., 2017; O'Driscoll et al., 2017). Importantly the length of weekly practice improved the level of mindfulness and the first year of study was related to most improvement in self-compassion (Collard et al., 2008; Rimes & Wingrove, 2011). This finding suggested that proportionally the level and amount of development in the first year of training may differ to other years or that there were unique factors specific to the cohort in the study. There was limited evidence for increased attentional accuracy, self-compassion, and openness to experience.

1.4.4 Changes in therapeutic outcome (client distress and clients' and TPTs' experience of therapy) post MBI

Grepmair et al. (2007a; 2007b) reported significant findings in reducing client distress. However, it was difficult to establish whether these were due to the MBI, the

experience of the MBI facilitator and/or the intensity of the MBI and/or other confounding variables. Further, in these studies the inpatient client group received a variety of therapeutic interventions (other than the TPTs' psychological intervention). As noted by Ivanovic et al. (2015), these findings are yet to be replicated in different settings.

Clients reported significant improvements in TPTs' behaviour and effectiveness of therapy sessions post MBIs. Clients' perceptions of 'therapist presence', however, demonstrated no change. Further, TPTs' self-reports of their 'perceived therapist presence' and 'perceived self-efficacy' showed significant improvements. These were consistent with the limited findings in this area for healthcare professionals in training (McConville et al., 2017). The range of findings might indicate a reliance on self-report rather than direct observations of therapist's change, and has been cited as limitation of the research (Hemanth & Fisher, 2015b).

1.4.5 Implications for education and practice

The present review found benefits for TPTs regarding aspects of TPTs' personal wellbeing, the development of MBI skills, improved clinical skills and therapeutic outcomes. These findings provide supportive evidence for the integration of MBIs into TPTs' training programmes. The growing evidence related to the benefits of MBIs for qualified healthcare professionals and healthcare professionals in training highlights the importance for healthcare services to consider supporting regular mindfulness-based practice in the workplace. Incorporating such interventions on an individual basis alongside the implementation of strategies to improve organisational cultures may ultimately improve health care professionals' health and wellbeing and patient care

(Boorman, 2009; 2010; Department of Health 2009a; 2009b; 2011; Department for Work and Pensions, 2009).

For TPTs, such ongoing practice could provide opportunities to measure the longer-term benefits to therapists, academic learning and performance and, importantly, therapeutic outcomes.

1.4.6 Future research

Future research should aim to address the limitations of the reviewed studies previously highlighted (see 1.3.6). An area for future research is investigating the impact of MBIs on TPTs' academic learning and performance. This would add to the limited research on MBIs for healthcare professionals in training (McConville et al., 2017). Further, there is limited evidence of MBIs acting as a protective factor against burnout for healthcare professionals (Daya & Heath Hearn, 2018). This appears to be an important area for future research for TPTs as MBIs were found to act as a protective factor for social work students moving into qualified positions (Trowbridge & Mische Lawson, 2016). Finally, given the evidence that MBIs are less effective for male healthcare professionals in training (Daya & Heath Hearn, 2018) and potentially male TPTs, further investigation into how other interventions can support male training and learning is warranted.

1.4.7 Limitations of the review

The reviewed studies originated from a variety of countries with divergent disciplines. This range of TPTs may be reflective of the psychological therapy workforce in the UK. One limitation was the inclusion of a study with some participants who were 'resident psychiatrists' (Rodriguez Vega et al., 2014). It could be argued that 'resident psychiatrists' are not considered part of the applied psychology professions. However, psychiatrists and other healthcare professionals train and specialise in psychotherapy.

As none of the reviewed studies provided information about participants' prior professional training, this research was included. Further, other psychological therapists such as art psychotherapists and music therapists are part of the UK health economy. At the point of the initial scoping for the review, no research was identified for these professions therefore they were excluded from the search terms.

The exploration of TPTs' qualitative experiences of MBIs was omitted from this review due to its quantitative focus. Further investigation of TPTs' views regarding the benefits and the difficulties that MBIs may present to TPTs is considered important. This is particularly pertinent given the ethical considerations highlighted in Murphy et al.'s (2018) recent review of mandatory personal therapy where TPTs reported their unhelpful experiences of therapy.

A strength and limitation of the review was the exclusion of non-peer reviewed research. This can lead to publication bias and the exclusion of formal research within academic intuitions, such as doctoral theses. As all studies were required to be written in English, therefore selection bias is also possible.

1.5 Conclusion

This review focused on the use of MBIs with TPTs and indicated that MBIs have a positive impact on some areas of TPTs' psychological wellbeing, therapeutic skills and therapeutic outcome. Factors influencing fidelity in the delivery of the MBI, inconsistent in reporting current/previous meditation practice or other current psychological therapy, amongst other issues may have influenced outcomes. Further areas of research have been highlighted to rectify these and other research limitations.

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Empirical Study

Compassion Focused Approaches to Nurse Mentoring

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Compassion Focused Approaches to Nurse Mentoring

Abstract

Objectives: Enhancing the underexplored nurse mentor-mentee relationship may improve the retention of pre-registration nurses. This study investigated the impact of a Compassion Focused Approaches to Nurse Mentoring Programme (CFA-MP) on nurse mentors and their mentoring practice.

Design: A repeated measures mixed methods design with the addition of a follow-up interview post CFA-MP was employed.

Methods: Standardised measures of compassion, wellbeing, a compassion practice diary and four vignettes were completed by participants who attended CFA-MP at four time points (pre-intervention (T1), post five day psychoeducation programme (T2), at the end of the tenth supervision session (T3), and at 2 months follow-up (T4)). After twelve months a semi-structured interview was completed.

Results: No significant changes other than changes in self-compassion and wellbeing (with medium effect sizes) were demonstrated between T1-T2. Content analysis of vignette responses identified an increased application of compassion focused approaches between T2-T3. Thematic analysis of follow-up interviews identified two themes 'Understanding Compassion' and 'Venturing into Compassion'.

Conclusions: The lack of statistical power and significant gaps in participants' responses led to the quantitative analyses being unable to detect, any measureable impact of CFA-MP on participants. Qualitative evidence suggested that CFA-MP is helpful in facilitating the mentoring processes and that its positive impact remained over a period of at least 12 months follow-up.

Practitioner Points:

- Qualitative data demonstrated the potential benefit of CFA-MP to support the nurse mentoring process.
- Replication of this study with a larger cohort (and a design incorporating a control group) is warranted.

2.1 Introduction

Reports investigating healthcare organisations in the United Kingdom (UK) exposed working cultures lacking compassionate care towards healthcare staff and patients. For example, Boorman (2009) highlighted how healthcare cultures adversely affected the health and wellbeing of its staff resulting in compromised patient care. Further, reports such as Winterbourne View (Department of Health 2012) and the Mid-Staffordshire Foundation Trust Public Inquiry (Francis, 2013) highlighted profound difficulties in healthcare cultures where patient care was severely flawed. In these reports issues such as a lack of registered managers, limited staff training, target driven healthcare and accepted cultures of bullying and harassment and the emotional demands of staff were not heeded by the appropriate authorities and generated stressful working environments (Boorman, 2009; Department of Health 2012; Francis 2013). Irrespective of the implementation of Department of Health's (2009a; 2009b; 2011a; 2011b) strategies to improve staff mental health and wellbeing, workplace stress remains widespread in the healthcare workforce (Lomas, Medina, Ivtzan, Rupprecht & Eiroa-Orosa, 2018). Dudman, Isaac and Johnson (2015) surveyed 3,700 National Health Service (NHS) employees and found that 61% reported feeling stressed all or most of the time. To increase retention of NHS staff a joint report by The Health Foundation, Nuffield Trust and King's Fund (2019) argued that the NHS needed to improve its status as an employer by for example addressing challenging working cultures, facilitating better work-life balance for staff and proving better support to staff at the start or end of their careers.

The largest and most integral part of the healthcare workforce are nurses (NHS Confederation, 2017). Workplace stress adversely affecting nurses' professional and

health related quality of life continues to be reported (Itzaki et al., 2018; Sarafis et al., 2016). Similarly to Boorman (2009; 2010) and Francis (2013), Itzaki et al. (2018) and Marangozov, Huxley, Manzoni, and Pike (2017) noted that factors contributing to nurses' stress include feeling overworked, insufficient staffing levels to meet patient care needs, increased staff sickness, financial hardship for lower salaried nurses, physical and verbal abuse, harassment and bullying from service users, carers and colleagues. Indeed, Marangozov et al. (2017) reported that more than a third (37%) of nurses were seeking new jobs and only 41% recommended nursing as a career (the lowest percentage for ten years). Workplace stress, alongside a diminished quality of life, may partly explain the national shortfall in nursing numbers and current recruitment/retention issues (Royal College of Nursing, 2018). Indeed The Health Foundation, Nuffield Trust and King's Fund (2019) estimated that by 2029 the shortfall in full time nurses in the NHS could reach 108,000.

2.1.1 Workplace Stress in Student Nurses

To address the nursing shortfall, the Department of Health and Social Care (2017) introduced funding reforms to increase the capacity for pre-registration nurse training. Importantly, student nurses undertake 50% of their training in practice education (Nursing and Midwifery Council [NMC], 2010). Therefore, student nurses are exposed to the same difficult working environments, as their qualified counterparts alongside the additional clinical and interpersonal stressors unique to training noted by McCarthy et al. (2018). Clinically, these included caring for critically and/or terminally ill patients. Interpersonal stressors such as difficult working relationships with colleagues and/or clinical educators were reported. Consequently, student nurses felt ignored or

unwanted by qualified staff, experienced a lack of support or anticipated criticism from staff nurses, and, pressure to appease or prove their worth to their colleagues. Finally, student nurses reported intimidation from other healthcare professionals (McCarthy et al., 2018). Health Education England (HEE; 2018a) reported similar issues to those cited above following their investigation into factors that affected healthcare student attrition and the retention of the newly qualified staff.

Reeve, Shumaker, Yearwood, Crowell and Riley (2013) and Grobecker (2015) reported that difficult clinical practice environments culminate in high levels of stress with increased anxiety, worry, and depression in student nurses. Both studies reported that student nurses experienced feelings of rejection (from qualified staff, their peers and patients), reduced levels of motivation to learn on placements, and, stemming from their inability to learn and adequately use their clinical skills, feeling inadequate. Beaumont and Hollins Martin (2016) suggested that the demands of training for midwifery students result in a constellation of cognitive, emotional, physical and behavioural, symptoms such as self-critical thinking, feelings of shame and anger, headaches, lacking self-care, withdrawing from others and from their academic training programme. Therefore, these interpersonal experiences may affect the student nurses' emotional states and their ability to regulate or manage their emotional responses. A key relationship for student nurses in practice education is with their mentor (HEE, 2018a). The Nursing and Midwifery Council (NMC; 2008) described the Nurse Mentor Role as involving a number of duties. These included arranging, monitoring and assessing practice learning tasks for student nurses, setting realistic learning targets, supervising clinical practice activities, observing and monitoring the development of the student's clinical skills, and providing constructive feedback. The nurse mentor gathers

evidence of the student's strengths and areas for further development for the educational providers and sign-off mentors. This evidence can then be utilised to make appropriate decisions regarding the eligibility of the student to qualify as a nurse at the end of their training. According to Watson (1999) however, student nurses felt like a burden to their mentor and found the workplace environment unwelcoming. Some student nurses sensed their mentor's manager was unsupportive of the mentoring process facing no alternative arrangements for support in the mentor's absence (Watson, 1999). Student nurses voiced experiencing inappropriate, unprofessional and unhelpful behaviours from their mentors, which resulted in them feeling excluded (Epstein & Carlin, 2012; Gibbons, 2010).

Increased discord between student nurse and mentor, and/or displays of resentment and hostility from qualified staff to student nurses may be experienced as threatening to student nurses and elicit feelings of shame (Bond, 2009). Indeed, feelings of guilt and shame are reported to be high for student nurses (Kaya, Aştı, Turan, Karabay & Emir, 2012). To manage their difficult feelings Bond (2009) and Johnson (2012) suggested that student nurses engage in shame responses that would impede the students' capacity to learn on placement. These responses include withdrawal, submission, avoidance and detracting away from their own distress or sense of threat (through hostile behaviours, Bond, 2009; Johnson 2012). Thus, Reeve et al. (2013) and Beaumont and Hollins Martin (2016) highlight the importance of nurse training programmes helping student nurses develop their skills and build their capacity to regulate their emotions/manage their distress. HEE (2018a) extended this by suggesting that healthcare providers, academic institutions and students to work together to find solutions to challenging healthcare cultures to improve attrition rates on training programmes and retention post

qualification. Further, they underlined the important influence nurse mentors have in helping to enhance student experiences in healthcare settings.

2.1.2 The Nurse Mentor - Student Nurse (Mentee) Relationship

Crucially, closer relationships between student nurses and their nurse mentors result in the retention of student nurses on training courses (Crombie et al., 2013; ten Hoeve, Castelein, Jansen & Roodbol, 2017; HEE, 2018a). Reviews exploring the mentor-mentee relationship (Rebeiro, Edward, Chapman & Evans, 2015; Wilkes, 2013) highlighted the importance of supporting nurse mentors to ensure they incorporate sufficient time to develop better working relationships with their mentees. Interventions from the nurse mentors' employing organisation (for increased staffing) or the student nurses' Higher Education Institution (HEI; for increased placement length) were suggested as ways of increasing time for the mentor-mentee relationship to develop (Rebeiro, Edward, Chapman & Evans, 2015; Wilkes, 2013). Neither review offered information on how increased time would improve mentor-mentee interpersonal interactions or what specific interventions would help improve these relationships. Mentors report being overwhelmed by their own workload, with insufficient time or space to appropriately mentor a student (Andrews & Chilton 2000; Andrews et al., 2010; Evans, Costello, Greenberg & Nicholas 2013; Nettleton & Bray, 2008). Therefore, mentors may experience a sense of threat from workplace stress alongside the mentoring role. They too might exhibit shame responses including withdrawal, being passive, avoiding and becoming hostile towards others (Bond, 2009; Johnson 2012)[9]. These responses

[9] These behaviours resemble those reported in the concept of 'Toxic Mentors' (Darling, 1985 cited in Barker, 2006) and include mentors being rarely available for student nurses with little or no guidance, withholding helpful information and, leaving students to be completely responsible for their work to micromanaging or undermining the student.

negatively affect the mentor-mentee relationship, impede the mentoring process and the student nurses' capacity to learn and develop appropriate nursing skills.

Current literature offers practical information to the mentor and student nurses about how to prepare for, and develop a helpful mentor-mentee relationship, and, how to manage difficulties within the mentee-mentor relationship. Whilst it is suggested that both student nurses and mentors engage in personal reflection, honest and non-blaming communication, and the development of alternative support networks (Barker, 2006; Smith-Jentsch, Sullivan & Ford, 2018), the appropriate management of shame responses for both the mentor and mentee is not addressed. Further, none of the case studies cited by (HEE, 2018b) that were implemented throughout the UK to enrich students' clinical experiences directly examine the nurse mentor-mentee relationship. Indeed, the current nurse-mentoring curriculum adheres to the mandatory standards produced by the NMC (2008). There is no capacity within the curriculum to provide in-depth training in understanding shame and regulating emotions to help the mentor-mentee relationship. Thus incorporating these concepts into additional mentor training could enhance existing mentor training programmes and facilitate improved emotional regulation and reductions in shame responses within mentor-student nurse relationships. Better mentor-student nurse relationships may then improve the retention of student nurses on training programmes and their recruitment post-registration. Currently, the average attrition rate of pre-registration nursing students in the UK appears to have remained relatively stable at 24% since 2006 (Jones-Berry, 2018). Finally, the development of such approaches might enhance nurse mentors' responses to stress and their professional quality of life.

2.1.3 Compassion Focused Therapy and Emotional Regulation: A brief overview

Compassion Focused Therapy (CFT; Gilbert 2014) is a relatively new therapeutic approach. One aspect of CFT is to help individuals manage their difficult emotions such as feelings of shame. Specifically, CFT suggests that there are three systems (threat-protection, drive and soothing) involved in the regulation of emotions. The threat-protection system is activated when individuals experience a threat (a lack of safety), typically reacting with strong negative emotions such as anger, anxiety and disgust. It can be activated by internal threats and/or external threats through high arousal states stimulating the amygdala (i.e. the fight or flight system). As outlined earlier, for nurse mentors and student nurses, the internal threats would include self-criticism and feelings of shame, whilst external threats would encompass the challenging working environments, clinical challenges and difficult working relationships where shame-based behaviours may occur.

The drive system relates to achievement, competition and reward (Gilbert, 2014) activating high arousal states. In extreme situations, an overactive drive system can lead to lack of sleep, ultimately exhaustion. For nurse mentors and student nurses, when activated, this system may negatively affect working relationships where the individual is more focused on achieving their goal than on maintaining positive relationships.

The soothing system is associated with contentment, calmness, safety and connection to others. Gilbert (2010) and Grobecker (2016) suggested that humans have an innate need to feel safe and experience a sense of belonging to others. This system is important to activate oxytocin (calming high arousal states) and induce more caring and compassionate states including caring of the self and others (Gilbert, 2014). When this system is activated, mentors or student nurses would be more able to engage in positive

relationships with each other, their colleagues, service users and carers. Indeed, Neff and Beretvas (2013) demonstrated increased self-compassion enhanced relationships and reduced levels of self-criticism. Therefore improving how student nurses and mentors respond to stress may enrich the working environment (Leary, Tate, Adams, Batts Allen, & Hancock, 2007). The recent implementation of a Compassionate Focused curriculum for post-registration nurses (Pettit, McVicar, Knight-Davidson & Shaw-Flach, 2019) highlighted the importance of adopting a "compassionate learning environment" (Pettit et al., 2019, p.3). This environment required the HEI and crucially the mentors to collaborate in order to develop a secure base from which the student could develop and learn.

2.1.4 Compassion Focused Approaches in Pre-Registration Nurse Training

Beaumont and Hollins Martin (2016) proposed that developing environments that nurture compassion might enhance midwifery students' abilities to cope with their distress during training, including their practice placements. Therefore embedding an intervention grounded in CFT, specifically Compassion Focused Approaches (CFA), into the students' HEI training programme was recommended. They suggested that CFA techniques[10] would help students to manage some of the previously described internal and external threats. Alongside improving self-compassion, Beaumont and Hollins Martin (2016) proposed that such an intervention would improve students' professional quality of life, their wellbeing, and improve their emotional resilience. This model does not address how to improve the mentor-mentee relationship. Further, it does not consider the mentors' experience of stress, their difficulties in regulating emotion and

[10] Mindfulness and focused attention, soothing rhythm breathing, compassion-focused imagery, and creating a safe place

managing theirs and others shame responses, and their diminished professional quality of life.

2.1.5 Rationale for the present study

Although change is advocated at an organisational level, the importance of enhancing students' clinical experiences and improving attrition rates by ensuring constructive nurse mentor-student nurse relationships has also been acknowledged (HEE, 2018a). CFT has been adapted to areas of "business, education and healthcare to science, research and the environment" (Leaviss & Uttley, 2014, p.1). As noted above, current practice environments are stressful and negatively impact on attrition, recruitment and retention rates for both student nurses and nurses (Andrews et al., 2010; Evans et al., 2013; Grobecker, 2015; Reeve et al., 2013, HEE, 2018a; The Health Foundation, Nuffield Trust & The Kings Fund, 2019). Beaumont and Hollins Martin (2016) and Pettit et al. (2019) suggested that the CFA has a role in improving the learning environment for pre and post-registration nurses. Here they highlight the importance of compassionate environments within the HEI and the practice learning environment. Further, Pettit et al. (2019) established the importance of embedding CFA into post-registration nurse training. Beaumont and Hollins Martin (2016) have proposed its central role in pre-registration midwifery training.

Given the pivotal role of the mentor-mentee relationship in the retention of student nurses (Crombie et al., 2013; ten Hoeve et al., 2017, HEE 2018a), consideration of how to enhance this under explored relationship is important. As previously discussed, student nurse's and nurse mentor's shame responses may compromise this crucial relationship. Thus far, interventions to support the mentor-mentee relationship have

been limited to practical advice (Barker, 2006; Smith-Jentsch et al., 2018) and have not focused on emotional and behavioural regulation within the relationship.

In summary, in order to address some of the problems identified in the literature, and to improve the practice learning environment for student nurses, a CFA programme designed to support mentors was devised and implemented. The author was unaware of any adaptation of any previous CFA specifically to support nurse mentors. The overall aim of the present study was to evaluate a Compassion Focused Approach to Nurse Mentoring Programme (CFA-MP). This involved training nurse mentors in the CFT model in order to increase their understanding of the emotional regulation systems with the expectation that they would then be able to recognise and address shame and self-criticism in themselves, their mentees, and within the mentoring relationship.

2.1.6 Research Question and Aims

The main research question was: What impact does CFA-MP have on nurse mentors in relation to their levels of compassion, wellbeing and professional quality of life and their nurse mentoring practice?

2.1.6.1 Aims

1. To investigate what (if any) changes CFA-MP has on nurse mentors ability to be compassionate to themselves and others;
2. To evaluate potential changes in wellbeing [11]as a result of CFA-MP;
3. To assess how nurse mentors apply CFA to themselves and to nurse mentoring issues;

[11] Previous research has defined subjective wellbeing as a combination of positive and negative affect and life satisfaction (Brown & Ryan, 2003). For the purpose of this study, this definition of wellbeing was adapted to include psychological distress (general mental health and stress) and quality of life (professional quality of life).

4. To explore what (if any) CFA-MP processes or techniques are utilised at a minimum of twelve months follow-up.

2.2 Method

2.2.1 Recruitment

Convenience sampling was used with CFA-MP being advertised by the course facilitators (Appendix F). Participants were recruited from the same NHS Trust. All applicants to the programme required their manager's written agreement to attend CFA-MP. Prospective participants were approached initially by CFA-MP facilitators to ask if they would be interested in taking part in the research. They were provided with a participant information sheet (Appendix G) and asked to complete a consent form (Appendix H).

2.2.2 Inclusion /Exclusion Criteria

The main inclusion criteria required participants to be qualified nurses who were eligible to mentor student nurses enrolled on nursing programmes at Coventry University (the provider of CFA-MP) and held the relevant qualification for nurse mentoring. The full inclusion/exclusion criteria are summarised in Table 2.1.

Table 2.1 Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
18 to 65 years old	Younger than 18 years and older than 65 years of age
Able to give informed consent (in the opinion of the researcher)	Unable and/or unwilling, in the opinion of the researcher, to give informed consent
With their manager's approval to attend the programme	Without their manager's approval to attend the programme

Qualified nurses who are eligible to mentor student nurses enrolled on nursing programmes at Coventry University Work within local NHS Trusts and offer practice placements Be fluent in English and hold the relevant qualifications for nurse mentoring	Not qualified nurses or qualified nurses not eligible to mentor student nurses enrolled on nursing programmes at Coventry University Work and offer practice placements within the independent sector Not fluent in English and do not hold the relevant qualifications for nurse mentoring.

2.2.3 Ethical Approval

The study was conducted in accordance to the British Psychological Society (BPS) ethical guidelines for research with human participants (BPS, 2010) and the University of Leicester, Code of Ethics. Ethical approval was provided by the University of Leicester and, approval was sought from the Research and Development Department of the host NHS Trust (Appendix I).

2.2.4 CFA-MP Intervention

A Consultant Clinical Psychologist and a Clinical Nurse Specialist with extensive expertise in and in the training of professionals in CFT facilitated CFA-MP.

CFA-MP was divided into two distinct phases:

The first phase involved a bespoke five consecutive day psychoeducation programme involving didactic and active learning methods such as role-play, practicing compassionate mind training exercises, and reflection. This was developed and adapted by the facilitators from literature within CFT in three main areas (Goss 2011a; Goss 2011b; Goss & Allan, 2010, 2014). Firstly, there was an emphasis on the concept of

compassion in clinical practice and practice education. This included information relating to the nurse mentor and mentee experiences in clinical practice, factors affecting student learning, and the nurse mentoring process. Secondly, participants received a more detailed account of CFA concepts and the supporting evidence base to clinical populations. Concepts included in CFA-MP can be seen in Table 2.2. Finally, CFA was directly applied to the mentoring process. For example, how participants would recognise the activation of specific emotional systems in themselves and/or the mentee and how to apply CFA to mentoring dilemmas. Further information is presented in Appendix J. All participants were provided with written materials to support the teaching and a CD with compassionate mind training exercises for personal use.

Table 2.2 CFA Concepts included in the first phase of CFA-MP

Psychoeducation Days	CFA Concept
1 & 2	The evolution of the brain i.e. concepts of "old brain" and "new brain" processes
	Understanding the types of affect regulation systems (i.e., drive, threat-protection and soothing systems) and how these may then impact on the mentoring process and student learning
	Understanding Shame, Guilt and Self-Criticism
3 & 4	Understanding what compassion consists of and what blocks it (e.g., threatened/competitive mind and blocks to soothing)
	Compassionate Mind Training exercises such as Practical Self-Soothing (PS-S), Soothing Breathing (SB), Safe Place Imagery (SPI), Compassionate Imagery: Me at My Best (CIMMB), Compassionate Imagery: Compassionate Companion (CICC), Allowing Others to be Compassionate to Me (AOCM), Behaving Compassionately to Others (BCO), and Behaving Compassionately to Myself (BCM)

The second phase involved mentors attending ten weekly group supervision sessions with CFA-MP facilitators to help build on and implement this knowledge within their mentoring practice. Attendance rates for both phases can be found in Appendix K.

2.2.5 Design

A mixed method design was employed. A repeated measures design was planned for the quantitative data at four time points; pre-intervention (T1), post five day psychoeducation programme (T2), at the end of the tenth supervision session (T3) and at 2 months follow-up (T4) to collate qualitative data in relation to nurse mentors' approach to mentoring over time.[12] All participants were invited to attend an additional

[12] All data would be collected by the researcher

follow-up semi-structured interview with the researcher at least twelve months from programme completion. Further information is provided below.

2.2.6 Measures[13]

2.2.6.1 The Compassionate Engagement and Action Scales (CEAS; Gilbert, et al., 2017)

The CEAS were selected to assess different qualities of compassion for nurse mentors. The scales were developed from the CFT model and, as such, aimed to measure directly changes in compassion targeted within CFA. The CEAS comprises of three main scales: Compassion for Self Scale (i.e. the ability to be compassionate to oneself), Compassion To Others Scale (i.e. the ability to be compassionate to others) and Compassion From Others Scale (i.e. the ability to receive compassion). Each of the main scales consists of a compassion engagement subscale (the motivation to engage in compassion) and, a compassionate action subscale (to attend to, learn about and act on what is helpful). Higher scores on each subscale indicate more compassion. This scale has not been used with the nurse population; however, it has been validated with students in the United Kingdom (UK), Portugal, and United States of America (USA). The internal reliability for the UK sample for each subscale is Compassion for Self Engagement (CSE) α=.77; Compassion for Self Actions (CSA) α=.90; Compassion To Others Engagement (CTOE) α=.90; Compassion To Others Actions (CTOA) α=.94; Compassion From Others Engagement (CFOE) α=.89; Compassion From Others Actions (CFOA) α=.91. Internal

[13] Rolstad, Adler and Rydén's (2011) meta-analysis demonstrated fewer measures improve the participant response rate and participant retention in research studies. Given the work pressures previously described for this participant group it was considered important to reduce participant burden (Lingler, Schmidt, Gentry, Hu & Terhorst, 2014) and to improve the response rate and the retention of participants. The number of measures therefore, was limited to one measure per outcome area (i.e., compassion, wellbeing, stress and professional quality of life).

reliability for participants in the present study were excellent[14] for all subscales except CSE α=.52 (CSA α=.97; CTOE α=.82; CTOA α=.96; CFOE α=.90; CFOA α=.96).

2.2.6.2 The General Health Questionnaire-12 (GHQ-12; Goldberg, 1972; Goldberg & Hillier 1979; Goldberg & Williams, 1988; Goldberg, 1991)

The GHQ-12 was selected to assess an aspect of nurse mentors' wellbeing (General mental health). It has previously been used to assess wellbeing in nurses and midwives (e.g., Foureur, Besley, Burton & Yu, 2013; Rodwell & Munro, 2013). The simple Likert scoring method 0-1-2-3 was used where higher scores suggest higher levels of psychological distress or a deterioration general mental health (Goldberg &Williams, 1988). This scoring method was chosen to decrease psychometric data skewing (Goldberg & Williams, 1988). This scoring method has elicited debate about the threshold for caseness with an optimal cut-off of 14 noted by Piccinelli, Bisoffi, Bon, Cunico, and Tansella, (1993). This cut-off was chosen for this study. For the participants in the present study, scores on the GHQ-12 revealed excellent internal reliability (α=.91).

2.2.6.3 The Stress Subscale of the Depression, Anxiety and Stress Scale (DASS21, Lovibond & Lovibond 1995)

The Stress Subscale (SS) of the DASS21 was used as a further measure of wellbeing. Increased scores indicate increased stress (or decreased wellbeing). The full DASS21 consists of three, seven-item, self-report scales measuring states of Depression, Anxiety and Stress. The DASS21 has been shown to have high internal consistency and has been

[14] Gliem and Gliem (2003) Excellent >.90; Good, .80-.89, Acceptable .70-.79; Questionable, .60-.69; Poor .50-.59 and Unacceptable <.50

used as a measure to assess stress-related outcomes in nursing staff (Foureur, Besley, Burton & Yu, 2013; Lan, Rahmat, Subramanian, & Kar 2013).The SS has been shown to be sensitive to levels of chronic non-specific arousal. Good internal reliability was demonstrated for the participants in the present study (α=.81).

2.2.6.4 The Professional Quality of Life Scale (ProQOL V; Stamm, 2009; 2010)

The ProQOL V was selected to assess changes in nurse mentors' quality of life at work as a further measure of wellbeing (quality of life). It has been extensively used within the literature in a variety of clinical settings and countries with health care professionals including nurses (Hunsaker, Chen, Maughan, & Heaston, 2015; Potter et al., 2013; Sacco, Ciurzynski, Harvey, & Ingersoll, 2015). This version has two scales. The first is Compassion Satisfaction Scale (CSS) with higher scores suggesting increased professional satisfaction from work. The second is Compassion Fatigue scale which comprises two subscales: Burnout (BS) and Secondary Traumatic Stress (STSS). Higher scores on either of the two Compassion Fatigue subscales suggest an increased sense of burnout or distress in the work environment. Stamm (2010) reported that the reliability for the CSS was α=.88, BS α=.75 and STSS α=.81 for a sample of healthcare professionals. In the present study, internal reliability was good for CSS (α=.81) and acceptable for STSS (α=.78), but low for BS (α=.62).

2.2.6.5 A compassion practice diary

A structured diary was used to capture descriptive information of the type, frequency, duration and utility of compassionate mind training exercises ("Compassionate Actions") that participants engaged in from T2. Participants were asked to complete

their diary prior to each of the ten supervision sessions and at two-month follow-up (T4). The diary was adapted by a CFA-MP facilitator from a diary used with a clinical population. Participants recorded the number of times they practiced each Action, its duration and how helpful they had found the Action[15] (Appendix L).

2.2.7 Vignettes

This was the first study to examine the impact of CFA on nurse mentoring. Therefore capturing qualitative data regarding any potential changes in nurse mentors' approach to mentoring was important.

Four vignettes of typical mentoring scenarios within mental health or general nursing were presented to the participants (Appendices M and N). The vignettes were developed from scenarios described in the nursing literature (Atkins & Williams, 1995; Evans et al., 2013) and reviewed for accuracy by three nurses with expertise in nurse mentoring. Vignette 1 (V1) related to a mentee witnessing a traumatic incident on a ward; Vignette 2 (V2) to a mentee advising a patient on their medication without any prior discussion; Vignette 3 (V3) to a demotivated or disinterested mentee; and Vignette 4 (V4) to an overwhelmed mentor with a highly motivated mentee. Participants were asked to read the vignettes and provide written responses about how they thought the mentor and mentee outlined in the vignette would react to the situation and consequently what issues they believed would need addressing.

2.2.8 Post twelve month follow-up interview

The semi-structured interview schedule was constructed by the researcher and aimed to focus on participants' learning from CFA-MP, including CFA theory and techniques,

[15] Using a scale of 0-10, where 0= not at all helpful and 10= very helpful

and the application of their learning to themselves, their mentoring practice, and to other aspects of their lives. The schedule is presented in Appendix O.

2.2.9. Data Analysis

2.2.9.1. Quantitative data

The quantitative research questions were aimed at assessing whether there would be changes in the scores of the self-report measures across T1-T4. It was anticipated that one-way ANOVAs would be used to assess differences across T1-T4. An a priori analysis using the G*Power program (Faul, Erdfelder, Lang, & Buchner, 2007) specified a sample size of 32 would be sufficient to detect a moderate effect (see Appendix P).

The following analyses were also planned: Any significant one-way ANOVAs would be subjected to post hoc tests to compare specific time points using repeated measures t-tests with Bonferroni adjusted alpha values. Additional quantitative analyses were conducted with data obtained at T1 to check whether participant responses were plausible and in line with what was expected from theory and the literature. Thus, participant mean score at T1 would be compared with normative data using one sample z-tests (Clark-Carter, 2010), and Pearson's correlations of T1 self-report data would explore the plausibility of these associations in line with the literature.

2.2.9.2 Qualitative data

A further research question was to examine whether participants' behaviours and approach to nurse mentoring would change over the duration of programme. Content analysis was chosen as it has previously been used to analyse the written responses to vignettes for other healthcare participants (Langer, Jazmati, Jung, Schulz, & Schnell, 2016). Further, Vaismoradi, Turunen and Bondas (2013) suggested this type of analysis

was useful for new areas of research. Given this was a novel research area an inductive content analysis was chosen (Elo & Kyngäs, 2008). The phases suggested by Elo and Kyngäs, (2008) were followed and these are presented in Table 2.3.

Table 2.3 Phases Followed in Content Analysis (Elo & Kyngäs, 2008)

Phase	Actions
Preparation	Selecting the unit to be analysed (in this case all participants' responses to each section asked about in the vignette); Making sense of the data through becoming immersed in the data (reading and re-reading written material).
Organising	Open coding (making notes and headings during the re-reading process); Developing coding sheets; Collating coding categories and grouping these Developing higher order categories; Abstraction i.e. providing a broad description of the overall category/categories that are collated during the process.
Reporting	A description of the analysis and the results should be reported in a transparent way in order to provide an explicit understanding of the process and any strengths and weaknesses to promote "trustworthiness". This is further enhanced by ensuring a link between the categories developed and the data.

Following the initial coding, the researcher met with a CFA-MP facilitator to agree and finalise codes. As agreement on the coding was reached by the third vignette, only three vignettes (V2, V3 and V4) were jointly coded. These codes were grouped into categories. Examples of the data coding and can be found in Appendix Q. Examples of written quotations for each of the higher order and lower order categories were abstracted from participant responses for each vignette (Appendix R). This analysis included observing if and how participants' application of CFA changed from T1-T4. Following

this, patterns in these higher and lower order categories across each of the four vignettes were pooled together and presented in the results section. All available data for each time point was used in the analysis.

Finally, thematic analysis (Braun & Clarke, 2006) was considered appropriate to allow for pooling of information elicited across the follow-up interviews into themes using the stages outlined in Table 2.4:

Table 2.4. Stages of Thematic Analysis (Braun & Clarke, 2006)

Stage	Action
1	Transcribing data: reading and re-reading the data, noting down initial ideas.
2	Systematically coding interesting features of the data
3	Collating codes into potential themes
4	Checking if the themes work in relation to the data
5	Refining the themes
6	Providing extract examples

Yardley's (2000) principles of sensitivity to context, commitment and rigour, transparency and coherence were addressed through the use of both a reflective journal and research supervision to discuss anomalies and finalise themes. To illustrate the analysis process a sample of a transcript and an example of the development of a theme are provided in Appendix S and Appendix T.

2.2.9.2.1 Reflexive Statement

The researcher was a clinical psychologist who worked on a clinical psychology training programme. They were also a Cognitive Behavioural Therapist accredited with the British Association of Behavioural and Cognitive Therapies (BABCP) and viewed their

clinical practice as mostly cognitive therapy, and used third wave approaches such as CFT, Mindfulness Based Cognitive Therapy (MBCT) and Acceptance and Commitment Therapy (ACT). Therefore, a potential bias was related to the researcher's confidence in CFT as an approach and the hope that CFA-MP would be helpful to the participants. Consequently, the researcher used a reflective journal and discussions with their supervisor and CFA-MP facilitators to identify how their own biases and experiences might influence the qualitative analysis and interpretation of the data.

2.3 Results

2.3.1 Participants

Twelve participants were recruited to CFA-MP over two cohorts (cohort 1, *N*=9, completed the programme between November 2015 and February 2016 and cohort 2, *N*=3, between November 2016 and April 2017). Participant demographic information is summarised in Table 2.5 and further demographic information can be found in Appendix U.

Table 2.5. Participant Demographic Information (*N*=12)

Nursing Qualification*			**Ethnic Origin**			**Gender**		**Mean Age [years] (*SD*)**	**Mean time mentoring [months] (*SD*)**
RMN	RLDN	RGN or RGN & RMN	White British	African/ Caribbean	Asian	Female	Male		
n=6	*n*=4	*n*=2	*n*=9	*n*=2	*n*=1	*n*=8	*n*=4	45.42 (9.19)	112.18 (77.69)

* Registered Mental Nurse (RMN), Registered Learning Disability Nurse (RLDN), Registered General Nurse (RGN)

During the course of CFA-MP four participants experienced major life events but did not withdraw from the study. Not all participants consistently completed measures at each stage and these details are included in Appendix V.

The number of participants recruited to CFA-MP was lower than anticipated. Further, the partial completion of data resulted in the total number of comparable completed measures was reduced from T1 and T2 (*N*=12), to T3 (*N*=8) to T4 (*N*=4). Thus the study was underpowered. The distribution of the SS and subscales of the CEAS (CSA, CTOA) were not normal according Shapiro-Wilk *p*>.05 (Pallant, 2016)[16]. Given that all the data did not meet parametric assumptions statistical analyses were conducted using non-parametric tests. Friedman Tests assessed differences across the four time points with the Wilcoxon Signed Rank Tests used for post hoc analyses[17]. Effect sizes were reported where appropriate. To maximise the data available for these analyses, missing data for one question in two measures was addressed at T4 for the GHQ-12 and at T1 for the SS. On both occasions the median and mean scores were identical and therefore used to replace the missing value.

When situating the sample, there is no non-parametric alternative to the one-sample z-test and so, given the exploratory nature of the study, participant mean scores at T1 were compared with normative data using one-sample z-tests as originally planned. However, (non-parametric) Spearman's Rho Correlations were used instead of (parametric) Pearson's Correlations to explore the associations between measures at T1 when checking the plausibility of these in line with the literature.

2.3.2 Situating the sample

Participants' scores on self-report measures were examined prior to the start of CFA-MP and compared with existing norms which are provided in Appendix W. The *z*-tests for each measure are presented in Tables 2.6 a-b. The *z*-tests for participants' mean

[16] Visual inspection of histograms and Q-Q plots also suggested the data was not normally distributed although Kurtosis and Skewness were not evidenced.

[17] Given the small sample size Bonferroni adjusted alpha levels were not used

scores for the CEAS were unremarkable except for CSE, which was significantly higher than the norm. The *z*-tests scores for the GHQ-12 and SS indicated that mean scores were within the normative range. Participants' mean score for the GHQ-12 indicated caseness (or psychological health concerns within the group). The *z*-tests for participants' mean scores for ProQOL V suggested that both subscales of the Compassion Fatigue Scale (BS and STSS) were significantly lower than the norm.

Table 2.6a. *z*-tests for compassion at T1

	Measure	Subscale	*z*-test
CEAS	Compassion for Self Scales	CSE	10.74 (p<.00001)
		CSA	.09 (p>.05)
	Compassion To Others Scales	CTOE	1.58 (p>.05)
		CTOA	-.57 (p>.05)
	Compassion From Others Scales	CFOE	2.05 (p<.05)
		CFOA	0.84 (p>.05)

Table 2.6b. *z*-tests for wellbeing at T1

Measure	Subscale	*z*-test
GHQ-12*		2.47(p>.05)
DASS21	SS	1.41(p>.05)
ProQOL V	CSS	-3.78 (p>.05)
	BS	-8.45(p<.00001)
	STSS	-9.72(p<.00001)

*Norms taken from Hankins (2008)

2.3.2.1 Associations between measures at T1

The plausibility of the relationships between different measures was explored using Spearman's Rho correlations (presented in Tables 2.7a and 2.7b). Strong correlations (Cohen 1988)[18] that did not correspond with the previous literature are noted below.

2.3.2.1.1 Correlations between CEAS subscales

The literature suggests that increased self-compassion can enhance relationships (Neff & Beretvas, 2013) and so positive correlations between Compassion for self and Compassion to and from others were anticipated. However, there was an unexpected strong negative correlation between CSA-CFOA ($p \leq .01$).

2.3.2.1.2 Correlation between CEAS and GHQ-12, SS and ProQOL V

The correlations here were in line with previous literature that suggests increased acts of compassion are associated with improvements wellbeing, reductions in stress and in improvements in professional quality of life[19] (Beaumont & Hollins Martin, 2016).

[18] .01-.29 "weak"; .30-.49 "moderate"; .50-.1.0 "strong" Cohen (1998)

[19] The other CEAS subscales did not yield significant associations with the ProQOL V except for a strong positive correlation between CSS and CSE, r_s=.62, p<.05.

Table 2.7a. Spearman's Rho Correlations across measures at T1 for the CEAS

				CEAS						GHQ-12	SS	ProQOL V		
				Compassion for Self Scales		Compassion To Others Scales		Compassion From Others Scales						
				CSE	**CSA**	**CTOE**	**CTOA**	**CFOE**	**CFOA**			**CSS**	**BS**	**STSS**
CEAS	Compassion for Self Scales	**CSE**	Correlation Coefficient *N*=12	1.00	.64*	.21	.64*	-.14	-.48	-.14	-.48	.62*	-.50	-.15
		CSA	Correlation Coefficient *N*=12	.64*	1.00	.00	1.00**	-.59*	-.67*	-.59*	-.67*	.51	-.89**	-.33
	Compassion To Others Scales	**CTOE**	Correlation Coefficient *N*=12	.21	.00	1.00	.00	.13	.03	.49	.17	.50	-.01	-.23
		CTOA	Correlation Coefficient *N*=12	.64*	1.00**	.00	1.00	.78**	.85**	-.59*	-.67*	.51	-.89**	-.33
	Compassion From Others	**CFOE**	Correlation Coefficient *N*=12	.59*	.78**	.13	.78**	1.00	.96**	-.60*	-.40	.52	-.76**	-.49
			Correlation Coefficient *N*=12	.56	.85**	.03	.85**	.96**	1.00	-.71**	-.58*	.53	-.82**	-.47

* Correlation is significant $p \leq 0.05$ (2-tailed)

** Correlation is significant $p \leq 0.01$ (2-tailed)

2.3.2.1.3 Correlations between GHQ-12, SS and ProQOL V

The ProQOL V inter subscale correlations were reported by Stamm (2005; 2010) to be small (5% shared variance). However, in the present study there was an unexpected strong positive correlation between subscales BS-CSS (p≤.05).

Table 2.7b. Spearman's Rho Correlations across measures at T1 for General Mental Health (GHQ-12), Stress (SS) and Professional Quality of Life (ProQOL V).

			GHQ-12	SS	ProQOL V		
					CSS	BS	STSS
GHQ-12		Correlation Coefficient *N*=12	1.00	.46	-.11	.56	.25
SS		Correlation Coefficient *N*=12	.46	1.00	.46	.62*	.31
ProQOL V	CSS	Correlation Coefficient *N*=12	-.11	-.35	-.35	-.45	-.05
	BS	Correlation Coefficient *N*=12	.56	.62*	.62*	1.00	.46
	STS	Correlation Coefficient *N*=12	.25	.31	.25	.46	1.00

* Correlation is significant $p \leq 0.05$ (2-tailed)
** Correlation is significant $p \leq 0.01$ (2-tailed)

2.3.3 Analyses Addressing the Aims of the Study

2.3.3.1 Aim 1: To investigate what (if any) changes CFA-M has on Nurse Mentors ability to be compassionate to themselves and others

To address the first aim, the CEAS was used to measure changes in compassion for nurse mentors from T1-T4. The medians and interquartile ranges (IQR) for the CEAS at each time point are presented in Table 2.8.[20]

Given the very low number of participants who provided data at T4, Friedman tests were only used to assess differences in CEAS scores across the first three time points; that is T1 (pre-CFA-MP), T2 (post 5 day course) and T3 (post 10 supervision sessions). These analyses yielded a significant difference in scores on the CSE subscale from T1 to T2 with a medium effect size $\chi^2(1)=6.40$, $p=.01$, $r=-.45$). Post hoc analysis using the Wilcoxon Signed Rank Test demonstrated a significant decrease in the median scores on this subscale between T1-T2 ($z=-2.19$, $p<.05$). Lowered scores suggest a reduction in participants' engagement with self-compassion. No further significant differences were demonstrated for the CEAS and the time points. For additional Wilcoxon Signed Rank Test analyses, see Appendix X.

[20] The means and standard deviations are also presented for comparison with the wider literature if needed

Table 2.8. CEAS Median (Inter Quartile Rating; *IQR*) and Mean (*SD*) for T1-T4

		T1 (*N*=12)	T2 (*N*=12)	T3 (*N*=8)	T4 (*N*=4)	χ^2(df) and *p* value (T1-T3 only)
CSE	Median (*IQR*)	41.50 (37.25-46.75)	38.00 (32.75-38.75)	41.00 (32.75-48.75)	42.00 (35.25-43.50)	χ^2 (2)=1.10, *p*>.05
	Mean (*SD*)	41.92 (6.53)	37.33 (5.35)	40.50 (10.04)	40.25 (4.92)	
CSA	Median (*IQR*)	32.00 (17.50-34.75)	29.00 (18.00-35.50)	25.50 (20.25-27.75)	32.50 (26.0-36.00)	χ^2(2)=1.10, *p*>.05
	Mean (*SD*)	27.25 (9.55)	27.00 (8.15)	25.00 (5.86)	31.50 (5.45)	
CTOE	Median (*IQR*)	44.50 (37.25-52.50)	44.50 (38.25-49.75)	45.00 (40.25-51.50)	44.50 (41.50-55.00)	χ^2 (2)=5.25, *p*>.05
	Mean (*SD*)	44.83 (8.84)	43.57 (6.79)	45.88 (6.31)	47.00 (7.62)	
CTOA	Median (*IQR*)	31.00 (17.50-34.75)	34.00* (31.00-35.00)	32.50† (29.25-35.75)	32.00 (20.00-39.00)	χ^2 (2)=1.56, *p*>.05
	Mean (*SD*)	27.25 (9.55)	33.00 (3.44) *	32.63 (3.54) †	31.50 (8.19)	
CFOE	Median (*IQR*)	37.50 (31.50-46.25)	33.00 (28.50-43.50)	34.50 (30.00-42.50)	39.00 (31.50-48.00)	χ^2 (2)=.75, *p*>.05
	Mean (*SD*)	37.67 (10.53)	34.25 (9.09)	36.50 (9.24)	39.50 (8.54)	
CFOA	Median (*IQR*)	24.50 (19.00-29.50)	26.50 (23.25-30.50)	26.50 (20.25-27.75)	25.50 (23.50-43.25)	χ^2 (2)=.21, *p*>.05
	Mean (*SD*)	24.75 (8.09)	25.75 (5.75)	25.00 (5.86)	27.75 (6.29)	

* *N*=11
† *N*=7

2.3.3.2 Aim 2: To evaluate potential changes in wellbeing as a result of CFA-M

The GHQ-12 and the SS V were used to explore changes an aspect of wellbeing (psychological distress). A further aspect of wellbeing (quality of life) was assessed using the ProQOL V.

2.3.3.2.1 'Psychological Distress'

The median scores and IQR's for both measures of 'psychological distress' (GHQ-12 and SS) across the time points are presented in Table 2.9[21]. Notably, at T1 the GHQ-12 mean score indicated caseness (with an acceptable internal reliability α=.91). The GHQ-12 mean at all other time points fell below the cut-off for caseness. Visual inspection suggested that there was a large decrease in the GHQ-12 median scores between T1 to T3 (T1 median=12.50 – T3 median=5.50). However, perhaps due to low number of participants and resulting lack of power, the difference between GHQ-12 median scores were not statistically significant using a Friedman test.

Table 2.9. 'Psychological Distress' Measures: Median (Inter Quartile Rating; *IQR*) and Mean (*SD*) for T1-T4

Measure		T1 (*N*=12)	T2 (*N*=12)	T3 (*N*=8)	T4 (*N*=4)	χ^2(df) and *p* value (T1-T3 only)
GHQ-12	Median (*IQR*)	12.50 (8.50-22.25)	7.00 (4.25-12.50)	5.50 (4.25-17.00)	8.50 (4.25-9.75)	χ^2(2)=3.17, *p*>.05
	Mean (*SD*)	14.08(6.58)	9.42 (7.51)	10.25 (10.38)	7.5 (3.11)	
SS	Median (*IQR*)	10.00 (8.00-16.00)	8.00 (4.50-14.00)	11.00 (4.00-22.00)	3.00 (0.50-19.00)	χ^2(2)=.07, *p*>.05
	Mean (*SD*)	13.50 (7.49)	9.83 (7.00)	14.00 (11.01)	7.50 (11.12)	

For the SS, all mean scores at all time-points were within the 'normal range'. Friedman Test analyses did not yield any significant changes in the SS medians across T1, T2 and T3.

[21] The means and standard deviations are also presented for comparison with the wider literature if needed

2.3.3.2.2 Quality of Life

The median and mean scores for the ProQOL V subscales for the four time-points are presented in Table 2.10[22]. No significant differences in median scores across T1, T2, T3 were found for CSS, BS, or STSS using Friedman tests. The participants' scores across all time points were consistently and significantly lower than the norms provided by Stamm (2010) for the ProQOL V Compassion Fatigue Scales (BS and STSS).

Table 2.10. Professional Quality of Life Version 5 (ProQOL V) Median (Inter Quartile Rating; *IQR*) and Mean (*SD*) for T1-T4

Measure		T1 (*N*=12)	T2 (*N*=12)	T3 (*N*=8)	T4 (*N*=4)	χ^2(df) and *p* value (T1-T3 only)
ProQOL V CSS	Median (*IQR*)	39.50 (35.25-42.75)	39.50 (33.25-44.75)	40.00 (36.25-43.75)	39.00 (33.50-46.00)	χ^2(2)=1.23, *p*>.05
	Mean (*SD*)	39.92 (4.54)	38.67 (5.76)	40.38 (4.47)	39.50 (6.61)	
BS	Median (*IQR*)	24.00 (22.00-31.50)	23.50 (1.25-29.75)	20.50 (16.00-29.25)	18.50 (16.25-22.25)	χ^2(2)=2.60, *p*>.05
	Mean (*SD*)	25.67 (5.28)	25.00 (5.22)	21.74 (7.63)	19.00 (3.16)	
STSS	Median (*IQR*)	21.50 (17.00-24.75)	22.00 (18.50-23.75)	19.00 (17.25-19.75)	16.50 (14.25-22.50)	χ^2(2)=.07, *p*>.05
	Mean (*SD*)	22.00 (5.72)	21.75 (5.26)	19.63 (3.54)	17.75 (4.50)	

[22] The means and standard deviations are also presented for comparison with the wider literature if needed

2.3.3.3 Aim 3: To assess the how Nurse Mentors apply CFA to themselves and to nurse mentoring issues

In order to investigate this aim, participants' engagement with the types of "Compassionate Actions" taught on CFA-MP was evaluated based on what they recorded on their compassionate activities diary. In addition, participant responses to vignettes were analysed to examine how participants applied their learning from CFA-MP to mentoring scenarios.

2.3.3.3.1 Compassionate Activities Diary

All the participants were asked to complete a weekly compassionate activities diary whilst they were attending the second phase of CFA-MP (supervision sessions; time points s1-s10) and at two months follow-up (time point s11). Eight participants partially completed their diaries and so, as a consequence, only the number of "Compassionate Actions" could be evaluated and reported. Appendix Y provides figures illustrating changes in the mean and median for each Action. Visual inspection of the median and mean number of all nine "Compassionate Actions"[23] did not appear to indicate any obvious pattern/trend in the number of times these Actions were practiced over time. Therefore it was decided to explore whether there was any preference in the use of "Compassionate Actions" irrespective of time. The relevant data is presented in Table 2.11 where it can be seen that the most practiced "Compassionate Action" was Practical Self Soothing (PS-S) and the least practiced was Safe Place Imagery (SPI).

[23] Practical Self-Soothing [PS-S], Soothing Breathing [SB], Safe Place Imagery [SPI], Compassionate Imagery: Me at My Best [CIMMB], Compassionate Imagery: Compassionate Companion [CICC], Allowing Others to be Compassionate to Me [AOCM], Behaving Compassionately to Others [BCO], and Behaving Compassionately to Myself[BCM]

Table 2.11. Marginal order of preference for "Compassionate Actions" practiced by all participants

Compassionate Action*	Most Frequent Median (Number of Time points)	Median Range	Mean Range
PS-S	4.0 (5)	2.0-4.0	2.44- 7.13
BCO	3.0 (5)	2.0-5.0	3.00-15.50
AOCM	2.0 (6)	1.0-2.5	1.67- 5.00
SB	3.0 (3)	1.0-4.0	3.17-13.00
BCM	1.0 (4)	1.0-4.0	2.56- 7.00
CIMMB	1.0 (4)	1.0-2.0	1.22- 4.33
CICC	2.0 (3)	0.5-2.0	0.60- 4.17
SPI	0.5 (3)	0.5-1.5	0.83- 6.17

* Practical Self-Soothing [PS-S], Soothing Breathing [SB], Safe Place Imagery [SPI], Compassionate Imagery: Me at My Best [CIMMB], Compassionate Imagery: Compassionate Companion [CICC], Allowing Others to be Compassionate to Me [AOCM], Behaving Compassionately to Others [BCO], and Behaving Compassionately to Myself[BCM]

2.3.3.3.2 Vignettes[24]

All participants were asked to respond in writing to four mentoring vignettes (V1-V4) at T1-T4. All available data for each time point was used in the analysis of all vignettes and the number of completed responses for each vignette at each time point is summarised in Table 2.12.

[24] All but one participant used the mental health nurse vignettes and one participant used general nursing vignettes 1-4 (see Appendices M and N)

Table 2.12. The number of completed responses for each vignette at each time point

	Vignette 1 (V1)	Vignette 2 (V2)	Vignette 3 (V3)	Vignette 4 (V4)
T1	*N*=12	*N*=12	*N*=11	*N*=11
T2	*N*=12	*N*=12	*N*=10	*N*=10
T3	*N*= 8	*N*= 8	*N*= 8	*N*= 8
T4	*N*= 7	*N*= 7	*N*= 7	*N*= 7

The vignettes' data was analysed using content analysis (Elo & Kyngash, 2008). Seven higher order categories emerged from the analysis which, as might be expected, were closely aligned with the questions asked about the four vignettes (see Figure 2.1). These categories were; 'Mentor Thinking', 'Mentor Feeling and Physical Experiencing', 'Mentor Action', 'Mentee Thinking', 'Mentee Feeling and Physical Experiencing', 'Mentee Action' and 'Mentee Issues to be Addressed'. (See Appendix R for additional supporting evidence.) These main findings with supporting quotations are described below.

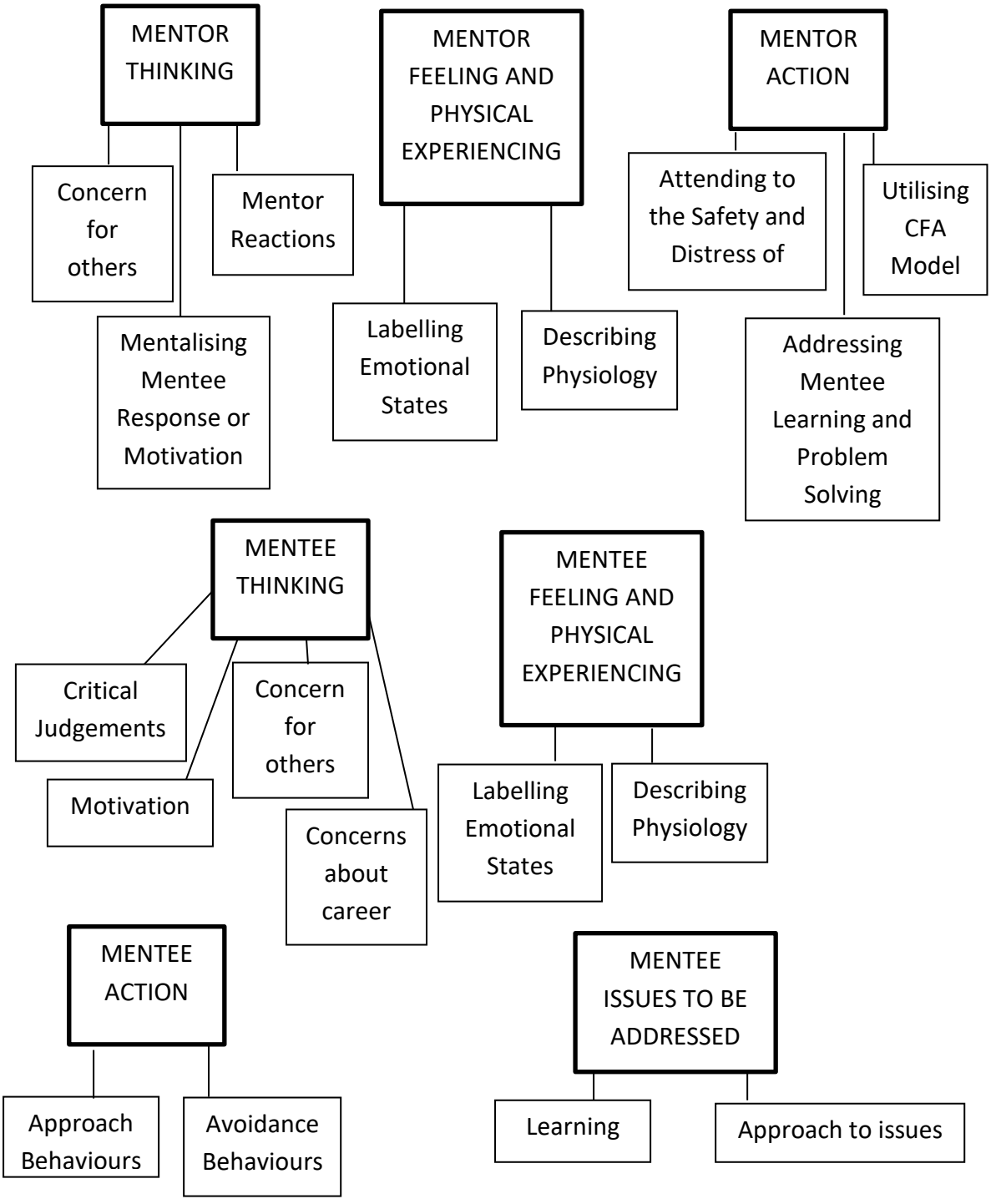

Figure 2.1. A diagrammatic representation of the Higher Order Categories and their corresponding Lower Order Categories resulting from the Content Analysis

2.3.3.3.1 Higher Order Categories

a. 'Mentor Thinking'

The Higher Order Category (HOC) of 'Mentor Thinking' related to participants' perceived patterns in mentor thinking in response to all vignettes and included three Lower Order Categories (LOCs; as shown in Figure 2.2). These are described below.

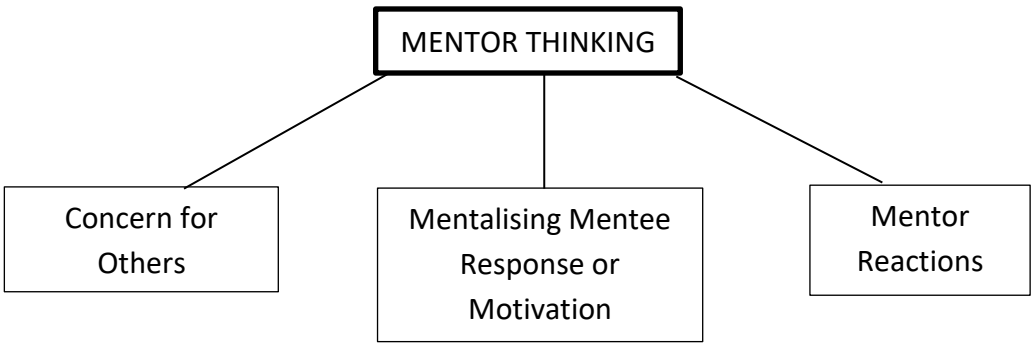

Figure 2.2. A diagrammatic representation of the Higher Order Category: Mentor Thinking with the lower order categories.

'**Concern for others'**: Participants provided expressions of compassionate concern and empathy for the mentee, colleagues, and the mentor and/or patients in the vignette. For V1, V2 and V4 this category was consistently described with little change across T1-T4. An example of the written responses included P12 "*What support do they need, is it first time experiencing violence in work place"* (V1, T3) and P3 *"That I haven't got time to help student and patients"* (V4, T2). This category was absent for V3.

'Mentalising the Mentee Response or Motivation': Participants noted the mentee's emotional and cognitive responses or participants' understanding of the mentee's motivations for their behaviours. For V1 and V3 participants' descriptions were more attuned to the CFA model for T2- T3. For example, P3 noted feelings of *"shame and anxiety and guilt"* (V1, T3). Further there were increased references to the threat system such as P6 who stated *"What system, threat, anxiety. Soothing"* (V3, T2).

For V3, across T1-T4, and V2 across T2-T3 participants described the mentor's attempts to understand the mentee's behaviour. There were increased references in understanding mentee's motivations using CFA, specifically the threat system at T2 and T3 for V2. For example, P8 noted *"Student may be threatened and need one to one session to clarify things. Might not be sure of what to do needs direction"* (V2, T3). Further, for the drive system P12 noted the student was *"Anxious, over compensating trying to belong. Trying to prove self"* (V2, T2). This category was not described for V4.

'Mentor Reactions': Participants provided the cognitive and emotional reactions of mentors, including critical appraisals of the student or the mentor, and how mentors would use CFA thinking or techniques to aid their responses. Evidence of critical appraisals towards the mentee from the mentor was apparent across V1-V4. For V1, these were present at T1 and T4. For V2 and V3 critical statements were reported across all time points. An example of critical appraisal towards the mentee included P3 *"That the student has made things worse. She wasn't working as a team member"* (V2, T2). For V4 participants described self-critical appraisals across T1-T3 including P12 *"can't ask anyone as failure, I haven't got time"* (V4, T2).

Alongside the presence of critical appraisals, participants described the use of CFA between T2 and T3 for V1, V2 and V4. These included the impact of the situation on the mentee. For example, P8 noted *"The student is threatened"* (V1, T3). Participants described using CFA to respond to the mentee. For example, P11 noted *"That we need to arrange a meeting to reflect over the above in a soothing way. Not been hard but assertive"* (V2, T2). Finally, there was some evidence of use of CFA in relation to self-compassion P3 wrote *"that I need to be more compassionate to myself"* (V4, T2).

b. 'Mentor Feeling and Physical Experiencing'

The HOC of 'Mentor Feeling and Physical Experiencing' was associated with participants' perceptions of the emotional and physical states of mentors and included two LOCs (see Figure 2.3). These are described below.

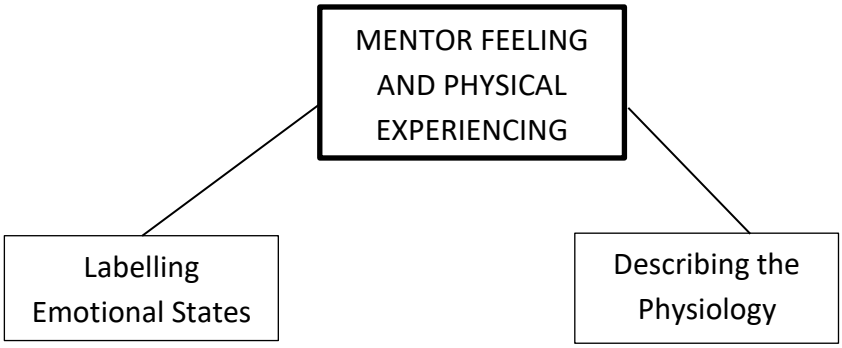

Figure 2.3. A diagrammatic representation of the Higher Order Category: Mentor Feeling and Physical Experiencing with the lower order categories

'Labelling emotional states': Participants noted the mentors' emotional states. This occurred across all vignettes and all time frames. For V1, V3 and V4 there were increased statements related to the use of CFA for T2 and T3. This included reference to the activation of the threat system. For example, P8 wrote *"Frustrated, threatened and worried"* (V3, T3) and P3 noted *"Threat mode"* (V4, T3). Participants described applying CFA to create a soothing state. For example, P12 stated *"in soothing for colleague and mentee"* (V1, T2).

'**Describing the physiology'**: This category referred to the mentors' physical states. Of note only one participant offered these descriptions for V1 (T3 and T4) and V4 (T2) for example, P12 *"Tense, heart rate increased"* (V4 at T2). This category was not described for V3.

c. 'Mentor Action'

The HOC of 'Mentor Action' encompassed the participants' descriptions of mentors' actions to the scenarios provided in the vignettes. This category included three LOCs (as shown in Figure 2.4) which are described below.

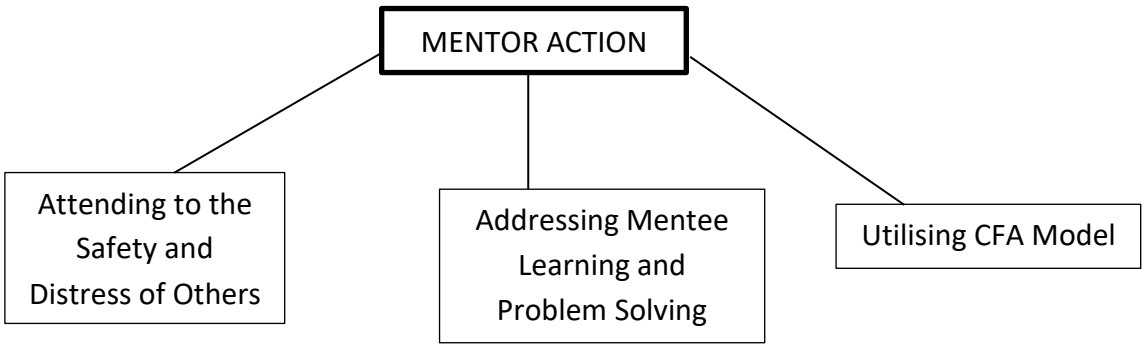

Figure 2.4. A diagrammatic representation of the Higher Order Category: Mentor Action with the lower order categories

'Attending to the Safety and Distress of Others': Participants described how they managed the distress of colleagues (including mentees) and patients. For V1 at T1-T3, participants reported increased action related to the immediate safety of those on the ward for example, P2 *"Maintain safe environment"* (V1, T2). The importance of a space for colleagues to debrief and reflect on the incident was highlighted across T1-T4. For example, P5 noted *"Ensure all had the opportunity to debrief and discuss how people were feeling"* (V1, T1). For V2 across T1-T4, participants described managing the patient's distress following the mentee's actions. This included removing/diverting the student and attending to the patient's distress as described by P1 *"Divert student to another task, calm patient then spend time with patient"* (V2, T4). Participants described using CFA to help manage patient distress including P2, *"Reassure patient get them into soothing state"* (V2, T3). This category was not described for V3 and V4.

'Addressing Mentee Learning and Problem Solving': Participants noted the mentor's understanding of the mentees' learning needs, including how these would be addressed and/or problem solved. For V2, V3 and V4, this occurred across all time points. For example, participants described addressing their concerns including educating the mentee about medication, the reliability of information and the roles of the mentee/mentor. For example, P11 noted *"Prepare and educate about importance and how internet information isn't always accurate and [can be] misleading"* (V2, T3). Participants suggested the mentor seek advice from others including P4 *"Speak to others for advice, arrange a time to meet student-discuss their values, what motivated them to do course, suggest some reading be honest that I was concerned re their attitude"* (V3, T1). Finally, P1 provided an example of a mentor problem solving a students' requests for additional mentor time *"Try and allocate student to other jobs, tasks – manage my time – set out boundaries"* (V4, T2). Fewer examples of this category were provided at V1.

'Utilising CFA Model': Participants specifically reported using CFA techniques prior to any mentor action. For all vignettes there was an increase in the use of techniques at T2 and T3. For example, participants described how they would use CFA techniques before supporting their colleagues. P2 noted, *"Ground myself before engaging in supervision"* (V1, T2). Participants described using a specific CFA technique (self-soothing) prior to meeting the mentee. For example, P4 noted, *"Suggest student has a break whilst I work on shifting my emotional state. Then meet with student to discuss how their actions impacted on individual"* (V2, T3). Participants recognised the need to be non-threatening. For example, P6 noted *"Focus on my thinking and approach in non-threating way, meet and discuss, set goals"* (V3, T2). Finally, for V4 participants reported

increased reference to CFA for example, P4, *"soothing state"* (V4, T2) and P11, using *"soothing", "wisemind"* (V4, T3).

d. 'Mentee Thinking'

The HOC of 'Mentee Thinking' related to the participants' ability to mentalise the mentee's cognitive responses to the vignettes. In this instance, the participants' ability to be aware of different thought processes (thoughts, desires, or beliefs) that may occur for the mentee. This category included four LOCs (as shown in Figure 2.5) which are described below.

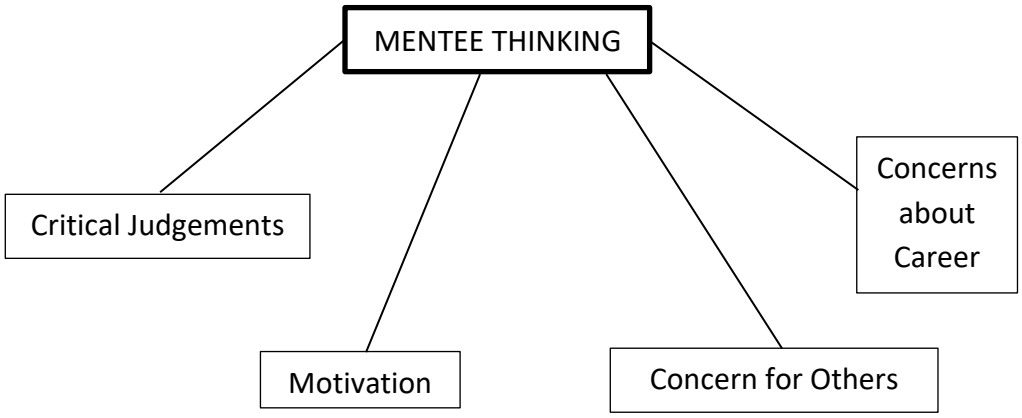

Figure 2.5. A diagrammatic representation of the Higher Order Category: Mentee Thinking with the lower order categories

'Critical Judgments': Participants noted mentee's self-critical judgements and mentee's critical appraisals of others. Participants provided mentee self-critical appraisals across all time points. For example, P3 wrote *"She didn't do a good job"* (V1, T1). P6 noted *"I'm scared, people will find out how little I know, I don't want to do this"* (V3, T3). Further, participants described critical judgements from others. For example, P11 noted *"What will my mentor think and other staff"* (V1, T2) and P2 wrote *"The mentor is shutting me up, I am angry"* (V2, T1). Examples of participants descriptions of mentor critical

appraisals included for P4 stated *"He/she is wasting my time"* (V3, T3). For V4, critical appraisals were present at all-time points including P7 who noted *"That the mentor can't time manage"* (V4, T2).

'Motivation': Participants provided explanations of the motivation behind specific mentee behaviours. These were present across all vignettes with some differences and included ideas for the mentee's inaction (V1 and V3), a need for the mentee to demonstrate their abilities (V2) and mentees lack of awareness of others' needs (V4). Examples included P7 who stated *"That the presence was not needed, and that student are not part of the team when it comes to certain situations"* (V1, T2). P11 noted *"Not bothered, don't care, uninterested"* (V3, T4). P6 stated *"I must be honest – duty of care"* (V2, T1) and P3 wrote *"That she (student) has tried to show initiative"* (V2, T3). Finally, P9 wrote *"That they are getting what they need, no consideration of the impact, ego centric thought process"* (V4, T2).

'Concerns about Career': Participants reported that the mentees may express doubts about becoming a nurse. This was present for V1 and V3 only. Across all time points for these two vignettes participants expected mentees would have second thoughts about their career as a nurse or that the work on the ward was not what the mentee had expected in their nursing role. For example, P3 noted *"Frightened and scared of the nursing job"* (V1, T1), and P4 stated *"I will never be a good nurse"* (V3, T3).

'Concern for Others': Participants noted that the mentee may be concerned that they had upset the mentor or that the mentee's capacity to understand the pressures experience by the mentor had increased. For example, P12 wrote *"Have I upset mentor"* (V4, T1), and P9 noted *"Potentially recognise the pressure of the mentor"* (V4, T4). Further, participants noted that the mentee would be concerned for the distress they

had caused to the patient. For example, P6 stated "How is the patient/my mentor" (V1, T2). This category was not described for V3.

e. 'Mentee Feeling and Physical Experiencing'

The HOC of 'Mentee Feeling and Physical Experiencing' pooled participants' descriptions of the mentee emotional and physical states. This category included two LOCs (as shown in Figure 2.6) which are described below.

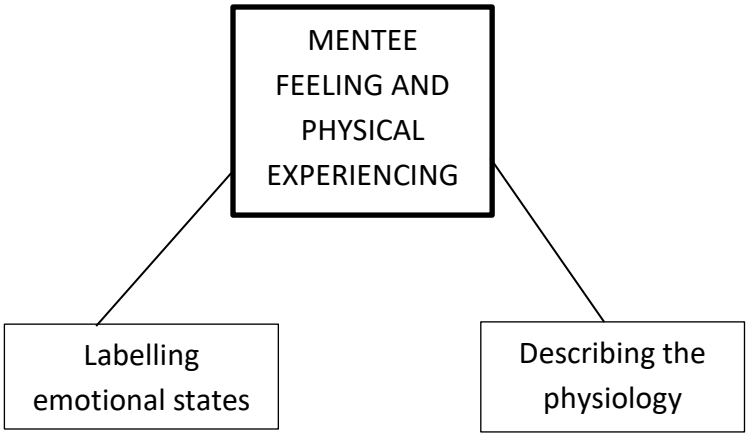

Figure 2.6. A diagrammatic representation of the Higher Order Category: Mentee Feeling and Physical Experiencing with the lower order categories

'Labelling Emotional States': Participants described the mentees' emotional states. For all four vignettes, participants described the emotional state of the mentee across T1-T4. For example, P3 noted *"Fear, guilt, anxiety, hopelessness"* (V1, T1) and P12 wrote *"Anxious, nervous"* (V3, T3). The range of emotions appeared consistent across the time frames. CFA was used by one participant, P6, to describe the threat state *"Threatened, anxious, defensive, angry, self-doubt"* (V2, T2) and of the drive system *"In drive – on high alert, keen, jumpy – may not realise"* (V2, T4). There were no other explicit links to CFA at the other time points.

'Describing the Physiology': Participants referred to the mentees' physical states. They consistently described this category for V1, V2 and V3 across T1-T4. For example, P5

noted *"Shaking, feeling sick, nervous"* (V1, T1) and P11 wrote *"sweating, upset, palpitations"* (V2, T2). For V4 this category was only described at T1 and T2. For example, P9 noted *"energetic posture, faster speech"* (V4, T1).

f. 'Mentee Action'

The HOC of 'Mentee Action' incorporated participants' descriptions of the mentees' actions to the scenarios provided in the vignettes. This category included two LOCs (as shown in Figure 2.7) which are described below.

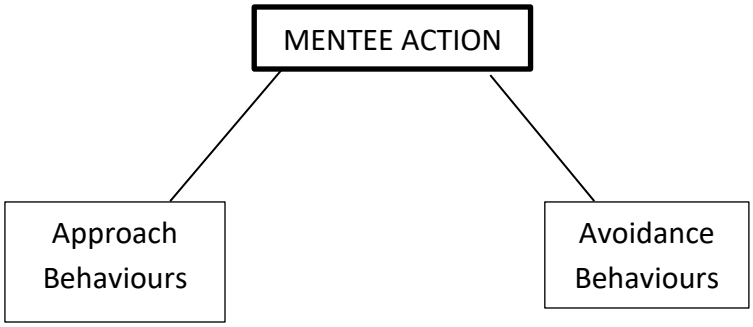

Figure 2.7. A diagrammatic representation of the Higher Order Category: Mentee Action with the lower order categories

'Approach Behaviours': These behaviours involved improving mentees' social connectedness with others by initiating support from others, re-establishing connection with their mentor or maintaining connections with colleagues. These included behaviours such as apologising, seeking support and helping others. Participants described approach behaviours across T1-T4. For example, P4 noted *"Crying, seeking reassurance, apologising"* (V1 at T1). P5 wrote *"Could be remorseful"* (V2, T2,). P6 stated "*Asking what to do/show interest in their learning"* (V3, T3).

For V4 there were descriptions of the drive system in action across T1-T4 with clearer recognition of this at T2 and T3. For example, P11 noted *"Over working, putting pressure in self, doing too much, burn out"* (V4, T2) and P3 stated *"Engaging in drive"* (V4, T3).

'Avoidance Behaviours': Participants noted behaviours where mentees withdrew from the situation. Avoidance behaviours were more clearly provided for V1, V2 and V3. For example, withdrawing from or avoiding the work environment, P9 described *"Back tracking, become less vocal and confident"* (V1, T1). Further, P5 noted *"May stay in office avoiding"* (V1, T3). Of interest some participants used language to describe signs of an activated threat system. For example, P12 wrote *"Talking fast, rambling, acting on 1st thought in mind"* (V2, T2). There was specific reference to "hiding" behaviours which may indicate an activated threat response. For example, P7 wrote *"Hiding away or avoiding the problem"* (V3, T2) and P11 noted *"Avoiding, hiding"* (V3, T3). Fewer avoidance behaviours were noted by participants for V4.

g. 'Mentee Issues to be Addressed'

The HOC of 'Mentee Issues to be Addressed' related to areas that participants considered important to address with the mentees for each vignette. This category included two LOCs (as shown in Figure 2.8) which are described below.

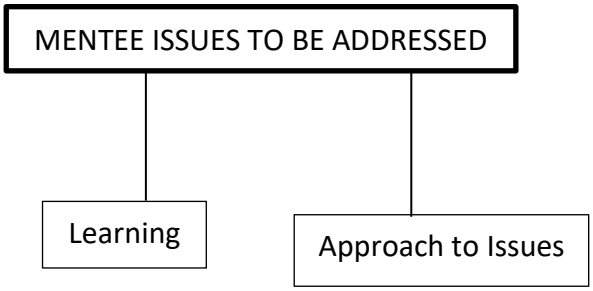

Figure 2.8. A diagrammatic representation of the Higher Order Category: Mentee Issues to be Addressed with the lower order categories

'Learning': Participants provided specific mentee learning needs across all vignettes. An area of learning was professional conduct (self-awareness, empathy and time management). For example, P12 noted *"Limitations of role, appropriateness of information sharing, aware of patient level of understanding"* (V2, T1). P11 stated *"Reflection of event and how has been acting on initiatives. How this upset client, and treatment of recovery"* (V2, T3). Further, the importance of the mentee learning about empathy and compassion for their actions was noted for example, by P9 who wrote *"Conduct, professionalism, appearance of student, person centred principles, compassion around impact of action"* (V2, T4).

Another area of mentee learning was to understand boundaries (student role, autonomy and expectations on placement). For example, P2 noted *"the role as a student, how do they feel, what do they think, are they safe"* (V1, T2). P4 wrote *"Drive – reasonable expectations of placement"* (V4, T3). Finally, participants raised team working as an area for learning. For example, P3 noted "*ability to work as team and test thoughts out with mentor/colleagues"* (V2, T2).

'Approach to Issues': Participants provided information about how the mentor would address issues with mentee. This included creating a reflective space, addressing mentee motivations and negative self-appraisals, the use of CFA to notice activated

emotion systems, how to manage these, exploring blocks, and the mentor adopting a compassionate stance. Across all vignettes between T2 and T3 participants' explicit reference was made to the CFA model. For example, P6 noted *"How they feel, what thoughts, learn. Debrief, systems, threat, anxiety soothing"* (V1, T2). P4 stated *"Drive system – how to switch this"* (V2, T3). There were increased descriptions of CFA such as exploring blocks and creating safety. For example, P5 wrote *"Are there any blocks to his learning experience? Is nursing for him? Is he getting 'lost' on a busy ward and is to worried to raise concerns? How can I help/support his learning safely?"* (V3, T2). Finally, descriptions of the mentor's compassionate stance were provided. For example, P11 noted *"Showing empathy, compassion to reflect on event and empower them. On what they are feeling or what may be going on. Who do they look up to, reasons of becoming a nurse"* (V4, T3).

2.3.3.4 Aim 4: To explore what, if any, CFA-M processes or techniques utilised at a minimum of twelve months follow-up.

Seven participants (58%) completed a follow-up interview. Four participants were from cohort 1 (P1, P2, P3 and P9) and three were from cohort 2 (P10, P11 and P12). Four interviews were completed face to face and three by phone. The length of time since the end of CFA-MP ranged from 13-31 months (*M*=20.71 months, *SD*=6.34).[25]

The thematic analysis (Braun & Clarke, 2006) resulted in two main themes 'Understanding Compassion' and 'Venturing into Compassion'. These themes were comprised of subthemes as illustrated in the thematic map (Figure 2.9) and shown in

[25] The length of the interview ranged from 10 minutes 18 seconds to 53 minutes 10 seconds (Mean=25 minutes and 14 seconds, SD=18 minutes 55 seconds).

Table 2.13. A more detailed summary of the themes and supporting evidence can be found in Appendix Z.

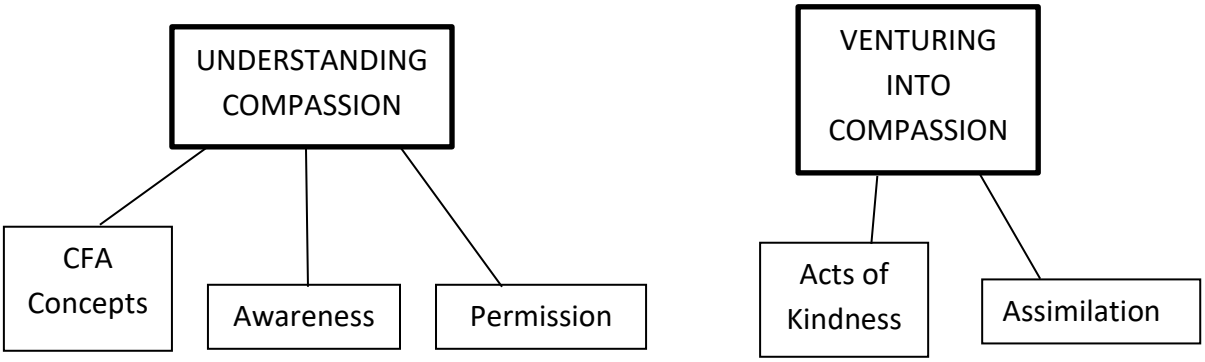

Figure 2.9. A Thematic Map of the main themes and subthemes

Table 2.13. Main themes with subthemes

Main themes	**Subthemes**
Understanding Compassion	CFA Concepts
	Awareness
	Permission
Venturing into Compassion	Acts of Kindness
	Assimilation

"Understanding Compassion"

The main theme of "Understanding Compassion" depicts participants' descriptions of changes in their understanding of compassion and includes three subthemes: '*CFA Concepts'*, '*Awareness'* and '*Permission'*. These are explained below.

'CFA Concepts'

Participants reported an increased appreciation of the concept of compassion. For example, having a clearer internal sense of compassion from applying CFA concepts to their work:

> *"…I started to put into practice actual stuff I had learned. I'd gone back to work and I was all kind of jubilant about compassion, as I understood it now, I really*

understood it, not in a cross legs Zen kind of wishy washy mindfulness type, I thought I had really got a handle on it." (P9).

Additionally, participants provided examples of CFA concepts during the interviews. These included understanding neurological concepts in CFA, "*the sort of neurological basis for compassion"* (P3). Participants appeared to embrace the idea of evolutionary brain processes in CFA (old brain, new brain). This concept enabled participants to recount the primary affect regulation systems (old brain) and how these relate the secondary process of thinking (new brain):

"this is old brain, this is new brain, this is how it works, these are drives, these are different systems, you know in the brain and on top of that you know we've got all our thought processes"(P2).

Moreover, participants recalled specific techniques from CFA-MP, such as SB, SPI and CIMMB:

"focusing on your breathing, and I remember the stuff about the ideal self, um and sort of your ideal place, location" (P1).

'*Awareness*'

Participants expressed that following CFA-MP they were more able to recognise signs of stress in themselves and the importance of responding proactively to their stress:

"I actually learned to read my own body language, my own signs of when I'm getting too stressed and how to deal with it a bit better" (P10)

Building from their increased self-awareness, participants voiced how their experiences of stress or their behaviours could affect others including patients and mentees:

"No I think it's just being more self-aware, it made me more self-aware that course of how I am, affect others as well so if I'm already in a state of high

arousal or anxiety sometimes your clients will feed off that and so will your mentee, so it's being more aware of yourself so you can project more good feelings onto other people rather than the nervous anxiety" (P12).

Additionally, participants recounted their increased awareness of the mentee's situation. They focused on how the mentee's personal experiences might affect the mentee's actions on placement:

"I guess it made me reflect more on what the previous sort of experience of the student's had and why they are making the decisions they are making and sort of a realisation as well that they are in the same situation as you so they might have had an argument with their children on the way into work in the morning" (P1).

Finally, participants noticed an increased awareness of their colleague's experiences. For example, a participant noticed their colleague's distress and understood their colleague's actions towards them and chose not to perpetuate the cycle of distress through compassionately recognising this was their "personal opinion":

"I've encountered colleagues that have obviously been under quite a bit of pressure, distress, um, I just try to be um, looking at them, kind of acts of kindness, because sometimes there's this self-culture or blame that people are picking on me, people are blaming me……it's just the personal opinion gets created and then when you're under your own stressors…I think that's when people become more fearful….." (P11).

'*Permission*'

This subtheme captured a sense of permission to act compassionately that participants observed from having attended CFA-MP. Participants noted a sense of empowerment to act with compassion towards themselves by taking a break or not over committing themselves at work:

> *"I learnt looking after myself was not anything that was selfish or it was just necessary…..I didn't have to say yes to everything just because somebody wanted it…..it gave me quite a lot of confidence to really start thinking no actually you are worth it"*(P9)

This sense of permission extended to others including students, *"Specifically, it was quite nice to have permission to be kind to people, um students"* (P2).

Additionally, this sense of permission appeared to allow participants to encourage others to apply self-compassion:

> *"if I see the signs, I can say to them, well this is how I normally cope with it if you know I'm feeling like that, and then hopefully they'll take it away with them."* (P10)

"Venturing into Compassion"

The main theme "Venturing into Compassion" captured how participants chose to act or respond with compassion using CFA. This theme included two subthemes: '*Acts of Kindness'* and '*Assimilation'* which are described below.

'Acts of Kindness'

This subtheme draws together changes that participants reported in their behaviours toward others including participants' active use of CFA techniques. Participants highlighted the different ways in which they responded to patients' and/or colleagues'

threat or drive system. One participant spoke about using a variety of techniques to initiate the soothing system with patients:

> *"I found that by helping them [patients] identify what their threats were and switching them back over to the soothing system over a period, using mindfulness, using psychoeducation, psychoeducation tools, and the psychosocial stuff, that they actually began to get some esteem from the engagement and they in every case, they left with hope"* (P2).

Another participant described the use of PS-S with colleagues after providing feedback on their emotion system:

> *"I've kind of been able to kind of allow people [colleagues] to notice themselves, how it's affecting them. I just kind of ask them to take two minutes for themselves and that is helping, just giving them a cup of tea, making a cup of tea, being kind."* (P11)

Participants emphasised the importance of providing space for others and reported increased efforts to understand other people's situations. As a mentor this involved recognising the mentee as a person, with difficulties or needs who required support. The importance of providing space and understanding the person to stimulate a change in the mentee was noted:

> *"I remember I spent, it amounted to 3 hours, it wasn't a quick hour alright this is the deal, this is where you put your bag and this is - it had taken 3 hours. By the time the 3 hours had ended she was crying between the, she started telling me about all this stuff [personal issues related to the mentee] and actually there was all these things and my boss actually came in at one point and pulled me out and said what are you doing and I was going well I think I am deconstructing this*

person's poor attitude, I'm actually being compassionate and I'm not just going OK I'm going to fill in this paperwork…I'm actually focusing on her as a person……for the remaining 3 months [student's name] turned into a different person" (P9).

Additionally, participants voiced the importance of labelling difficulties that needed to be addressed with mentees. This process was considered crucial to alleviating mentee distress and facilitating opportunities to change behaviours:

"So in terms of it going disastrously wrong the compassionate thing would be to sort of address that with the student and sort of deal with those rather than trying to avoid them because it's more compassionate for them to know that they are going wrong and things like that and having the opportunity to address that and things like that" (P1).

Participants extended labelling issues to colleagues to address these in the workplace. For a participant, this involved raising concerns with the team in order to enhance the team's compassionate stance:

"I said in actual fact this is what you should be doing as a professional, you should not be judgmental, you should be working to enhance people's experience, whether its patients, whether its students or whether its each other, you know that's what we should be doing as professionals. You know, and I saw it as a role to build compassion and understanding in the team…." (P2).

Finally, participants described the importance of valuing mentees through their actions of welcoming students into the placement. For instance, the importance of the mentee's name on the board:

"…we're here to support you [student] and to make them feel more valued and respected, just a simple thing like making sure their name is there on the board in the morning….. because they feel part of the team" (P10).

Importantly P3 noted that their valuing mentees existed prior to CFA-MP:

"I don't think it's made a huge difference…….I've got a student now as it happens and I always try to make sure she feels safe, she feels valued, that I take her very seriously" (P3).

'Assimilation'

This subtheme incorporates participants' reports of how CFA has been integrated into other aspects of their working or personal lives. Specifically, in their work practice, participants reported enhanced understanding of carers and clients. Further some participants described how they applied CFA with mentees and clients:

"I'm trying to link it in and use these skills, and how this can then be applied with clients and students that I am having regularly" (P11)

Additionally, participants endeavoured to integrate CFA into their working environment by disseminating information to their team or to colleagues. For instance the cascading information was considered beneficial following CFA-MP sessions:

"when I came back from the sessions, that you know, I would talk to them [colleagues] about it and you know you want to try, you want to try and take a step back cos we are as nurses a bit snowed under with everything and you can get railroad into just keep going and going but, it's better if sometimes you take step back and I cascade that information back to them." (P10)

Alongside the workplace, some participants used the information gained from CFA-MP with family members for example, recognising the stresses experienced by their children:

> *"… not just within practice but within home as well, cos you're children are under pressure"* (P11).

Finally, most participants reflected on the impact of CFA-MP on them personally and how their learning has been integrated into their lives as highlighted by:

> *"it did make you look at your own life, a bit more, you know, it's not just about work, it's not just about um students, colleagues it's how you deal with life in general, yourself."* (P10).

2.4 Discussion

This section initially focuses on how the above outcomes inform the aims of this research. This is followed by the limitations of this study, its implications and future research.

2.4.1 Aim1: What changes does CFA-M have on Nurse Mentors' ability to be compassionate to themselves or others?

The CEAS assessed changes in participants' ability to be compassionate. The unexpected strong negative correlation between CSA-CFOA at T1 would suggest increased acts of self-compassion are associated with reductions in receiving compassion from others. Pettit et al. (2019) found that nurses initially perceived self-compassion as "indulgent" during CFA training and were concerned that their increased emotional attunement may negatively affect their professionalism. Therefore, prior to CFA-MP participants may have viewed receiving compassion from others (without self-compassion) as more acceptable to their role.

Other than CSE, across all time points, the median and mean scores for the CEAS subscales were similar to previous UK norms (Gilbert et al., 2017). Surprisingly there was a significant reduction in CSE scores between T1 and T2 with a medium effect size. This outcome could reflect the CSE's poor internal reliability (α=.52), a lack of power and/or nurses concerns that self-compassion could compromise their professionalism (Pettit et al., 2019). Although this does not explain the consistently higher than norm scores for this subscale, participants' motivation to engage in self-compassion may have reduced during the first phase of CFA-MP and improved as their concerns were addressed during the supervision phase.

2.4.2 Aim 2: What (if any) changes does CFA-M have on participants' wellbeing

2.4.2.1 'Psychological distress'

The significant decrease in scores for the GHQ-12 with a medium effect size noted between T1-T2 indicated an improvement for participants' general mental health. It is unclear from this result whether the reduction was a product of participants attending a course for five days away from ordinary stresses of the working week, whether aspects of CFA-MP improved their general mental health, or for some other reason. Further, a large reduction in median score between T1 and T3 may reflect insufficient power to detect significant change. Given the low sample size the potential to assess whether CFA-MP improved 'psychological distress' as measured by the GHQ-12 or SS was not achieved in this study.

2.4.2.2 Quality of Life

No significant differences in scores were demonstrated between time points for the ProQOL V. Notably, the mean and median scores appeared consistent for the CSS. Both

Compassion Fatigue subscales were consistently and significantly below the norms. Further, the surprisingly strong positive correlations between ProQOL V subscales (BS-CSS ($p \leq .05$) and the questionable internal reliability for BS ($\alpha = .62$) at T1 may reflect unique factors associated with the participant group or the low sample size[26].

In relation to all the quantitative data, the current study did not consider the organisational cultures of the participants. Boorman (2009; 2010) highlighted variance in healthcare services, with those addressing staff welfare demonstrating improved staff health and wellbeing. Although participants were from the same NHS Trust there may be variability within their specific services' working environments which may have accounted for some the unpredictability of both the completion of outcomes measures and the unexpected correlations between measures at T1.

2.4.3 Aim 3: How do Nurse Mentors apply CFA to themselves and to nurse mentoring issues?

2.4.3.1 Nurse Mentors' Application of CFA to themselves

The inconsistent reporting of the duration of the practice and the helpfulness of each "Compassionate Action" may be related to perceived participant burden or a lack of clarity in how the diary was to be completed. The most practiced "Compassionate Action" was PS-S. Participants' statements in the vignettes and follow-up interviews also referenced PS-S (e.g., taking a short break or having a hot drink) when noticing theirs or others' activated threat system. Thus, PS-S may be an accessible Action for

[26] More recently, the ProQOL V has been criticised regarding its construct validity (Heritage, Rees, & Hegney, 2018) specifically for the Burnout and Secondary Traumatic Stress scale and recommended the use of the ProQOL21. At the time of the study, the ProQOL21 had not been published, this issue would warrant further attention, if the participant numbers had been more consistent and greater.

nurse mentors to implement in the busy working environment. Nothing further could be concluded from the available data.

2.4.3.2 Nurse Mentors' application of CFA to nurse mentoring issues

Analysis of the vignette responses revealed an increased reference to and application of CFA across five of the seven HOCs between T2 and T3 ('Mentee Thinking', 'Mentor Feeling and Physical Experiencing', 'Mentor Action', 'Mentee Action' and 'Mentee Issues to be Addressed'). This was for at least two of the vignettes in each of the five HCOs. Predominantly these included (i) noticing the emotional regulation systems (threat, drive and soothing), (ii) specific CFA techniques (including self-soothing, wise mind), and adopting a compassionate stance (including working to understand the mentee's blocks and motivations) and (iii) noticing shame responses (such as critical appraisals and avoidance behaviours).

2.4.3.2.1 Emotional Regulation Systems

Participants noted mentors using CFA to notice and manage the mentee's activated threat and drive systems (HOC 'Mentee Issues to be Addressed') across all vignettes. This suggests participants directly applied their learning and recognition of these systems to the vignettes. Further, participants increasingly referenced the drive, threat and soothing systems (HOC 'Mentor Feeling and Physical Experiencing'). This was in contrast to the same LOC for the HOC 'Mentee Feeling and Physical Experiencing'. These may have been more accessible to participants given that the initial focus of CFA-MP was on the mentors' awareness of their physical states.

2.4.3.2.2 CFA Techniques and Compassionate Stance

Participants described the mentor engaging in 'soothing' or 'wise mind' techniques prior to addressing the mentee (HOCs 'Mentor Action' and 'Mentee Issues to be

Addressed'). Further participants noted the mentor's compassionate stance when exploring mentee's blocks or motivations behind their behaviours for the HOC 'Mentee Issues to be Addressed'. This suggests that participants understood the importance of the mentor managing their activated threat system before responding to mentees across all vignettes.

2.4.3.2.3 Shame Responses

There were fewer critical appraisals reported from the mentor towards the mentee and an increase in the use of CFA (recognising the threat system) for these time points (HOC 'Mentor Thinking'). This suggests participants' recognition of the mentee's distress may influence changes in mentor's shame responses. Where critical appraisals and the use of CFA were both evident this may be related to the specific scenario presented in the vignette and/or participants ability to hold critical appraisals and compassionate responses simultaneously. Participants identified mentee shame responses of avoidance (HOC 'Mentee Action') and self-critical appraisals (HOC 'Mentee Thinking'). Further they provided an understanding of the motivation behind these responses (LOC 'Motivation'). This suggests that participants were able to recognise, articulate and understand mentee shame responses. Participant responses to the HOC 'Mentee Issues to be Addressed' indicated that participants became more able to consider ways in which a mentor would respond to these shame responses.

It is assumed that the supervision phase of CFA-MP maintained participants' references to CFA at T3. Fewer if any references to CFA were observed once the supervision phase had ended (T4). This outcome was consistent with reviews that demonstrated the importance of ongoing supervision to maintain the learning and implementation of new skills post training (Beidas & Kendall, 2010; Lyon, Stirman, Kerns and Bruns, 2011).

2.4.4 Aim 4: What (if any) CFA-M processes or techniques are utilised at a minimum of twelve months follow-up?

Analysis of the follow up interviews produced two main themes. Participants described changes in their understanding of the concept of compassion in the main theme 'Understanding Compassion'. This included participants' increased awareness and attention to their distress and the distress of others. Further, CFA-MP provided participants with permission to be compassionate to themselves and others alongside supporting others to act compassionately. 'Understanding Compassion' resonated with two themes identified by Pettit, et al. (2019) 'Change: the realization of compassion' and 'A culture lacking in compassion'. In the latter theme a loss of compassion in the caring professions was described (Pettit et al., 2019). This may explain the importance participants in the present study placed on having permission to act compassionately in the workplace. Further, these themes may reflect ongoing challenges within some of the participants' working cultures and the emotional demands of caring as outlined in Boorman (2019; 2010), Francis (2013) and The Health Foundation, Nuffield Trust and The King's Fund (2019).

Participants reported acting or responding with compassion in their working practice as mentors, practitioners and colleagues in the main theme 'Venturing into Compassion'. They described improvements in their mentee's interpersonal and nursing abilities as a direct result of the application of CFA techniques. Further, this theme highlighted how participants integrated CFA into other aspects of their work or home life. These findings matched Pettit et al.'s (2019) idea that CFA "had instigated transformational personal change and growth" (p. 7) and may be indicative of interventions within organisations

that might help to support work-life balance (The Health Foundation, Nuffield Trust & The King's Fund, 2019).

Contrary to the vignette responses, where CFA related material diminished at T4, participants articulated many CFA-MP concepts at least twelve months follow-up. Participants appeared to internalise and practice these concepts in their mentoring practice, and with themselves, their patients, colleagues, and families. Whilst the present study did not directly observe or measure these changes, 50% of participants offered examples of their application in practice over this period. Further, some reported CFA-MP had a direct impact on mentees' problematic behaviours although improvements in the mentor-mentee relationship were not explicitly described by participants.

Finally, participants' accounts from both types of qualitative data provide more positive descriptions of their mentoring practice. In contrast to previous literature, participants at follow-up did not remark on having insufficient space or time to mentor student nurses as reported by Andrews and Chilton, (2000), Andrews et al. (2010), Evans, et al. (2013), Nettleton and Bray (2008), Rebeiro, et al. (2015) and Wilkes (2013). This finding may be unique to this participant group, reflect the cultures of the specific services that participants work in and/or suggest CFA-MP resulted in participants approaching their mentoring practice differently.

2.4.5 Limitations

This study has several limitations, the most pertinent being the lack of statistical power and inconsistent data completion, which hampered the quantitative analyses and their interpretation. Further, as no control group was included in this study only an indication of change for compassion and wellbeing would have been provided.

Limitations associated with the vignettes included the brief written responses which were open to interpretation bias. Further, the presentation of V1, provided participants with information about the mentee's feeling states which compromised participants' responses to the corresponding questions. Finally, some vignettes may have facilitated more CFA responses than others.

The qualitative analyses may have been exposed to confirmation bias (Smith & Noble, 2014). Noble and Smith's (2015) strategies were employed to enhance the credibility of the analyses. The researcher used a reflective journal, jointly coded vignettes with a programme facilitator, documented the process, used supervision to triangulate codes and provided quotations to support codes for the content analysis (Appendices R and S). A similar approach to ensure credibility was adopted for the thematic analysis (Appendices T and U). Respondent validation, however, was not sought for either analysis (Long & Johnson, 2000). This was to reduce participant burden. Importantly, there was some resonance to previous themes noted by Pettit et al. (2019).

2.4.6 Implications for practice and future research

The qualitative data from this study demonstrated the potential benefit of CFA-MP to support the nurse mentoring process. The interaction between student nurse and nurse mentor for pre- or post-registration students has not been considered in previous CFA training models (Beaumont & Hollins Martin, 2016; Pettit et al., 2019). The training of nurse mentor alongside student nurses in CFA would enhance these models; improve the quality of the mentee-mentor relationship and the retention of student nurses to the profession. Thus CFA-MP could be a useful adjunct to nurse mentor training and would require additional investigation.

Given the lack of statistical power, replication of this study with a larger cohort (and a design incorporating a control group) is warranted. This would require the use of robust and valid measures of compassion, quality of life, and wellbeing. Additionally an adaptation of the compassion practice diary is suggested to explore whether specific "Compassionate Actions" influence participants' engagement and ability to act with compassion towards themselves or others. Attention should be given to describe and observe behaviour change within the mentor-mentee relationship. Finally, although Crombie, et al. (2013), ten Hoeve, et al. (2017); and HEE (2018a) highlight the importance of the nurse mentor-mentee relationship as crucial to the retention of student nurses it would be important to consider interventions such as CFA-MP in tandem with organisational change. Specifically investigating the impact of CFA-MP within services where its implementation complements the healthcare organisation's and training institution's strategy to improve staff and student welfare (HEE, 2018a).

2.5 Conclusion

The lack of statistical power and significant gaps in participants' responses led to the quantitative analyses being unable to detect, any measureable impact of CFA-MP on nurse mentors compassion, wellbeing, quality of life, and the practice of "Compassionate Actions" (even if such changes had actually taken place). However, the qualitative evidence from this exploratory study suggested that CFA-MP was helpful in facilitating the nurse mentoring processes and that some of its positive impact remained over a period of at least 12 months.

2.7 References

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Critical Appraisal

By Joanna Kucharska

3.1 Critical Appraisal

In this paper, I will explore areas relating to research process for this thesis. This will include the choice of research topics, issues specifically relating to the research paper and literature review, my professional and personal reflections and learning from the process.

3.1.1 Choice of topic

Initially, embarking on the process of doctoral level research was more of a priority for me than the research topic. I work on a doctorate clinical psychology programme, and I do not have a doctorate level qualification myself. Prior to this job, I worked as a clinical psychologist within the NHS having qualified with an MSc in Clinical Psychology prior to the DClinPsy qualification. Part of my current role includes the supervision of doctorate level research therefore, I wanted to go through the process myself to improve my research supervision skills.

Over fourteen years ago, I completed a learning styles questionnaire (Honey & Mumford, 1986b) and I discovered my strong preference for an 'activist' learning style. Overtime I strengthened my abilities to learn through the other learning styles such as the 'reflector', the 'theorist' and the 'pragmatist' (Honey & Mumford, 1986a). I never completed another questionnaire, although, I believe that now I balance these four learning styles better. However, I still have a natural preference for an 'activist' learning style. Therefore, I knew I would learn best from immersing myself in the research process, whatever the topic, to learn from the inside out.

My experience as a research supervisor provided me with the wisdom of ensuring my research focused on an area that I was passionate about. My own observations of supervisees have shown me the importance for them to reconnect with their passion

during the inevitable obstacles that arise during their research journeys. My passion is working with others to understand and collaboratively apply psychological models which is pertinent to my current job. The idea for the research paper coincided with nursing colleagues and I meeting with a local clinical psychologist to discuss ways of improving compassionate approaches in nurse mentoring following the publication of the Francis report (Francis, 2013). In particular we began to consider what Compassion Focused Therapy (CFT; Gilbert, 2009, 2010, 2014) could offer for the nurse mentoring process. I enrolled on the Doctor of Psychology 'top-up' programme to develop this idea further. I knew that I would need to draw on all four learning styles (Honey & Mumford, 1986a). Further, I knew I would learn through my own research supervision. What I had not appreciated is how much I would learn from the research supervision at the start of this process or how vital the research supervision would be to learn more about research design, the discipline of academic writing and how I read and supervise other people's research.

The literature review topic needed to be aligned with my passion of exploring the application of some psychological models with others. I also wanted to build on my own interest of the application of the third wave approaches. From the initial scoping of the literature, what became apparent was how mindfulness based interventions (MBIs) were being used across student groups in the healthcare professions. This partially related to third wave approaches, therefore, I chose to consider MBIs. I wanted to investigate how MBIs are applied to the training of healthcare professionals, in this instance to Trainee Psychological Therapists (TPTs).

The research paper and the literature review are now considered separately with some of my own reflections of my learning from being immersed in this process.

3.2 Research Paper

3.2.1 Choosing a methodology

The methodology was driven by my epistemological position (Appendix AA) and consequently my research question. Hook (2015) highlighted the importance of providing a context to the epistemological position in relation to the development of the research, specifically, qualitative research. I thought this would be useful to address in this paper in the context of my research, albeit a mixed methods approach that evolved from the epistemology.

At the start of the research process, I wanted to have a clear epistemological stance and found myself drawn to a critical realist position. I was attracted by the idea that reality is independent of human knowledge and the complexities that exist in discovering new knowledge or information (Bhaskar, 2014). I was aware that the topic of my research was exploratory, with many unknowns and therefore it appeared right to adopt this stance. I liked the idea that a mixed methods approach fitted with a critical realist approach and that it would enable me to develop some ideas about the mechanisms and processes involved in nurse mentoring. As noted in Appendix AA the use of repeated measures design was to provide information of the changes in nurse mentoring over time, specifically how nurse mentoring practices changed alongside the Compassion Focused Approach to Nurse Mentoring Programme (CFA-MP). This epistemological stance, methodology and design, provided me with an opportunity to learn more from quantitative methods. This was important to me, as I was aware of my limited knowledge of SPSS. I wanted to have some experience of this package, as I knew how much SPSS had changed since my experience of SPSS-DOS as a trainee.

3.2.2 Research design limitations

I found the identification of limitations useful not only as a critical appraisal of the research but also as an opportunity to consider how to improve the designs of my future research. The lack of statistical power was noted in the research paper and will not be discussed further here. Therefore, I will outline further limitations that were not raised in the research paper due to the limited word count. These include the implementation of psychological concepts in healthcare environments, data collection points, measuring compassion, the vignettes, the 'compassionate actions diary' and researcher bias.

3.2.2.1 The implementation of psychological concepts in healthcare environments

I had not placed as much emphasis as I would have liked in the design of the Compassion Focused Approach to Nurse Mentoring Programme (CFA-MP) itself in the research paper. Consequently, there was a lack of reference to the evidence base for implementing newer psychological concepts into healthcare environments. Beidas and Kendall (2010) recommend that contextual variable such as the quality of the training programme, therapist [mentor] variables, organisational support, and client [mentee] variables are considered in relation to any behaviour change in the therapist [mentor]. These are briefly explored below.

a. Quality of CFA-MP training

Psychological training in healthcare should include "a workshop, a manual and clinical supervision" (Beidas & Kendall, 2010, p. 2). Further, the style of training should be a mixture of didactic and active learning strategies (such as role-play). I considered CFA-MP to be of high quality. All participants attended a five-day workshop, a variety of teaching methods was used, all participants were

provided with comprehensive written information (albeit not a manual) and a CD of compassionate mind exercises to practice. Further, the programme was designed to incorporate 10 additional supervision sessions.

b. Mentor Variables

The research design, did not directly address contextual mentor variables such as the participants' previous mentoring experience, their theoretical orientation (in this instance, potentially how they approach and understand their mentees), and their attitudes towards new evidence-based practices (Beidas & Kendall, 2010). The participants demonstrated a broad variance in their experience, which in retrospect would have been useful to explore. Further, two participants provided information about their previous experience with CFT and Cognitive Behaviour Therapy (CBT). This information, alongside gaining an understanding of participants' stance with other theoretical orientations would have been useful to gather at the start of the programme and may have enabled me to reflect on potential differences between participants who opted in and opted out of the follow-up interview. My assumption is that those who attended the follow-up interviews were more engaged in the process and with CFA; however this may not have been the case. Therefore, what is left unknown is the explicit relationship between CFA-MP and the above mentor factors.

Further, there was a difference in cohort sizes. The first cohort consisted of nine participants and the second of three. The second cohort reported that there were fewer participants to learn from during the sharing of mentoring experiences. Rotem and Manzie (1980) noted that for healthcare professionals small group should consist of six to ten members. This was not achieved for the

second cohort. I have learnt that for the second cohort it would have been more beneficial to delay the programme to increase their cohort numbers.

c. Organisational support

An inclusion criterion of the research was that participants attending the programme had their manager's support. I hoped that this would guarantee the participants' consistent attendance of both stages of the CFA-MP. Managerial support may differ from the support of the participants' colleagues. Anecdotally, some participants described differences in the receptivity of their service to apply CFA concepts. Consequently, how, if at all, the culture of the service influenced some of the implementation of CFA-MP remains unclear.

d. Mentee variables

It was beyond the scope of this study to explore the mentees' variables including their experience of those mentors trained in CFA-MP. Therefore, the design did not address any interactions that were present between mentees and mentors.

These contextual limitations provide valuable insights into future research areas and fit with the critical realist position of a constant reworking of information and ultimately building on an ever-changing reality (Danermark, Ekström, Jakobsen, & Karlsson, 2002). As a researcher, such limitations highlight that there are always limits to what can be investigated, whether these are related to issues in the research design or what is possible to explore within the constraints of a research study.

3.2.2.2 Data collection points

Four participants volunteered they had experienced significant life events during the course of CFA-MP. These events may have influenced their scores from T2 (end of first phase), T3 (end of second phase) and T4 (follow-up). It remains unknown whether

other participants had encountered any such events. An adapted version of Elliot's change interview (Elliot, Slatci & Urman, 2001) would have been useful to include within the questionnaire packs to ascertain what other factors beyond CFA-MP may have influenced the completion of the questionnaires. Going forward this would have helped me to contextualise some of the changes in scores.

3.2.2.3 Measuring compassion

There are "no standardised measures of compassion that are routinely used in the NHS" (Papadopoulos & Ali, 2016, p. 134), which did present me with a dilemma about what measure to use. The CEAS (Gilbert et al., 2017) was designed on the theoretical underpinnings of CFT and therefore considered the most appropriate measure to use (albeit with no norms for the nursing population, as noted in the research paper). This measure was considered more appropriate as a measure of compassion than other compassion scales such as Neff's Self Compassion Scale (2003) and the Compassion For Others Scale (Pommier, et al., 2011). In retrospect however, it may have been useful to include these measures in addition to the CEAS, particularly given some of the lower Crohnbach's alpha scores noted in the research paper. I think the choice of measures is a useful learning point for me, and something I will take forward into future research. I would consider using additional established measures alongside any newly developed measure.

3.2.2.4 Vignettes

Participants were asked to select one version of four vignettes (either a set of mental health nursing vignettes or general nursing vignettes). Whilst I consulted with nurses working within these settings during the development of the vignettes, there was no further external validation of them. In addition, vignettes more appropriate for Learning

Disability Nurse Mentors had not been developed. This was particularly pertinent given that over a third of the participants were Registered Learning Disability Nurses. Anecdotally, some of these nurses remarked that this did not create difficulties but this was an oversight that may have influenced how much some participants engaged with the vignettes.

3.2.2.5 'Compassionate activities diary'

What was missing from the overall design of the research was a connection between the participants' use of compassionate mind exercises (recorded in the 'compassionate activities diary') with the Compassion Engagement and Action Scales (CEAS; Gilbert et al., 2017). I would have liked to have made explicit links to the measure by asking questions such as how has each compassionate mind exercise helped with each participant's compassion engagement (the motivation to engage in compassion), and compassionate action (to attend to, learn about and act on what is helpful). Further, exploring how each compassionate mind exercise interacted with participants' self-compassion, compassion to others and receiving compassion from others would have been useful.

Additionally, I was disappointed by the lack of useful data supplied by 'compassionate activities diary'. This may have been the result of a lack of clarity in how to complete the diaries or some other issue. In relation to the overall development of the diary, it would have been important to seek advice from representatives of the potential participant group (in this instance, my nursing colleagues). Consultation with these representatives would have helped with the clarity of the diary and provided useful feedback on the practicality of its completion.

3.2.2.6 Researcher bias

The researcher position for the semi-structured interview was explored in the research paper (section 2.2.9.2.1) and therefore will not be repeated here. I have learnt that I cannot underestimate the power of researcher bias and at times, I had to work hard to remain open during the interviews particularly to information that disconfirmed my bias. I was reassured when analysing the transcripts to discover information I had not anticipated, and therefore outside of my own views and opinions relating to CFA-MP. On reflection however, I wondered about the importance of a bracketing interview (Ahern, 1999; Rolls & Relf, 2006). This is more common in Interpretative Phenomenological Analysis but I think this would have enhanced the credibility of my data collection and analysis. In the future I would be keen to consider some form of bracketing interview. I would use the information gained from it to remind me of some of my own biases before each interview. I hope this would help me to be more conscious of the information I collate and prompt me to give equal attention to information that confirmed and disconfirmed my own predictions.

3.3 Literature Review

3.3.1 Choosing a methodology

I wanted the emphasis of the literature review to be on quantitative research, to build on my skills in quantitative methods. A meta-analysis would have enabled me to further embrace quantitative methods especially as it is viewed as the best methodology for a systematic literature review (Akonbeng, 2005). However, this was not possible for the current review due to the lack of homogeneity in the outcomes of the pooled papers and the lack of randomised control trials. Therefore, a systematic review without a meta-analysis was undertaken.

3.3.2 Limitations

Below I outline some additional limitations to the literature review specifically the quality framework and researcher bias.

3.3.2.1 The quality framework

The use of a quality framework suitable for a variety of methodologies was the strength of the literature review (The Crowe Critical Appraisal Tool [CCAT]; Crowe, 2013). I found the process of using the quality rating measure an informative process as it helped me to formalise and develop my critical appraisal skills of published research. The process of utilising an additional independent rater for the studies was instructive, as it allowed me to compare and consider the differences between our ratings where they existed. I was surprised therefore, to see one Kappa coefficient with a moderate strength of agreement *K*=.62 with only one point difference between the independent rater and myself. Neither of us had used the CCAT before and it highlighted the precarious nature of how slight differences in opinion could affect the quality rating and the strength of agreement. Therefore, I gained a better understanding of the importance where possible, of communication between independent raters to come to some agreement if the discrepancies had been greater.

3.3.2.2 Researcher bias

I enjoyed exploring the variety of MBIs TPTs participated in particularly as I had previous experience as a MBCT group facilitator for trainee clinical psychologists. However, I was conscious of my position as a researcher and I was aware this might activate my own bias (the part of me that wanted to demonstrate that MBIs were helpful to TPTs). It was important for me to acknowledge this in my reflective diary. It was helpful to use a data extraction format to facilitate drawing the same type of information from each study to

keep my biases in check. I was struck by how often researchers used different outcome measures or adapted protocols which then lead to difficulties in comparing results. This led me to reflect on my own research practice and in the future to utilise, where appropriate, standardised protocols and measures from high quality studies, to build systematic evidence for specific models or interventions.

3.4 Professional and Personal Learning

I believe there has been a huge amount of learning and growth both professionally and personally through completing this thesis.

3.4.1 SPSS

It has been important for me to revisit SPSS and to enjoy the advances of this statistical package. I am very grateful to my supervisor for recommending some specific statistical text books. I believe I would be better equipped to consider quantitative research in the future which is an area for my future development given my preference for qualitative methods.

3.4.2 Ethics

The experience of seeking ethical approval was initially an extensively covered topic within my reflective journal! As with others, my experience was not straightforward and there were a number of obstacles that needed to be overcome within tight time constraints. I had to draw on my abilities to manage stress, when the process was particularly difficult. I was continually trying to balance my stress and frustration alongside understanding the importance for an appropriate level of scrutiny and ensuring correct ethical procedures were followed. The value of ongoing open communication between the different organisations involved in the ethical approval process was crucial. Further, developing good working relationships were vital to the

process (with phone calls far outweighing emails). The process helped me to provide better advice to my own research supervisees, enhancing my supervision skills. I have a better appreciation of some of the struggles faced by trainees both practically and emotionally. I have learnt not to underestimate the emotional impact of the ethical process when obstacles and tight timeframes coexist.

3.4.3 Research supervision

One of the most important pieces of learning has been my positive experience of research supervision. Throughout this process, I have reflected upon the difference between the experience for this thesis and other academic endeavours. Part of my reflection was about my own responsibility to utilise supervision appropriately and ask for the advice and guidance I needed. I believe the process has been a corrective experience (Brown & Pedder, 1991). My supervisor provided me with a space and permission not to know but to find out. It has been important for me to have had someone working alongside me to help me think about every aspect of the research. I believe I have been fortunate to have had a supervisor who has been able to offer clear, honest and constructive feedback. An important aspect of this has been the compassion that I have experienced throughout the process. I have been aware of my parallel learning process in relation to research participants' descriptions of approaching and labelling issues that need addressing to enable their mentees to learn. There have been times when the feedback alerted me to issues I have needed to address despite them being difficult to acknowledge. This included my avoidance and its consequences (i.e. the amount of time remaining to complete the thesis and consequently the amount of work I needed to do). A further issue was my writing style. I needed to hear these issues

being named out loud to help me acknowledge they were real. I am grateful to my supervisor for raising them. It helped me to take responsibility for them and to change. The academic writing process was helpful in moving me from a position of knowing what was important to write to applying this in actual practice. This reminded me of the Declarative-Procedural-Reflective (DPR) Model of Therapist Skill Acquisition (Bennett-Levy, 2006). As a research supervisor I had developed the declarative system (what would be important to include and write in the thesis). I now had the opportunity to hone my procedural system (the writing). I found that research supervision, the feedback, and opportunities for my own reflections and discussions with peers (the reflective system) helped me integrate these two knowledge systems better and improve my academic writing skills. Alongside this I learnt about research supervision for my own supervisory role enabling me to be more confident and competent as a researcher and a more confident, competent and compassionate research supervisor.

3.5 Dissemination and Future areas of research

I will be required to disseminate the research paper to the faculty Practice Education Group (PEG). This group consists of the range of professionals from health and social care courses run by my employer. I believe that the dissemination of information, in whatever format (presentations, posters and publications) is important to inform others of new information that may be helpful to their practice.

I would like to disseminate my literature review to my clinical psychology course team colleagues. This will help inform the personal and professional development aspect of the current programme. I would be keen to submit the review for publication and present the information within the training community for psychological therapists.

Regarding future research, I would like to investigate how the CFA-MP would work for other healthcare professionals. This could include developing the model proposed by Beaumont and Hollins Martin (2016) by a) an investigation of the CFA training for those who support health and social care students in practice, and b) an evaluation of the implementation of CFA programmes for health and social care students and for colleagues who run the training programmes.

3.6 Summary

This paper has addressed a number of areas, from the reasons for undertaking doctoral level research, the choice of topics and research limitations, to personal and professional learning. I believe that the work required to complete this thesis has provided me with the invaluable opportunity to be immersed in the process of research. It has enabled me to develop as a researcher and a research supervisor.

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Service Evaluation

An Evaluation of a Training Programme in Compassion Focused Approach to Nurse Mentoring

By Joanna Kucharska

Executive summary

In response to the recommendation to enhance nurse training (Francis, 2013), Coventry University (CU) decided to target nurse mentor training in particular, it was decided to develop better practice learning environments for student nurses by targeting the student-mentor relationship. Previous research has noted difficulties that student nurses experience in their practice learning environments (e.g., Buante, Gabato, Galla, Maneje, Paje, & Pradia, 2012; Epstein & Carlin, 2012). Such environments can lead to increased anxiety and elicit shame and self-criticism processes affecting the student's capacity to learn (Bond, 2009; Johnson, 2012).

Therefore, as part of CU nurse mentor training, an additional training programme was developed in collaboration with local experts drawing on aspects of Compassion Focused Therapy (CFT), which addresses self-criticism and shame (Gilbert, 2009; 2010). This Compassion Focused Approach (CFA) programme was evaluated using a qualitative methodology (thematic analysis) to address the following evaluation aims:

1. To identify the key CFA concepts and skills that can be applied to and assist with the nurse mentoring process.
2. To note the degree to which nurse mentors are socialised to and engage with the CFA model.
3. To gain direct feedback from participants in relation to the organisation of the programme i.e. what aspects of the programme needed changing or worked well.
4. To explore areas of agreement and/or difference of opinion with participants and trainers regarding how CFA assists the mentoring process, issues of participants' engagement and areas for programme development.

The programme had two stages, a five day training course followed by ten supervision sessions for eight participants, from a variety of nursing disciplines. Participants and trainers were interviewed after both stages of the programme.

Three themes emerged that aligned with the above aims: 'Utility of the Model' (understanding CFA theory and the application of associated skills); 'Receptiveness' (participants' engagement with and embodiment of CFA); 'Learning' (aspects of the programme that facilitated learning).

Key findings

1. The first two themes highlight that participants valued CFA as a model and were able to utilise CFA within their mentoring roles. These views were supported by the trainers and suggested that CFA may have a place in nurse mentor training.
2. The third theme highlighted areas participants and trainers identified as important to the learning process.

Recommendations

The results generated the following recommendations:

1. **Integrating CFA within Nurse Mentor Training** would complement existing nurse mentor preparation training/mentor update by offering a compassion focused approach that is accessible and can be readily applied to the nurse role as a mentor;
2. **Maximising learning** of future CFA programmes through maintaining a broad mix of nursing disciplines and the development of a maintenance programme;
3. **Maximising attendance within the programme** through appropriate recruitment of well-informed individuals with sufficient pre-course information;

4. **Building an evidence base** for a CFA to nurse mentoring through on-going delivery and evaluation of successive programmes.

It is hoped that these recommendations and the findings of this report will enable the development of an innovative programme to further strengthen the student-mentor relationship, improve opportunities for students to learn by enhancing the quality the practice learning environment and begin an evidence base for CFA to support the finding that CFA is a relevant approach to nurse mentor training.

4.1 Introduction

4.1.1 Pre-registration student nurse mentoring

Currently, all pre-registration nurse training programmes are required by the Nursing and Midwifery Council (NMC) to be 50% practice and 50% theory (Royal College of Nursing [RCN], 2007). Half of every pre-registration nurse training programme involves students learning in practice with the support of nurse mentors. The mentor role incorporates many aspects of practice learning from the organising, monitoring, assessing to supervising the student's clinical activities (NMC, 2008). There is a mandatory requirement for pre-registration students to have a mentor (NMC, 2008). Hence the mentor role is pivotal for student nurse training and all nurse mentors are trained via approved mentorship preparation training programmes (NMC, 2006 cited in RCN, 2007).

4.1.2 Nurse mentor training

Nurse mentor preparation training programmes curriculum incorporate the NMC standards for nurse mentoring and covers eight specified domains (NMC, 2008)[27]:

1. Establishing effective working relationships (e.g., the role and responsibilities of the mentor, the mentor-mentee relationship, interprofessional working).
2. Facilitation of learning (e.g., learning styles/needs, facilitating reflective practice).
3. Assessment and accountability (e.g., determining competence/public protection (duty of care), NMC mentor requirements, failing a student).

[27] The domains are expanded upon from the University of East Anglia (UEA) mentoring curriculum (UEA, 2012).

4. Evaluation of learning (e.g., measurement of student performance, meaningful documentation/feedback, recording achievements).
5. Creating an environment for learning (e.g., supporting the student in the practice learning environment, assisting in transitions between environments).
6. Context of practice (e.g., record keeping, local strategies/policies).
7. Evidence-based practice (e.g., the application of theory to practice).
8. Leadership (e.g., the importance of role modelling professional practice).

The training programmes lasts a minimum of ten days, five of which are protected learning time (NMC, 2008). Therefore there is limited is capacity for additional mentor training material from the relevant academic intuitions. The mentor training at Coventry University (CU) is consistent with the above structure as required by the NMC.

4.1.3 Compassion in nurse mentor preparation training at CU

An absence of a compassionate culture towards staff and patients in healthcare organisations have been described in reports such as, Boorman's (2009) 'NHS Staff Health and Well-being', the Department of Health (2012) 'Winterbourne View' and the Mid-Staffordshire Foundation Trust Public Inquiry (Francis, 2013). These reports noted issues such as a lack of registered managers, limited staff training, target driven healthcare and accepted cultures of bullying and harassment were not heeded by the appropriate authorities and generated stressful working environments (Boorman, 2009; Department of Health 2012; Francis 2013).

The Francis Inquiry (Francis, 2013) suggested that the reduction in compassionate care and quality of care directly affects the quality of the student learning environment, describing it as "deficient" (Francis, 2013, p.60). The report highlighted the importance

of an “increased focus of compassion and caring in nurse recruitment, training and education” (Francis, 2013, p. 76). Subsequently, CU reviewed their existing nurse mentoring training packages to address compassionate care in the mentoring of nursing students. This resulted in a Compassion Focused Approach (CFA) for nurse mentoring programme (adapted from Compassion Focused Therapy, Gilbert, 2010). The purpose of the new training was to enhance the values and behaviours associated with compassionate care in current nurse mentoring practice.

4.1.4 Compassion focused therapy, shame and student learning

Compassion Focused Therapy (CFT) evolved as a theoretical framework from an understanding of self-criticism and shame (Gilbert, 2009; 2010). High levels of self-criticism are believed to be a response to experiences of shame.

4.1.4.1 Shame and student learning

There is a complex relationship between shame, self-criticism, and student learning, which relates to the student’s internal processes and the student’s learning environment. In brief, difficult early life experiences lead some individuals to become “sensitive to the negative feelings and thoughts about the self *in the mind of others*” (Gilbert, 2010, p. 83). This engenders a lack of safety (threat) and a complex set of coping behaviours that interact with the learning environment to hinder the student’s capacity to learn. The practice learning environment may contribute to this sense of threat as evidenced by research exploring student nurse experiences of their practice learning environments (Bond, 2009; Johnson, 2012). Areas that might compromise their sense of safety include:

- Breaches in ethical practice i.e. “respect for others, beneficence, and justice” and “unprofessional behavior and a lack of caring” (Epstein & Carlin, 2012);
- Qualified colleagues/mentors “taking over, making condescending comments, being irritated or not interested and not giving feedback or opportunities to reflect” Lofmark and Wikblad (2001, cited in Buante, Gabato, Galla, Maneje, Paje, & Pradia 2012);
- Students feeling excluded in their learning environments (Charlston & Happell, 2005 cited in Epstein & Carlin, 2012) and less likely to question poor practice (Levett-Jones & Lathlean, 2009 cited in Epstein & Carlin, 2012).

In light of the Francis Inquiry (2013) such experiences do not appear exceptional and potentially fuel shame episodes.

4.1.4.2 CFT and self-criticism

CFT is shown to be effective for mood disorders, particularly those high in self-criticism (e.g., Kelley et al., 2009, and Shapira & Mongrain, 2010 both cited in Leaviss & Uttley, 2014). CFT highlights the importance of recognising and managing factors that compromise a sense of safety in the self, i.e. developing self-compassion, before being able to do so for others (Gilbert, 2005; 2009; 2010). CFT principles have been adapted to a number of settings including business, education, and healthcare (see Leaviss & Uttley, 2014). Therefore, CFT principles could be applied to the practice learning environment, specifically to nurse mentors to enhance the sense of safety in student nurses.

4.1.4.3 Compassion focused approach (CFA) and student mentoring

CFA training may enhance the student-mentor relationships and facilitate more helpful learning experiences in practice education. Consequently CFA could enable more

facilitative practice learning environments for nursing students. The CFA nurse mentoring programme (CFA-MP) aimed to build on existing expertise in nurse mentoring by ensuring a compassion focused framework where mentors learned to:

- Recognise and understand when their own sense of safety (threat) is activated;
- Manage their own threat system;
- Recognise when threat is activated within student nurses;
- Help student nurses to manage this system.

It was anticipated that this would improve student learning in their practice learning environments.

4.1.4.4 Structure of the CFA-MP

The first phase of CFA-MP involved a bespoke five consecutive day psychoeducation programme. This was developed and adapted by the facilitators from literature within CFT (e.g., Goss, 2011a; Goss, 2011b; Goss & Allan, 2014; Goss & Allan, 2010). The programme included topics such as a theoretical introduction to Compassion Focused Theory including concepts such as:

- The evolution of the brain i.e. concepts of "old brain" and "new brain" processes;
- Understanding the types of affect regulation systems (i.e. drive, threat and soothing systems) and how these may then impact on the mentoring process and student learning;
- Understanding what compassion consists of and what can block compassion (e.g., a threatened/competitive mind and blocks to soothing);
- Compassionate Mind Training exercises (e.g., practical self-soothing; safe place; compassionate companion; compassionate self; behaving compassionately to others and/or to the self; receiving compassion from others).

The second phase involved mentors attending supervision sessions to help build on and implement this knowledge within the mentoring process.

In summary, the nurse mentor role is a crucial part of nurse training which has been compromised by the pressures of difficult working environments. Further, due to the limited capacity for additional material, the current nurse mentor curriculum does not directly address how mentors can help students manage experiences of shame and consequently improve their learning in practice. Given the successful application of CFA in other areas, CFA could be of benefit here.

4.1.5 Evaluation aims

To the author's knowledge this was the first time CFA had been applied to nurse mentor training; therefore this service evaluation of the mentoring programme had four main aims:

1. To identify the key CFA concepts and skills that can be applied to and assist with the nurse mentoring process.
2. To note the degree to which nurse mentors are socialised to and engage with the CFA model.
3. To gain direct feedback from participants in relation to the organisation of the programme i.e. what aspects of the programme needed changing or worked well.
4. To explore areas of agreement and/or difference of opinion with participants regarding how CFA assists the mentoring process, issues of participants' engagement and areas for programme development, the programme trainers' views of facilitating the programme were also sought.

4.1.6 Methodological approach

Given the early developmental stage of the programme, the current service evaluation used a qualitative methodology. Thematic analysis (Braun & Clarke, 2006) was chosen

over content analysis at it would offer a way of pooling 'common threads' of information gained from a variety of interviews. This would be done whilst holding in mind the context of the data (e.g., participants' working environments; the trainers' expertise etc.). It is understood analysing data in this way falls within the thematic analysis methodology (DeSantis, Noel & Ugarriza, 2000 and Loffe & Yardley, 2004 both cited in Vaismoradi, Turunen & Bondas, 2013). The themes evolving from the analysis would directly inform engagement with and applicability of the model to nurse mentoring.

4.2 Method

4.2.1 Participants

Participants were included in the programme if they were qualified nurses with experience of nurse mentoring.

Of the eight[28] participants who attended CFA-MP:

- One participant was male;
- Three participants were actively involved in mentoring students[29];
- Two participants were practice education facilitators[30];

[28] 8 was the total number of participants that came forward for the programme.

[29] The Nursing and Midwifery Council (NMC; 2008) described the Nurse Mentor Role as involving a number of duties. These included arranging, monitoring and assessing practice learning tasks for student nurses, setting realistic learning targets, supervising clinical practice activities, observing and monitoring the development of the student's clinical skills, and providing constructive feedback. The nurse mentor gathers evidence of the student's strengths and areas for further development for the educational providers and sign-off mentors. This evidence can then be utilised to make appropriate decisions regarding the eligibility of the student to qualify as a nurse at the end of their training.

[30] "The Practice Education Facilitator works to improve the quality of care through the development of the health and social care workforce. Nurses in this role may: assess the quality of clinical and other practice learning environments and propose interventions for improvement; facilitate the development of clinical practice mentors /educators; provide supervision and support within a development structure; provide on-site support and continuous professional development activities for staff and practice mentors /educators; develop and maintains links with HEI to support mentor and practice education." National Health Service (NHS, 2010)

- Three participants were involved in mentor related activities at CU (e.g., mentor training, placement strategy and allocation) ;
- Four participants were qualified as RMNs (Registered Mental Health Nurse);
- Four participants were qualified as State Registered Nurses (SRN).

Additional qualifications and training included Learning Disabilities, Paediatrics, Oncology, Neurology, Surgery, and Cognitive Behaviour Therapy.

The placements offered varied in length from three to twelve weeks. The placement length for specialist practice students was 12 months. Given the small sample size and the specific job roles of some participants, anonymity of participants was preserved by not separating out ages/backgrounds or the use of pseudonyms. Instead, participants were categorised by numbers i.e. N1 to N8 with summaries of ages, years of qualification and experience of mentoring provided in Table 4.1.

Table 4.1. A summary of the mean age, years of qualification and mentoring for participants

	MEAN (years)	**Standard Deviation (*SD*)**	**RANGE (years)**
Age	53	5	45-60
Years qualified	27	10	6-38
Experience of mentoring	16	6	5½-24

4.2.2 The structure of the training programme and recruitment

CFA-MP was divided into two distinct sections:

Stage 1: Five consecutive days training specially targeting the theory behind CFA. Subjects included the evolution of the brain; emotions and managing learning through understanding the three systems of threat, drive and soothing; understanding compassion; the practice of self-compassion; compassionate mentoring.

Stage 2: Ten, weekly sessions of group supervision. Participants were able to reflect in depth how the information from the five-day course would be applied in their mentoring practice.

The recruitment of participants to the project was gained from expressions of interest from nurse mentors who attended a one-day interdisciplinary conference on Compassion Focused Approaches (where information about the project was provided) and via email invitations across Trusts that host placements for CU nursing students.

4.2.3 Ethical considerations

All participants were provided with an information sheet about the service evaluation (Appendix AB). Consent to record interviews was gained prior to each recording with recordings being held securely and wiped post transcription. Confidentiality was addressed by all data being anonymised (Appendix AC). The local NHS Trust's Research and Development (R&D) department confirmed a service evaluation status. Therefore, no formal ethical approval was required (Appendix AD).

4.2.4 Attendance

Stage 1: 100% attendance by all eight participants.

Stage 2: The mean attendance for each supervision session was 60%. (See Table 4.2 for a summary of attendance.)

4.2.5 Trainers

The two trainers (a Clinical Psychologist and a Clinical Nurse Specialist) work clinically with clients with complex needs and have considerable expertise in the delivery and training of Compassion Focused Therapy to staff groups.

Table 4.2. Attendance of supervision sessions

Participant	Total Number of Supervision Sessions Attended
N1	9
N2	7
N3	2
N4	10
N5	7
N6	0
N7	5
N8	7
Mean attendance of all participants per supervision session	**6 (*SD*=3)**
Mean attendance per session as a percentage	**60%**
Range of attendees per supervision session	**3 to 7**

4.2.6 Interview procedure

The evaluation of the programme involved two semi-structured interviews for each participant to complement the programme structure and to independently evaluate both stages of the programme:

Stage 1: Participants were interviewed between two to five weeks after the end of the five-day training programme in CFA. After Stage 1 both trainers were invited to submit written feedback;

Stage 2: All participants and the trainers were interviewed between two and nine weeks after the end of the supervision sessions.

The interview schedules can be seen in Appendices AEi to AFiii. All participants and trainers were interviewed at convenient venues (e.g., their home, CU). All interviews were recorded and transcribed verbatim. Due to a number of practical issues after Stage 1, one participant was not interviewed at all and one participant only provided written information.

4.2.7 Data analysis

Braun and Clarke's (2006) recommended process of thematic analysis was followed (see Appendix AG for a full outline; summary is provided in Table 4.3).

Table 4.3 A Summary of Stages in the analysis of data using thematic analysis

Stage	Action
1	Transcribing data: reading and re-reading the data, noting down initial ideas
2	Systematically coding interesting features of the data
3	Collating codes into potential themes
4	Checking if the themes work in relation to the data
5	Refining the themes
6	Providing extract examples

A sample of a transcript is provided in Appendix AH to illustrate the analysis process. To enhance the quality of this qualitative analysis Yardley's (2000) principles of sensitivity to context, commitment and rigour, transparency and coherence were considered through the use of both a reflective journal and research supervision to discuss anomalies and finalise themes.

4.2.8 Evaluator's position

The evaluator is an employee of CU, a clinical psychologist by profession and not involved in any aspect of nurse mentoring. From an epistemological perspective a

critical realist position (Braun & Clarke, 2006) was adopted in order to draw all the themes of the participants together into the broader context of the mentoring process.

4.3 Results

For the purposes of this report, the results of the thematic analysis were divided into three parts to address the first three aims of the evaluation. (Given that the trainers' views were very similar to those of participants the results pertinent to Aim four were integrated into these three sections and are not presented separately.) These three themes were comprised of subthemes as illustrated in the thematic map (Figure 4.1) The most pertinent themes are outlined with tabulated quotations from transcripts to support the themes.[31]

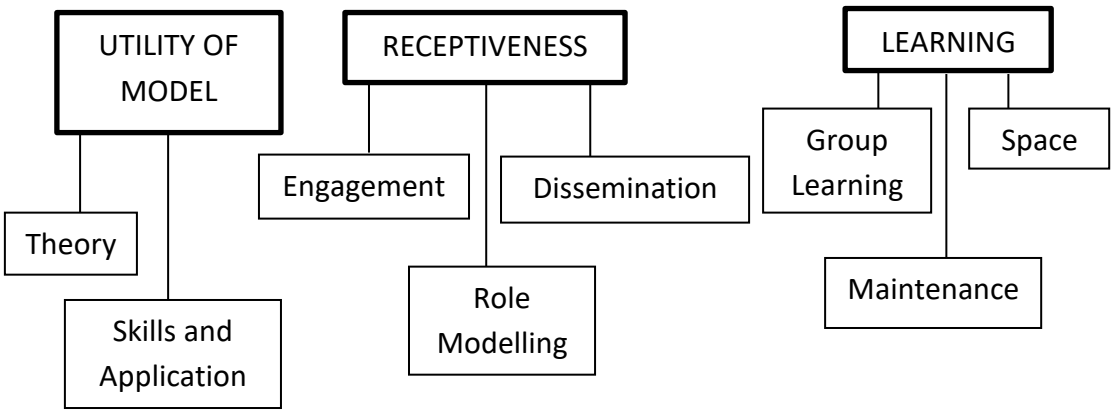

Figure 4.1. A Thematic Map of the main themes and subthemes

[31] S1 denotes the interview post stage 1 and S2 post stage 2

4.3.1 Part 1: 1. To identify the key CFA concepts and skills that can be applied to and assist with the nurse mentoring process.

4.3.1.1 'Utility of the model'

This theme (represented in Figure 4.2) encapsulates the participants' knowledge and understanding of key concepts within the Compassion Focussed Approach (CFA). It integrates participants' understanding of CFA and how this has been applied to nurse mentoring and to other areas. The subthemes are 'Theory' and 'Skills and Application'.

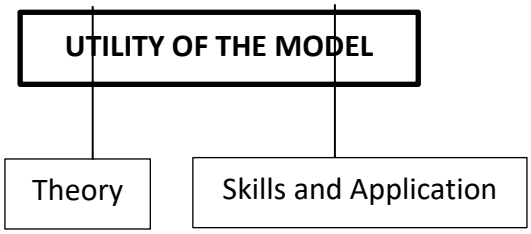

Figure 4.2. A diagrammatic representation of the theme 'Utility of the model' and its subthemes

4.3.1.1.1 'Theory'

This subtheme describes the key CFA concept that participants voiced. This was their increased awareness of and ability to articulate the theory of the affect regulation systems of threat, drive and soothing used in CFA. Further, the theme refers to how participants' theoretical understanding of this key concept could be applied to the nurse mentoring process (and other aspects of their work).

Participants stressed the CFA theory of the affect regulation systems as being helpful to them both with mentoring and with other areas of their lives. For example, participant N2 described drawing on the affect regulation systems to understand a student's interrupting behaviours and to help facilitate a colleague in their mentoring process (see Table 4.4).

From recognising and understanding which of the three systems operate in specific situations it is suggested that participants became more conscious of how this CFA concept can be used to understand the responses of their mentees and themselves to certain situations. Further, where possible, participants considered acting on this new awareness and knowledge.

Table 4.4. Quotations for the subtheme 'theory'

Participant	Quotations
N2	"we've got a student at the moment, …… I think she's in drive, I think she's permanently in drive…… I've already started talking with her mentor, ….. I hope she's going to calm down a bit cos she's having some problems with interrupting, because she's so keen to get things across, that actually she's not recognising …….. there's a time and a place for when you voice things" p.8 (S2)
N8	"what it did do, is may be make me stop and think, you know if I was going into a meeting or whatever, it did make me think about you know, make sure you are in the right zone as it were" p. 3 (S2)
N4	"I feel now that if I was challenged how I approach my mentees, I have got evidence to say I'm actually doing it the right way….., I feel confident enough to say to someone, actually there's evidence to show that helping them and guiding them and getting information for them is the right approach…. now I feel like I've got evidence, it's not just me, it's not just my feelings or my perception" p.3 (S1)
N6	"there's a difference between mentoring somebody and really supporting them which I think is what this approach taught us really" p. 3 (S1)

Participants consistently voiced an internal shift in how they approached mentoring and their work. They described a difference in their internal approach to their work as a direct result of their awareness of this CFA concept. Notably N8 appeared to consider what system they may be operating from and whether this would be helpful for their next work task (see Table 4.4).

A further key CFA concept was participants' understanding of compassion. For instance participants reported that compassion was related to being helpful and guiding mentees alongside raising and addressing difficult issues. Participants noted that CFA offered a theoretical model to validate their current mentoring approach and information to offer colleagues when confronted about their mentoring style (e.g., N4 Table 4.4). Further the CFA programme facilitated participants to reconnect with the importance of the mentoring role and the value of the mentoring process (see N6 Table 4.4). Participants described this expanded understanding as being helpful to be more direct with students. This is noted further in the next subtheme 'Skills and Application'.

4.3.1.1.2 'Skills and Application'

This subtheme highlights how participants and trainers described applying aspects of the theory and techniques learnt into mentoring and other contexts. Examples of the three areas of application are described below:

a. The quality of the mentoring relationship and practice

Participants described the expanded understanding of the concept of compassion in CFA as being helpful for them to be more direct with students when difficulties arose including concerns about failing mentees. Further utilising the supervision model (which was collaboratively developed by participants and facilitators during the programme) appeared to facilitate this process enhancing quality in the relationship and in the students' professionalism. A positive consequence of this was voiced by N2 noting sense of feeling more respected by the mentee (Table 4.5).

Table 4.5. Quotation for the quality of the mentoring relationship and practice

Participant	Quotation

N2	"I did an interview with a student um last week and um yeah, so I used some of the questions…….I think I have been more successful. This student um is fine, but things like time keeping wasn't good …… you couldn't just brush it off anymore, you had to address it, and I found that I was able to do that constructively, and um the student understood where I was coming from" p. 6 (S2)

b. Applying self-compassion

Another key concept in CFA is the development of self-compassion including the use of self-soothing techniques. This facilitates compassion towards others (e.g., T2 Table 4.6).

Table 4.6. Applying self-compassion

Participant	Quotation
T2	"I think it opened their eyes a lot to the need for self-compassion and that they need to take care of themselves, to enable them to effectively take care of their mentees, of their patients, so for whoever it is they're caring for. I think they got very, I think they were very open about the fact that they had kind of forgotten themselves, in everything, so they, I feel they learnt to look after themselves a bit more" p.17 (S2)
N1	"I am being compassionate, am I in soothing, no I am not, because I am anxious about my job role, der de der, all those threats…… it's not just you giving you've got actually to be in a place where, you are not blaming the student, where you can give it" p. 2 (S1)

Interestingly, N1 (Table 4.6) noted how the lack of applying the CFA technique of self-soothing (or indeed self-compassion) can be detrimental to the mentor-student relationship. In this instance N1 voiced how this could potentially lead to blaming the student (highlighting the importance in maintaining self-compassion).

c. Other contexts

Although the CFA programme's specific focus was to help facilitate the mentoring process, participants noted that key CFA concepts such as of the affect regulation

systems and understanding compassion could be applied in a variety of contexts outside of mentoring. Some noted CFA could be applied to the practice environment to improve contact with colleagues, patient care, as well as mentoring and generalised into other aspects of participants' lives including their way of life N3 (Table 4.7).

Table 4.7. CFA in other contexts

Participant	Quotation
N3	"sort of how you treat your colleagues is hopefully going to be how you treat your clients which would hopefully be the way you treat your family, friends, and the rest, and it's that philosophy of life almost" p. 9 (S1)

4.3.2 Part 2: To note the degree to which nurse mentors are socialised to and engage with the CFA model.

4.3.2.1 'Receptiveness'

This theme (Figure 4.3) describes how participants have individually responded to CFA demonstrating both their engagement and socialisation to CFA. The subthemes here are 'Engagement', 'Dissemination' and 'Role Modelling'.

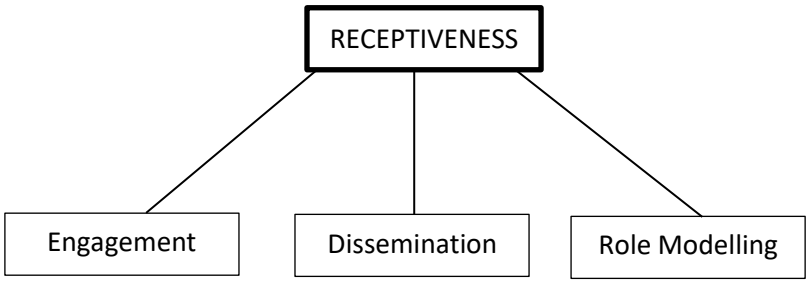

Figure 4.3. A diagrammatic representation of the theme 'Receptiveness' and its subthemes

4.3.2.1.1 'Engagement'

This subtheme draws together the active engagement that participants have shown towards CFA. Participants appeared engaged with the evidence base which resonated with their professional stance and the biological underpinnings of CFA (e.g. N1 Table 4.8). The sense of engagement is noted by participants utilising CFA in other contexts (see above: 'Utility of the Model' subtheme 'skills and application').

Table 4.8. Quotation that supports the subtheme 'engagement'

Participant	Quotation
N1	"the biological part I think is really important because if you're, if you are talking to nurses, which this is obviously meant for, the nurses work by evidenced based and if there is no evidence, you know, so the thing about evolution, just in the simplest terms, and the brain and how that works, um and the old brain new brain…… if the evidence says, this is what's happening to your brain, then I am much more likely to, to go with that. And I think nurses, these days, perhaps not long ago, but, these days, need that evidence" p. 14 (S2)

4.3.2.1.2 'Dissemination'

Cascading information to colleagues is often a prerequisite of attending training; the drive of participants to disseminate CFA suggested that this was due to the level of engagement with CFA (T1, Table 4.9). Most participants were keen to cascade the

information in a meaningful way that would convey their learning and the impact of CFA on their practice (N4, Table 4.9).

Table 4.9. Cascading information

Participant	Quotation
T1	"it did feel slightly more evangelical in the nicer sense of the word, of how do we [the participants] spread this to a wider audience, how do we share this with our team, how do we get other people of training course, and they were keen to get their colleagues to come along and experience. It was very positive" p.4 (S2)
N4	"I actually gonna give a 45 minute slot, and that sort of a combination of me going on it from the very beginning I wanted it to be more than just I go on a training course I want to be able to deliver this to other people that was my aim, not just to learn something for myself ….. The fact that I will be able to take it forward in a constructive way you know not just talking to my colleagues about it, oh it's really good, but actually to be able to have a package to deliver to them to people, other mentors, other nurses" p.1 (S2)

4.3.2.1.3 'Role Modelling'

Role Modelling was added to this section as it incorporates how participants engaged and embodied their learning in CFA: To role model this in their working environments. Participants spoke about the importance of role modelling in nursing per se. Role modelling aspects of CFA appeared to be an important part of mentoring and a demonstration of participants' engagement with the model (N1, Table 4.10).

Table 4.10. Quotation that support the subtheme 'Role Modelling'

Participant	Quotation
N1	"So I guess, if, we are being compassionate with them, that influences them, we are their role models, so from a role model point of view they should be doing the same with their other patients. So there should be that influence really" p. 10 (S1)

4.3.3 Part 3: To gain direct feedback from participants in relation to the organisation of the programme i.e. What aspects of the programme needed changing or worked well.

4.3.3.1 'Learning'

This theme (Figure 4.4) brought together some of the aspects of the programme that worked well or needed changing. The subthemes were 'Group Learning', 'Space' and 'Maintenance'.

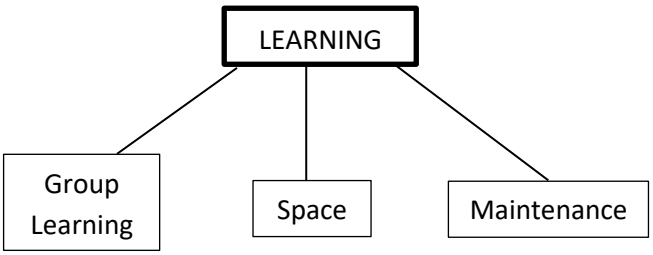

Figure 4.4. A diagrammatic representation of the theme 'Learning' and its subthemes

4.3.3.1.1 'Group Learning'

Trainers and participants noted two aspects of learning as a group that seemed to aid their learning i.e. being in a group per se and the mix of disciplines.

a. Being in a group

A feature that worked well for participants was noted in the subtheme of being part of a group. Participants described the importance of learning from each other. For instance, N7 noted the usefulness of other participants sharing ideas or from learning through their application of CFA (Table 4.11).

Table 4.11. The process of being in a group

Participant	Quotation
N7	"it was also listening to other people talk about their own experiences and that's the bit that I enjoyed the most probably. And how they had tried to use it in different ways, and um some of the elements that I struggled with they helped me clarify my understanding" p. 3 (S2)

b. Mix of disciplines

Another aspect of the programme that worked well was the diversity of participants' nursing backgrounds in this subtheme. This distinctive feature was highlighted by participants as enhancing their learning. N6 described the uniqueness and novelty of training with other nursing disciplines and how this appeared to add to their overall learning experience (Table 4.12). The difference in the professional disciplines of the trainers was believed to enhance the training experience with participants valuing and benefiting from the cross working between psychology and nursing (T2, Table 4.12).

Table 4.12. Mix of disciplines

Participant	Quotation
N6	"It's rare, very, very rare that you go on a course and you are surrounded by people that are the same level as you, but from different backgrounds. You will very frequently come across a group of RMNs or a group of home managers whatever, but not people from such diverse backgrounds and I found that fascinating, it was really interesting, because you don't get it" p.2 (S2)
T2	"they [the participants] pick up on or comment on was the fusion of nursing and psychology. …… we'd spoken about it was really nice to have a nursing background and a psychology background working together" p. 5 (S2)

4.3.3.1.2 'Space'

An aspect of the programme that both worked well and appeared to need change related to the subtheme of space. Firstly, trainers and those participants that attended

the both stages of the programme described the importance placed on having the opportunity to reflect on their work and their learning in CFA. T1 (see Table 4.13a) noted how the training offered space for participants to consider their values, manage difficulties and reflect on the practice of caring for others.

Table 4.13a. Importance of space

Participant	Quotation
T1	"I think it helped them reflect on a lot of their core values about why they do what they do and also how to deal with the difficult things that they have to do, in a way that looked after them and looked after the people they were trying to care for as best they could" p. 17(S2)
N8	"they [supervision sessions] made me stop and think, sometimes some of the activities were challenging, but from that point of view it made it even better because in actual fact it did make you really have to think about what you were doing, and probably challenge your understanding, your interpretation of things" p. 2(S2)

N8 emphasised how the physical space became protected space to reflect on their current working styles and the application of their learning (Table 4.13a).

Those participants who did not complete both stages of the programme emphasised how the work/home situations limited their capacity to utilise the space and learning opportunities provide by the programme (N6, Table 4.13b). Participants who did not complete the programme said they were engaged with the programme. They expressed a preference for more space between the two parts of the programme to support their learning alongside personal/work commitments (N3, Table 4.13b).

Table 4.13b. Insufficient space

Participant	Quotation
N6	"I really enjoyed the course and I really, really wanted to complete it ……. I did genuinely, and I think, here, once I get in, I can't get out…. everybody wants a piece of you, don't they and it's very, very difficult, to say, no I've got to go now, it is hard" p.1 (S2)
N3	"when they do the next course, if I could go and I won't be able to, if I could go onto do the supervision sessions with the people that do it next time, that would probably be the timing for me" p. 2 (S2)

4.3.3.1.3 'Maintenance'

Finally, both participants and trainers highlighted an area for change in the programme in this subtheme. Participants discussed the importance of maintaining their learning through on-going groups, reading materials or refresher sessions to support their application of CFA to supplement, consolidate and maintain their learning (N1, Table 4.14).

Trainers raised their own quandaries about the exclusion of a maintenance plan within the programme protocol as it became an important aspect for the participants. T1 noted that ending the programme with no follow up was not satisfactory (Table 4.14). The trainers were keen to develop a group for graduates of the programme interested in maintaining and building upon their learning in CFA.

Table 4.14. The importance of maintenance

Participant	Quotation
N1	"I always find that, is that you forget it, or you don't really use it, it would be good, to have a refresher, say, a couple of hours every three months or something, just to um, I guess everybody's got the soothing now because that's but it would be good say, let's just have a brief practice on self-soothing but going over certain aspects of the model or how it's used, how people have been using it in practice, and getting people who have sort of used it, um to say how they've been using it that would be good, because that would just refresh your mind" p.12 (S2)
T1	"I think is a dilemma because it's not in the protocol, it's not in the programme and it's, so there's a kind of, there is something about how would we help people take that forward and support it, either as peer supervision or something else wider that they can connect into" p.2 (S2)

4.3.4 Additional information

Participants and trainers were explicitly asked what they would like to keep/change for stages 1 and 2, and, the programme as a whole. This information is summarised in Appendix AI.

4.4 Discussion

4.4.1 Summary and Clinical Implications

This qualitative service evaluation of a new course initiative at CU for nurse mentors demonstrated that the participants were able to utilise CFA within their mentoring roles (Theme 1: Utility of the Model) and that CFA approach was valued by participants (Theme 2: Receptiveness). This suggested that CFA may have a place in nurse mentor training. Theme 3: Learning, highlighted areas participants identified as important to the learning process. These themes are discussed in more detail below.

4.4.1.1 'Utility of the Model'

Participants and trainers provided clear accounts of the application of specific CFA concepts/skills to nurse mentoring. Specifically, participants' use of the three systems model (threat, drive and soothing) for themselves and with mentees (e.g., recognising and managing the activation of the threat system). This could address processes that impede mentee learning when the threat system is activated (e.g., mentee shame; Bond, 2009; Johnson, 2012).

Participants reported that CFA enabled them to address difficulties in mentee behaviour and how to implement changes in these. This was facilitated by the use of the supervision model developed in the programme. Addressing such difficulties using CFA may help mentors approach students in ways that decreases the activation of shame/self-criticism mechanisms in students. This may facilitate better learning outcomes within the practice learning environment.

Finally, the mentors' use of self-soothing techniques to manage challenging work situations may enhance the practice environment.

4.4.1.2 'Receptiveness'

This theme emphasised the extent of engagement and socialisation of participants to CFA (e.g., the participants' enjoyment of the programme, their descriptions of engaging and applying CFA professionally and personally; the expressed enthusiasm to disseminate information to their work colleagues). This, alongside descriptions of role modelling CFA to students and colleagues, may begin to positively influence their working/practice learning environments (e.g. Buante et al., 2012; Epstein & Carlin, 2012; Francis, 2013) optimising student learning experiences.

These two themes suggested that CFA is an acceptable approach for nurse mentors to use in their mentoring practice. What is yet to be established is whether this would enhance the mentor-mentee relationship and if participants' embodiment of CFA would have a direct influence on practice environments.

The evidence here suggested the mentors apply CFA to themselves and that CFA heightens their understanding of the students' position (e.g., which systems are active for the student). Therefore mentors would be more effective in the mentoring and care of students with CFA enabling better student-mentor relationships/practice learning environments (Buante et al., 2012; Bond, 2009), where student nurses feel welcomed (Lofmark & Wikblad, cited in Buante et al., 2012).

It is hoped that if mentors actively recognise the systems activated in students (e.g., the threat system), then there would be increased opportunities to support students to manage shame/self-criticism responses using CFA techniques (e.g., mentors enabling students to access their soothing system from which they may be able to learn more effectively). This might assist in the development of positive practice learning environments where students are enabled to reflect on their experiences and learn from these throughout their training.

Further, CFA offers an evidence base to participants which supports their mentoring practice. Potentially, the dissemination of their training in CFA and, the skills they have developed in managing the activation of their own threat systems, might be accessed at times when their practice environments become difficult and/or they become engaged in challenging exchanges with less receptive colleagues (as highlighted for example in Francis, 2013).

4.4.1.3 'Learning'

Dedicated space and a mixture of nursing disciplines added a unique dimension to the participant learning process on the programme. The "fusion" between psychology and nursing in the trainers also appeared beneficial to participants' and trainers' learning. It is unclear how much influence each of these aspects had on the learning process.

All participants and trainers highlighted the value of a formal way of maintaining their learning. Suggestions included on-going supervision, refresher sessions and/or a handbook which had not been included in the programme. For those participants who did not complete the programme the opportunity to attend supervision sessions of subsequent programmes was raised. The areas identified here provide valuable information for the development and delivery of future programmes in CFA for nurse mentoring.

4.4.2 Limitations of the evaluation

Two participants and both trainers were not interviewed after Stage 1 of the programme. One participant was unable to be interviewed due to personal circumstances. One participant and the trainers provided written responses to the semi-structured interview; however, these responses lacked the richness gained through the interview process.

No quantitative data was gained to support the participants' qualitative data. Such information would help demonstrate further the reported use of self-compassion techniques such as self-soothing, through the use of self-monitoring including diaries or self-compassion scales (e.g. Neff 2003) prior to the start of the programme and following stages 1 and 2. This would be an area for future service evaluations.

4.4.3 Recommendations

These preliminary findings result in the following recommendations:

4.4.3.1 Integration of CFA within Nurse Mentor Training

CFA was demonstrated to be accessible to nurse mentor participants and they were able to apply CFA within their role as a mentor. Therefore, it would be important to build on this through the integration of CFA into nurse mentor training, including offering the programme to nurse mentors to complement the existing nurse mentor preparation training and mentor update courses.

4.4.3.2 Maximising Learning for future CFA programmes

Elements pooled from the thematic analysis and the additional information (Appendix AG) would suggest the following to maximise learning within future CFA programmes:

Participants valued the opportunity to learn from a mix of nursing disciplines noting that this enhanced their learning experience. This would be a consideration for future programmes. Additionally, all participants highlighted the importance of on-going supervision to maintain their new skills, which is a further recommendation. Finally, participants and trainers noted that the content of day two (stage one of the programme) was too dense and that the information needed to be spread across the remaining days, to help participants assimilate the information.

4.4.3.3 Maximising Attendance

The feedback obtained from all the participants suggested that to maximise attendance for future programmes the following changes are recommended:

A preliminary meeting between the trainers and prospective participants is arranged to discuss the course outline, its demands, and the competing stresses of participants'

work/home life. This would provide an opportunity to collaboratively consider whether prospective participants could commit to the current programme.

The option for future participants to attend the supervision sessions of subsequent programmes was highlighted as important by participants who did not complete the programme. These participants emphasised the opportunity for a longer period of time to assimilate their learning between the stages of the programme and/or to manage external factors that impact on their attendance on the programme.

In line with feedback (Appendix AI) it would be useful to review the current marketing materials for the programme and their dissemination. In particular, providing explicit information on aims and objectives of the course; what is required of participants and orientation materials (e.g., pre-course reading).

4.4.3.4 Building an evidence base

Future CFA-MPs nurse mentoring programmes should be appropriately evaluated. The current evaluation did not include any quantitative data to support the qualitative accounts. Such data could include compassion measures such as the self-compassion scale (Neff, 2003) and compassion for others scale (Sprecher & Fehr 2005). Data could be collated prior to the programme, then after stages 1 and 2, and then at regular follow up intervals (irrespective of a developed maintenance programme).

Further evaluations could investigate the effects of student nurses' practice learning experience for those directly mentored by CFA trained mentors. This could include examining areas such as the quality of the student-mentor relationship; considering whether the approach improves the students' general learning of nursing practices; and whether there are any changes the student practice milieu that disconfirm previous

research findings such as those where students report a lack of respect (Epstein & Carlin, 2012) or feeling excluded (Charlston & Happell, 2005 cited in Epstein & Carlin, 2012).

4.4.5 Dissemination

Prior to the submission of this thesis, the service evaluation information findings were disseminated to the service. Firstly, a brief PowerPoint presentation following data collation/during the early stages of analysis to provide some preliminary themes (see Appendix AJ). Secondly a truncated version of the report (see Appendix AK) was submitted to colleagues at CU involved with nurse training (i.e. Head of School of Nursing, Midwifery and Health, Associate Dean Quality and Accreditation and the Strategic Lead for Nursing). It was anticipated that this truncated report would be submitted to Health Education England: West Midlands as part of the evidence for ECQ 2015/16 following consultation with the above colleagues. Additionally, a summary of the evaluation would be presented to practice partners who support nurse training at CU through partnership and strategic placement meetings. All participants in the study would receive a copy of the report.

4.5 Critical appraisal

The main weakness of this evaluation has been the lack of quantitative data and suggestions on how to take this forward have been addressed in the recommendations section. Additional weaknesses include the potential biasing of the data as not all participants were actively mentoring and therefore unable to directly apply the skills to mentoring practice. Furthermore most of the participants were involved in the education of nurses (e.g., practice educators, mentor trainers, lecturers) and senior

members of the profession. Therefore a positive bias towards the programme may be present from those invested in developing nurse mentoring.

The strengths of this evaluation included the qualitative methodology as it provided a vehicle for the collation and analysis of rich data from both participants and trainers, which is pertinent given the small sample size (n=8).

Often data from participants that discontinue programmes under evaluation is lost and opportunities to uncover contributing factors to this are missed. In this evaluation, data was obtained from participants who did not complete the programme, and this provided valuable insights that may help maximise attendance rates in future programmes.

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APPENDICES

Appendices for Literature Review

Appendix A. Summary of quality assessment scores for the reviewed papers[32].

First Author Date	Preliminaries [Score 0-5]	Introduction [Score 0-5]	Design [Score 0-5]	Sampling [Score 0-5]	Data Collection [Score 0-5]	Ethical Matters [Score 0-5]	Results [Score 0-5]	Discussion [Score 0-5]	Total Score % [/40]
Beaumont 2017	3	4	3	1	2	1	3	3	50% [20]
Bohecker 2016	4	4	4	4	4	1	4	4	70% [28]
Cohen 2009	4	4	4	2	3	1	4	3	67.5% [27]
Collard 2008	4	5	3	2	4	3	4	4	73% [29]
Finaly-Jones 2016	5	5	3	4	3	1	5	5	77.5% [31]
Grepmair 2007a	5	4	4	4	4	4	4	4	83% [33]
Grepmair 2007b	3	3	4	2	3	3	3	4	62.5% [25]
Hopkins, 2013	4	5	3	4	3	3	4	3	72.5% [29]
Ivanovic 2015	5	4	3	3	4	2	4	3	70% [28]
Leppma 2016	2	5	4	3	3	3	5	4	72.5% [29]
Lesh 1970	1	4	4	2	4	2	4	5	65% [26]
Moore 2008	3	5	3	3	4	3	4	4	72.5% [29]
Pakenham 2015	4	5	1	2	3	3	4	4	65% [26]
Rimes 2011	4	1	1	2	3	3	3	4	52.5% [21]
Rodriguez Vega 2014	3	5	2	3	4	4	4	4	72.5% [29]
Schomaker 2015	3	5	3	3	3	3	4	4	70% [28]
Shapiro 2007	4	5	4	3	4	1	5	4	75% [30]
Stafford-Brown 2012	4	5	3	4	4	2	4	4	75% [30]
Swift 2017	4	5	3	4	4	1	5	4	75% [30]

[32] Scores highlighted are 2 or below

Appendix B. Summary of the types of MBI, the protocol used and the delivery of the MBI.

Type of MBI	Number of studies	Number using standard Protocol	Number using Adapted Protocol	Number where Protocol not specified	Number Facilitated	Number Not facilitated	Authors
MBSR	4	2			2		Shapiro, Brown and Biegel, (2007), Rodriguez Vega et al., (2014)
			2		2		Cohen and Miller, (2009), Schomaker & Ricard, (2015)
MBCT	3	3			3		Collard, Anvy and Boniwell, (2009), Hopkins and Proeve, (2013), Rimes and Wingrove, (2010)
Zen	3			3	2		Grepmair, Mitterlehner, Loew, Bachler, Rother, and Nickel, (2007a), Grepmair, Mitterlehner, Loew and Nickel, (2007b)
						1	Lesh, 1970
CMT	2		1		1		Beaumont, Rayner, Durkin and Bowling, (2017)
			1			1	Finlay-Jones, Kane and Rees (2016)
ACT	2			2	2		Pakenham, 2015; Stafford-Brown and Pakenham, 2012
MT	2	2			2		Ivanovic, Swift, Callahan, and Dunn, (2015), Swift, Callahan, Dunn, Brecht, and Ivanovic (2017)
MESG	1			1	1		Boheker and Doughty Horn, (2016)
LKM	1			1	1		Leppma and Young (2016)
Vipassana	1			1		1	Moore (2008)
Totals	**19**	**8**	**3**	**8**	**16**	**3**	

Appendix C. Summary of facilitators' experience of facilitating the specific MBI and additional supervision.

Type of MBI	Number of studies	Number of studies facilitated	Number of studies where experience of MBI facilitators specified	Authors where facilitator experience stated	Type of Experience and where specified additional supervision/advice
MBSR	4	4	3	Cohen and Miller (2009)	The facilitator was an experienced mindfulness teacher and practitioner with advanced training in mindfulness and related techniques
				Rodriguez Vega et al. (2014)	A consistent co-therapist across all MBSR groups who was personally trained and was experienced in Tibetan mindfulness practice and had attended MBSR training
				Schomaker and Ricard (2015)	The facilitators were mindfulness practitioners and the primary instructor completed 1 year of mindfulness study and practice. There was an advisory instructor trained in MBCT with over 4 years of practice
MBCT	3	3	3	Collard et al. (2008)	Minimal experience noted with the full MBCT programme
				Hopkins and Proeve (2013)	The facilitator had completed MBCT training and received on-going supervision from an experienced instructor to insure adherence
				Rimes and Wingrove (2010)	The facilitators were undertaking a post-graduate certificate in mindfulness based approaches. However, the training course was not specifically MBCT
Zen	3	2	2	Grepmair et al. (2007a),	A Zen master
				Grepmair et al. (2007b)	A Zen master
CMT	2	1	0		
ACT	2	2	1	Stafford-Brown & Pakenham (2012)	The facilitator had extensive training, clinical experience and on-going supervision in ACT
MT	2	1	1	Swift et al., (2017)	Three researchers led the different groups each with personal experience with mindfulness practice
MESG	1	1	1	Bohecker and Doughty Horn (2016)	The facilitators were doctoral level students with intensive training in the MESG curriculum and supervision from first author
LKM	1	1	0		
Vipassana	1	0			
Totals	19	16	11		

Appendix D. Summary of the improvements in wellbeing and life satisfaction for TPTs following their participation in MBIs

Summary of the improvement in psychological distress and social connectedness for TPTs post MBI

Measure	MBI	Number of studies (Percentage of those studies) indicating:		Authors and level of significance (where applicable)	Quality: High (>70%), Good (60-69%), Moderate (50-59%)
		Improvement	No Change		
GENERAL MENTAL HEALTH					
General Health Questionnaire (**GHQ-28;** Goldberg, 1978)	ACT	1 (50%)*	1 (50%)	Pakenham (2015)/ Stafford-Brown and Pakenham (2012) $p<.05$	Good /High
STRESS					
Perceived Stress Scale (**PSS;** Cohen, Kamarck, & Mermelstein, 1983)	MBSR	1 (100%)		Shaprio, Brown and Biegel (2007) $p=.0001$	High
	CMT/MAB	1 (100%)	-	Finaly-Jones, Kane and Rees (2016) $p<.001$ effect size $d=.85$	High
Perceived Stress Scale (**PSS14;** Cohen, Kamarck, & Mermelstein, 1983)	Vipassana	-	1 (100%)	Moore (2008)	High
PSS14/PSS	MBCT	-	2 (100%)†	Hopkins and Proeve (2013)/Rimes and Wingrove (2011)	High/ Moderate
Stress Subscale (Depression Anxiety and Stress Scales [DASS-21], Lovibond & Lovibond, 1995)	CMT/MAB	1 (100%)	-	Finaly-Jones, Kane and Rees (2016) $p<.001$ effect size $d=.85$	High
Mental Health Professional Stress Scale (**MHPSS;** Cushway, Tyler, & Nolan, 1996)	ACT	1(50%)‡	1 (50%)	Pakenham (2015)/ Stafford-Brown and Pakenham (2012) $p<.05$	Good/High

* The reduction in caseness in the MBI group was maintained at ten weeks follow-up with minimal change in caseness for the control group (Stafford-Brown & Pakenham, 2012)

† Significant decreases in stress post MBI for first year TPTs (p=.028 Rimes &Wingrove, 2011)

‡ Professional Self-doubt subscale only (Stafford-Brown & Pakenham, 2012)

Measure	MBI	Number of studies (Percentage of those studies) indicating:		Authors and level of significance (where applicable)	Quality: High (>70%), Good (60-69%), Moderate (50-59%)
		Improvement	No Change		
ANXIETY					
State-Trait Anxiety Inventory (**STAI;** Spielberger, Gorsuch & Lushene, 1982) STAI: **State** Anxiety	MBSR	2 (100%);	-	Rodriguez Vega et al. (2014) *p*=.002; Shaprio Brown and Biegel, (2007) *p*=.04	High
STAI: **Trait** Anxiety	MBSR	1 (50%)	1 (50%)	Rodriguez Vega et al., (2014); Shaprio, Brown and Biegel (2007) *p*=.0002	
Beck Anxiety Inventory (BAI; Beck 1990)	MBSR	1 (100%)	-	Cohen and Miller (2009) *p*<.05 effect size *d*=.47	High
Anxiety Subscale (**Depression Anxiety and Stress Scales** [**DASS-21],** Lovibond & Lovibond, 1995)	CMT/MAB	1 (100%)	-	Finaly-Jones, Kane and Rees (2016) *p*=.003 effect size *d*=.52	High
Anxiety Subscale **(Hospital Anxiety and Depression Scale** [**HADS],** Zigmond & Snaith, 1983)	MBCT		1 (100%)	Rimes and Wingrove (2011)	Moderate
RUMINATION					
Rumination-Reflection Questionnaire (**RRQ;** Trapnell & Campbell, 1999)	MBCT	1 (100%)	-	Rimes and Wingrove (2011) *p*<.0005	Moderate
	MBSR	1 (100%)	-	Shaprio, Brown and Biegel (2007) *p*=.0006	High
DEPRESSION					
Beck Depression Inventory (**BDI;** Beck & Steer, 1993)	MBSR	1 (100%)	-	Rodriguez Vega et al., (2014) *p*=.029	High
Depression Subscale(**Depression Anxiety and Stress Scales** [**DASS-21],** Lovibond & Lovibond, 1995)	CMT/MAB	1 (100%)	-	Finaly-Jones, Kane and Rees (2016) *p*=.002 effect size *d*=.54	High
Centre for Epidemiological Studies-Depression (CESD; Radloff, 1977)	MBSR	-	1 (100%)	Cohen and Miller (2009)	High
Depression Subscale **The Hospital Anxiety and Depression Scale** [**HADS],** Zigmond & Snaith, 1983)	MBCT	-	1 (100%)	Rimes and Wingrove (2011)	Moderate

Measure	MBI	Number of studies (Percentage of those studies) indicating:		Authors and level of significance (where applicable)	Quality: High (>70%), Good (60-69%), Moderate (50-59%)
		Improvement	No Change		
AFFECT					
Positive and Negative Affect Schedule (**PANAS;** Watson, Clark & Tellegen, 1988). **Positive Affect**	MBCT	-	1 (100%)	Collard, Anvy and Boniwell (2008)	High
	MBSR	1 (100%)	-	Shaprio, Brown and Biegel (2007) *p*=.0002	High
Negative Affect	MBCT	1 (100%)	-	Collard, Anvy and Boniwell (2008) *p*<.05 effect size *r*=.54	High
	MBSR	1 (100%)	-	Shaprio, Brown and Biegel (2007) *p*=.04	High
ANGER					
State-Trait Anger Expression Inventory-2 (**STAXI-2;** Spielberger, 1999) STAXI-2 **State** Anger	MBSR	-	1 (100%)	Rodriguez Vega et al. (2014)	High
STAX-2I **Trait** Anger		1 (100%)	-	Rodriguez Vega et al. (2014) *p*=.001	
HAPPINESS					
Authentic Happiness Inventory (**AHI;** Peterson & Park, 2008)	CMT	1 (100%)	-	Finaly-Jones, Kane and Rees (2016) *p*<.001 effect size *d*=.59	High
SOCIAL CONNECTEDNESS					
Social Connectedness Scale-Revised (SCS-R; Lee, Draper & Lee, 2001)	**MBSR**	**1 (100%)**		**Cohen and Miller (2009)** *p<.002*, *d*=.59	**High**

Summary of improvements with life satisfaction for TPTs pre-post MBI.

Measure	MBI	Number of studies indicating (Percentage of those studies)		Authors	Quality High (>70%), Good (60-69%), Moderate (50-59%)
		Improvement	No Change		
Meaning in Life Questionnaire (**MLQ;** Steger, Frazier, Oishi & Kaler 2006)	MBSR	-	1 (100%)	Cohen and Miller (2009)	Good
Satisfaction With Life Scale (SWLSa; Pavot & Diener 1993**)**	MBSR	1 (100%)	-	Cohen and Miller (2009) $p<.01$ $d=.45$	Good
Satisfaction With Life Scale (SWLSb; Diener, Emmons, Larsen & Griffin, 1985)	MBCT	-	1 (100%)	Collard et al. (2008)	High
	ACT	-	1 (100%)	Stafford-Brown and Pakenham (2012)	High

Appendix E. Summary of improvements for therapeutic skills measures post MBI and TPTs' Mindfulness-Based skills post MBI.

Summary of improvements for therapeutic skills measures post MBI

Skills Measure	MBI	Number of studies indicating (Percentage of those studies)		Authors	Quality High (>70%), Good (60-69%), Moderate (50-59%)
		Improvement	No Change		
EMPATHY					
Interpersonal Reactivity Index (**IRI;** Davis, 1980)	CMT	-	1 (100%)	Beaumont, Rayner, Durkin and Bowling (2017)	Moderate
	MBCT	-	2(100%)*	Hopkins and Proeve (2013)/ Rimes and Wingrove (2011)	High/ Moderate
	MESG	1(100%)	-	Bohecker and Doughty Horn (2016) *p*=.007	High
	LKM	-	1(100%)†	Leppma and Young (2016)	High
Affective Sensitivity Scale (**ASS;** Kagan, Krathwohl, & Farquhar 1965; Kagan et al., 1967)	Zen	1(100%)	-	Lesh (1970) *p*<.01	Good
COMPASSION					
Compassion for Others Scale (**CFOS;** Pommier, 2011)	CMT	-	1(100%)	Beaumont, Rayner, Durkin and Bowling (2017)	Moderate
Self-Compassion Scale (SCS; Neff, 2003)	MBCT	1 (100%)		Rimes and Wingrove (2011) *p*=.016	Moderate
	MBSR	1 (100%)		Shaprio, Brown and Biegel, (2007) *p*=.0001	High
	ACT	1 (50%)	1(50%)*	Pakenham (2015)/ Stafford-Brown and Pakenham, (2012) *p*<.001	Good/High

* For the Fantasy subscale only (Hopkins & Proeve , 2013) *p*<.01

† For the Empathic Concern subscale only (Leppma & Young, 2016) *p*=.006

* For the Self-Kindness only (Pakenham, 2015) p<.05

	CMT	2 (100%)		Beaumont, Rayner, Durkin and Bowling, (2017) p=.022/ Finaly-Jones, Kane and Rees (2016) p<.001, d=.86	Moderate/ High
	Vispassana	1 (100%)*		Moore, (2008)	High
EMOTIONAL INTELLIGENCE					
Self-Report of Emotional Intelligence (SREIT; Shutte et al., 1998)	MBSR	1 (100%)	-	Cohen and Miller (2009) p<.05, effect size d=.40	Good
Skills Measure	MBI	Number of studies indicating (Percentage of those studies)		Authors	Quality High (>70%), Good (60-69%), Moderate (50-59%)
		Improvement	No Change		
EMOTIONAL REGULATION					
Difficulties in Emotion Regulation Scale (**DERS;** Gratz & Roemer, 2004)	CMT	1 (100%)	-	Finaly-Jones, Kane and Rees (2016) p<.001 d=.62	High
SELF- DEVELOPMENT: OPENNESS TO EXPERIENCE					
The Experience Inquiry (TEI; Fitzgerald 1966)	Zen	1(100%)		Lesh (1970) p=.05	Good
SELF-EFFICACY					
Counseling Self-Estimate Inventory (**COSE**; Larson et al., 1992)	MESG	1(100%)	-	Bohecker and Doughty Horn (2016) p=.025	High
Counselor Activity Self-Efficacy Scales-Helping Skills (**CASES**; Lent, Hill, & Hoffman, 2003)	ACT	2(100%)	-	Pakenham (2015) p<.05/ Stafford-Brown and Pakenham (2012) p<.05	Good/High
ATTENTIONAL CONTROL					
Stroop task (Stroop, 1935)	MBSR	1(100%)•	-	Rodriguez Vega et al. (2014) p=.023 and p=.046	High
Continuous Performance Test (**CPT**; Rosvold, Mirsky, Sarason, Bransome, & Beck 1956)	MBSR	-	1(100%)	Rodriguez Vega et al. (2014)	High

• Increase **Variable Errors** p=.023 and **Perseverations** p=.046 in the control group

THERAPIST ALLIANCE					
Working Alliance Inventory-Short Form (**WAI-SF**; Tracey & Kokotovic, 1989)	ACT	-	2(100%)[‡ ǂ]	Pakenham (2015) *p*<.05 /Stafford-Brown and Pakenham (2012) *p*<.05	Good /High

Summary of improvements in TPTs development of mindfulness-based skills post MBI.

Measure	MBI	Number of studies indicating (Percentage of those studies)		Authors	Quality High (>70%), Good (60-69%), Moderate (50-59%)
		Improvements	No Change		
MINDFULNESS					
Five Facet Mindfulness Questionnaire (**FFMQ**; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006)	MESG	1 (100%)	-	Bohecker and Doughty Horn (2016) , *p*=.023	High
	ACT	1 (100%)	-	Pakenham (2015) *p*<.001	Good
	MBCT	1 (50%)	1(50%)[*]-	Rimes and Wingrove (2011) *p*=.0008/Hopkins & Proeve (2013)	Moderate/ High
	Mindfulness Training Programme (MTP)	1 (100%)		Swift et al. (2017) p<.001	High
Mindfulness Attention Awareness Scale (MAAS; Brown and Ryan 2003)	MBSR	3 (100%)	-	Cohen and Miller (2009) *p*=.005, *d*=.49/ Rodriguez Vega et al. (2014) *p*<.001/ Shaprio, Brown and Biegel (2007) *p*=.006	Good/High /High
Freiburg Mindfulness Inventory (FMI; Walach, Buchheld, Buttenmuller, Kleinknecht, & Schmidt, 2006)	MBCT	1 (100%)	-	Collard, Anvy and Boniwell (2008) *p*<.05	High

[‡] Pakenham (2015) Client therapist Alliance *p*<.05 and Goal subscale *p*<.05

[ǂ] Stafford-Brown and Pakenham (2012) Bond subscale only

[*] Hopkins and Proeve (2013) had significant improvements on selected subscales only but not overall score: Observe: *p* <.05; Non-judge: *p*<.01; Non-react: *p*<.01.

Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004)	Vipassana	1 (100%)	-	Moore (2008) *p*=.04	High
Toronto Mindfulness Scale (TMS; Lau et al., 2006)	MTP	1 (100%)		Swift et al. (2017) p<.05	High
ACCEPTANCE					
Acceptance and Action Questionnaire (**AAQ**; Bond & Bunce, 2003)	ACT	2 (100%)	-	Pakenham (2015) *p*<.001/Stafford-Brown and Pakenham (2012) *p*<.05	Good/High
COGNITIVE DEFUSION					
The White Bear Suppression Inventory (**WBSI**; Wegner & Zanakos, 1994)	ACT	2 (100%)	-	Pakenham (2015) *p*<.001/Stafford-Brown and Pakenham (2012) *p*<.05	Good/High
VALUES					
Valued Living Questionnaire (**VLQ**; Wilson, Sandoz, Kitchens & Roberts, 2010)	ACT	2 (100%)	-	Pakenham (2015) *p*<.001/Stafford-Brown and Pakenham (2012) *p*<.001	Good/High

Appendices for Empirical Paper

Appendix F. Flyer for the CFA-MP

Free training in a Compassion Focused Approach to Mentoring

Coventry University has secured funding for **free training** in a Compassion Focused Approach to Mentoring (CFAM). Free places are available for up to 36 Nurse Mentors of Coventry University Mentees. CFAM is a new model to help Mentors to use compassion more effectively in their everyday practice with Mentees. **To support attendance staff backfill funding is available for employers.**

What are the benefits of attending the course?

For the individual:

- Enhances wellbeing and emotional resilience
- Enables individuals to further their personal, career and professional development
- Strengthens individuals skills in supporting learners in the work place

To the employer:

- Enhances staff's ability to deliver compassionate care
- Enhances staff's physical and mental well being
- Strengthens the individual skills to support junior members of staff and learners

Course Overview

The course comprises of a five day workshop and 10 follow-up sessions. The 5 day course will introduce key concepts and skills used in the Compassion Focused Approach (CFA) will provide further opportunities for practice and for reflection on using the CFA model for yourself and with your Mentees. The workshop will use a variety of teaching methods in a supportive learning environment.

We will be evaluating the course and be asking for your participation and feedback.

Course Dates

The course will begin on the [redacted]. The five day workshop will run from 9.30 am – 4.30 pm between the [redacted]. Weekly follow-up sessions last for 2 hours (5.30pm to 7.30pm) and take place over 10 consecutive weeks commencing [redacted]. Training will be held at Coventry University.
Attendance on both parts of the course is required.

To find out more and to book a place: please email [redacted] and include your contact details by [redacted].

Appendix G. Participant information sheets

Participant information sheet for the CFA-MP

PARTICIPANT INFORMATION SHEET

Study Title:

Compassion Focused Approach to Nurse Mentoring

Invitation:

I'd like to invite you to take part in a research study which is being undertaken myself, Jo Kucharska (Lead Researcher) as part fulfilment of a Doctor of Psychology Course at the University of Leicester. The research will be supervised by Steven Allan (Academic Supervisor, University of Leicester).

Joining the study is entirely up to you, before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through this information sheet with you, to help you decide whether or not you would like to take part and answer any questions you may have. I'd suggest this should take up to 30 minutes. Please feel free to talk to others about the study if you wish.

The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part.

Then we give you more detailed information about the conduct of the study.

Do ask if anything is unclear.

Summary

This research intends to evaluate the effect of a training programme in the Compassion Focused Approach to Mentoring (CFAM). In particular the effect on nurse mentoring practice and nurse mentors levels of compassion and well-being.

The training programme is an innovative project. It has been developed to help address some of the nurse mentoring literature which suggests that there can be considerable pressure on mentors to manage the competing demands of the workplace. Consequently, leading to experiences of increased stress, which within a Compassion Focused Approach (CFA0 would lead to an increased loss of “safety in the self”. If this is the case, it is possible that this would impact on a mentors ability to mentor student nurses as well as they would hope to. It is anticipated that training in a CFA will work with nurse to build on a sense of safeness through the compassionate mind training. By working with mentors directly, it is hoped that mentors can learn to recognise and understand when their own systems of threat (lack of safety) are activated and learn to manage these. When mentors are proficient with this, it is hoped that they would then be able to recognise this within student nurse and help them to manage these systems and therefore enhance student learning in practice education. Further, within

the context of nurse mentoring is it is possible to consider training in CFA may enhance student-mentor relationships and facilitate more helpful learning experiences in practice education.

The training programme has two parts:

A five day intensive training session on Compassion Focused Theory and Approaches which would take place over one working week;

Ten weekly group supervision sessions to facilitate the application of CFA to nurse mentoring.

Research Aims

The aim of the research is to would be to find out how if at all, this programme affects your approach to mentoring and your general well-being and quality of life at work.

Who is eligible to participate in the research?

All participants attending the CFAM training programme to be held at Coventry University are invited to attend.

All participants:

- Are between the ages of 18 and 65 years;
- Should be able in the opinion of the Investigator, and willing to give informed consent;
- Must have their manager's approval to attend the programme;
- Be qualified nurses who are eligible to mentor student nurses enrolled on nursing programmes at Coventry University;
- Work within local NHS Trusts for practice placements;
- Be fluent in English and hold the relevant qualifications for nurse mentoring.

What's involved?

Mentors participating in the programme will be asked to complete a number of questionnaires. They will be asked to read four mentoring scenarios and asked to write responses to them. There will be no right or wrong answers to any of these, as I am interested in your views and experiences. The questionnaires and the scenarios will take no more than an hour to complete.

The questionnaires and the scenarios will be given to you to complete at 4 stages. The questionnaires and scenarios will be completed at the beginning and end of the five day training programme, and at the tenth supervision session. Time will be allocated within the training and supervision days for you to complete these. The final data collection will occur 2

months after the supervision sessions finish. Therefore the extra demand on your personal time will be approximately 1 hour.

At the start of each supervision session and at the 2 month follow up, you will be asked to complete a very brief questionnaire on your use compassion focused practice exercises and how helpful you have found them.

In summary your participation in the study will end once you have completed the 2 month follow up questionnaires.

Confidentiality

The facilitators will not have access to your responses and they will be placed in an envelope for collection by the lead researcher (Jo Kucharska).

All participants will therefore be allocated a number to write on their questionnaires and scenario pack at each time period. The only person who will have access to the personally identifiable data collected in this study will be the lead researcher.

The data gained from these questionnaires and scenarios will be anonymised and you will not be able to be identified. All anonymised data will analysed as part of a doctoral thesis and consequently, it will be shared with the research supervisor. Further, you will not be identifiable in any shared anonymised data including direct quotations in any presentations or publications. If for any reason a direct quotation does compromise your anonymity, the lead researcher will contact you directly to ask for your consent to share this information in any presentations or publications.

All anonymised study data may be looked at by authorised individuals from the University of Leicester (who sponsor the research) or the appropriate NHS R&D departments for monitoring and audit purposes.

How will information be stored?

Your consent forms and all anonymised data information will initially be held securely in a locked filing cabinet at the university of Leicester. Any electronic data will be stored on a password protected computer and/or encrypted data stick. On completion of the study, the data will be stored securely at the University of Leicester for 5 years in line with the university's procedures (at which it will be destroyed)

Will participating in this study be distressing?

It is unlikely that completing the questionnaires or scenarios will create distress. If however they do so, the programme facilitators will be on hand to sign post you to the appropriate support services if required. In the event that your wellbeing questionnaire responses indicate you may require additional support the lead researcher will contact you directly to signpost you to appropriate support.

What if I am harmed by the study?

It is very unlikely that you would be harmed by taking part in this type of research study. However, if you wish to complain or have any concerns about the way you have been approached or treated in connection with the study, you should ask to speak to Jo Kucharska (Lead Researcher Tel: 0116 229 7198) or Steve Allan (Academic Supervisor Tel: 0116 223 1650) who will do their best to answer your questions.

In the event that something does go wrong and the you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against University of Leicester but you may have to pay your legal costs. Further, normal National Health Service complaints mechanisms will still be available to you (if appropriate).

What will happen to the information from this study?

1. The results will be disseminated to participants, if requested; senior staff in the relevant Trust organisations, staff at Coventry University involved in nurse mentoring and nurse training. The research project will also be submitted for publication in a scientific journal, or presented at scientific conferences.

It is possible that your data, in accordance with the requirements of some scientific journals and organisations, may be shared with other competent researchers. The coded data may also be used in other related studies. Your name and other identifying details will not be shared with anyone.

Can I withdraw from the study?

Participation in this research is voluntary. Anyone who decides not to take part in the research is free to withdraw at any time up until tenth supervision without giving a reason. I can let the lead researcher know via email or telephone by using the contact details below before the last supervision session to ask for your data to be destroyed. If you do not do so, the anonymised data already collected from you, may be used in the analysis and write up/publication of the research.

The lead researcher/person responsible for the research is:

Jo Kucharska (Post Graduate Student, Department of Neuroscience, Psychology and Behaviour,
Doctor of Psychology Programme, University of Leicester).

If there are any queries or concerns please contact Jo on:

Email: jmk25@le.ac.uk

Phone: 0116 2297198

Participant information sheet for follow-up interviews

PARTICIPANT INFORMATION SHEET

Study Title:

Compassion Focused Approach to Nurse Mentoring – Follow Up Interview

Invitation:

Thank you for taking part in the Compassion Focused Approach to Nurse Mentoring Study. I would now like to invite you to take part in a follow up interview as part of this research study. As you will previously be aware which is this study id being undertaken myself, Jo Kucharska (Lead Researcher) as part fulfilment of a Doctor of Psychology Course at the University of Leicester. The research will be supervised by Steven Allan (Academic Supervisor, University of Leicester).

Taking part in a follow up interview is entirely up to you, before you decide I would like you to understand why the research is being done and what it would involve for you.

The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part.

Then we give you more detailed information about the conduct of the study.

Do ask if anything is unclear.

Summary

This research intends to evaluate the effect of a training programme in the Compassion Focused Approach to Mentoring (CFA-M). In particular the effect on nurse mentoring practice and nurse mentors levels of compassion and well-being. What would be helpful to find out from a follow-up interview is what impact if any the training programme has had for nurse mentor participants.

As you will be aware the training programme is an innovative project. It has been developed to help address some of the nurse mentoring literature which suggests that there can be considerable pressure on mentors to manage the competing demands of the workplace. Consequently, leading to experiences of increased stress, which within a Compassion Focused Approach (CFA) would lead to an increased loss of “safety in the self”. If this is the case, it is possible that this would impact on a mentor’s ability to mentor student nurses as well as they would hope to.

The training programme had two parts:

A five day intensive training session on Compassion Focused Theory and Approaches which would take place over one working week;

Ten weekly group supervision sessions to facilitate the application of CFA to nurse mentoring.

Research Aims

The aims of the research are:

To learn how if at all, this programme affects your approach to mentoring and your general well-being and quality of life at work;

To find out what if any CFA-M practices have been applied and maintained by you after a minimum period of 12 months after the end of the programme.

Who is eligible to participate in the research?

All participants who attended the CFA-M training programme held at Coventry University.

What's involved?

Mentors participating in the programme will be asked take part in a semi-structured interview which would take place either by phone or face to face and would last about 40 minutes. The interviews will be an opportunity to reflect on the programme and discuss what if any practices developed on the programme were helpful to you and how if at all you have managed to maintain CFA-M. All interviews will be audio-recorded. Once they have been transcribed verbatim the recordings will be wiped. All transcripts will be annoymised.

Confidentiality

The facilitators will not have access to your responses. All audio recordings (before being transcribed) and transcripts will be held securely and confidentially and only I (Jo Kucharska, Lead Researcher) and/or Steve Allan (academic supervisor) will have access to them.

Further that all anonymised transcripts maybe looked at by authorised individuals from the University of Leicester (who sponsor the research) or the appropriate NHS R&D departments for monitoring and audit purposes.

All anonymised data will analysed as part of a doctoral thesis and consequently, it will be shared with the research supervisor. Further, you will not be identifiable in any shared anonymised data including direct quotations in any presentations or publications. If for any reason a direct quotation does compromise your anonymity, the lead researcher will contact you directly to ask for your consent to share this information in any presentations or publications.

How will information be stored?

Your consent forms and all anonymised data information will initially be held securely in a locked filing cabinet. Any electronic data will be stored on a password protected computer. On completion of the study, the data will be stored securely at the University of Leicester for 5 years in line with the university's procedures (at which it will be destroyed)

Will participating in this study be distressing?

It is unlikely that the interview will create distress. If however they do so, I will sign post you to the appropriate support services if required.

What if I am harmed by the study?

It is very unlikely that you would be harmed by taking part in this type of research study. However, if you wish to complain or have any concerns about the way you have been approached or treated in connection with the study, you should ask to speak to Jo Kucharska (Lead Researcher Tel: 0116 229 7198) or Steve Allan (Academic Supervisor Tel: 0116 223 1650) who will do their best to answer your questions.

In the event that something does go wrong and the you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against University of Leicester but you may have to pay your legal costs. Further, normal National Health Service complaints mechanisms will still be available to you (if appropriate).

What will happen to the information from this study?

The results will be disseminated to participants, if requested; senior staff in the relevant Trust organisations, staff at Coventry University involved in nurse mentoring and nurse training. The research project will also be submitted for publication in a scientific journal, or presented at scientific conferences.

It is possible that your data, in accordance with the requirements of some scientific journals and organisations, may be shared with other competent researchers. The coded data may also be used in other related studies. Your name and other identifying details will not be shared with anyone.

Can I withdraw from the study?

Participation in this research is voluntary. Anyone who decides not to take part in the follow up is free to withdraw at any time up until two weeks after the interview without giving a reason. You can let the lead researcher know via email or telephone by using the contact details below to ask for your data to be destroyed. If you do not do so, the anonymised data already collected from you, may be used in the analysis and write up/publication of the research.

The lead researcher/person responsible for the research is:

Jo Kucharska (Post Graduate Student, Department of Neuroscience, Psychology and Behaviour, Doctor of Psychology Programme, University of Leicester).

If there are any queries or concerns please contact Jo on:

Email: jmk25@le.ac.uk

Appendix H. Consent forms

Consent form for the CFA-MP

Participant Consent Form

Centre Number:

Study Number:

Participant Identification Number for this study:

CONSENT FORM

Title of Project: **[Compassion Focused Approach to Nurse Mentoring]**

Name of Researcher: **[Jo Kucharska]**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated today **[DATE:]** (version 4 20.10.15) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time up until the tenth supervision session without giving any reason. ☐

3. I understand that all my data will be anonymised and will be held securely and confidentially at the University of Leicester and that Jo Kucharska (Lead Researcher) and/or Steve Allan (academic supervisor) will have access to them. Further that all anonymised study data maybe looked at by authorised individuals from the University of Leicester (who sponsor the research) or the appropriate NHS R&D departments for monitoring and audit purposes. ☐

4. I will be able to obtain general information about the results of this research by stating how feedback will be given (e.g., by giving the researcher my email address now). ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Please turn over the page

If you would like to receive a summary of the results when the study is complete please provide your email address: _____

If you have further questions about this study, you may contact *Jo Kucharska via email on* jmk25@le.ac.uk or phone: 0116 2297198 This study was reviewed by the University of Leicester Psychology Research Ethics Committee (PREC). You may contact the Chair of PREC Professor Mark Lansdale at ml195@le.ac.uk if you have any questions or concerns regarding the ethics of this project.

Please note that this form will be kept separately from your data

Consent form for the follow-up interviews

Participant Consent Form

Centre Number:

Study Number:

Participant Identification Number for this study:

CONSENT FORM

Title of Project: **[Compassion Focused Approach to Nurse Mentoring – Follow Up]**

Name of Researcher: **[Jo Kucharska]**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **[DATE:]** (Version 1 15.12.17) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time up until two weeks after the interview without giving any reason. ☐

3. I understand that the recordings of the interviews will be wiped once they have been transcribed and they will be anonymised. All audio recordings (before being transcribed) and transcripts will be held securely and confidentially at the University of Leicester and that Jo Kucharska (Lead Researcher) and/or Steve Allan (academic supervisor) will have access to them.
   Further that all anonymised transcripts maybe looked at by authorised individuals from the University of Leicester (who sponsor the research) or the appropriate NHS R&D departments for monitoring and audit purposes. ☐

4. I will be able to obtain general information about the results of this research by stating how feedback will be given (e.g., by giving the researcher my email address now). ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Please turn over the page

If you would like to receive a summary of the results when the study is complete please provide your email address: _____

If you have further questions about this study, you may contact *Jo Kucharska via email on* jmk25@le.ac.uk or phone: [redacted]. This study was reviewed by the University of Leicester Psychology Research Ethics Committee (PREC). You may contact the Chair of PREC Professor Mark Lansdale at ml195@le.ac.uk if you have any questions or concerns regarding the ethics of this project.

Appendix I. Ethical approval, indemnity, NHS Research and Development (R & D)

Permission and relevant substantial amendment paperwork

Ethical Approval Letter from Leicester University

University Ethics Sub-Committee for Psychology

25/09/2015

Ethics Reference: 3290-jmk25-neuroscience,psychologyandbehaviour

TO:

Name of Researcher Applicant: Joanna Kucharska

Department: Psychology

Research Project Title: Compassion Focused Approach to Nurse Mentoring

Dear Joanna Kucharska,

RE: Ethics review of Research Study application

The University Ethics Sub-Committee for Psychology has reviewed and discussed the above application.

1. Ethical opinion

The Sub-Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:

I approve this application

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:

As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

4. Reporting requirements after ethical approval

You are expected to notify the Sub-Committee about:

- Significant amendments to the project
- Serious breaches of the protocol
- Annual progress reports
- Notifying the end of the study

5. Use of application information

Details from your ethics application will be stored on the University Ethics Online System. With your permission, the Sub-Committee may wish to use parts of the application in an anonymised format for training or sharing best practice. Please let me know if you do not want the application details to be used in this manner.

Indemnity

Our Ref: sdb6 2015-2016 – 279

29th October 2015

ESTATES AND FACILITIES MANAGEMENT DIVISION
University Road
Leicester
LE1 7RH
Tel: +44 (0)116 229 7631
Fax: +44(0)116 229 7633

To whom it may concern,

UNIVERSITY OF LEICESTER CLINICAL TRIAL/PROFESSIONAL INDEMNITY INSURANCE

Title of Study: Compassion Focused Approach to Nurse Mentoring

Chief Investigator: Ms Jo Kucharska

I confirm that the University of Leicester will provide Clinical Trials and Professional Indemnity insurance cover in respect of its legal liability in relation to the above trial within the UK only.

Any significant departure from the programme of research as outlined in the application (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be communicated to us.

The cover is provided subject to normal policy terms and conditions.

R&D Permission Letter

13 November 2015 – re-issue 4 December 2015

Ms J Kucharska
Doctorate Course in Clinical Psychology, HLS
Coventry University
Priory Street
Coventry
CV1 5FB

Dear Ms J Kucharska

Project Title: **Compassion Focused Approach to Nurse Mentoring**

REC Ref: **3290-jmk25-neuroscience,psychologyandbehaviour**

I am pleased to inform you that the R&D review of the above project is complete, and

The permission has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
Ethics Approval Letter		25.09.2015
Final R&D Form	189948/870707/14/317	
Final SSI	189948/873095/6/470/302506/335081	
Protocol	7	27.10.2015
Participant Information Sheet	5	02.11.2015
Consent Form	5	02.11.2015
Demographic Information	2	20.10.2015
Compassionate Activities Diary	2	20.10.2015
Vignettes	5	20.10.2015
Stress Subscale DASS	1	07.09.2015
The Compassion Attributes and Action Scales		
ProQOL_5_English	5	2009
General Health Questionnaire (GHQ-12)		

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF), to ICH-GCP standards (if applicable) and to NHS Trust policies and procedures. Permission is only granted for the activities agreed by the relevant authorities.

All amendments (including changes to the local research team and status of the project) need to be submitted to the REC and the R&D office in accordance with the guidance in IRAS. Any urgent safety measures required to protect research participants against immediate harm can be implemented immediately. You should notify the R&D Office within the same time frame as any other regulatory bodies.

It is your responsibility to keep the R&D Office and Sponsor informed of all Serious Adverse Events. All SAEs must be reported within the timeframes detailed within ICH-GCP statutory instruments and EU directives.

In order to ensure that research is carried out to the highest governance standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely

Letter requesting substantial amendment

[redacted],
Chair of Ethics Committee
Department of Neuroscience, Psychology and Behaviour
University of Leicester
University Road
Leicester
LE1 9HN

10th May 2016

Dear [redacted],

RE: Substantial Amendment: Compassion Focused Approach to Nurse Mentoring, ref: 3290-jmk25-neuroscience,psychologyandbehaviour

I would like to apply for a substantial amendment for my current research. When I originally contacted Research Governance at the University of Leicester, I was advised by Wendy Gamble, former Research Governance Manager, to complete a substantial amendment form via the IRAS system. I have been unable to access this and quote an email from the IRAS team explaining this:

"As your project does not include an NHS REC form it is not possible for you to generate the Notice of Substantial Amendment form in IRAS. It has been agreed that an acceptable solution would be for you to create and submit a letter or Word document that mirrors the content of the Non-CTIMP Notice of Substantial Amendment form in lieu of the usual form. This will need to include the usual content of the Notice of Substantial Amendment form for non-CTIMPs…"

Therefore I have followed their guidance below and I hope this is sufficient for your purposes of applying for a substantial amendment to my research.

Please let me know if you require any further information.

Yours sincerely,

Jo Kucharska

Details of the Chief Investigator : **Jo Kucharska**
[redacted]
Email: jmk25@leicester.ac.uk
Jo.kucharska@coventry.ac.uk

Tel: [redacted]

PROJECT DETAILS:

Full Title:	**Compassion Focused Approach to Nurse Mentoring**
Ref:	**3290-jmk25-neuroscience, psychology and behaviour**
Lead Sponsor:	[redacted]
	University of Leicester
Date study commenced:	**16.11.2015**
Protocol Reference Number:	**8 (08.03.16)**
Amendment Number:	**1**
Date of Amendment:	**10.05.16**

Describe the type of amendment, specifically whether it is an:

a) *Amendment to information previously given in IRAS?* ***Yes***/~~*No*~~
If yes, please refer to relevant sections of IRAS in the "summary of changes" section.
A change to the definition of the end of the study i.e. to change the end date of the study from 16.11.2016 to 31.12.2017
An additional number of participants to be recruited i.e. a maximum of 24 additional participants (NHS staff)

b) *Amendment to the protocol?* ***Yes***/~~*No*~~
If yes, please submit either the revised protocol with a new version number and date, highlighting changes in bold, or a document listing the changes and giving both the previous and revised text.
Please see Revised Protocol 9 (dated 10.05.16) Changes are in bold and highlighted
Please also see Revised Cost for Research Version 3 (updated 10.05.16) Changes are in bold and highlighted

c) *Amendment to the information sheet(s) and consent form(s) for participants, or to any other supporting documentation for the study? Yes/* ***No*** ~~*–*~~
If yes, please submit all revised documents with new version numbers and dates, highlighting new text in bold.

Summary of changes

This should briefly summarise the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study.
If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained.

The most pertinent changes are:

1. **An extension of the end date of the research until 31.12.2017 to accommodate an additional cohort attending the Compassion Focused Approach to Nurse mentoring Programme which is due to run late summer/early autumn 2016;**
2. **The recruitment of an additional 24 participants (maximum).**

Any other relevant information
You should indicate any specific issues relating to the amendment, on which the opinion of a reviewing body is sought.
N/A

List of enclosed documents [for each document you should list the document type, version number and date]
Protocol 9 (dated 10.05.16)
Cost for Research Version 3 (updated 10.05.16)

Declaration by Chief Investigator Note: this should be signed to show that the CI is declaring the following two points:
"1. I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I consider that it would be reasonable for the proposed amendment to be implemented."

Jo Kucharska 10.05.16
Chief Investigator

Declaration by the sponsor's representative Note: this should be signed to show that the Sponsor is declaring the following point:
" *I confirm the sponsor's support for this substantial amendment." After the signature the Sponsor should print their name, provide their job title and organisation, date the declaration.*

Date: 10.05.2016

Ethics Approval for Substantial Amendment

Department of Neuroscience, Psychology & Behaviour
College of Medicine, Biological Sciences & Psychology
Maurice Shock Medical Sciences Building
PO Box 138
University Road
Leicester LE1 9HN
UK
T +44 (0)116 252 2922 *(Departmental Enqs)*
F +44 (0)116 252 5045

12th May 2016

To who it may concern

Re: Amendment: Compassion Focused Approach to Nurse Mentoring,
Ref: 3290-jmk25-neuroscience, psychologyand behaviour

I confirm I am happy to give formal ethics Chair approval to this amendment for Jo Kucharska.

Should you need any further information I will be happy to do so.

Email confirmation HRA regarding substantial amendment

amendments hra (HEALTH RESEARCH AUTHORITY)
<hra.amendments@nhs.net>

Fri 05/08/2016, 16:07

Dear Jo

Further to the below, I am pleased to confirm that HRA Approval has been issued for the referenced amendment, following assessment against the HRA criteria and standards.

The sponsor should now work collaboratively with participating NHS organisations in England to implement the amendment as per the below categorisation information. This email may be provided by the sponsor to participating organisations in England to evidence that the amendment has HRA Approval.

Please contact hra.amendments@nhs.net for any queries relating to the assessment of this amendment.

Yours sincerely,

Health Research Authority
HRA, Ground Floor, Skipton House, 80 London Road, London, SE1 6LH
E: hra.approval@nhs.net

www.hra.nhs.uk

The HRA is keen to know your views on the service you received – our short feedback form is available **here**

Email confirmation from NHS R&D

[redacted]

|

Fri 05/08/2016, 16:41

Hi Jo
having checked, I have just realised that the issue re [redacted] premises was not actually part of this amendment.I can confirm that I have all the information I need to issue a notice of no objection to this amendment and I will complete the formal emails on Monday.

Have a good weekend
[redacted]

Senior Research Support Facilitator | CRN: [redacted]
| NIHR Clinical Research Network (CRN)

---

t. [redacted] | **e.** [redacted]
a. [redacted]

NIHR Clinical Research Network: West Midlands

Please note that from 31 March 2016 all applications to conduct research in the NHS in England come under HRA Approval.
HRA Approval is available for all study types and applicants are required to start new applications using HRA Approval (http://www.hra.nhs.uk/research-community/applying-for-approvals/hra-approval/). If you require advice on a new or existing study please contact your local R&D department in the first instance or alternatively get in touch with the Study Support Service team (e: studysupport.crnwestmidlands@nihr.ac.uk).

Letter applying for a further substantial amendment

[redacted],
Chair of Ethics Committee
Department of Neuroscience, Psychology and Behaviour
University of Leicester
University Road
Leicester
LE1 9HN

19th December 2017

Dear [redacted],

RE: Substantial Amendment: Compassion Focused Approach to Nurse Mentoring, ref: 3290-jmk25-neuroscience, psychology and behaviour

I would like to apply for a substantial amendment for my current research. When I originally contacted Research Governance at the University of Leicester, I was advised by Yasmin Godhania, Research Governance Officer, to complete a substantial amendment form via the IRAS system. I have been unable to access this and quote an email from the IRAS team explaining this:

"As your project does not include an NHS REC form it is not possible for you to generate the Notice of Substantial Amendment form in IRAS. It has been agreed that an acceptable solution would be for you to create and submit a letter or Word document that mirrors the content of the Non-CTIMP Notice of Substantial Amendment form in lieu of the usual form. This will need to include the usual content of the Notice of Substantial Amendment form for non-CTIMPs…"

Therefore I have followed their guidance below and I hope this is sufficient for your purposes of applying for a substantial amendment to my research.

Please let me know if you require any further information.

Yours sincerely,

Jo Kucharska

Details of the Chief Investigator: **Jo Kucharska**
[redacted]
Email: jmk25@leicester.ac.uk
Jo.kucharska@coventry.ac.uk

PROJECT DETAILS:

Full Title:	**Compassion Focused Approach to Nurse Mentoring**
Ref:	**3290-jmk25-neuroscience, psychology and behaviour**
Lead Sponsor:	**[redacted] (Research Governance Officer) University of Leicester**
Date study commenced:	**16.11.2015**
Protocol Reference Number:	**8 (08.03.16)**
Amendment Number:	**2**
Date of Amendment:	**18.12.17**

Describe the type of amendment, specifically whether it is an:

d) *Amendment to information previously given in IRAS?* ***Yes***/~~*No*~~
If yes, please refer to relevant sections of IRAS in the "summary of changes" section.
A change to the definition of the end of the study i.e. to change the end date of the study from 31.12.2017 to 30.04.2019
The addition of a follow up semi structured interview for all participants after a minimum of a year of completing the Compassion Focused the maximum number of participants is 12 (NHS staff)

e) *Amendment to the protocol?* ***Yes***/~~*No*~~
If yes, please submit <u>either</u> the revised protocol with a new version number and date, highlighting changes in bold, or a document listing the changes and giving both the previous and revised text.
Please see Revised Protocol 10 (dated 15.12.17) Changes are tracked
Please also see Revised Cost for Research Version 3 (updated 18.12.17)

f) *Amendment to the information sheet(s) and consent form(s) for participants, or to any other supporting documentation for the study? Yes/****No*** ——
If yes, please submit all revised documents with new version numbers and dates, highlighting new text in bold.
Follow up Participant information sheet v1 15.12.17
Follow up Consent form v1 15.12.17
Follow up Semi Structured Interview Schedule V1 15.12.17
Email Invitation to Participants V1 19.12.17

Summary of changes

This should briefly summarise the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study.
If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained.

The most pertinent changes are:

3. **An extension of the end date of the research until 30.04.2019 to accommodate an additional follow up semi structured interview and analysis thereof;**

4. **The addition of a follow up interview of between 30-40 minutes for a maximum of 12 participants (NHS staff).**

Any other relevant information

You should indicate any specific issues relating to the amendment, on which the opinion of a reviewing body is sought.

The semi-structured interview and processes relating to this

List of enclosed documents [for each document you should list the document type, version number and date]

Protocol Version 10 (dated 15.12.17)
Cost for Research Version 4 (updated 18.12.17)
Follow up Participant information sheet v1 15.12.17
Follow up Consent form v1 15.12.17
Follow up Semi Structured Interview Schedule V1 15.12.17
Email Invitation to Participants V1 19.12.17

Declaration by Chief Investigator Note: this should be signed to show that the CI is declaring the following two points:

"1. I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I consider that it would be reasonable for the proposed amendment to be implemented."

Jo Kucharska 18.12.17
Chief Investigator

Declaration by the sponsor's representative Note: this should be signed to show that the Sponsor is declaring the following point:

" *I confirm the sponsor's support for this substantial amendment." After the signature the Sponsor should print their name, provide their job title and organisation, date the declaration.*

Signature:

Date: ***19th December 2017***

Ethical Approval for further substantial amendment

Department of Neuroscience, Psychology & Behaviour
Centre for Medicine
University Road
Leicester LE1 7RH
United Kingdom
T +44 (0)116 229 7174

Dr Jo Kucharska
Clinical Director/Senior Lecturer
Clinical Psychology Doctorate
Faculty of Health & Life Sciences
Coventry University
Priory Street
Coventry
CV1 5FB

21st December 2017

Dear Dr Kucharska

RE: Substantial Amendment: Compassion Focused Approach to Nurse Mentoring, ref: 3290-jmk25- Neuroscience, Psychology and Behaviour

Thank you for submitting your amendment to this project, which I am happy to approve on behalf of the Psychology Research Ethics Committee.

Kind regards

Chair, Psychology Research Ethics Committee

Sponsor confirmation for further substantial amendment

Research & Enterprise Division
University of Leicester
Research Governance Office
Fielding Johnson Building
University Road
Leicester, LE1 7RH
Email: uolsponsor@le.ac.uk
Tel: 0116 373 6410 / 223 1660

9 January 2018

Ms Jo Kucharska
Doctorate Course in Clinical Psychology
Coventry Univeristy
Priory Street
CV1 5FB

Dear Ms Kucharska

Ref:	**UOL 0547 / IRAS project ID:**
Study title:	**Compassion Focused Approach to Nurse Mentoring**
Status:	**Approved**
End Date:	**30/04/2019**

Thank you for submitting documentation for **Substantial Amendment number 1** for the above study.

I confirm that the amendment has been noted by the University of Leicester as Sponsor and and may be implemented with immediate effect.

Please ensure that all documentation and correspondence relating to this amendment are filed appropriately in the relevant site file.

If your study is adopted onto the Clinical Research Network Portfolio please ensure that your recruitment figures, end dates and study status are the same on the EDGE database and Open Database Platform (ODP) CPMS.

Yours sincerely

Email confirmation from NHS R&D for substantial amendment

RE: Compassion Focused Approaches to Nurse Mentoring

[redacted]

[redacted]

Thu 04/01/2018, 13:02

Jo Kucharska

Flag for follow up.

Hi Jo

Happy New Year to you too, I hope you had a good one.

Thank you for sending the Ethics approval letter through to me. I have now completed my review of your amendment and I can confirm that [redacted] Warwickshire Partnership NHS Trust can accommodate your amendment.

Therefore you may implement the amendment immediately.

Many thanks for keeping R&D informed.

[redacted]

Appendix J: An outline of the psychoeducation programme for phase one CFA-MP

Day	Main Themes of the each session of for the first phase of CFA-MP	
1	Introduction*	To outline the role of compassion in clinical care To explore the role of compassion in supporting students in clinical practice To review the role of compassionate self-care for mentors in clinical practice Compassion in the context of clinical care Factors affecting student learning Mentor factors that help students learn Psychological processes that can block learning Mentee experience Clinician experience in healthcare The Compassion Focused Approach (CFA) • Basic Overview of CFA o Understanding the nature of the human mind (evolution theory, "old" brain and "new" brain, interactions between "old" and "new" brain) o How his applies to mentees o Social Brain and Social Mentality: CFA o Applying these concepts to mentees • The components that create and undermine a compassionate mind o Defining Compassion o Psychology of Caring-Nurturance o Competencies of Compassion (Compassionate Mind Engagement and alleviation) o Importance of seeking/receiving care/help o Biological and neurological changes • The 3 circles/our emotions o Making sense of the Threat system o Varieties of Positive Emotions o Making sense of the Drive system o Making sense of the Affiliative-Soothing system

2	The Threat System	Compassionate Knowledge – Understanding how our minds evolved, the jobs our minds evolved to do and how our minds cause suffering Acquiring Threat reactions and safety strategies Understanding the Complexity of the Threat System • Self-Protection • Protective Emotions • Defensive/Protective Behaviours • Defensive/Protective Cognitive Processes Shame • Living in the mind of others • Shame as a Multi-Faceted Experience • Shame Foci and Language • Coping with Shame (emotion, behaviours and cognitive processes) • Making sense of shame • Soothing and Shame Guilt • Types of Self-conscious Experience • Comparing Shame and Guilt Self-Criticism • How self-compassion and self-criticism influence neurology • Self-Critical Thinking Styles • Function of Self-Criticism Understanding the functions of emotion and attachment • Understanding motives and emotions • Types of affect regulation systems • Social signals and communications Safeness, affiliation and emotional regulation • Safeness – connecting and the parasympathetic system • "New brain" with frontal cortex and parasympathetic system • Physiological Systems • Functional Safeness • Internal Threat Soothing and Threat Attachment • Functions of caring- attachments • Secure base • Attachment Styles • Being cared for and Physiology Caring Minds/Soothing • Importance of caring Minds • Safeness vs. Safety • Evolution of Safeness • Emotion System for Care • Building Capacity for Safeness • Turning on the Soothing System • Blocks to Soothing System
3	Compassion	Compassion evolved from a Social Mentality • What is compassion?

		• Soothing/Affiliation • Compassion and Evolution • Compassionate Mind • The two psychologies of Compassion • Compassion Focused Therapy and Social Mentality • Compassionate behaviour (Engagement and Alleviation) • Compassion as Flow CFA Exercises and Imagery • Compassion Cultivation • Aspects of Mindfulness • Rationale for Compassionate Imagery • Types of Compassionate Imagery The Compassionate Self • Creating a compassionate self • Qualities of the compassionate self Compassionate Mind Exercises Compassion Process
4	The soothing system	Soothing Exercises Types of Affect Regulation Systems Blocks to Soothing System Compassionate Mind (Engagement and Alleviation) Blocks to compassion • Threatened Mind • Competitive Mind Making sense of mentee issues Using the Affect regulation systems to make sense of mentee issues
5	Using CFA with Mentees*	Working through Mentor-Mentee dilemmas Recognising which System is active in Mentor or Mentee • Physiology • Attention/thinking • Behaviours • Threat-Anger, Threat-Anxiety or Drive CFA for the participants Next steps and preparing for supervision

*Areas highlighted were specifically added to CFA-MP

Appendix K: Attendance rates for both phases of the CFA-MP

Attendance of 5 day Course	Number of Supervision Sessions Attended	Number of Participants *N*=12
N=12	10	*n*=2
	9	*n*=4
	8	*n*=1
	7	*n*=2
	6	*n*=2
	5	*n*=0
	4	*n*=1
	3	*n*=0
	2	*n*=0
	1	*n*=0

Appendix L. Compassion practice diary

Participant Number _____ Date:_____

COMPASSIONATE ACTIVITIES:
Please complete the form for activities you tried in the past week
(page 1 of 3)

Compassionate Actions	*How many times*	*What did you do and for how long?*	*How helpful was the activity* *Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful*
Practical Self-Soothing (please specify)			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful
Soothing Breathing			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful
Safe Place Image			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful

Compassionate Activities Diary Version 2 20.10.15

Participant Number _____ Date:_____

COMPASSIONATE ACTIVITIES:
Please complete the form for activities you tried in the past week
(page 2of 3)

Compassionate Actions	*How many times*	*What did you do and for how long?*	*How helpful was the action* *Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful*
Compassionate Imagery: Me At My Best			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful
Compassionate Imagery: Compassionate Companion			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful
Allowing others to be compassionate to me			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful
Behaving compassionately to others			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful

Participant Number _____ Date:_____

COMPASSIONATE ACTIVITIES:
Please complete the form for activities you tried in the past week
(page 2of 3)

Compassionate Actions	*How many times*	*What did you do and for how long?*	*How helpful was the action* *Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful*
Behaving compassionately to myself			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful
Other (please Specify			Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful Not at all 1 2 3 4 5 6 7 8 9 10 Very helpful

Compassionate Activities Diary Version 2 20.10.15

Appendix M. Mental health nursing vignettes

Vignettes for compassion focused approaches for nurse mentoring

Participant Number:____ **Date: _____**

Vignettes

For Mental Health Nurse Mentors

1. The mentor and student are working together on a busy acute mental health unit. There has been a new admission to the ward last night. The patient is male and of big build. He has been agitated overnight but appears to have settled. A colleague is showing the student how to dispense medications from the trolley. Suddenly the newly admitted patient starts shouting; he has seen the medication trolley and does not want any medication. His voice is becoming louder, his face has gone white and he is pacing and staring at the nurse/student. The nurse at the trolley, asks the student to collect a medication chart from the office where the mentor is. The nurse continues to give medication to other patients however; the unsettled patient is now swearing and is charging towards her. The nurse prepares to defend herself from physical assault and pulls her alarm. The patient assaults the nurse; punching her a number of times before the response team, including the mentor are able to reach her. The patient is restrained. The student has observed this all from the office and is aware she did not react to the alarm, she felt helpless and that she should have done something to support the nurse. She feels guilty and believes that she shouldn't have left the nurse to collect the chart. She thinks that if she had been there she may have been able to help prevent the assault. The student also feels relieved that it wasn't her and feels bad for thinking this.

1. As a mentor:

a) What would you be thinking?

b) What would you be feeling (emotions) and physically experiencing?

c) What would you do?

2. What do you think the mentee would be:

a) Thinking?

b) Feeling (emotions) and physically experiencing?

c) Doing?

3. What mentee issues need to be addressed?

2. The mentor and student are working together for a shift on an inpatient unit. The mentor has been becoming increasingly concerned about student as he is aware that she seems overly confident and that over the past few days appears to have been acting from her own initiative without discussing her ideas with him or their colleagues. He has decided to work more closely with her, to model how to work with patients and as part of a team. One of the patients is being prepared for discharge and the mentor is planning to go through her on-going treatment plan/aftercare. He has discussed with the student how he will be discussing the patient's medications and encouraging the patient to raise any concerns that the patient may have with her discharge.
   They approach the patient together; the mentor begins explaining the medications to the patient. When the student hears the name of one of the medications, she mentions to the patient and the mentor that she was reading about this medication recently and that it had a number of significantly harmful side effect that would be important for the patient to know about and therefor questions why the patient has been prescribed this and at such a high dosage.
   The patient has become distressed by the information that she has received.

1. <u>As a mentor:</u>

   a) What would you be thinking?

   b) What would you be feeling (emotions) and physically experiencing?

   c) What would you do?

2. <u>What do you think the mentee would be:</u>

   a) Thinking?

   b) Feeling (emotions) and physically experiencing?

   c) Doing?

3. What mentee issues need to be addressed?

3. The student comes to the mental health unit with preconceived ideas about psychiatry. He believes there is nothing that can be done to help people with a psychiatric diagnosis, and that nothing will change. He does not seem motivated to try and engage with the patients on the unit and spends most of his time sitting in an office. His mentor has tried to encourage the student to interact with both colleagues and patients on the unit and to complete some observations that are required. The student doesn't do anything and seems disinterested. The mentor is under pressure with her own workload and has started to give up trying.

1. <u>As a mentor:</u>

a) What would you be thinking?

b) What would you be feeling (emotions) and physically experiencing?

c) What would you do?

2. <u>What do you think the mentee would be:</u>

a) Thinking?

b) Feeling (emotions) and physically experiencing?

c) Doing?

3. What mentee issues need to be addressed?

4. The mentor is feeling under pressure as the have a student with them all day. He feels he will have less time to devote to some of the nursing needs of the patients e.g. if he is explaining things to the student, he'll have less time to interact with patients. He knows that he needs some help to lessen his workload but his colleagues are all very busy and he feels unable to ask for support from them to lessen his workload and/or reduce his coordinator activities. His student is also very keen and asked to meet at the end of the shift so that he can be supported to reflect on his learning from the day. Although these discussions are stimulating and enjoyable, the mentor knows that when they have done this on previous occasions he ends up working beyond his normal working hours of his shift.

1. <u>As a mentor:</u>

a) What would you be thinking?

b) What would you be feeling (emotions) and physically experiencing?

c) What would you do?

2. <u>What do you think the mentee would be:</u>

a) Thinking?

b) Feeling (emotions) and physically experiencing?

c) Doing?

3. What mentee issues need to be addressed?

Appendix N. General nursing vignettes

Vignettes for compassion focused approaches for nurse mentoring

Participant Number:____ **Date: _____**

Vignettes

For General Nurse Mentors

1. The mentor and student are working together on a busy acute ward. There has been a new admission to the ward last night. The patient is male and of big build. He has been physically unsettled overnight. A colleague is showing the student how to dispense medications from the trolley. The colleague, asks the student to collect a medication chart from nurses station where her mentor is. Suddenly the nurse becomes alerted to the sound of a machine and newly admitted patient appears to be having a cardiac event. The nurse dispensing medication is closest to the patient, shouts for help, raises the alarm for the crash team and begins CPR. The crash team arrive spending some time working to revive the patient. The student has observed this all from the nurses and is aware she that did not react to the sound, she felt helpless and that she should have done something to support the nurse and the patient. She feels guilty and believes that she shouldn't have left the nurse to collect the chart. She thinks that if she had been there she may have been able in some way, perhaps getting to the patient more quickly. The student also feels relieved that she wasn't closer as she's not sure what she would have done and feels bad for thinking this.

1. <u>As a mentor:</u>

a) What would you be thinking?

b) What would you be feeling (emotions) and physically experiencing?

c) What would you do?

2. <u>What do you think the mentee would be:</u>

a) Thinking?

b) Feeling (emotions) and physically experiencing?

c) Doing?

3. **What mentee issues need to be addressed?**

2. The mentor and student are working together for a shift on an inpatient unit. The mentor has been becoming increasingly concerned about student as he is aware that she seems overly confident and that over the past few days appears to have been acting from her own initiative without discussing her ideas with him or their colleagues. He has decided to work more closely with her, to model how to work with patients and as part of a team. One of the patients is being prepared for discharge and the mentor is planning to go through her on-going treatment plan/aftercare. He has discussed with the student how he will be discussing the patient's medications and encouraging the patient to raise any concerns that the patient may have with her discharge.
   They approach the patient together; the mentor begins explaining the medications to the patient. When the student hears the name of one of the medications, she mentions to the patient and the mentor that she was reading about this medication recently and that it had a number of significantly harmful side effect that would be important for the patient to know about and therefor questions why the patient has been prescribed this and at such a high dosage.
   The patient has become distressed by the information that she has received.

1. **<u>As a mentor:</u>**

   a) **What would you be thinking?**

   b) **What would you be feeling (emotions) and physically experiencing?**

   c) **What would you do?**

2. **<u>What do you think the mentee would be:</u>**

   a) **Thinking?**

   b) **Feeling (emotions) and physically experiencing?**

   c) **Doing?**

3. What mentee issues need to be addressed?

3. The student comes to the oncology unit with preconceived ideas about cancer. He believes there is nothing that can be done to help people diagnosed with cancer, and that nothing will change. He does not seem motivated to try and engage with the patients on the unit and spends most of his time sitting in an office. His mentor has tried to encourage the student to interact with both colleagues and patients on the unit and to complete some observations that are required. The student doesn't do anything and seems disinterested. The mentor is under pressure with her own workload and has started to give up trying.

1. <u>As a mentor:</u>

a) What would you be thinking?

b) What would you be feeling (emotions) and physically experiencing?

c) What would you do?

2. <u>What do you think the mentee would be:</u>

a) Thinking?

b) Feeling (emotions) and physically experiencing?

c) Doing?

3. What mentee issues need to be addressed?

4. The mentor is feeling under pressure as the have a student with them all day. He feels he will have less time to devote to some of the nursing needs of the patients e.g. if he is explaining things to the student, he'll have less time to interact with patients. He knows that he needs some help to lessen his workload but his colleagues are all very busy and he feels unable to ask for support from them to lessen his workload and/or reduce his coordinator activities. His student is also very keen and asked to meet at the end of the shift so that he can be supported to reflect on his learning from the day. Although these discussions are stimulating and enjoyable, the mentor knows that when they have done this on previous occasions he ends up working beyond his normal working hours of his shift.

1. **<u>As a mentor:</u>**

   a) **What would you be thinking?**

   b) **What would you be feeling (emotions) and physically experiencing?**

   c) **What would you do?**

2. **<u>What do you think the mentee would be:</u>**

   a) **Thinking?**

   b) **Feeling (emotions) and physically experiencing?**

   c) **Doing?**

3. **What mentee issues need to be addressed?**

Appendix O. Semi-structured follow-up interview

Follow Up Semi-Structured Interview – Compassion Focused Approaches to Nurse Mentoring (CFA-M) Programme

1. It has been some time since you attended the CFA-M programme, what do you remember about it?

2. What was helpful about the programme?
   - To you personally
   - To your practice as a nurse mentor
   - In other aspects of your work/life

3. What did you learn from the programme?

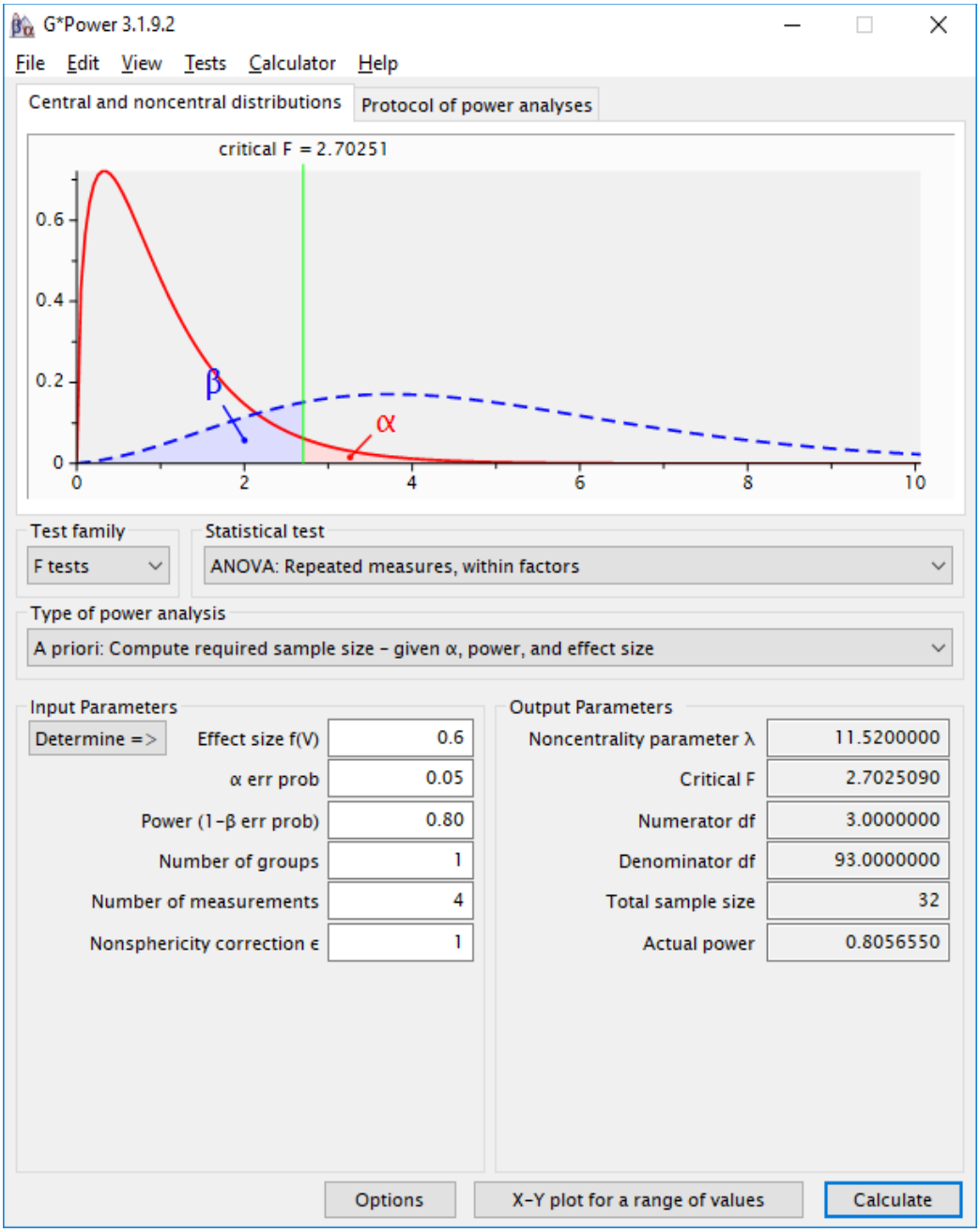
4. What exercises, techniques or ideas from the programme do you remember?

5. What if any of these do you use/practise/apply?
   - For yourself
   - In your practice as a nurse mentor
   - In other aspects of your work/life

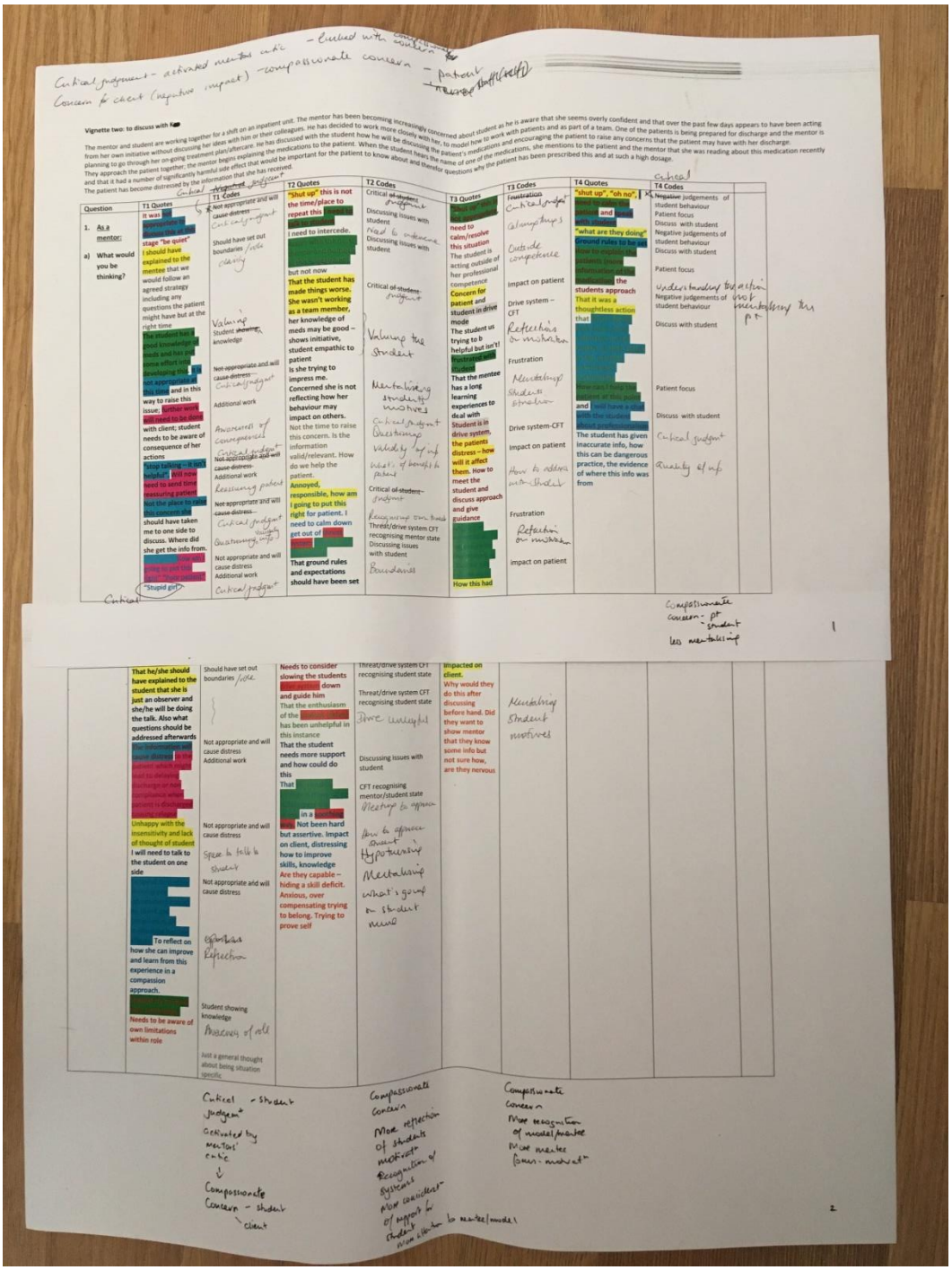
6. How do you use/practice/apply them?
   - To you personally
   - To your practice as a nurse mentor
   - In other aspects of your work/life

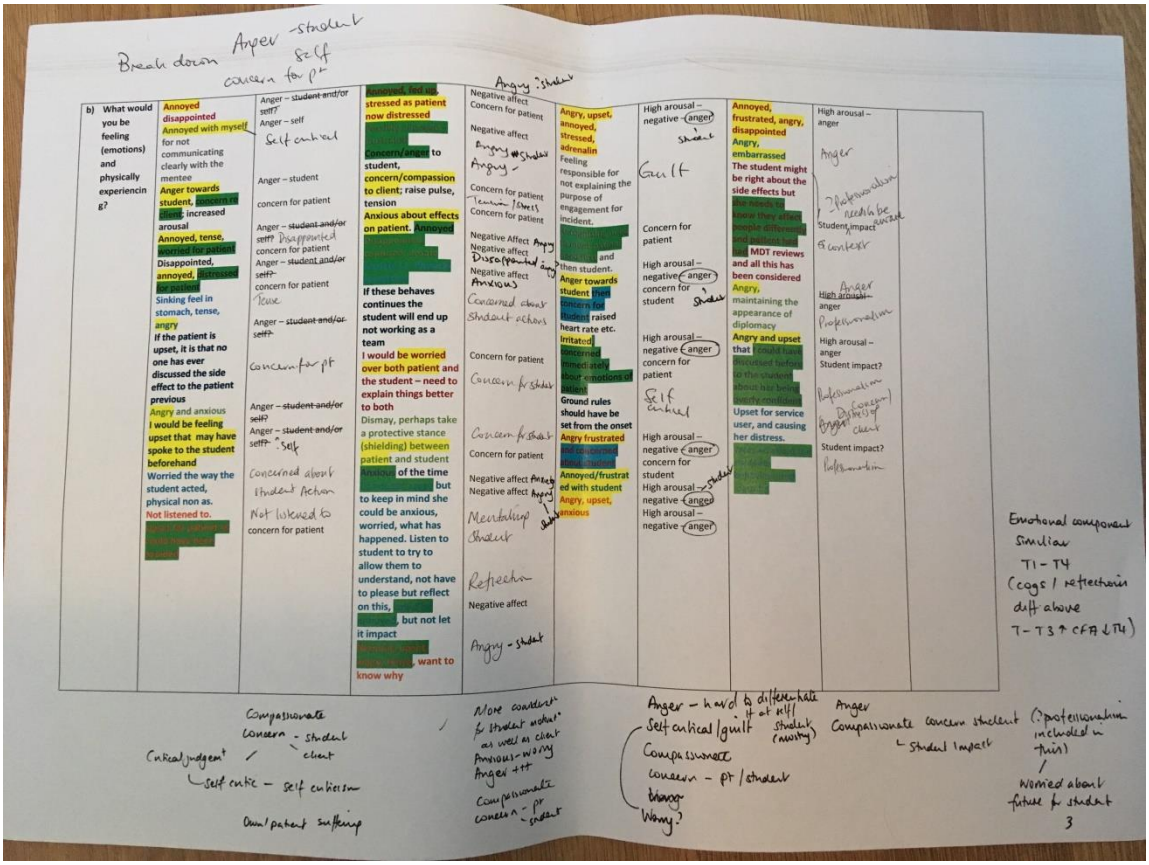
7. What else do you think would be helpful for me to know about the programme at this time?

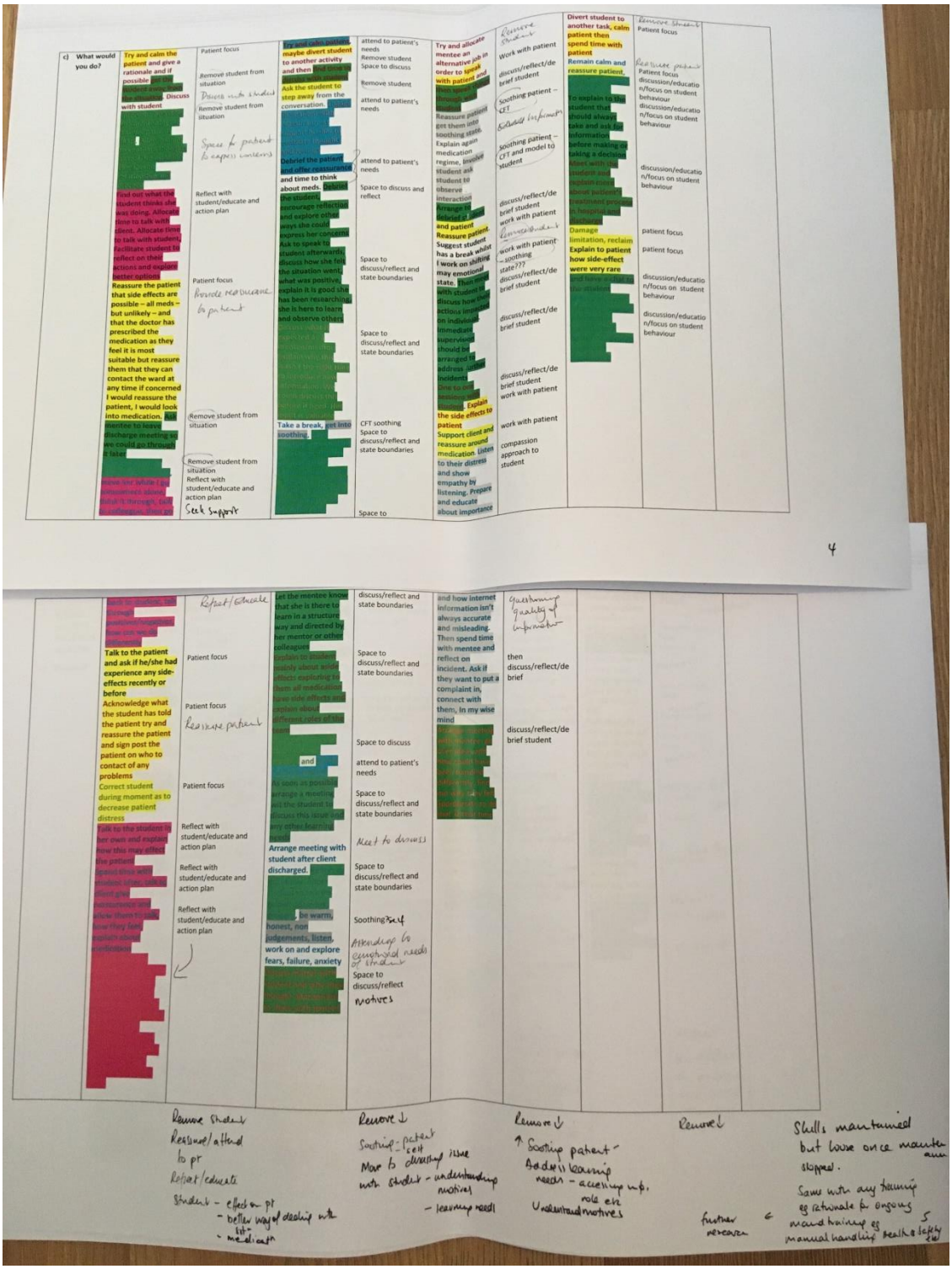
Appendix P. Power Calculation using G*Power programme

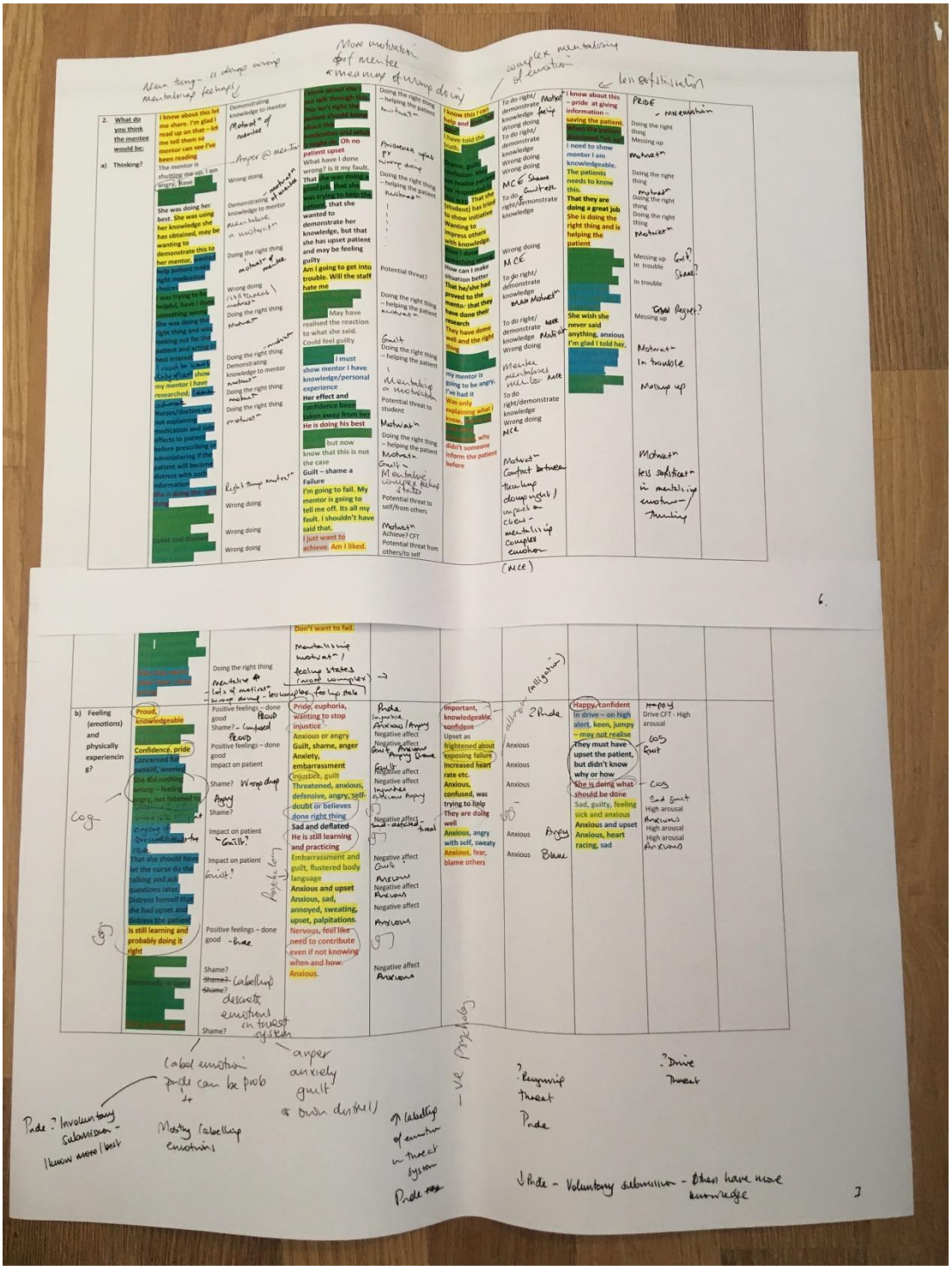


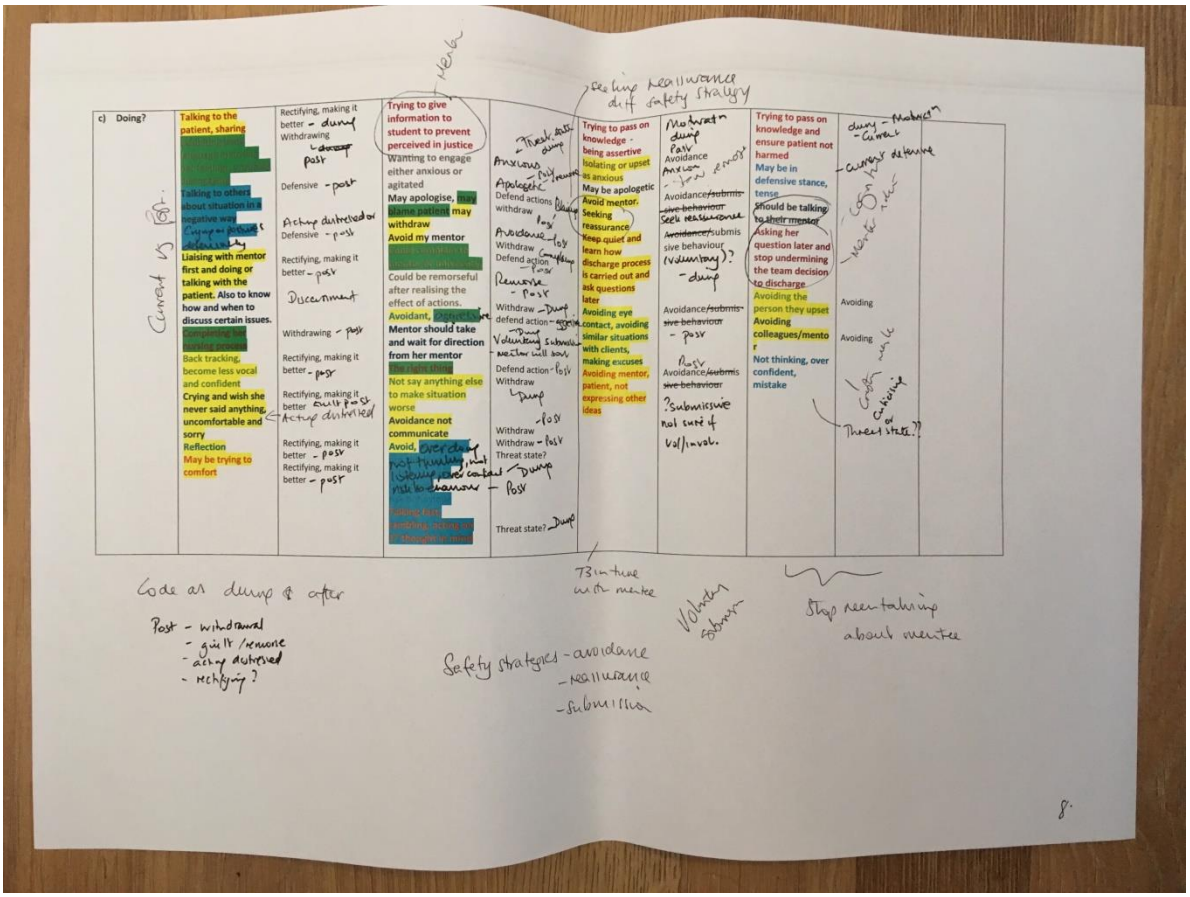
Appendix Q. Example of the data coding for vignettes

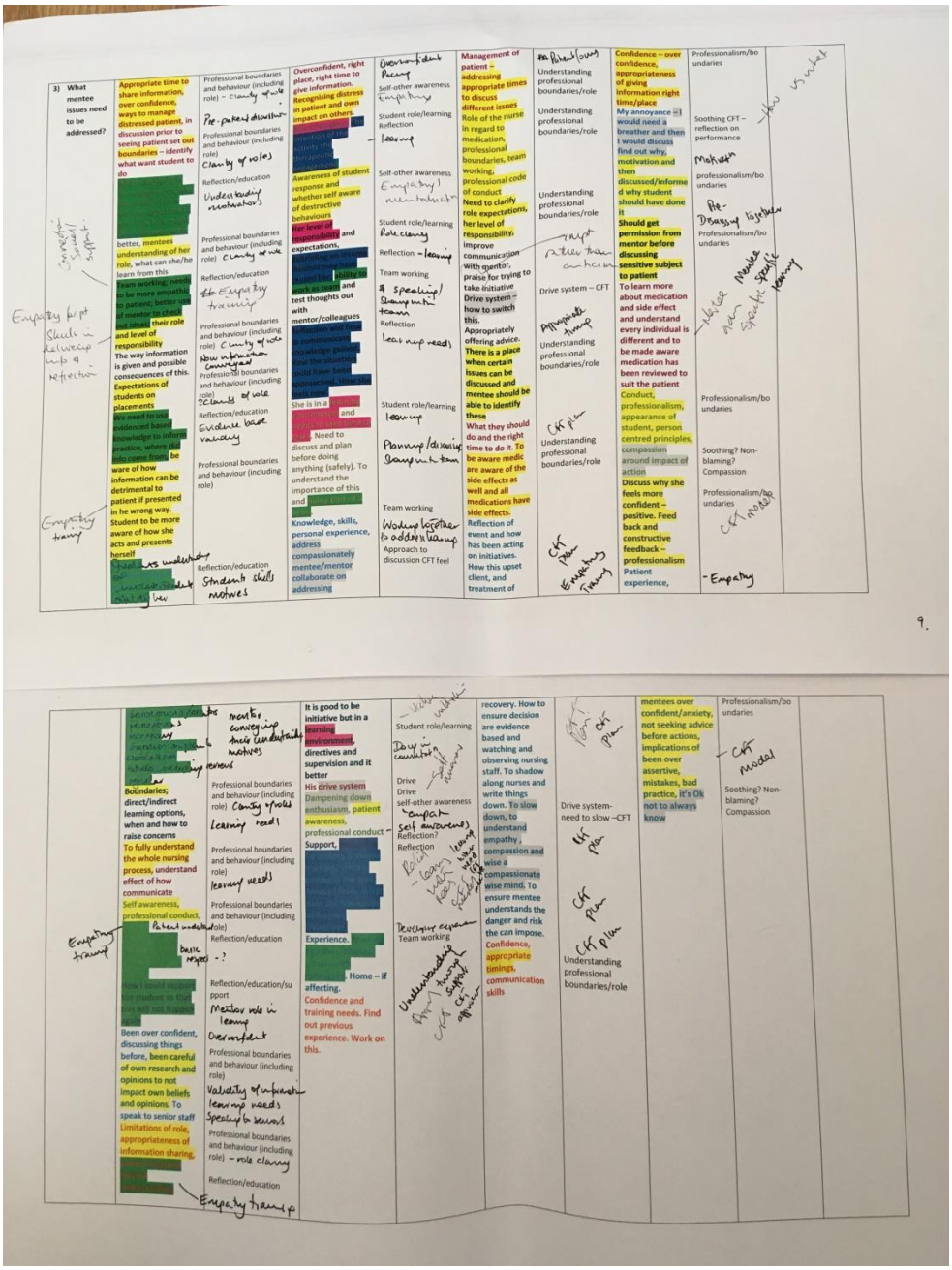



Break down Anger - student
self
concern for pt
Angry - student
b) What would you be feeling (emotions) and physically experiencing?
Annoyed disappointed
Annoyed with myself
for not communicating clearly with the mentee
Anger towards student, concern re risk; increased arousal
Annoyed, tense, worried for patient
Disappointed, annoyed, frustrated
Sinking feel in stomach, tense, angry
If the patient is upset, it is that no one has ever discussed the side effect to the patient previous
Angry and anxious
I would be feeling upset that may have spoke to the student beforehand
Worried the way the student acted, physical non as.
Not listened to.
Anger – student and/or self?
Anger – self
Self critical
Anger – student
concern for patient
Anger – student and/or self? Disappointed
concern for patient
Anger – student and/or self?
concern for patient
Tense
Anger – student and/or self?
Concern for pt
Anger – student and/or self?
Anger – student and/or self? Self
Concerned about Student Action
Not listened to
concern for patient
Annoyed, fed up, stressed as patient now distressed
Concern/anger to student, concern/compassion to client; raise pulse, tension
Anxious about effects on patient. Annoyed
If these behaves continues the student will end up not working as a team
I would be worried over both patient and the student – need to explain things better to both
Dismay, perhaps take a protective stance (shielding) between patient and student
Anxious of the time but to keep in mind she could be anxious, worried, what has happened. Listen to student to try to allow them to understand, not have to please but reflect on this, but not let it impact want to know why
Negative affect
Concern for patient
Negative affect
Angry - Student
Concern for patient
Tension/Stress
Concern for patient
Negative Affect Angry
Negative affect
Negative affect
Concerned about Student action
Concern for patient
Concern for student
Concern for student
Concern for patient
Negative affect Anxious
Negative affect
Mentalising Student
Reflection
Negative affect
Angry - student
Angry, upset, annoyed, stressed, adrenalin
Feeling responsible for not explaining the purpose of engagement for incident.
and then student.
Anger towards student then concern for student raised heart rate etc.
Irritated concerned immediately about emotions of patient
Ground rules should have be set from the onset
Angry frustrated and concerned about student
Annoyed/frustrated with student
Angry, upset, anxious
High arousal – negative anger
Student
Guilt
Concern for patient
High arousal – negative anger
concern for student
Student
High arousal – negative anger
concern for patient
Self critical
High arousal – negative anger
concern for student
High arousal – negative anger
High arousal – negative anger
Annoyed, frustrated, angry, disappointed
Angry, embarrassed
The student might be right about the side effects but
the need to know they affect people differently and patient led but MDT reviews and all this has been considered
Angry, maintaining the appearance of diplomacy
Angry and upset that could have discussed before to the student about isn't being professional
Upset for service user, and causing her distress.
High arousal – anger
Anger
Professionalism
Student impact
& context
High arousal – anger
Student impact?
High arousal – anger
Professionalism
Disappointed
Anger
client
Student impact?
Professionalism
Emotional component
Similar
T1 – T4
(cogs / reflection diff above
T – T3 ↑ CFA ↓ T4)
Compassionate
Concern - student
client
Critical judgment
Self critic – self criticism
Own patient suffering
More confident for student mother as well as client
Anxious - worry
Anger +++
Compassionate
concern - pt student
Anger – hard to differentiate
Self critical/guilt
it at self/ student (anxiety)
Compassionate
concern - pt/student
Worry?
Anger
Compassionate concern student
Student impact
(professionalism included in this)
/
Worried about future for student
3


c) What would you do?
Try and calm the patient and give a rationale and if possible get the student's perspective on the situation. Discuss with student
Find out what the student thinks she was doing. Allocate time to talk with client. Allocate time to talk with student, facilitate student to reflect on their actions and explore better options
Reassure the patient that side effects are possible – all meds – but unlikely – and that the doctor has prescribed the medication as they feel it is most suitable but reassure them that they can contact the ward at any time if concerned I would reassure the patient, I would look into medication. Ask mentee to leave discharge meeting so we could go through it later
Patient focus
Remove student from situation
Reflect with student/educate and action plan
Seek support
Debrief the patient and offer reassurance and time to think about meds. Explain to the student, encourage reflection and explore other ways she could express her concerns. Ask to speak to student afterwards, discuss how she felt the situation went, what was positive, explain it is good she has been researching, she is here to learn and observe others
Take a break, get into soothing
attend to patient's needs
Remove student
Space to discuss
Space to discuss and reflect
CFT soothing
Space to discuss/reflect and state boundaries
Space to
Try and allocate mentee an alternative job in order to speak with patient and student
Reassure patient, get them into soothing state. Explain again medication regime, involve student ask student to observe interaction
Arrange to debrief at later date and patient. Reassure patient. Suggest student has a break whilst I work on shifting may emotional state. Then meet with student to discuss how their actions impacted on individual, immediate supervision should be arranged to address incident. One to one session during. Explain the side effects to patient
Support client and reassure around medication. Listen to their distress and show empathy by listening. Prepare and educate about importance
Work with patient
discuss/reflect/de brief student
Soothing patient – CFT
Soothing patient – CFT and model to student
work with patient – soothing state??
Divert student to another task, calm patient then spend time with patient
Remain calm and reassure patient
To explain to the student that should always take and ask for information before making or taking a decision about with the student and explain correct about patient treatment process in hospital and
Damage limitation, reclaim
Explain to patient how side-effect were very rare
Patient focus
discussion/educatio n/focus on student behaviour
Talk to the patient and ask if he/she had experience any side-effects recently or before
Acknowledge what the student has told the patient try and reassure the patient and sign post the patient on who to contact of any problems
Correct student during moment as to decrease patient distress
Talk to the student in her own and explain how this may effect the patient
Arrange meeting with student after client discharged.
Be warm, honest, non judgement, listen, work on and explore fears, failure, anxiety
Space to discuss/reflect
notives
Meet to discuss
Attendings to emotional needs of student
Soothing?
Questioning quality of information
then discuss/reflect/de brief
Remove student
Reassure/attend to pt
Reflect/educate
Student – effect on pt
– better way of dealing with
– medication
Remove ↓
Soothing – patient
Move to discussing issue with student – understanding motives
– learning needs
Remove ↓
↑ Soothing patient –
Address learning needs – accessing info, role etc
Understand motives
Remove ↓
Skills maintained but knowledge once maintained stopped.
Same with any training eg rationale for ongoing mandatory training eg manual handling health & safety law
further research




c) Doing?
Talking to the patient, sharing
Talking to others about situation in a negative way
Liaising with mentor first and doing or talking with the patient. Also to know how and when to discuss certain issues.
Back tracking, become less vocal and confident
Crying and wish she never said anything, uncomfortable and sorry
Reflection
May be trying to comfort
Rectifying, making it better - dump
Withdrawing
Defensive - post
Rectifying, making it better - post
Withdrawing - post
Rectifying, making it better - post
Rectifying, making it better - post
Rectifying, making it better - post
Trying to give information to student to prevent perceived in justice
Wanting to engage either anxious or agitated
May apologise, may blame patient may withdraw
Avoid my mentor
Could be remorseful after realising the effect of actions.
Avoidant,
Mentor should take and wait for direction from her mentor
Not say anything else to make situation worse
Avoidance not communicate
Avoid,
Anxious
Apologetic
Defend actions
withdraw
Avoidance
Withdraw
Defend action
Remorse
Withdraw
defend action
Withdraw
Withdraw
Withdraw
Threat state?
Threat state?
Trying to pass on knowledge - being assertive
Isolating or upset as anxious
May be apologetic
Avoid mentor.
Seeking reassurance
Keep quiet and learn how discharge process is carried out and ask questions later
Avoiding eye contact, avoiding similar situations with clients, making excuses
Avoiding mentor, patient, not expressing other ideas
Avoidance
Seek reassurance
Avoidance/submissive behaviour
Avoidance/submissive behaviour
Avoidance/submissive behaviour
Trying to pass on knowledge and ensure patient not harmed
May be in defensive stance, tense
Should be talking to their mentor
Asking her question later and stop undermining the team decision to discharge
Avoiding the person they upset
Avoiding colleagues/mentor
Not thinking, over confident, mistake
Avoiding
Avoiding
Code as dump & after
Post - withdrawal
- guilt /remorse
- acting distressed
- rectifying ?
Safety strategies - avoidance
- reassurance
- submission
Stop reen taking about mentee



Appendix R. Examples of written quotations for each of the higher order and lower order categories for each vignette

Vignette 1 and Examples of Higher Order Categories

The mentor and student are working together on a busy acute mental health unit. There has been a new admission to the ward last night. The patient is male and of big build. He has been agitated overnight but appears to have settled. A colleague is showing the student how to dispense medications from the trolley. Suddenly the newly admitted patient starts shouting; he has seen the medication trolley and does not want any medication. His voice is becoming louder, his face has gone white and he is pacing and staring at the nurse/student. The nurse at the trolley, asks the student to collect a medication chart from the office where the mentor is. The nurse continues to give medication to other patients however; the unsettled patient is now swearing and is charging towards her. The nurse prepares to defend herself from physical assault and pulls her alarm. The patient assaults the nurse; punching her, a number of times before the response team, including the mentor are able to reach her. The patient is restrained. The student has observed this all from the office and is aware she did not react to the alarm, she felt helpless and that she should have done something to support the nurse. She feels guilty and believes that she shouldn't have left the nurse to collect the chart. She thinks that if she had been there she may have been able to help prevent the assault. The student also feels relieved that it wasn't her and feels bad for thinking this.

Question	Higher Order and Lower Order Categories	Time Frame (T1, T2, T3, T4)	Examples of each Category (I, II, III, etc.) at each time point
1. <u>As a mentor:</u> a) What would you be thinking?	**MENTOR THINKING** **I. Concern for others** **II. Mentalising Mentee Response or Motivation** **III. Mentor Reactions**	**T1**	I. "Ensure the student is OK and seek one to one for compassion, empathy and support"P2 II. "it wasn't her fault – she is likely to feel very unsettled about this" P4 III. "on a human level though, other things could be done to assist colleagues" P9
		T2	I. "I need to speak to the student somewhere "safe""P2 II. "Must have been an awful scary situation for her." P4 III. "thinking about the incident itself and trying to make sense of it"P1
		T3	I. "What support do they need, is it first time experiencing violence in work place."P12 II. "The student may be feeling shame and anxiety and guilt. She may be questioning her suitability as a nurse"P3 III. "The student is threatened" P8
		T4	I. "Was anyone else affected by the incident i.e. other patients" P9 II. "the student must be scared if what happened"P12 III. "Is the student ready to be a nurse." P8

b) What would you be feeling (emotions) and physically experiencing?	**MENTOR FEELING AND PHYSICAL EXPERIENCING** **I. Labelling emotional states** **II. Describing the physiology**	**T1**	I. "Guilty, upset and relieved" P10 II. "increased heart rate etc." P3
		T2	I. "Sad, worried, concerned, responsible"P5, "in soothing for colleague and mentee" P12 II. "More physically aroused – full of adrenalin" P1
		T3	I. "Anxiety, anger", P12 "In drive to deliver support to the student" P2 II. "Hyped up, adrenalin" P1
		T4	I. "Upset, anxious" P2 II. "Hyped up, adrenalin" P1
c) What would you do?	**MENTOR ACTION** **I. Attending to the safety and distress of others** **II. Addressing Mentee Learning and Problem Solving** **III. Utilising CFA model**	**T1**	I. "I would seek to restrain the patient" P2, "Ensure all had the opportunity to debrief and discuss how people were feeling."P5 II. "by reflecting on how we could help support the student and anything we could change"P10, "Debrief with the student, what I could have done. Reflecting on incident, this wasn't nice and how to prevent incident again" P11
		T2	I. "Maintain safe environment."P2, "Take a few minutes to reflect and debrief with colleague and the student" P7 II. "Also thinking about the incident itself and trying to make sense of it"P1, "debrief for student. How have they coped with the incident"P9 III. "Ground myself before engaging in supervision." P2
		T3	I. "Ensure situation is resolved and calm" P1, "Find somewhere quiet and offer debrief – give reassurance" P4 II. "Why did she leave her and not say anything."P12 III. "Take some soothing breaths, approach nurse check how she was" P11
		T4	I. "When ward has calmed down – spend time doing one to one with student" P1 "Talk to colleagues, talk to student and other patients" P9

2. <u>What do you think the mentee would be:</u> a) Thinking?	**MENTEE THINKING** **I. Critical Judgements** **II. Motivation** **III. Concern for Others** **IV. Concerns about Career**	**T1**	I. "She didn't do a good job; she let her colleagues down; she's not a good nurse; also she's coward" P3 II. "Oh God we're in danger" P6 IV. "Frightened and scared of the nursing job" P8
		T2	I. "What will my mentor think and other staff" P11 II. "That the presence was not needed, and that student are not part of the team when it comes to certain situations" P7 III. "How is the patient/my mentor"P6 IV. "Am I right for this job" P4
		T3	I. "I should have helped" P1, "What are people going to think of me. The team will think badly of me"P4 IV. "She may be questioning her suitability as a nurse"P3
		T4	I. & IV. "It's all my fault, shouldn't have left the nurse, I will never be a good nurse, I cannot do this job"P11
b) Feeling (emotions) and physically experiencing?	**MENTEE FEELING AND PHYSICAL EXPERIENCING** **I. Labelling emotional states** **II. Describing the physiology**	**T1**	I. "Fear, guilt, anxiety, hopelessness" P3 II. "Shaking, feeling sick, nervous"P5
		T2	I. "Traumatized, anxious, angry, guilty. Shame, agitation " P3 II. "Struggling to breath, tingle hands, muscle tightness." P11
		T3	I. "Guilt, fear, blame, shame" P12 II. "heart rate increased, hot/flushed, sweaty palms"P4
		T4	I. "scared, guilty, angry, relieved" P1 II. "heart racing, difficult breathing" P11

c) Doing?	**MENTEE ACTION** **I. Approach Behaviours** **II. Avoidance behaviours**	**T1**	I. "Crying, seeking reassurance, apologising" P4 "Should have joined the team use initiative and support where possible"P8 II. "Keeping out of the way, staying in office"P5, "avoiding another situation if ever arised"P12
		T2	I. "Should be looking at how to help and support others. Should also be asking how she can help."P8 II. "Removing herself from attention of others"P9
		T3	I. "Apologising, help seeking" P3 "Ask if she could help in any way"P8 II. "May stay in office avoiding" P5, "Avoiding, to put self in these situations, staying in office, making excuses"P11
		T4	I. "Trying to seek out mentor from support"P1, "Talk how she feel and express her threats to someone" P8 II. "Avoidance, keep out of situation" P11
3. What mentee issues need to be addressed?	**MENTOR ISSUES TO BE ADDRESSED** **I. Learning** **II. Approach to issues**	**T1**	I. "Discuss expectations of a student in alarm situation"P1 II. "Her experience, what actually happened, how she felt, what she did, what lessons could be learned" P2, "How to have deescalated situation, how it impacted on her blaming self , exploring this, emotions, compassion, trauma"P11
		T2	I. "the role as a student, how do they feel, what do they think, are they safe" P2, "Status on ward. Protocols and safe working." P9 II. "Where about student. How they feel, what thoughts, learn. Debrief, systems, threat, anxiety soothing"P6
		T3	I. "Role of student and limitations - expectations in conflict situation"P1 II. "How can we work together to minimise her anxiety, guilt and blame. Learn to be more compassionate and noticing any feels/fears. What she can do to empower herself. By exposure and sitting and tolerating uncertainty. Safe place, compassionate companion."P11
		T4	I. "Expectation of student nurse"P1 II. "Why she feels guilty/bad and relieved. How she could help next time and help understand her emotions, how the mentor could give her more support"P10, "Obligation to respond to incident (supernumerary status does not exclude from physical "management training)"P9

Vignette 2 and Examples of Higher Order Categories

The mentor and student are working together for a shift on an inpatient unit. The mentor has been becoming increasingly concerned about student as he is aware that she seems overly confident and that over the past few days appears to have been acting from her own initiative without discussing her ideas with him or their colleagues. He has decided to work more closely with her, to model how to work with patients and as part of a team. One of the patients is being prepared for discharge and the mentor is planning to go through her on-going treatment plan/aftercare. He has discussed with the student how he will be discussing the patient's medications and encouraging the patient to raise any concerns that the patient may have with her discharge. They approach the patient together; the mentor begins explaining the medications to the patient. When the student hears the name of one of the medications, she mentions to the patient and the mentor that she was reading about this medication recently and that it had a number of significantly harmful side effect that would be important for the patient to know about and therefore questions why the patient has been prescribed this and at such a high dosage. The patient has become distressed by the information that she has received**.**			
Question	**Higher Order Categories**	**Time Frame (T1, T2, T3, T4)**	**Examples**
1. <u>As a mentor:</u> a) What would you be thinking?	**MENTOR THINKING** **I. Concern for others** **II. Mentalising Mentee Response or Motivation** **III. Mentor reactions**	**T1**	I. "The information will cause distress to the patient"P8 III. "That he/she should have explained to the student that she is just an observer and she/he will be doing the talk. Also what questions should be addressed afterwards"P7
		T2	I. "That the student has made things worse. She wasn't working as a team member, her knowledge of meds may be good" P3 II. "Anxious, over compensating trying to belong. Trying to prove self"P12 III. "That we need to arrange a meeting to reflect over the above in a soothing way. Not been hard but assertive."P11
		T3	I. "The student is acting outside of her professional competence"P2 II. "The student us trying to be helpful but isn't!"P4 III. "Student is in drive system"P8
		T4	I. ""oh no", I need to calm the patient and speak with student"P1 III. "That it was a thoughtless action that there should have been some reflection on the impact of their status in the 'patient-practitioner' relationship" P9

b) What would you be feeling (emotions) and physically experiencing?	**MENTOR FEELING AND PHYSICAL EXPERIENCING** **I. Labelling emotional states** **II. Describing the physiology**	**T1**	I. "Anger towards student" P3, "Annoyed with myself for not communicating clearly with the mentee" P2 II. "Sinking feel in stomach, tense"P6
		T2	I. "Annoyed, fed up, stressed as patient now distressed " P1, "Nervous, upset, angry, tense, want to know why" P12 II. " raise pulse, tension" P3
		T3	I. "Anger towards student then concern for student raised" P3, "Feeling responsible for not explaining the purpose of engagement for incident."P2 II. "adrenalin"P1
		T4	I. "Annoyed, frustrated, angry, disappointed"P1, "Angry and upset that I could have discussed before to the student about her being overly confident" P10
c) What would you do?	**MENTOR ACTION** **I. Attending to the safety and distress of others** **II. Addressing Mentee Learning and Problem solving** **III. Utilising CFA model**	**T1**	I. "Try and calm the patient and give a rationale and if possible get the student away from the situation" P1 II. "Facilitate student to reflect on their actions and explore better options" P2
		T2	I. "Ask the student to step away from the conversation. Engage the patient with reassurance as support his/her to ventilate thoughts and feelings" P2 II. "Discuss what is expected as a mentee/mentor, explain why this wasn't the right time to introduce new information" P5 III. "Take a break, get into soothing, have meeting with student when calm" P6
		T3	I. "Reassure patient get them into soothing state" P2 II. "Prepare and educate about importance and how internet information isn't always accurate and misleading" P11 III. "Suggest student has a break whilst I work on shifting may emotional state. Then meet with student to discuss how their actions impacted on individual" P4
		T4	I. "Divert student to another task, calm patient then spend time with patient"P1 II. "Inform of how her information caused client distress and could cause non compliance" P11

2. <u>What do you think the mentee would be:</u> a) Thinking?	**MENTEE THINKING** **I. Critical Judgements** **II. Concerns for Others** **III. Motivation**	**T1**	I. "The mentor is shutting me up, I am angry. Have I done something wrong, is this my fault" P2 II. "she has upset patient and may be feeling guilty" P3 III. "I must be honest – duty of care; show my mentor I have researched; I am an advocate" P6
		T2	I. "I'm going to fail. My mentor is going to tell me off. Its all my fault. I shouldn't have said that." P11 II. & III. "I know about this I can talk through this. This isn't right the patient should know about this medication and what it might do. Oh no patient upset" P1
		T3	I. & II. "I've messed up, the client is upset, my mentor is going to be angry, I've had it" P11 I. & III. "Have I done something wrong. How can I make situation better " P4 III. "That she (student) has tried to show initiative" P3
		T4	I. "I'm going to get into trouble off my mentor, worried as I have messed up"P11 II. "Horror at their actions because it has affected a patient directly" P9 III. "I need to show mentor I am knowledgeable" P6
b) Feeling (emotions) and physically experiencing?	**MENTEE FEELING AND PHYSICAL EXPERIENCING** **I. Labelling emotional states** **II. Describing the physiology**	**T1**	I. "Confused, possible angry or upset" P2, "Confidence, pride" P3, " Anxious, upset, worried, annoyed, angry, guilty"P12 II. "increased heart rate" P6, "Emotionally drained"P10
		T2	I. "Guilt, shame, anger"P3, "Pride, euphoria"P1, "Threatened, anxious, defensive, angry, self-doubt"P6 II. "flustered body language"P9, "sweating, upset, palpitations" P11
		T3	I. "Anxious, angry with self" P11, "Important, knowledgeable, confident" P1 II. "Increased heart rate etc."P3
		T4	I. "Sad, guilty"P9 , "In drive – on high alert, keen, jumpy – may not realise" P6 II. "In drive – on high alert, keen, jumpy – may not realise"P6, "heart racing" P11

d) Doing?	**MENTEE ACTION** **I. Approach behaviours** **II. Avoidance behaviours** **[during and after event]**	**T1**	I. During: "Talking to the patient, sharing" P1 After: "Liaising with mentor first and doing or talking with the patient" P7, II. "Back tracking, become less vocal and confident" P9
		T2	I. During: "Wanting to engage either anxious or agitated" P2 "Talking fast, rambling, acting on 1st thought in mind" P12 I. & II. After: "Could complain to mentor or university. Could be remorseful"P5 II. After: "Avoid my mentor" P4
		T3	I. During: "Trying to pass on knowledge - being assertive"P1, After: "May be apologetic" P3 II. "Avoiding mentor, patient, not expressing other ideas"P12
		T4	I. During: "Trying to pass on knowledge and ensure patient not harmed"P1 II. After: "Avoiding the person they upset" P9, "Avoiding colleagues/mentor"P10

3. What mentee issues need to be addressed?	**MENTOR ISSUES TO BE ADDRESSED** **I. Learning** **II. Approach to issues**	**T1**	I. "Appropriate time to share information, over confidence, ways to manage distressed patient, in discussion prior to seeing patient set out boundaries – identify what want student to do"P1, "Self awareness, professional conduct, patient understanding, person centred behaviour, basic respect", P9 "Limitations of role, appropriateness of information sharing, aware of patient level of understanding"P12
		T2	I. "Recognising distress in patient and own impact on others" P1, "Awareness of student response and whether self aware of destructive behaviours" P2, "ability to work as team and test thoughts out with mentor/colleagues"P3 II. "His drive system" P8, "Dampening down enthusiasm, patient awareness, professional conduct" P9
		T3	I. "Role of the nurse in regard to medication, professional boundaries, team working, professional code of conduct" P2, "Need to clarify role expectations, her level of responsibility, improve communication with mentor" P3, "Reflection of event and how has been acting on initiatives. How this upset client, and treatment of recovery"P11 II. "Drive system – how to switch this" P4
		T4	I. "Conduct, professionalism, appearance of student, person centred principles, compassion around impact of action" P9 II. "I would discuss find out why, motivation and then discussed/informed why student should have done it"P6

Vignette 3 and Examples of Higher Order Categories

The student comes to the mental health unit with preconceived ideas about psychiatry. He believes there is nothing that can be done to help people with a psychiatric diagnosis, and that nothing will change. He does not seem motivated to try and engage with the patients on the unit and spends most of his time sitting in an office. His mentor has tried to encourage the student to interact with both colleagues and patients on the unit and to complete some observations that are required. The student doesn't do anything and seems disinterested. The mentor is under pressure with her own workload and has started to give up trying.			
Question	**Higher Order Categories**	**Time Frame (T1, T2, T3, T4)**	**Examples**
1. <u>As a mentor:</u> a) What would you be thinking?	**MENTOR THINKING** **I. Mentalising Mentee Response or Motivation** **II. Mentor Reactions**	**T1**	I. "Why is this student so distracted and not engaging"P2, "Why did they apply to be a nurse? How am I going to approach them? How can I get through to them/what can I do?"P4 II. "I can't manage the student" P1, "Concerned it will take more time and intensive input to support mentee"P5
		T2	I. "Need to understand where student is at professional/personal experience. What system, threat, anxiety. Soothing"P6, "Why he behaves like this is it motivated by threat system"P4 II. "I can't be bothered if they can't , this is giving me more work - what's the point"P1
		T3	I. "How to educate, why bother, have they researched their placement" P12, "Student may be threatened and need one to one session to clarify things. Might not be sure of what to do needs direction"P8 II. "I give up"P1 "This student is wasting my time"P11
		T4	I. "Student is not ready to be a nurse"P8, "Do they want to be there, do they understand the area are they scared"P9 II. "Fed up. Why's he here. This is more work than I need"P1

b) What would you be feeling (emotions) and physically experiencing ?	**MENTOR FEELING AND PHYSICAL EXPERIENCING Labelling emotional states**	**T1**	"Annoyed, demotivated, fed up "P1, "Frustration, disbelief, worried"P5
		T2	"Fed up, increased stress, annoyed"P1, " Worried for the student might be hard to deal with"P8, "Anxious threatened myself" P6, "Tense, guarding, anxious"P12
		T3	"Annoyed, demotivated, disinterested" P1, "Frustrated, threatened and worried"P8, " Concern for student"P2
		T4	"Angry, annoyed, disheartened, frustrated"P1, "Worried about his practice"P11
c) What would you do?	**MENTOR ACTION** **I. Addressing Mentee Learning Problem solving** **II. Utilising CFA Model**	**T1**	I. "Try and address with student – through evaluations in book – possibly speak with university"P1 "Speak to others for advice, arrange a time to meet student-discuss their values, what motivated them to do course, suggest some reading be honest that I was concerned re their attitude"P4
		T2	I. "Ask the student if anything was concerning him" P10 I. & II. "Arrange a meeting. In a compassionate mind. Be honest and listen. To allow student to reflect, learn, empower." P11 " Focus on my thinking and approach in non threating way, meet and discuss, set goals"P6
		T3	I. "Seek to understand and resolve student issues to make plan to achieve this"P2 II. "Have a meeting, explore learning and what gets in the way. Reason for coming into nursing – any earlier experiences or prejudices. For student to identify if nursing is for him, try to empower by being compassionate in wise mind and be truthful to where can they see self." P11
		T4	I. "Talk to student honestly, challenge their beliefs, fitness to practice, if views entrenched" P9, "Ask the student why he felt like this and try and explain that he should try and be more motivated when nursing patients" P10 "Consult my manager to discuss the student and their attitude towards the job" P8

2. <u>What do you think the mentee would be:</u> a) Thinking?	**MENTEE THINKING** **I. Critical Judgments** **II. Motivation** **III. Concern for Career**	**T1**	I. & II. "I am frightened, I don't understand, I've made a mistake"P6 II. "I am bored, what's the point, nothing changes/I could be doing something else – this was a waste of time/my mentor isn't bothered" P4 III. "worried and feel out of their depth, a façade"P5
		T2	I. & II. "I'm no use, this is boring. No point being here. Not sure what I am going to learn"P4 II. "Why am I observing not getting better, what am I observing. If I sit here and look but I might not get asked"P12 III. "That the job is not worthwhile" P3, "He is not interested in the job/unit"P8
		T3	I. "He/she is wasting my time" P4 II. "Nothing is helping, I can't change anything, I can't be bothered"P1 III. "Is this for me?" P4
		T4	I. & II. "I'm scared, people will find out how little I know, I don't want to do this" P6, "Not bothered, don't care, uninterested. I cannot do the job. These people are all the same"P11 III. "This is not what am expecting for the course"P7, "Not what they expected. They are not ready to make changes in peoples life"P8
b) Feeling (emotions) and physically experiencing?	**MENTEE FEELING AND PHYSICAL EXPERIENCING** **I. Labelling emotional states** **II. Describing the physiology**	**T1**	I. "Hopeless, unhappy" P3, "Bored, discontent" P4 II. "Lethargic" P1, "tired, lethargic" P4
		T2	I. "Scared, frightened" P12, "Sad, anxious" P10 II. "drained" P1 ", palpitations, clammy" P11
		T3	I. "Bored" P1, "Anxious, nervous" P12, "Hopeless, isolated from patients/staff"P3 II. "Tired" P4, "fidgety"P11
		T4	I. "Confused, anxious, guilty, sad, depressed" P10, "Not connected" P12 "Boredom, disinterest" P9 II. " lethargy"P9

c) Doing?	**MENTEE ACTION** **I. Approach behaviours** **II. Avoidance Behaviours**	**T1**	I. "To work with his mentor" P7 II. "Sitting in office. Very little productively" P1, "avoiding all situations"p12
		T2	I. "Hopefully prepared to engage"P2 II. "Withdrawing; distracting himself"P3, "Hiding away or avoiding the problem" P7, "Not wanting to do things, avoidance" P11
		T3	I. "Asking what to do/show interest in their learning" P6 II. "Avoiding, hiding" P11
		T4	II. "Avoidant Nothing – upsetting patient with some of their ideas" P7, "Giving up nursing/not attending work/placement" P10

3. What mentee issues need to be addressed?	**MENTOR ISSUES TO BE ADDRESSED** **I. Learning** **II. Approach to issues**	**T1**	I. "Professional conduct, attitude, suitability, learning needs and outcomes" P9, "Education around mental health units and psychiatry, beliefs around change" P12 II. "work with student and university to action plan and support student; No – speak with student and university about whether other factors are play e.g. don't like placement? Staff? me?"P5, "Is he in the right job, what are his motivations, any non work related issues he needs support with"P3
		T2	I. "expectations of the role of a student on the ward and what would be required to pass the course."P1 II. "His motivation; expectations; any other personal issues need dealing with; his approach to team work and problem solving." P2, "Are there any blocks to his learning experience? Is nursing for him? Is he getting 'lost' on a busy ward and is to worried to raise concerns? How can I help/support his learning safely?"P5
		T3	I. "Role of student at work, student outcomes, blocks to achieving these"P2 II. "Their drive – what motivates them" P4, "Fears, anxieties, avoidance – how to be empathy, show compassion. Writing things down, how to be more caring to self, not to put pressure on self and learn about empathy"P11
		T4	I. "Professionalism, confidence – education [on client group]"P10, "Expectations if wants to pass."P1 II. "one to one meetings with the student find out if they have other personal problems, are they ready to work as a team, are they interested in learning, discuss with university link tutor to assist the student further"P8

Vignette 4 and Examples of Higher Order Categories

The mentor is feeling under pressure as the have a student with them all day. He feels he will have less time to devote to some of the nursing needs of the patients e.g. if he is explaining things to the student, he'll have less time to interact with patients. He knows that he needs some help to lessen his workload but his colleagues are all very busy and he feels unable to ask for support from them to lessen his workload and/or reduce his coordinator activities. His student is also very keen and asked to meet at the end of the shift so that he can be supported to reflect on his learning from the day. Although these discussions are stimulating and enjoyable, the mentor knows that when they have done this on previous occasions he ends up working beyond his normal working hours of his shift.			
Question	**Higher Order Categories**	**Time Frame (T1, T2, T3, T4)**	**Examples**
1. <u>As a mentor:</u> a) What would you be thinking?	**MENTOR THINKING** **I. Concern for others** **II. Mentor Reactions**	**T1**	I. "I cannot carry on like this. I need support to do my job and support student appropriately"P5, "How can I help me/patient/student."P12 II. "I have too much to do, I am stressed, I don't want to stay over"P1, "This is too much, I can't cope, bloody students"P6 "Annoyed at another detail to manage. Impact on home life. Allocate time within the day for it. Pre-arrange another time. Ask them to write reflection, bring it back for discussion"P9
		T2	I. "Anxious how I could support the student"P10 ""That I haven't got time to help student and patients; that I need to organise my time better"P3 II. "that I need to be more compassionate to myself"P3, "Need to keep supervision within time available, Need help and support from colleagues as will not be able to continue this way"P5, "Why can this not take place in the working day, what barrier is causing that"P10, "Why me, I'm busy. Best be ok, can't ask anyone as failure, I haven't got time"P12
		T3	I. & II. "May be their team should not be having student if they are that busy"P7, II. "I'm not doing my job very well" P3 "I am already overload, lot to do, how will I get this done, I'll have to tell mentee unable to see after work"P11
		T4	I. "How to explain to the student my situation and arrange to meet another day"P8, "not assume that nobody would help out just because they have as much work"P9 II. "That student are added stress and workload"P7, "This is too much. I want to be able to work with patients and student but don't want to go home late" P1

b) What would you be feeling (emotions) and physically experiencing?	**MENTOR FEELING AND PHYSICAL EXPERIENCING** **I. Labelling emotional states** **II. Describing the physiology**	**T1**	I. "Stressed, annoyed, fed up"P1 II. "Drained and exhausted" P7
		T2	I. "Stressed, pressured, fed up"P1, "Enthusiastic about making the day run well and responding to blocks and adapting plan to my availability"P2 II. "Tense, heart rate increased" P12
		T3	I. "Anxious, angry, frustrated"P11, "Pleased to have a plan to work to" P2, "Threat mode"P3 II. "Drained" P7
		T4	I. "Guilt, disappointment"P9 II. "Tired"P6

c) What would you do?	**MENTOR ACTION** **I. Addressing Mentee Learning Problem solving** **II. Utilising CFA model**	**T1**	I. "Try and structure my own time. Be clear I have only set time. Ask student to write reflections in own time"P4, "Speak to colleagues/manager at work about giving time to support student" P5, "Talk to the other team members how they can help me to spend more time with the student" P10
		T2	I. "Try and allocate student to other jobs, tasks – manage my time – set out boundaries"P1, "Arrange to meet, discuss how he is feeling now. Are there any concerns/fears- discuss he will learn a lot from observations and will not always be able to learn everything/manage expectations"P4 , " delegate task, speak to work colleague to support student learning, inform student unable to meet after work but will arrange another time"P11, II. "Take time to get in soothing state."P4, "Stop. Take stock of what happened"P7, "Praise work" P11
		T3	I. "Arrange for student to spend time working with others, ask for set times for his student"P12, "Explain to student can't meet today. Agree for another time"P3, II. "Ensure I am in soothing system. Arrange a time to see them."P4, "Get into my wise mind. Delegate tasks to other colleagues, not to be hard on self, to be compassionate to self"P11
		T4	I. "Cancel the meeting explain why rearrange during work time and then discuss and plan mutually agreed support plan"P6, "Speak to mentee that another time/day will be arranged, speak to another colleague"P9 , "I would try and delegate some of my tasks and probably stay behind after work"P10 II. "Be honest to the student not possible to meet but arrange to meet another day giving reason" P8, "Speak to colleague stop catastrophising, have honest discussion with student, find a solution"P9

2. <u>What do you think the mentee would be:</u> I. Thinking?	**MENTEE THINKING** **I. Critical Judgements** **II. Motivation** **III. Concern about Career** **IV. Concern for Others**	**T1**	I. "Mentor is annoyed by me."P1, "Frustration, his learning is not valued"P3 II. "I have so much to do and learn, I need to appear keen, I can't do it on my own" P6, "The learning experience not the impact on others, outside of their needs" P8, "I want to please my mentor, Will I achieve my objective, am I doing things as my mentor expects" P11 IV. "Am I annoying people"P4 "Have I upset mentor or are they to busy for me"P12
		T2	I. "Am I doing enough/I want to learn as much as possible/I'm scared of getting it wrong"P4 "That the mentor can't time manage" P7 II. "This is engaging and interesting, I am being listened to, I have a role I understand" P2, "That they are getting what they need, no consideration of the impact, ego centric thought process"P9 IV. "may pick up on some difficulties with mentor"P3
		T3	I. "I'm no good,"P11 "They have no time for me"P12 II. "I want to learn, I need to be with my mentor to get the most out of this but they don't seem to have time"P1 III. "I'll never be a good nurse"P11 IV. "Worried I have upset my mentor" P11
		T4	I. "That they've been treated unfairly" P7 "They may think that you're not giving them enough" P10 II. "I want to show how keen I am, I need to know how I am doing"P6, IV. "Potentially recognise the pressure of the mentor"P9
II. Feeling (emotions) and physically experiencing?	**MENTEE FEELING AND PHYSICAL EXPERIENCING** **I. Labelling emotional states** **II. Describing the physiology**	**T1**	I. "Scared, anxious, excited"P6 II. "energetic posture, faster speech"P9
		T2	I. "Anxiety/excitement, driven to achieve/learn as much as poss"P4 II. "Tense"P12
		T3	I. "In drive mode possibly threat too"P3, "Anxious"P4
		T4	I. "Excited, anxious, worried" P6 "Happy, over excited, enthusiastic"P11

c) Doing?	**MENTEE ACTION** **I. Approach Behaviours** **II. Avoidance Behaviours**	**T1**	I. "Trying to be involved in everything, trying to learn, asking mentor for time" P1, "Pressuring/pushy"P6, "Complaining to managers or university"P7
		T2	I. "Engaging in the days activities"P2 , "Over working, putting pressure in self, doing too much, burn out"P11 II. "Avoidance quiet"P10,
		T3	I. "Seek reassurances – over questioning"P12. "Engaging in drive"P2 II. "avoid mentor eventually" P12
		T4	I. "Seeking to be with mentor all of the time asking questions"P1, "Being pushy"P6 II. "Not attending his placement"P10
3. What mentee issues need to be addressed?	**I. Learning** **II. Approach to issues**	**T1**	I. "Understand how his objectives fit in with other people's; but he needs to ensure his objectives are met"P3, "Time management, self organisation, self awareness (or impact of need on others) insight, understanding what is reasonable and at what time"P9 II. "reflection meeting, self belief, keep diary and record learning"P12
		T2	I. "Role of student - level of autonomy – what they can do when day is busy. Get student to recognised importance of mentor having own time"P1, " to meet/time management, discussion around learning needs, self-confidence, self-worth"P12 II. "manage their enthusiasm with compassion"P5, "That it doesn't matter if few objectives are not met at the time specified they would in time. That nursing is a process that doesn't end in one particular placement." P7, " To praise work, to be kind to self"P11
		T3	I. "Self awareness of own behaviours on experience of patients. Own self management issues"P2, "Drive – reasonable expectations of placement" P4 II. "Showing empathy, compassion to reflect on event and empower them. On what they are feeling or what may be going on. Who do they look up to, reasons of becoming a nurse"P11
		T4	I. "Boundaries, role of student" P1, "Can they understand when there is pressure and use initiative to prioritise"P8 II. "Now the student appears very keen and willing to support the mentor it's the mentor that needs support with time management and how to ask for support when needed"P10

Appendix S. A sample of a transcript illustrate the thematic analysis process

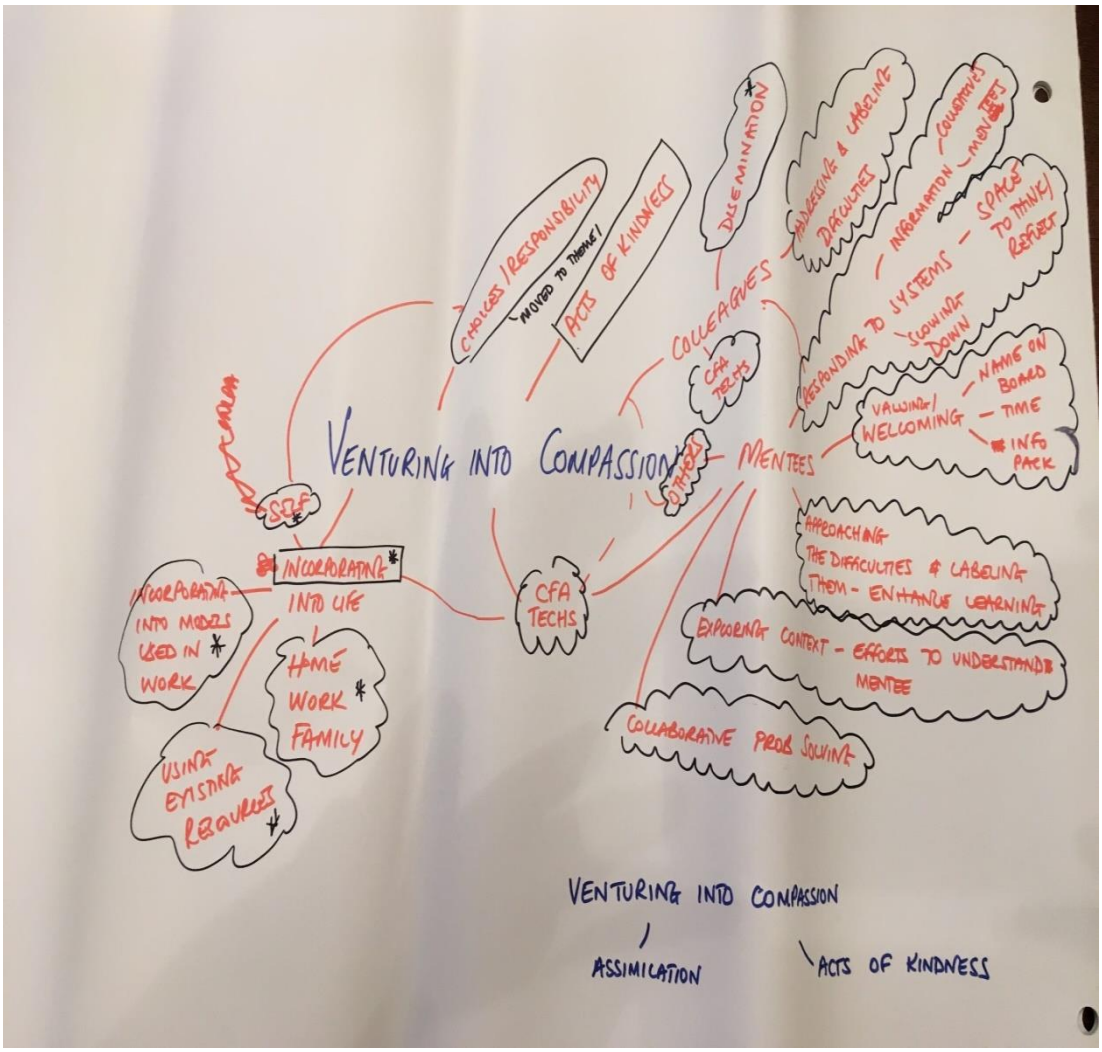
	R: [Laughs] you've actually told me quite a lot there. So what was helpful about the programme to you personally?	
	P: um I guess it was I suppose taking a little step back yourself and exploring sort of the self compassion side as well, sort of making sure that you look after yourself and things like cos that's something you avoid in nursing isn't it	Taking a step back, self-compassion
	R: Mmm	
	P: you forget that, I suppose I've been through a particularly stressful situation recently but you forget the impact your own situation is having and how it makes you judge the situation that you are in and also I guess it made you reflect more on what the previous sort of experience of the student's had and why they are making the decisions they are making and sort of a realisation as well that they are in the same situation as you so they might have an argument with their children on the way to work in the morning	Things influencing judgement The humanness of students – life outside of placement
	R: Yeah	
	P: and that might be why they are acting the way they are and they might be upset they might be blunt with people and that's because of what's happened this morning rather than that's them as a person sort of thing	Understanding the context of student behaviour
	R: Yeah, Ok, lovely, so you've said a bit about you personally and you've started to answer the next question which was about what was helpful about it in your practice as a nurse mentor. Is there anything else that you'd want to say about that?	

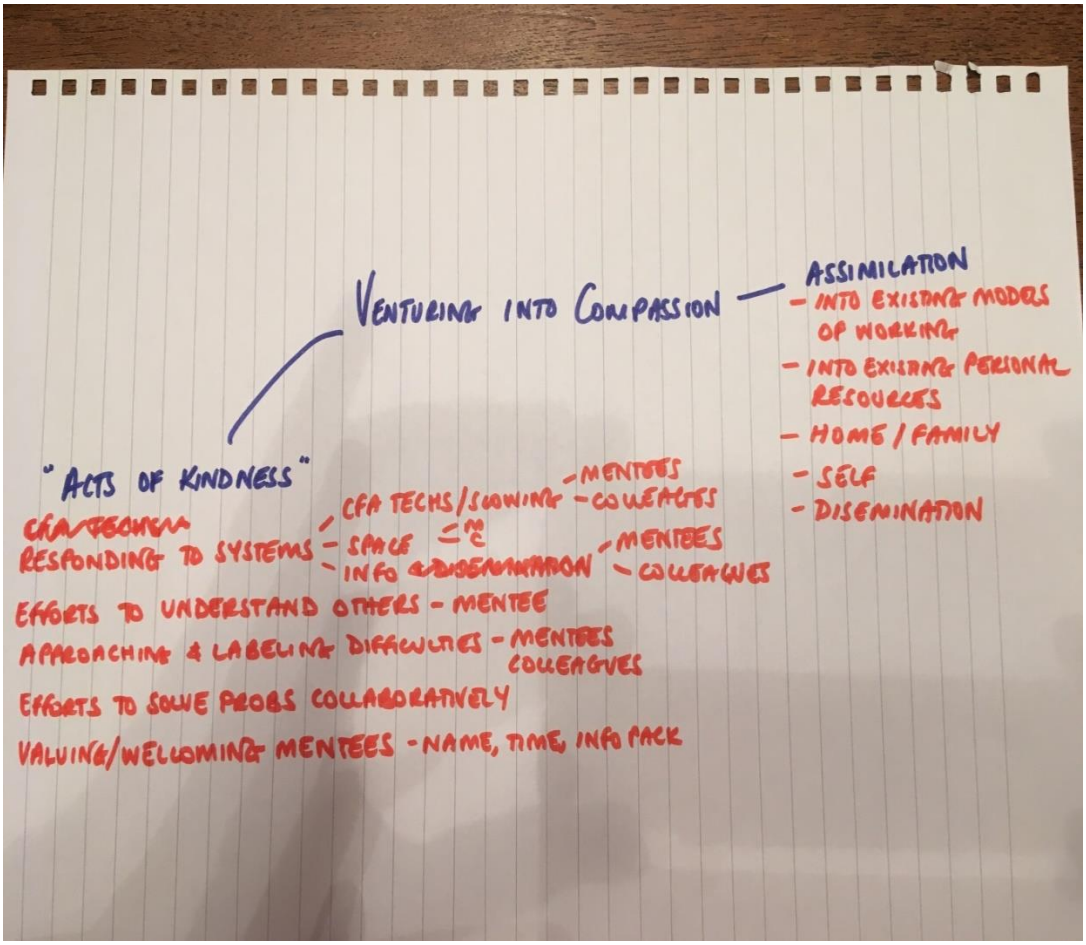
Belonging	P: um I guess that sometimes it's about taking a little bit more time to get to know the student and welcome them as part of the team and sort of making sure you do take account of what's been going on for them in their situation and things like that as well, it's not just – it's making sure you see them as a person and not just a student sort of thing. You have to explore that they've got needs as well and it has made me think a little bit more about things. R: Ok, lovely, ok, the last part of this question is what has been helpful about the programme in any other aspects of your work or life? P: um, I suppose it's about the self compassion and things like that, I mean R: Mmm P: I've had a quite lengthy period of time off sick and normally that would really really upset me and things like that but obviously sort of knowing all of this and in my personal life its knowing that has to take precedent over things in my professional life at the moment and that I couldn't be an effective nurse with the situation I've been in at home. So it's kind of the self compassionate sort of thing is looking after myself rather than going in to work and sort of not being a very effective practitioner because I'm not looking after myself, do you understand what I mean? R: So it's enabled you to P: Yeah, to not have that feeling of guilt about not being at work and things like that and that knowing that it's the best thing for me and for me as a nurse to take the time out .	Taking time with student Welcoming them-part of team Students humanness Permission to be self compassionate and understanding its purpose Self-permission to take care be self-compassionate

	R: Umm, Ok thank you. You may have answered this question already but apologies if you have, but if anything else springs to mind please say so, what did you learn from the programme?	Things to teach others
	P: umm, I guess the same as well really, um that I suppose that there are different strategies out there to sort of um, that you could teach other people and that you could utilise yourself to relax and take time out and things like that, um, I suppose it made me just think a little but more about why other people respond, and the way they are responding and sort of I guess take that step back and look at that situation. I suppose sometimes you know when you're stressed and irritable and things like that and you behave in the way that you are, and may be take that step back and you know think this is why you are doing this and not, to give yourself a bit of a break really	Thinking about the context of others and their action Reflecting on own context and giving self a break
	R: Yeah, ok, lovely, so the next question, I know you're already answered so forgive me for asking it again but it's to double check to see if anything else springs to mind, what exercises, techniques or ideas from the programme do you remember?	
	P: um I think it was sort of more of the relaxation type stuff that I remember, so it was sort of about the breathing, um focusing on your breathing and I remember the stuff about your ideal self, um and sort of your ideal place, location, um and things, relaxation type stuff and um, I guess just utilising other the stuff that you would use to relax so go for a run, having a bath or taking time out,	CFA techniques Practical Self Soothing
	R: Mmm	
	P: so I guess it was just, I don't know the talking to other people, exploring what's going on for them maybe and their techniques and things um	Understanding others' contexts CFA techniques
No more than usual	R: Yeah, ok lovely, OK, what if any of these do you use, practice or apply for yourself?	

	P: Um, I think I probably use more of the stuff that I would have used anyway, sort of the more relaxation like having a bath, and um going for a run and things like that, taking time out, um I think more of that sort of stuff rather than um R: and are you saying that you are doing more of that because of the programme or are you saying you would have been doing that stuff anyway? P: um, I think I was probably doing that stuff anyway, perhaps, a little bit more	Practical self soothing

Appendix T. An example of the development of a theme




VENTURING INTO COMPASSION
ASSIMILATION
- INTO EXISTING MODES OF WORKING
- INTO EXISTING PERSONAL RESOURCES
- HOME / FAMILY
- SELF
- DISEMINATION
"ACTS OF KINDNESS"
CFA TECHS
RESPONDING TO SYSTEMS
CFA TECHS / SHOWING
SPACE
INFO & DISEMINATION
MENTEES
COLLEAGUES
MENTEES
COLLEAGUES
EFFORTS TO UNDERSTAND OTHERS - MENTEE
APPROACHING & LABELING DIFFICULTIES - MENTEES
COLLEAGUES
EFFORTS TO SOLVE PROBS COLLABORATIVELY
VALUING/WELCOMING MENTEES - NAME, TIME, INFO PACK

Appendix U. Additional demographic information: Length of time since qualifying, length of placement provided and additional qualifications

Length of time since qualifying

		Mean (*SD*)	Min-Max
Length of time since qualifying (months)	*N*=12	157.17 (94.48)	49-360

Length of placement provided by participants

	Length of placement (weeks)					
	2-12	4-12	6	8-12	12	10-18
N=11	*n*=1 (9.1%)	*n*=1 (9.1%)	*n*=1 (9.1%)	*n*=6 (54.5%)	*n*=1 (9.1%)	*n*=1 (9.1%)

Qualifications*

N=11

MSc	BSc	Diploma	ENB or other
n=1 (8.3%)	*n*=1 (8.3%)	*n*=2 (16.7%)	*n*=7 (66.7%)

*2 participants stated CBT training 1 to diploma level (other not stated)

Appendix V. Participant completions of measures

Summary of Participant Completion of Questionnaires Phase 1

T1 (Start of 5 day programme)														T2 (End of 5 day programme)												
Participant No.	CEAS						GHQ-12	SS (DASS21)	ProQOL V	Vignettes				CEAS						GHQ-12	SS (DASS21)	ProQOL V	Vignettes			
	CSE	CSA	CTOE	CTOA	CFOE	CFOA				1	2	3	4	CSE	CSA	CTOE	CTOA	CFOE	CFOA				1	2	3	4
1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
7	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
8	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
9	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Summary of Participant Completion of Questionnaires Phase 2 and follow-up

Participant No.	T3 (End of supervision sessions)													T4 (Follow-up)											
	CEAS						GHQ-12	SS (DASS21)	ProQOL V	Vignettes				CEAS						GHQ-12	SS (DASS21)	ProQOL V	Vignettes			
	CSE	CSA	CTOE	CTOA	CFOE	CFOA				1	2	3	4	CSE	CSA	CTOE	CTOA	CFOE	CFOA				1	2	3	4
1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	×	×	×	×	×	×	×	×	×	×	×
3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	×	×	×	×	×	×	×	×	×	×	×
4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	×	×	×	×	×	×	×	×	×	×	×
5	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×
6	×	×	×	×	×	×	×	×	×	×	×	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
7	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
8	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9	×	×	×	×	×	×	×	×	×	×	×	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10	×	×	×	×	×	×	×	×	×	×	×	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	×	×	×	×	×	×	×	×	×	×	×

Summary of Participant completion of compassionate activities diary

Participant No	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11
1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×
3	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	×
4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×
5	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×
6	✓	✓	✓	✓	✓	✓	×	×	×	×	✓
7	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
8	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9	✓	✓	✓	✓	×	×	×	×	×	×	✓
10	✓	✓	×	✓	✓	✓	✓	✓	✓	×	×
11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
12	✓	✓	×	×	×	×	×	×	×	✓	×

Appendix W. The mean scores, scoring criteria and *z*-test for each measure at T1

Participants Mean Scores for CEAS at T1

Measure CEAS	N	Mean (*SD*)	Min – Max Score	Scoring Criteria	*z*-tests
Compassion for Self Scales				Norm/ Means (*SD*)	
CSE	12	41.92 (6.53)	32-54	21.93 (6.43)	10.74 (*p*<.00001)
CSA	12	27.25 (9.55)	11-36	24.01 (8.18)	.09 (*p*>.05)
Compassion To Others Scales					
CTOE	12	44.83 (8.84)	30-60	39.76 (11.10)	1.58 (*p*>.05)
CTOA	12	27.25 (9.55)	11-36	28.47 (7.40)	-.57 (*p*>.05)
Compassion From Others Scales					
CFOE	12	37.67 (10.50)	17-55	31.90 (9.78)	2.05 (*p*<.05)
CFOA	12	24.75 (8.09)	9-38	23.07 (6.97)	0.84 (*p*>.05)

Participants Mean Scores for GHQ-12 at T1

Measure	N	Mean (*SD*)	Min – Max Score	Scoring Criteria	*z*-test
GHQ-12	12	14.08 (6.58)	6-23	Caseness Cut-off 13/14	
				Mean (*SD*)*	2.47
				10.6 (4.9)	(*p*>.05)

* Norms taken from Hankins (2008)

Participants Mean Scores for SS at T1

Measure	N	Mean (*SD*)	Min – Max Score	Scoring Criteria	*z*-test
SS	12	13.50 (7.49)	4-26	Normal 0-14; Mild 15-18; Moderate 19-25; Severe 26-33; Extreme 34< **Mean (*SD*)** 10.29 (7.91)	1.41 (*p*>.05)

Participants Mean Scores for ProQOL at T1

Measure ProQOL V	N	Mean (*SD*)	Min – Max Score	Scoring Criteria **Norms -Means (*SD*) Quartiles**	*z*-tests
CSS	12	39.92 (4.54)	31-46	50 (*SD*=10) Lower=43 Upper=57	-3.78 (*p*>.05)
BS	12	25.67 (5.28)	19-34	50 (*SD*=10) Lower=43 Upper=57	-8.45 (*p*<.00001)
STSS	12	22.00 (5.72)	16-35	50 (*SD*=10) Lower=43 Upper=57	-9.72 (*p*<.00001)

Appendix X. Wilcoxon signed rank test analyses for CEAS across T1-T3

Additional Wilcoxon Signed Rank Test analyses were used to explore changes in scores on the CEAS between T1-T2 and T2-T3. Medium effect sizes were shown for the CTOE, for a decreased mean score between T1-T2 (z=-1.57, p=.89, r=-.32) and increased mean score between T2-T3 (z=-1.61, p=.11, r=-.40). Increased scores suggest an increased engagement with compassion towards others. Regarding CTOA, medium effect sizes were demonstrated for an increased mean score between T1-T2 (z=-1.63, p=.10, r=-.35) and the maintenance of the mean score at T2-T3 (z=-1.38, p=.17, r=-.44). Increased scores suggest an increase in compassionate actions towards others.

The low participant numbers resulted in difficulties interpreting medium effect sizes achieved for CFOE and CFOA. Interestingly, the CTOE subscale mean scores reduced between T1-T2 and increased from T2-T3. Thus it could be suggested that participants' ability to attend to, learn about and act on what is helpful to alleviate suffering of others was re-activated during the supervision phase of the programme. In relation to the aim, however, the scores on the CEAS did not demonstrate sustained changes in the mentors' ability to be compassionate to themselves or others as previously proposed.

Appendix Y. Figures illustrating changes in the mean and median for each of the "Compassionate Actions"

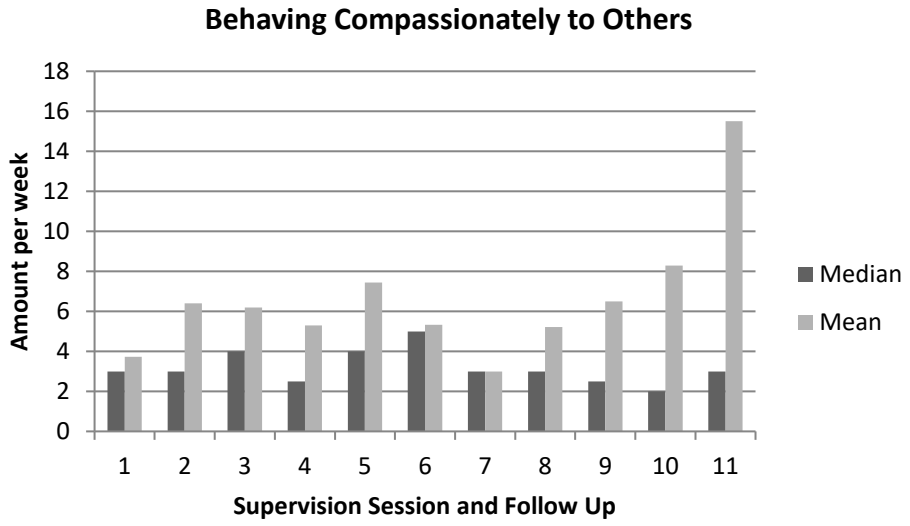


Figure 1. Frequency of Compassionate Action: Behaving Compassionately to Others

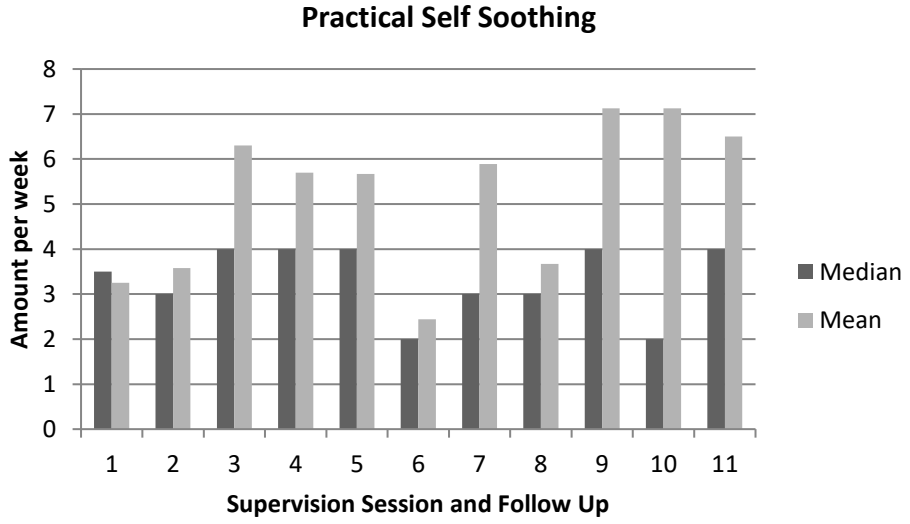


Figure 2. Frequency of Compassionate Action: Practical Self Soothing

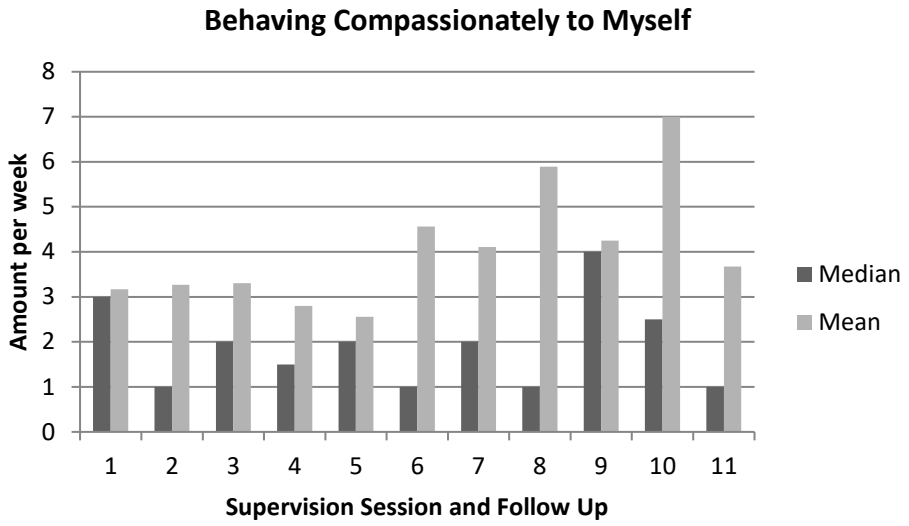


Figure 3. Frequency of Compassionate Action: Behaving Compassionately to Myself

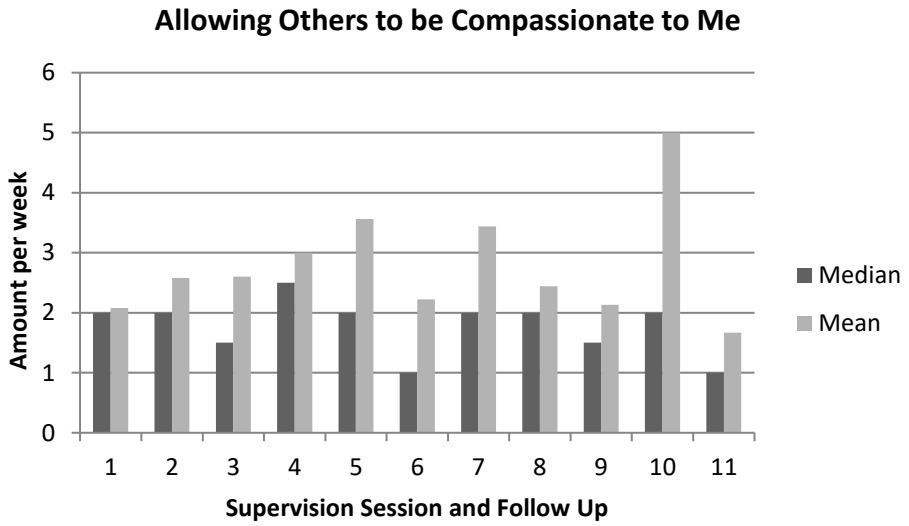


Figure 4. Frequency of Compassionate Action: Allowing Others to be Compassionate to Me

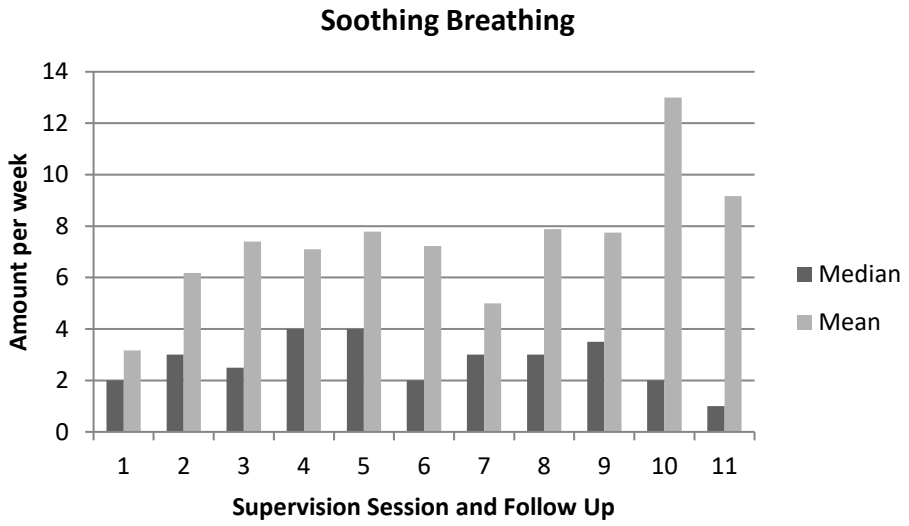


Figure 5. Frequency of Compassionate Action: Soothing Breathing

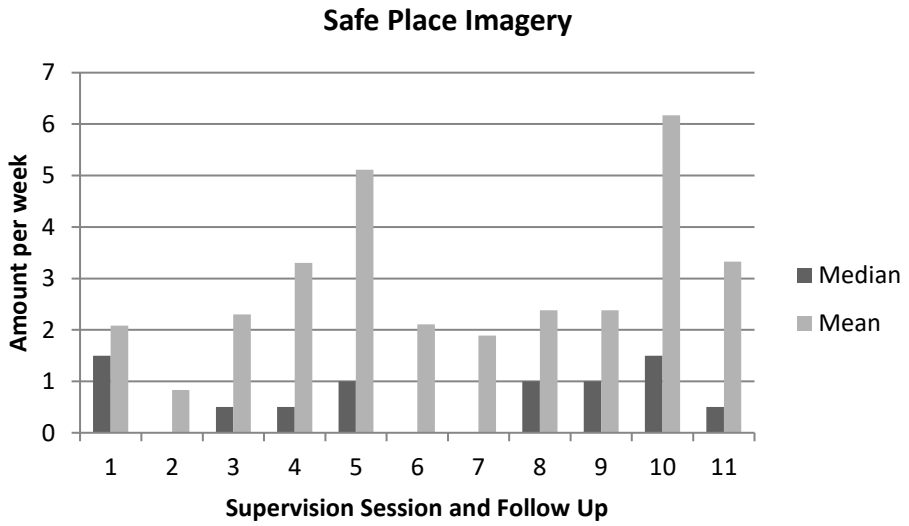


Figure 6. Frequency of Compassionate Action: Safe Place Imagery

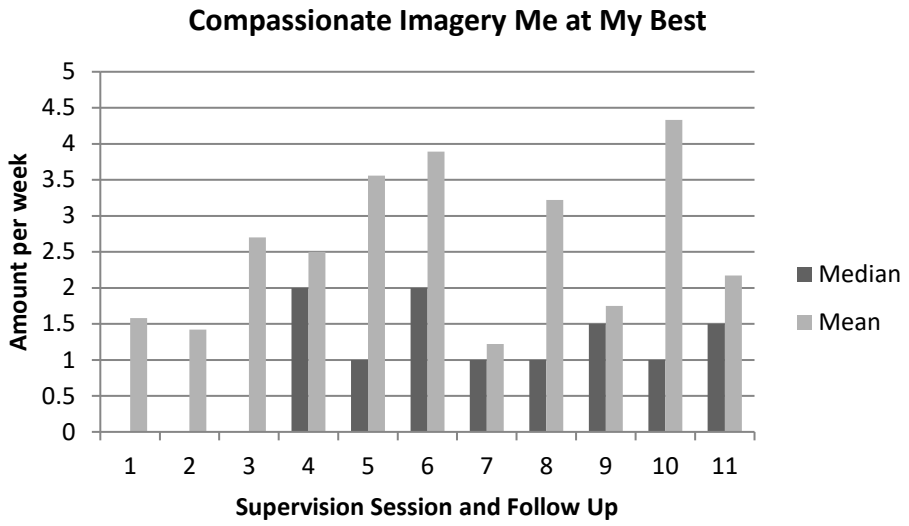


Figure 7. Frequency of Compassionate Action: Compassionate Imagery Me at My Best

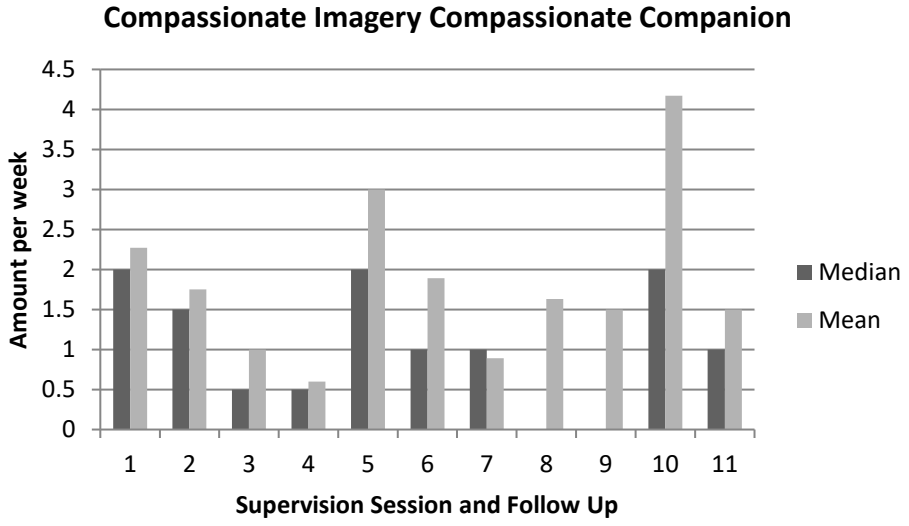


Figure 8. Frequency of Compassionate Action: Compassionate Imagery Compassionate Companion

Appendix Z. Detailed summary of themes following a thematic analysis of the follow-up interviews

Theme 'Understanding Compassion', with 'CFA Concepts', 'Awareness' and 'Permission' subthemes and participant quotations examples

Theme	Subtheme	Quotations from Participants
Understanding Compassion	**1. CFA Concepts**	**Understanding Compassion** P9"…I started to put into practice actual stuff I had learned. I'd gone back to work and I was all kind of jubilant about compassion, as I understood it now, I really understood it, not in a cross legs Zen kind of wishy washy mindfulness type, I thought I had really got a handle on it."p.2 P11 "I think that's important to understand it's the way you approach somebody, it's the way you talk and also the way the individual can be kind." p.4 **Examples of concepts:** P3 "the sort of neurological basis for compassion" p.1 P2 "this is old brain, this is new brain, this is how it works, these are drives, these are different systems, you know in the brain and on top of that you know we've got all our thought processes"p.4 P11 "the evolution brain because we've got the compassionate brain at the front the evolution brain at the back, looking at the wise mind" p.1 P9 "the lizard brain idea and the monkey brain thing, and how you try and treat your emotions and how you perceive threat" p.2 P12 "old brain, new brain, how our brains are evolved and what we are good at and what we are not good at, so we automatically go back to fear and the more old brain coping mechanisms" p.1 **Examples of using techniques:** P1 "focusing on your breathing, and I remember the stuff about the ideal self, um and sort of your ideal place, location"p.3 P10 "thinking about nice things, relaxing um…..shut my eyes, feet on the floor to um think about something nice…..in my little world, I have a little dog there next to me."p.2 P11 "trying to allow them [students] to learn these techniques is crucial because it's a step by step process, cos at first it's about your breathing, understanding your breathing, breathing in through your nose and out through your mouth, and then just focusing on your body and how your body's relaxing and the next stage it will just introducing you know anything they want to take to a safe place….."p.6

Theme	Subtheme	Quotations from Participants
Understanding Compassion	**2. Awareness**	**Self-Awareness:** P9 "I had completely neglected myself in that respect and it was kind of, have someone actually make me aware of what was going on"p.1 P10 "I actually learned to read my own body language, my own signs of when I'm getting too stressed and how to deal with it a bit better"p.1 **Self/Other awareness:** P1 "you forget the impact your situation is having and how it makes you judge the situation that you are in" p.2 P11 "sometimes you are running from place to place and you notice and you know you need a few minutes in the car, you do the breathing, you close your eyes, it doesn't have to be lengthy but then it kind of allows you to be more focused for the next individual, you're not kind of holding onto something that you've dealt with for the next person, and it's very important for the students as well"p.2 P12 "No I think it's just being more self-aware, it made me more self-aware that course of how I am affect others as well so if I'm already in a state of high arousal or anxiety sometimes your clients will feed off that and so will your mentee, so it's being more aware of yourself so you can project more good feelings onto other people rather than the nervous anxiety" p.3 **Awareness of mentees:** P1 "I guess it made me reflect more on what the previous sort of experience of the student's had and why they are making the decisions they are making and sort of a realisation as well that they are in the same situation as you so they might have had an argument with their children on the way into work in the morning" p. 2 P3 "one of the things that struck me particularly was the difficult experiences that some students have obviously had, and I didn't realise they would, for some students they hadn't actually been dealt with compassionately with their mentor"p.1 P10 "it made me realise you know, different ways of looking at um students, and looking at behavioural and body language, behavioural signs and body language, to actually understand them better, you know." p.1
Theme	**Subtheme**	**Quotations from Participants**
Understanding Compassion	**Awareness**	**Awareness of colleagues** *Colleagues* P10 "you know to read people a bit better" p.1

		P11 “I’ve encountered colleagues that have obviously been under quite a bit of pressure, distress, um, I just try to be um, looking at them, kind of acts of kindness, because sometimes there’s this self-culture or blame that people are picking on me, people are blaming me……it’s just the personal opinion gets created and then when you’re under your own stressors…I think that’s when people become more fearful…..”p. 3
Theme	**Subtheme**	**Quotations from Participants**
Understanding Compassion	**3. Permission**	**Permission to be kind** *self:* P1”to not have that feeling of guilt about not being at work and things like that, knowing it’s the best thing for me and for me as a nurse to take time out.”p.3 P9 “I learnt looking after myself was not anything that was selfish or it was just necessary…..I didn’t have to say yes to everything just because somebody wanted it…..it gave me quite a lot of confidence to really start thinking no actually you are worth it”p.8-9 P12 “realising we don’t have to do everything at 400 miles an hour, give us time between each client….take that 2 to 5 minutes in the care before you move onto the next client, so you’ve recharged and refocused your brain” p.1 *Others:* P2 “Specifically, it was quite nice to have permission to be kind to people, um students”p.5 *Giving permission to others:* P10 “if I see the signs, I can say to them, well this is how I normally cope with it if you know I’m feeling like that, and then hopefully they’ll take it away with them.” p.3 **Recognising choice/responsibility to act:** P9 “I’ve got choices here, wouldn’t have thought about that before.” p. 12 P11 “I notice when I’ve walked into the work environment, I’ve noticed this is tension, I walk back out…take some few breaths and kind of calm myself down and don’t get snappy and irritable”p.3

Theme 'Venturing into Compassion', with "Acts of kindness" and 'Assimilation' subthemes and participant quotations examples

Theme	Subtheme	Quotations from Participants
Venturing into Compassion	**1. "Acts of kindness"**	**Responding to Threat/Drive System** *Mentees* P10 "just try this [to the student], you know just try to relax, you know give yourself time to think, you haven't got to jump in and answer things straight away [drive]"p.2 P11 "it's about obviously looking at how the anxiety and the fears [threat] impinge on their [students] learning, and how that can also be misinterpreted by others ……. but it's not because they don't want to learn, there may be other kind of blocks within them. Now again, it's our own approach, it's about sitting with ourselves and kind of looking at the student and obviously factors which may have impinged on all the personal to them that could impinge on their learning and kind of empowering them through that journey and that's where we kind of did the flower thing and we did the kind of things they could do like, like help themselves do some breathing techniques or help them visualise some images and take themselves to a safe place, or you can be using sensories like smell or touch like some kind of mindfulness…"p.1-2 P12 "some are over keen and over eager [drive]so it's like lets break it down and then we break it right down and if they're feeling quite stressed you know it might be a bit silly but you take that 5 minutes to yourself, let's try and relax cos they are very like erruummmahhh so you need to refocus them so we do a lot of the breathing."p.2 *Self:* P12 "I just come down here sometimes and just take that 5 minutes and then you can calm yourself down and then you can look at everything you need to with a clearer mind rather than being in that one focus of everything being either drive or threat, you know you're not really going to get very far……I notice quite a lot now and I can recognise when I need to take that time, and before I'd just be like "oh I need to do it now, I need to do it now and I'm not getting nothing done cos I've got 400 things to do" but now I break it right down, into smaller more achievable chunks and I get more done." p. 3

Theme	Subtheme	Quotations from Participants
Venturing into Compassion	**1. "Acts of kindness"**	**Responding to Threat/Drive System** *Clients:* P2 "I found that by helping them [clients] identify what their threats were and switching them back over to the soothing system over a period, using mindfulness, using psychoeducation, psychoeducation tools, and the psychosocial stuff, that they actually began to get some esteem from the engagement and they in every case, they left with hope"p.3 *Colleagues:* P2 "so this was a very useful tool for that, and going through and um debating with people [colleagues] why they should behave in a professional way, it was really quite valuable and it made people re-evaluate their professional standing" p. 3 P11 "I've kind of been able to kind of allow people [colleagues] to notice themselves, how it's affecting them. I just kind of ask them to take two minutes for themselves and that is helping, just giving them a cup of tea, making a cup of tea, being kind." p.2 **Space** *With mentees:* P10 "it was helpful because it made me more apparent to actually looking at a student um and you know giving more time and realising how stressful it must be um going to new placements all the time, so, I was able to take a step back you know and thought that's right you know, um perhaps did they need more time, more one to ones" p.1 P12 "I think my student now, the students have had since [the programme] have had more from me, I think I feel and the feedback I've had is quite good" p.3 *With clients:* P2 "I would be an hour and a half, or 2 hours, on the first session" p.5 *With strangers:* P9 "So, we spent about 2 hours, we were talked about our backgrounds [background information] and anything other than what was happening at the moment we talked about and then we got back onto oh I'm worried about [personal circumstances] At the time, I was thinking OK you've never had any control in terms anything [personal circumstances] right or wrong I said this is something you can control now" p.3

Theme	Subtheme	Quotations from Participants
Venturing into Compassion	**1. "Acts of kindness"**	**Efforts to understand others** *Mentee/student* P1 "….sort of making sure you do take account of what's been going on for them in their situation and things like that as well, it's not just – it's making sure you see them as a person and not just a student sort of thing. You have to explore that they've got needs as well and it has made me think a little bit more about things."p2 P9 "I remember I spent, it amounted to 3 hours, it wasn't a quick hour alright this is the deal, this is where you put your bag and this is - it had taken 3 hours. By the time the 3 hours had ended she was crying between the, she started telling me about all this stuff [personal issues related to the mentee] and actually there was all these things and my boss actually came in at one point and pulled me out and said what are you doing and I was going well I think I am deconstructing this person's poor attitude, I'm actually being compassionate and I'm not just going OK I'm going to fill in this paperwork…I'm actually focusing on her as a person……for the remaining 3 months [student's name] turned into a different person"p.4 *Others* P1 "I guess it made me think a little bit more about why other people respond, and that way they are responding and sort of I guess take that step back at and look at the situation."p.3 **Approaching and Labelling Difficulties** *Mentees* P1 "So in terms of it going disastrously wrong the compassionate thing would be to sort of address that with the student and sort of deal with those rather than trying to avoid them because it's more compassionate for them to know that they are going wrong and things like that and having the opportunity to address that and things like that"p.1 P9 "so she [student] started learning through this, through me trusting her and me kind of having a bit of faith in her that actually the way you are composing yourself at the moment you won't get to where you want to get it's a pipe dream because the way you appear, the way you speak, the way you talk to people, will immediately prevent you from accessing this. So she went on this massive cognitive shift, and I just carried on as I am, and I didn't really consider it and then actually, I think about it now, it was quite a massive thing" p.4 *Colleagues* P2 "I said in actual fact this is what you should be doing as a professional, you should not be judgmental, you should be working to enhance people's experience, whether its patients, whether its students or whether its each

		other, you know that's what we should be doing as professionals. You know, and I saw it as a role to build compassion and understanding in the team…."p.2
Theme	**Subtheme**	**Quotations from Participants**
Venturing into Compassion	**1. "Acts of kindness"**	**Efforts to collaboratively problems solve** *Mentee* P9"I sat down and said, "OK what can we do here? Rather than slide into this pity pit what can we do, what are you going to do?" She [mentee] went "I don't know, I don't know", and I went "Ok have a little think, let's think about this systematically what are you going to do?" "I could phone the uni and try and get a new book". I went "yeah, there you go that's the first step, let's do that then" I even backed her up you know" (p. 8). P11 "As a nurse mentor it's also going to go hand in hand with my students kind of empowering them and that and going to the model of drawing, smelling, noticing how they can apply it in their day to day and its things, I didn't notice that anxiety, where's it coming from before it builds up, if they can do something mindful, you know mindfulness techniques, slow themselves down, kind of be kind themselves" p.4 *Colleagues* P2 "One [student] …….., felt he knew enough and he didn't need to get involved which was taken in hand and given a very hands on approach, which I wasn't really a supervising or a mentor to that person, but interestingly the lady who was, she talked to me about him at times about what I thought about his behaviour…..she used the concepts, um quite well with him and he got through, which was the most important thing and he learned from it." p. 6 **Valuing Mentees** P2 "…to begin to make a plan for people coming into the service, it made quite an impact for students because I put together a bit of a pack. I wrote about a little bit about the philosophy of compassionate focused therapy and how, and how it links in with the national health service…how professionals should behave with students and what students should expect and how students should behave when they come into placement……which gave the students some power, um and they've certainly used it"p.5 P3 "I don't think it's made a huge difference…….I've got a student now as it happens and I always try to make sure she feels safe, she feels valued, that I take her very seriously" p.2 P10 "…we're here to support you [student] and to make them feel more valued and respected, just a simple thing like making sure their name is there on the board in the morning….. because they feel part of the team" p.2 P1 "I guess that sometimes it's about taking a little bit more time to get to know the student and welcome them as part of the team". P2

Theme	Subtheme	Quotations from Participants
Venturing into Compassion	**2. Assimilation**	**CFA into other aspects of work** P2 "I have adopted it, I fitted it in with what I believe and what I know, I still use other techniques as well"p.8 P9 "Professionally, I became very aware of the circumstances of the parents I worked with [example of a carer's issues], I can come in here telling her how to deal with things, this woman has to deal with this 24 hours a day and why shouldn't she get some help and why shouldn't I fight harder to get them help."p.7 P11 "I'm trying to link it in and use these skills, and how this can then be applied with clients and students that I am having regularly" p.7 **Dissemination** P2 " So I fed that back to the whole team in about 5 different sessions, so I had 5 different sessions in order to capture everybody in the team, um and it was accepted really well" p.2 P9 "I actually actively passed this flyer around to all my colleagues and said OK someone else have a go now"p.11 P10 "when I came back from the sessions, that you know, I would talk to them [colleagues] about it and you know you want to try, you want to try and take a step back cos we are as nurses a bit snowed under with everything and you can get railroad into just keep going and going but, it's better if sometimes you take step back and I cascade that information back to them." p.3 P11 "that [teaching others about the use of self-soothing techniques] would also apply to colleagues…who are highly stressed and have got a number of students they need to see, before they speak to them, so that they can reduce their anxieties, bring themselves down, understand and kind of be mindful of what you are doing and how you are delivering yourselves"p.2 **Team Changes** P2 "it changed how they [the team] shared things with everybody, it changed the atmosphere quite dramatically, for quite a while, um, people stopped shouting in the office, one or two characters very loud and which is very difficult they were challenged by me at times, because it was not professional and it needed to stop…..this was a very useful tool for that" p. 3 P9 "…people started coming to me, just close my office door and tell me stuff". p.6 P12 "we use it [thinking about others more] all the time now, in the office" p.1

Theme	Subtheme	Quotations from Participants
Venturing into Compassion	**2. Assimilation**	**Family** P9 "…….also made me become totally introspective about my entire life, which is the next stage; it had me questioning um a case of why is my attitude about this like that? Presently, like, why do you feel like that? Why are you scared when your daughter goes to do something? .... so it started off that kind of process for me, personally." p.7 P11 "that act of kindness and not being self-critical and I think is the thing that I kind of empowering and trying to drive forward in, within my practice and I, not just within practice but within home as well, cos you're children are under pressure"p.3 **Personally** P2 "I think for my whole career I had been looking for something, to fit my beliefs that was also professional and it was also research based and that it was something that was acceptable in practice" p.4 P10 "it did make you look at your own life, a bit more, you know, it's not just about work, it's not just about um students, colleagues it's how you deal with life in general, yourself." p.4 P9 "So yes, it's affected me profoundly, my personal life, it's started me on a journey where I think OK, you are worth something and you are worth caring about and OK where did all this stuff come from, where did you get all this that you weren't, that you shouldn't be cared about, and you should get on with dying inside if someone says thank you, or something. So yeah, where did all that come from, so that personally that's where is started there."p.11 P11 "I think it was something that's going to stand with me and you know and it's going to be used in every area, of my journey and that's at home, work, when I'm meeting others and I think it's a reflection of me at times as well" p. 7 P12 "I found it was really valuable for myself because I wasn't very compassionate to myself and now I am and I feel better" p.4

Appendix for Critical Appraisal

Appendix AA: Epistemological Position

Critical Realism: A brief overview

The epistemological position for the current research was drawn from Critical Realism (CR). CR however, is much broader than an epistemology. "One of the most important tenets of CR is that ontology (i.e. what is real, the nature of reality) is not reducible to epistemology (i.e. our knowledge of reality). Human knowledge captures only a small part of a deeper and vaster reality" (Fletcher, 2017, p. 182). Further, CR suggests reality is stratified, containing a multitude of layers of mechanisms and tendencies in objects. As such, CR is concerned with causation which is understood as discovering what mechanisms are present in objects and how these mechanisms work rather than a specific relationship between two events (more commonly associated with a positivist approach; Danermark, Ekström, Jakobsen, & Karlsson, 2002). Causation therefore, helps to explain reality from discovering the layers of information present in an object (Brannan, Fleetwood & O'Mahoney, 2017; Fletcher 2017). Fundamentally, CR argues that the world and objects within it exist independently of human knowledge or our ability to manipulate them (Michel, 2012). Therefore, it is the mechanisms and tendencies within these layers or strata that provide a deeper reality irrespective of our knowledge of them (Brannan et al., 2017). Thus CR views reality as operating within an open system, as not all of reality has been accessed by human knowledge and not all mechanisms present in an object or system are known. This contrasts with a closed system more common in positivism or natural science where it is thought possible for the researcher to manipulate and control all mechanisms present (Robson, 2002). In summary, the complexities of reality exist irrespective of human knowledge and understanding and are constantly evolving. At its best research attempts to uncover layers, mechanisms or tendencies of reality without necessarily achieving absolute knowledge of an object or objects. Essentially this "helps the

researcher to be more aware of and reflective about the complicated relation between their research and reality" (Isaksen, 2016, p. 246).

CR in Social Science

In relation to the social sciences, CR suggests that objects are socially defined and socially produced and are part of reality (Danermark et al., 2002). Further, Bhaskar (2014) argues that societies are complex and stratified. Firstly, they evolve through an individual's interaction with the natural world and the materials and objects that exist in the world. Secondly, societal strata exist in the interactions between people, and an individual's interactions with different social structures, such as employment, education, family, peer and financial structures to name but a few. An individual's identification with or motivations to attend these social structures is a further example of the interaction between them. Additionally, social layers are developed from interactions with different personality types within these different social strata. Therefore, societies and social structures are constantly evolving with a variety of strata and mechanisms. Psychological strata are considered part of the social strata (Danermark et al., 2002).

Brief critique of CR

From the perspective of scientific language it can be argued that CR lacks coherence as an ontology. Specifically, Michel (2012) highlights hidden assumptions in CR directly related to the nature of an object as opposed to its existence. "It rather brings to bear pre-established categories of judgment upon the world and thereby establishes the being of the entity in question, but not the entity itself" (Michel, 2012 p. 219).

Further, Michael (2012) highlights that CR lacks a clear research method or theory of how to access knowledge of reality and thus can be seen as an over inclusive approach of pluralist epistemologies and methodologies that tend to be inconsistently described in literature and

applied in research. These inconsistencies in the description and application of the methodology result in practical problems such as the researcher being uncertain if they can correctly "describe reality or actually find the generative mechanism" (Isaksen, 2016, p. 257). Irrespective of these concerns however, CR provides an open approach to the study of social phenomena. Further, some CR literature have described and suggested how to apply specific methodologies in social science, information systems and international relations research (Danermark et al., 2002; McAvoy & Butler, 2017; Michel, 2012). Information relating to the use of CR in social sciences (more pertinent to the field of psychology) will be briefly discussed below.

Pluralist Methodology

Given that reality evolves and exists independently of human knowledge, it is important to acknowledge that any theory developed will change and develop as new information about reality emerges. Therefore, theory can be considered a transitive conceptualisation (Bhaskar, 2014). To explore these transitive theories or conceptualisations of reality, an epistemological approach would incorporate accessing knowledge through the structures that exist within and between these layers of reality known as 'Abdunction' and 'Retroduction'. 'Abdunction' involves the reworking or redescribing of a conceptualisation, whilst 'Retroduction' relates to an exploration of the different components of a phenomenon (e.g., the causal mechanisms and the properties necessary for it to exist). Thus CR can be seen as utilising a pluralistic methodological approach. Importantly however, this means embracing qualitative ('intensive') and quantitative ('extensive') approaches together within a CR framework. The 'extensive' approaches may not provide any causal explanations as they tend to describe 'empirical manifestations' of mechanisms. More emphasis is provided to qualitative or 'intensive' approaches. These are thought to expose new generative mechanisms and causal

explanations of a phenomenon using double hermeneutic approach in which researchers are interested in others' interpretations and "interpret other people's interpretations" (Danermark et al., 2002, p.32).

The position described by Danermark et al. (2002) can be seen to parallel to the concept of a formulation in psychological therapy. "Formulation can be defined as the process of co-constructing a hypothesis or "best guess" about the origins of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them. It provides a structure for thinking together with the client or service user about how to understand their experiences and how to move forward. Formulation draws on two equally important sources of evidence: the clinician brings knowledge derived from theory, research, and clinical experience, while the service user brings expertise about their own life and the meaning and impact of their relationships and circumstances" (Johnstone, 2017, p. 3). Such formulations require constant reworking on the basis of new information gathered throughout the therapeutic process from a variety of methods and information sources including those employed in the assessment and intervention processes (Kuyken, Padesky, & Dudley, 2009). Further, it is also recognised that although theory drives formulation and practice, practice also develops theory and formulation (Withers & Nelson, 2015). This embraces the idea that theories and formulations are only as good as the information available to create them.

CR in the context of the current research

In relation to the current research, social interactions between mentor-mentee are at the core of nurse mentoring process. Given the complexities of this social interaction and the many layers that are involved in nurse mentoring process, a CR approach appeared pertinent

as it would help to develop knowledge and meaning from the exploration of its specific aspects. Firstly, CR was used to explore the interaction between mentors' learning from the Compassion Focused Approach to Nurse Mentoring Programme (CFA-MP), including the nurse mentors' ability to engage with and act compassionately towards themselves and others, as well as their receptiveness to (or interaction with) compassion from others. Secondly, to explore how CFA-MP interacted with nurse mentors' wellbeing and quality of life. Finally, to explore in what way CFA-MP might influence the mentoring practice of participants, as well as other aspects of their work and home lives. Once this epistemology was clearly identified, and the research questions conceptualised, so too was the development of a methodological approach. As pluralistic methodologies are embraced by CR, a mixed methods approach was adopted to begin to tentatively recognise mechanisms or tendencies within these interactions (Danermark et al., 2002; Fletcher, 2017). Further, accessing information at different time frames reflects the changing nature of information (Bhaskar, 2014). Therefore, a mixed method, repeated measures design and later a semi-structured follow-up interview was considered an appropriate methodology to match this epistemological and ontological position.

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Appendices for Service Evaluation

Appendix AB. Participant information sheet

PARTICIPANT INFORMATION SHEET

Service Evaluation of Compassion Focused Approach to Mentoring (CFAM)

The current Compassionate Focused Approach to Mentoring (CFAM) programme is an innovative project to develop a training package for mentors in this approach. The training programme has two parts:

Part 1: Five Day Training Programme in CFAM
Part 2: Ten Supervision Sessions for Mentors

In this initial phase, the aim of the evaluation would be to gain some qualitative feedback from mentor participants about both parts of the training programme. This would help to inform and develop future training programmes in this approach.

To gain qualitative information, I would like to invite mentors participating in the programme to attend two semi-structured interviews. The first interview would be following the completion of part 1 of the programme. The second interview would be on completion of part 2 of the programme.

The interviews would aim to gain mentors' views and experiences of the programme and how it might be developed. The data gained from these interviews will only be used to develop the resources being used for CFAM and to assist practitioners in their role of supporting learning and assessment in practice.

Each interview would be recorded and take approximately one hour to complete.

All audio recording would be kept securely and will be destroyed once the data has been processed/ transcribed in accordance with the data protection act. Further, the information gained from the interview will be used to write a formal evaluation report of the programme.

Participation in this evaluation is voluntary. Anyone who decides to take part in the evaluation is free to withdraw at any time without giving a reason. Withdrawing from the evaluation will not impact on the training you receive through attending the course.

Finally, for those participants who have attended the training programme and are not actively mentoring at this time, I would like to invite you to complete a short questionnaire evaluation of the programme.

The person responsible for the evaluation is:
Jo Kucharska (Clinical Psychologist/Clinical Director for Doctorate Programme in Clinical Psychology, Coventry University).

If there are any queries or concerns please contact Jo on:
Email: aa3539@coventry.ac.uk
Phone: [redacted]

Appendix AC. Consent form

CONSENT FORM

Service Evaluation of Compassion Focused Approach to Mentoring (CFAM)

Lead Evaluator: Jo Kucharska (Clinical Psychologist/Clinical Director for Doctorate Programme in Clinical Psychology, Coventry Univeristy)

Please initial box

1. I confirm that I understand the evaluation is part of a process to enable the development of the CFAM programme as outlined by Jo Kucharska on 08.04.14 and that I have received an information sheet. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. This will not impact on the training I receive through attending the course. ☐
3. I consent to my interview being audio recorded and interview transcript being used to draw out themes of how to develop the programme. ☐
4. I understand and consent to the information gained from the interview being used to write a formal evaluation report of the programme. ☐
5. I understand that information will be anonymised and treated as Confidential. ☐
6. I understand that any audio recording will be kept securely and will be destroyed once the data has been processed/ transcribed in accordance with the data protection act. ☐
7. I agree to take part in this evaluation. ☐

Name of Participant	**Date**	**Signature**
Witnessed by (Name)	**Date**	**Signature**

Appendix AD. Email confirmation from local Research and Development department

Sent: Tue 18/11/2014 15:08

From: [redacted]
To: Jo Kucharska
Cc:
Subject: Re: Follwoing our phone call today

Dear Jo,

Many thanks for sending in your study documentation. Having reviewed these documents on 10th November 2014, I can confirm that we consider this to be a service evaluation and therefore the project would not require ethics or Trust (RD&I) approval.

Service evaluations define and judge existing service delivery, where researchers can trial a new approach. Where agreed levels of service are systematically monitored and evaluated, this would be excluded from the normal remit of the Research Ethics Committee (REC) and you therefore do not need to apply for REC approval.

I have therefore, registered your study on behalf of the trust.

Very best wishes,

[redacted]

[redacted]
Research Governance Specialist

Research, Development & Innovation

[redacted]

Email: [redacted]

Tel: [redacted]

Appendix AEi. Interview schedules post 5 day course

Participant Questions for Service Evaluation Part 1 (Mentors)

Post 5 day course:

1. How did you find the course?

2. What parts of the course have been most helpful to you?
   Prompts:
   a) Personally?
   b) In your role as a Mentor?
   c) How if at all will [these things] help you personally?
   d) How if at all will [these things] help you in your mentoring role? (you as a mentor)
   e) How if at all have [these things] helped you in your mentoring relationship? (interactions with mentees)

3. As a consequence of coming on the course, what if anything has changed in your approach to
   a) Yourself?
   b) Mentoring?
   c) Your mentoring relationships?

4. How if at all, do you think the training will impact on your mentees?
   Prompts:
   E.g. what changes could there be in:
   a) Their approach to learning?
   b) Their approach to mentoring?
   c) Their approach to patients?
   d) Their approach to working with colleagues and peers?

5. Were there aspects of the course that were harder to understand or didn't make any sense to you?

6. If there were aspects of the course that didn't make sense to you, what were they?

7. If the course were to run again, what would you keep?

8. And what would you change?
   a) Content (use timetable as prompt)
   b) On a practical level what things would you like to change about the course? E.g. venue, timings, size of the group, content and order of the course etc. (perhaps have the course structure/programme as a guide).

Appendix AEii. Interview schedules post 5 day course

Participant Questions for Service Evaluation Part 1 (Participants not currently mentoring)
Post 5 day course:

1. How did you find the course?

2. What parts of the course have been most helpful to you?

3. Were there aspects of the course that were harder to understand or didn't make any sense to you?

4. If there were aspects of the course that didn't make sense to you, what were they?

5. If the course were to run again, what would you keep?

6. And what would you change?

a) Content?

b) On a practical level?

Appendix AEiii. Interview schedules post 5 day course

Service Evaluation for Trainers Part 1

Post 5 day course

1. What went well?
   Was there anything you were surprised about that went well?

2. What didn't go so well?
   Was there anything you were surprised about that didn't go as well?

3. What struck you as being the most helpful learning points about CFAM (Compassion Focused Approach to Mentoring) with the course?
   Was there anything about these that led them to be more helpful?

4. What struck you as being the least helpful learning points about CFAM with the course?
   Was there anything about these that led them to be less helpful?

5. What do you think just didn't quite hit the mark about CFAM within the course?

6. In light of this, what would you keep?

7. And what would you change?
   Would you use different teaching materials/approaches, structure etc.?

Appendix AFi. Interview schedules post supervision groups

Participant questions for service evaluation Part 2 (All attendees)

Post supervision Groups

1. What's you age?
2. How many of the supervision sessions where you able to attend?

3. What got in the way of you attending all of them?

4. How have you found the supervision groups?

5. What parts of the supervision groups have been most helpful to you?
   Prompts:
   a) Yourself?
   b) To your mentoring role?
   c) To your mentoring relationships?
   d) To your relationships with students?
   e) To your relationships with colleagues/peers?
   f) With patients?
   g) Other aspects of your work?
   h) Other people (who?)
   i) How if at all will [these things] help you?
   j) How if at all will [these things] help you in your mentoring role? (you as a mentor)
   k) How if at all have [these things] helped you in your mentoring relationship? (interactions)

6. What impact has supervision had on the above?
   How if at all, is this different to what you gained from the 5 day course?

7. How has supervision has impacted on your mentees/students?
   Prompts: e.g. what changes have there been in:
   a) Their approach to learning?
   b) Their approach to mentoring?
   c) Their approach to patients?
   d) Their approach to working with colleagues and peers?

8. How if at all, is this different to what you gained from the 5 day course?
9. What skills and techniques if any, that you have learned from the course and supervision sessions are you using?
   Prompts
   a) Self soothing
   b) Imagery
   c) Writing
   d) Supervision model

10. How if at all are you using these skills for
    a) Yourself?

b) Your mentees?
c) Students?
d) Colleagues?
e) Patients?
f) Other aspects of your work?
g) Other people (who?)

11. How do you use the 3 systems model and the supervision model in your practice?
    a) With mentees?
    b) Colleagues?
    c) Patients?
    d) Others?
    e)

12. How do you apply it [the supervision model]?

13. Were there aspects of the supervision that were challenging, or didn't make any sense to you? If there were aspects of the supervision that, challenging, or didn't make any sense to you what were they?

14. What, if anything, has changed in how you think about your role as a mentor [or trainer if not mentoring] since attending this programme?

15. What do you think you would need to maintain your leaning in this approach?

16. What wider impact has this programme had on you personally?

17. If the programme were to run again, what would you keep?
    a) Supervision group?
    b) Course as a whole?

18. And what would you change?
    a) Supervision group?
    b) Course as a whole?
    c) On practical level? E.g. venue, timings, size of the group, content and order of the course etc. (perhaps have the course structure/programme as a guide).

Appendix AFii. Interview schedules post supervision groups

DNA Participant questions for service evaluation Part 2

Post supervision Groups

1. What's your age?
2. What got in the way of you attending the supervision group?
   Prompts blocks, set up/timing of sessions, personal circumstances, workload etc.

3. How have you found the supervision groups?

4. What skills and techniques if any that you have learned from the course are you using?
   Prompts
   a) Self soothing
   b) Imagery
   c) Writing
   d) Supervision model
   e) 3 systems model

5. How if at all are you using these skills for
   a) Yourself?
   h) Your mentees?
   i) Students?
   j) Colleagues?
   k) Patients?
   l) Other aspects of your work?
   m) Other people (who?)

6. What, if anything, has changed in how you think about your role as a mentor [or trainer if not mentoring] since attending this programme?

7. What do you think you would need to maintain your leaning in this approach?

8. What wider impact has this programme had on you personally?

9. If the programme were to run again, what would you keep?
   a) Supervision group?
   c) Course as a whole?

10. And what would you change?
    a) Supervision group?
    d) Course as a whole?
    e) On practical level? E.g. venue, timings, size of the group, content and order of the course etc. (perhaps have the course structure/programme as a guide).

Appendix AFiii. Interview schedules post supervision groups

Questions service evaluation for trainers Part 2

Post Supervision Groups

Thinking about the supervision groups as a whole

1. What did you do in the supervision groups?

2. How were the supervision groups structured Session structure? Overall structure?

3. How long was each session? How many came to each session?

4. Were you both there for all the sessions?

5. What topics were covered? What methods/techniques did you use to address these topics?

6. How did the supervision evolve/ develop over the 10 sessions?

7. How was supervision different to the teaching/training on the course?

8. What went well?

Prompt: Was there anything you were surprised about that went well?

9. What didn't go so well?

Was there anything you were surprised about that didn't go as well?

10. What struck you as being the most powerful learning points about CFAM within the supervision group?

11. What do you think just didn't quite hit the mark about CFAM within the supervision group?

12. In light of this, what would you keep within the supervision group?

13. And what would you change within the supervision group?

14. Would you use different teaching materials/approaches, structure etc.?

15. What would you do differently with further groups i.e. not the pilot group?

Thinking about the course as a whole (the 5 day training and the 10 session supervision)

1. What went well?
   Prompt: Was there anything you were surprised about that went well?

2. What didn't go so well?
   Was there anything you were surprised about that didn't go as well?

3. What struck you as being the most powerful learning points about CFAM within the Course as a whole?

4. What do you think just didn't quite hit the mark about CFAM within the Course as a whole?

5. In light of this, what would you keep within the Course as a whole?

6. And what would you change within the Course as a whole?
   Would you use different teaching materials/approaches, structure etc.?

7. What would you do differently with further groups i.e. Not the pilot group?

8. What do you think the participants are going to take from the course?
   a) For themselves personally?
   b) For their mentoring skills?
   c) For their mentoring relationships?
   d) For other relationships/roles?

9. How if at all, do you think the participants will take their learning forward?

10. What support do you think they would need to maintain their leaning in this approach?

Appendix AG. Braun and Clarke (2006) stages in the analysis of data using thematic analysis

"Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis. " (Braun and Clarke, 2006 p.87)

Appendix AH. Sample of coding transcript

P: Possibility a bit. I've got a student at the moment who's doing management placements and that's the following placements and I've used it on him, so he doesn't finish until September so it will be useful to see what he puts in his evaluation.	Applying to mentee
R: So that's too so, so has it had an impact on any of your colleagues?	
P: Too early, but they wouldn't, I probably hadn't	
R: I'm not sure the next question is particularly relevant it's how at all is this different from the 5 day course? I will ask that in terms of the impact on you, is there anything different, I know that might be hard to ask now, from when you completed the 5 day course?	
P: Um, I think, the supervision gave you more chance, the 5 day course was very intense, whereas the supervisor was very relaxed where it enabled sort of the system to be a bit more embedded in you, rather than, when you did the course, the 5 days it was very intense and you like had to recover from it so to speak, and then you did the supervision and the supervision has been in a relaxed way, so it, although you were talking about things you talked about on the 5 day course, obviously because you've done the 5 day course you already had the knowledge so it was just, it was reinforcing things and you know and application that sort of thing	Supervision relaxed; embedded learning Reinforcing learning and application
R: So it was a real opportunity for things to kind of germinate	
P: No to me it was kind of luxurious, because although we were relaxed there you know we all, as a course you are given these 5 days and then, you know you've been given a whole week and then you're given these 10 sessions of 2 hours just talking, and being paid for it and that's quite luxurious really and you need to be making the best of it, the most of it so um….	Luxurious: whole week and 10 supervision sessions ?space
R: and did that feel possible, you were able to do that?	
P: Um yes, however, like I said with the travelling you were a bit tired when you got there, so you had to recover from the travelling and start to relax, and then it was time to go home [laughs]	Impact of travel on supervision session
R: so on those days where it was a different shift or it was a day you weren't going to work, was there a difference?	
P: Oh yes	
R: OK so thinking about the course and supervision sessions, what skills and techniques that you learnt from the course are you still using?	Application: observing reactions; old brain/new brain, awareness, recognising stress reactions, understanding its old brain
P: Um, well, things like observing people's reactions, and all that sort of thing perhaps a bit more than I used to do and being more aware of old brain new brain and how people's um and my own, not talking about everybody else, and how you know when we are in stress we react in certain ways, cos it's our old brain kicking in, that sort of thing. So, yeah, I've been using that.	
R: OK so um that's been around, what about some of the skills, like self-soothing or the imagery	
P: Yeah now, the problem, I'm fairly relaxed, actually I'm saying I'm relaxed but I can get het up about things but um I do um find that I can relax fairly easily, so you know there are times when I	Naturally self-soothes/relaxes

Appendix AI. Additional information from participants and trainers about what to keep or change about the programme

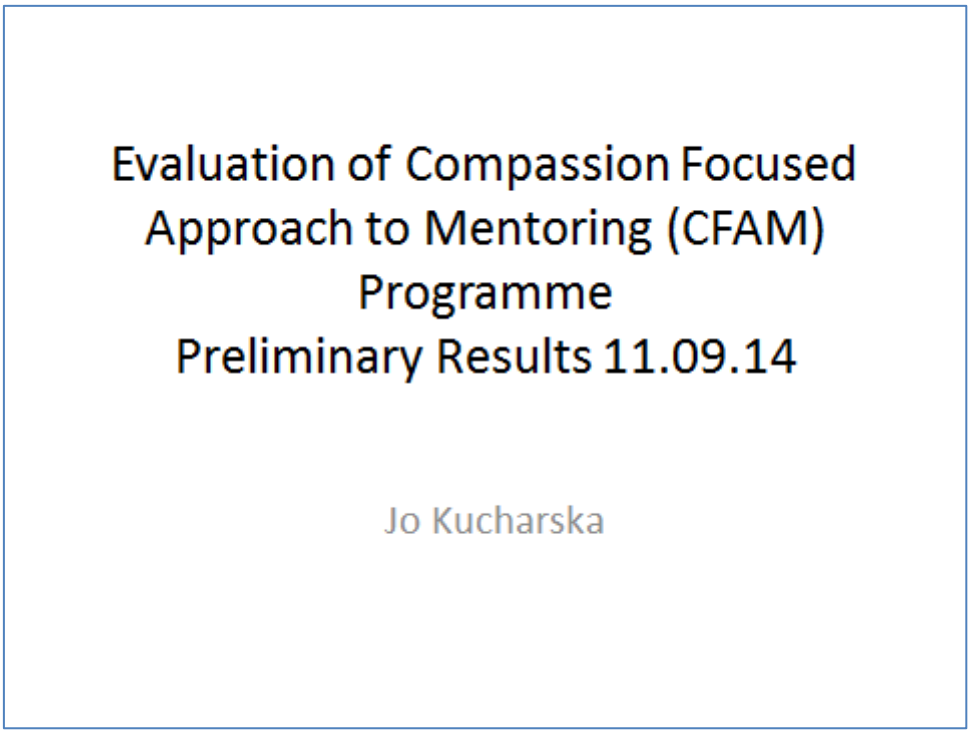
PARTICIPANTS VIEWS				
STAGE	Keep/Change	Response		
Five day training	Keep	**Content:** - The theory behind CFA especially the idea of the evolution of the brain i.e. the concepts of the old brain and the new brain - The evidence base for the theoretical framework. - The significance of learning about concepts of guilt, shame, safeness and soothing - The biological basis of the theory being based in the evolution of the brain - Learning about the three systems (threat, drive and soothing) and how to recognise these systems operating in others. An experiential element to the teaching	**Structure:** - Maintaining the overall structure of the course (five days) - To facilitate learning and consistent attendance that five consecutive days would be preferable. Some participants expressed mixed views about the five consecutive days and whether managers would release others over this timeframe. - Shortened in length less theory.	**Other aspects:** Trainers' expertise and teaching styles. Participants were keen for the trainers to remain the same for the next programme.
Ten weekly supervision sessions	Keep	**Process of supervision:** - The flexible and informal approach of the trainers - Balance between sharing experiences, skills development (of particular note self-soothing) and theory	**Practicalities:** - The trainers to remain the same and "not to water down" the sessions by using inexperienced facilitators to draw on the trainers' expertise - Email contact between sessions helped facilitate their learning and hold in mind CFA between sessions - Refreshments	
	Change	**Supervision:** - Supervision could be in part of the working day		

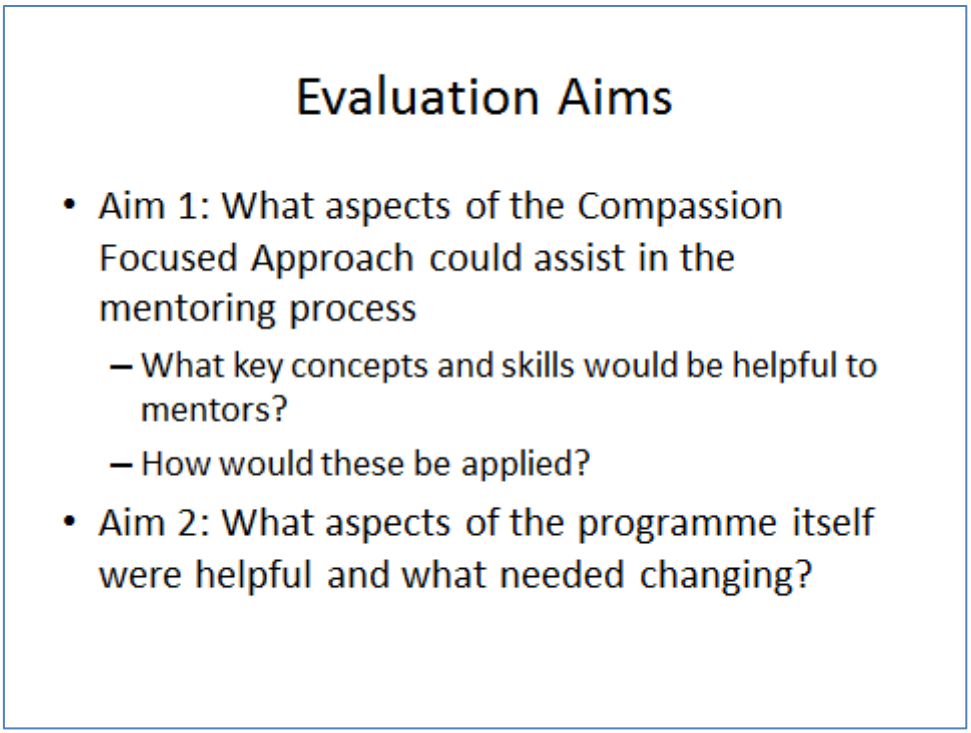
		- Reducing the length of time of each the supervision session - Venue (access issues) - An ongoing group to support their learning following the end of the supervision sessions (e.g. monthly to every two months). - More active mentors within the supervision group - The development of a book to go alongside the supervision for reference and to facilitate their learning		
TRAINERS VIEWS				
STAGE	Keep/Change	Response		
Five days training	Keep	Keeping the content of the course as planned.	Keeping exercises around the definitions of compassion and the use of role play on day four as a learning approach.	
Ten weekly supervision sessions	Keep	**The practicalities:** - A preference for evenings to demarcate work from supervision. - To keep the duration to two and a half hours. - To maintain refreshments and there were no reported issues with the venue.	**Structure of supervision:** - To maintain a structure in supervision where the application of CFA skills to the participants (i.e. the self) and to others (i.e. mentees) is included. - To incorporate contact between sessions as part of the overall supervision structure as this had appeared to work well. - To keep the flexibility of the content of supervision given that part of the agenda would be led by participants' issues. - To the format of "book in, check-in check-out" mirroring what would occur in therapy, a provisional agenda (with a default agenda) and therefore a structured task earlier in supervision followed by more open and flexible discussion including hot topics (i.e. a list of topics that group had devised of issues they would value exploring).	**Content:** - Developing the group rules and the focus of this in the earlier sessions. - Maintaining a practical led (i.e. skills development) focus in conjunction with current issues brought by participants. - A list of hot topics in collaboration with participants of issues they would like to pursue in supervision. - The co-creation of a supervision Use this model in subsequent supervision sessions.

	Change	**Practicalities:** - Increasing the size of the group - Trainer roles to change from one trainer had taking more of a role in the sharing of processes that had arisen in supervision and communicating information to the group between sessions. The other group facilitator had taken a more active role in the facilitation of supervision and skills development within sessions. Both facilitators noted that they would prefer to share out these roles more equally in future supervision groups The trainers noted three factors that had not been considered: - The opportunity for participants who had completed the 5 day course to opt out of the supervision groups - The addition of support sessions for graduates of the group (proposing a monthly occurrence) to support their on-going learning and application of the CFA model in their mentoring practice - The recognition that participants of the programme would not yet reached a sufficient level of understanding and experience in the application of the CFA model to begin supervising future groups immediately after completing the programme For less experienced in mentors the trainers would want to ensure the following changes: - Increase the sharing of experiences of participants with mentoring, including drawing on the anonymised experiences (in terms of potential scenarios) of the previous group where appropriate to facilitate the learning and application of CFA to mentoring - Increase the focus of the work on the activation and management of the threat system in the new participants; - Decrease the initial emphasis on the formulation and understanding of the situation until the threat systems were being adequately managed and understood by new participants
Both Stages	Keep	When reflecting on the programme as a whole the trainers wanted to keep: - The structure of five consecutive days training course and ten sessions weekly sessions of supervision; - The mix of disciplines within the nursing profession; - The pause between the 5 day course and the start of the supervision sessions; - That both trainers work together in the supervision sessions.
	Change	Include more on supervision and what this would entail on the day five (of the five day course) i.e. what it is, the process of supervision is, what it means and what we do, and what's involved in it. The letter writing had not worked and may need omitting in future groups.

Appendix AJ. Brief preliminary presentation

(PowerPoint Slides)





Evaluation Process

- 5 day course (semi-structured interview post course of participants* and trainers*)
- 10 weekly sessions (semi-structured interview post supervision of participants and trainers, including those who dropped out)

- * 1 participant was not interviewed; 1 participant and both trainers completed interview via written feedback due to timing unforeseen circumstances, timing etc

Evaluation

- Interviews were recorded
- The material would be analysed through thematic analysis
- Currently: All participants and trainers have been interviewed (completed last week)
- Timeframe has not yet allowed for complete analysis

Demographics

8 participants

[3/4 mentor, 2 Practice/education facilitators, 3 from uni mentor related]

4RMN; 4SRN [Mix of additional training: LD; Paediatrics; Oncology; Neuro; CBT etc]

Placement length variable between:	**3-12** weeks **12** months
MEAN Age	**53** (range 45-60)
MEAN years qualified	**27** (range 6-38)
MEAN years mentoring	**14** (range 5½-24)

Attendance

Course (5 Consecutive Days course)	**8** attended
Supervision (10 weekly sessions)	**1** DNA **1** attended 3 sessions **6** attended (between 6-10 sessions) – MEAN **8**

Preliminary and very tentative analysis*

Aim 1: Key concepts and skills and how they are applied?
Main theme:

Learning from others ← **"Fine Tuning"**

Naming the Process
Evidenced based Theory
Validation of practice
Understanding compassion (conceptually)

Internal Processes
"Stop and think" - Old Brain vs New Brain
- 3 Systems
- Self-soothing

No visible behaviour change 'I wasn't doing anything different'

*These may alter as analysis progresses

Preliminary and very tentative analysis*

Aim 1: Key concepts and skills and how they are applied?
Main theme:

Not just for mentees

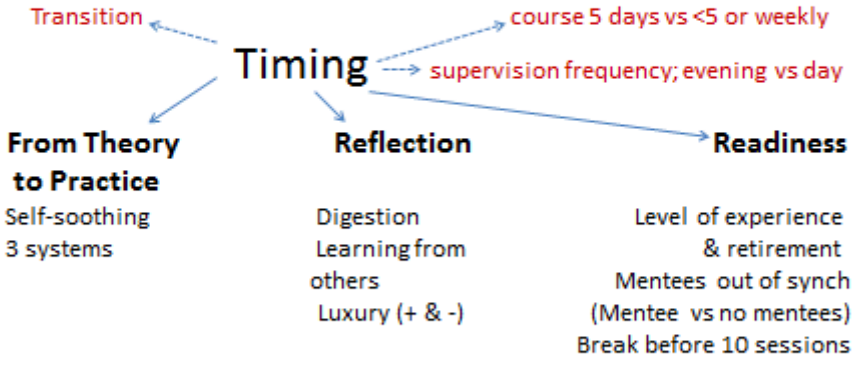
Personal
'Way of life'
Boosting Resilience:
- Shift to self-compassion
- Permission for self-care

Professional
Applicable to mentees, colleagues and patients
Other working situations
Permission to take care of mentees/others

*These may alter as analysis progresses

Preliminary and very tentative analysis*

Aim 2: What aspects of the programme itself were helpful and what needed changing?



*These may alter as analysis progresses

Preliminary and very tentative analysis*

Aim 2: What aspects of the programme itself were helpful and what needed changing?

*These may alter as analysis progresses

Additional Comments: To keep or to change

Nothing but……..

- Keep Ken and Hannah
- More prep information
- Day 2
- 5 day vs 3day vs weekly
- More mentors (bigger group)

- Option to attend next 10 session supervision
- Maintenance (monthly, six weekly, annual refresher) supervisions
- Venue not JS
- Working Hours vs evenings

Appendix AK. Truncated service report (boxed)

Report for School of Nursing, Midwifery and Health - Coventry University

Service Evaluation of a Training Programme in Compassion Focused Approaches to Nurse Mentoring

Compiled by Jo Kucharska May 2016 (in collaboration with Ken Goss, Consultant Clinical Psychologist, Hannah Andrews, Clinical Nurse Specialist, and Steve Allan, Research Supervisor University of Leicester)

EXECUTIVE SUMMARY

The following is a brief summary of a service evaluation for an additional nurse mentoring programme training programme: Compassion Focused Approaches to Nurse Mentoring offered at Coventry University.

Key findings from the thematic analysis:

The Service Evaluation had 3 main aims:

1. What aspects of the CFA would assist the mentoring process: what concepts and skills would be helpful and how would they be applied?
   The main theme "Utility of the Model" demonstrated the participants' knowledge and understanding of the concepts within the Compassion Focussed Approach (CFA). Participants were able to describe their understanding of CFA and how they had applied to nurse mentoring.

2. To what extent would the programme facilitate full engagement and socialisation to the CFA model?
   The theme "Receptiveness" clearly described how participants were able to demonstrate both their engagement and socialisation to the CFA model.

The first two aims and consequent themes highlight that participants valued CFA as a model and were able to utilise CFA within their mentoring roles. This would suggest that CFA has a place in nurse mentor training.

3. What aspects of the programme itself were helpful and what needed changing?
   This theme "learning" brought together some of the areas that were helpful and unhelpful for participants within the programme including subthemes highlighting Group Learning; Space; Maintenance.

Recommendations:

The themes generated the following recommendations:

1. Building an evidence base for CFA to nurse mentoring through on-going delivery and evaluation of successive programmes;
2. Maximising Learning for future CFA programmes through maintaining a broad mix of nursing disciplines and the development of a maintenance programme;
3. Maximising attendance within the programme through appropriate recruitment of well-informed individuals.

It is hoped that these recommendations and the findings of this report will enable the development of an innovative programme to further strengthen the student-mentor relationship, improve opportunities for students to learn by enhancing the quality the practice learning environment and begin an evidence base for CFA to support the finding that CFA is a relevant approach to nurse training.

INTRODUCTION:

This is a brief summary of a service evaluation which was conducted to evaluate an additional nurse mentor training package offered at Coventry University (CU) as part of an

ECQ (Education Commission for Quality) initiative. A training programme was developed in Compassion Focused Approaches (CFA) to Nurse Mentoring and was adapted from key concepts within Compassion Focused Therapy (see Gilbert 2009; 2010). This training package was intended to complement existing nurse mentor training.

Structure of the Training

The CFA programme was divided into two distinct sections:

Stage 1: Five consecutive days training specifically targeting the theory behind CFA.

Stage 2: Ten, weekly sessions of group supervision.

The Trainers:

Ken Goss (Consultant Clinical Psychologist) and Hannah Andrews (Clinical Nurse Specialist) developed and delivered the training. They both have considerable expertise in the delivery of and training in Compassion Focused Therapy,

Participants:

Participants were included in the programme if they were qualified nurses with experience of nurse mentoring.

The mean ages, year since qualification and years of mentoring practice for the participants can be found in table 1.

	MEAN (years)	RANGE (years)
Age	53	45-60
Years qualified	27	6-38
Experience of mentoring	16	5½-24

Table 1. A summary of the mean age, years of qualification and mentoring for participants.

Attendance of the programme

Stage 1: 100% attendance of all eight participants.

Stage 2: The mean attendance per supervision session was 63%. One participant did not attend any supervision sessions and another attended two sessions

Evaluation Process

Following the 5 day training programme a semi-structured interview was conducted with individual course participant and trainers[33])

After the 10 weekly supervision sessions were completed all participants and the trainers were interviewed using a semi-structured interview including the two participants who discontinued their attendance of the programme.

All interviews were recorded and transcribed verbatim.

The data was analysed using thematic analysis (Braun and Clarke 2006)

RESULTS:

The results of the thematic analysis (Braun and Clarke 2006) are divided into three sections to address the three main aims of the evaluation. For brevity; quotations from transcripts are not included but are available on request.

AIM 1: What aspects of the compassion focused approach (CFA) would assist the mentoring process: what concepts and skills would be helpful and how would they be applied?

THEME 1: UTILITY OF THE MODEL

This theme is represented in figure 1 and encapsulates the participants' knowledge and understanding of the concepts within the Compassion Focussed Approach (CFA). It integrates participants' understanding of CFA and how this has been applied to nurse mentoring and to other areas. The subthemes are **Theory; Skills and Application**.

[33] One participant was not interviewed; one participant and both trainers completed interview via written feedback due to timing unforeseen circumstances, timing etc.

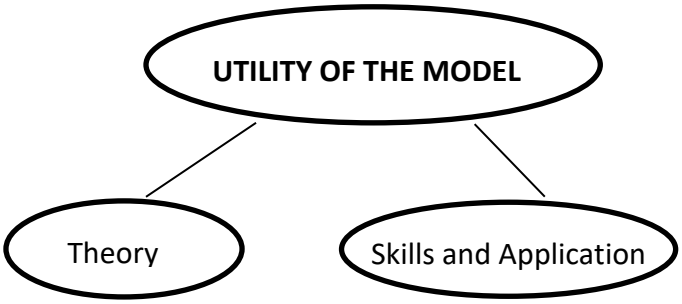


Figure 1. A diagrammatic representation of the theme Utility of the Model and its subthemes.

Theory

This subtheme directly describes participants' increased awareness of and ability to articulate core concepts within the CFA model i.e. the affect regulation systems of threat, drive and soothing. Participants described:

- Conceptualising student behaviour in relation to these three affect systems e.g. to understand a student's interrupting behaviours and to help facilitate a colleague in their mentoring process;
- Actively considering what particular affect regulation system they were experiencing and whether this would be a facilitative place for their next work task.

Participants reported being more conscious of how to use CFA to understand mentees and themselves through recognising and understanding which of the three affect systems were operating in specific situations. Where possible, participants considered using this new awareness and knowledge to shape their interactions with mentees/colleagues etc. in their working environment.

Skills and Application

This subtheme highlights how participants and trainers applied aspects of the theory and CFA techniques into mentoring and other contexts. Examples of the three areas of application are described below:

(i) The quality of the mentoring relationship and practice

Participants noted that the programme had enabled them to reconnect with the importance of the mentoring role and the quality of the mentoring process.

In relation to CFA, participants' understanding of compassion incorporated addressing difficult issues with trainees, including failure. This facilitated a more direct approach with mentees, resulting in mentors feeling more respected by the mentee. The supervision model collaboratively developed by participants and facilitators during the programme facilitated this process enabling better quality in the mentee-mentor relationship and students' professionalism.

Finally, participants noted that CFA offered a theoretical model to validate their current mentoring approach and to provide an evidence base to colleagues when confronted about their mentoring style.

(ii) Applying self-compassion.

An important aspect in CFA is the development of self-compassion. This facilitates compassion towards others. Some participants described developing these skills as being helpful to shield them from absorbing additional stresses of those around them, enabling them to better manage the demands of their job.

Other participants noted absence of self-compassion skills can be detrimental to the mentor-student relationship e.g. one participant described a lack of self-compassion triggered the potential to blame the student for some unrelated issue.

(iii) Other contexts

Participants noted that CFA could be applied in a variety of contexts outside of mentoring e.g. to improve contact with colleagues, patient care, as well as mentoring.

AIM 2: To what extent would the programme facilitate full engagement and socialisation to the CFA model?

RECEPTIVENESS

This theme describes how participants have individually responded to CFA demonstrating both their engagement and socialisation to CFA. A diagrammatical representation of this theme can be seen in figure 2. The subthemes here are **Engagement; Dissemination; Role Modelling**.

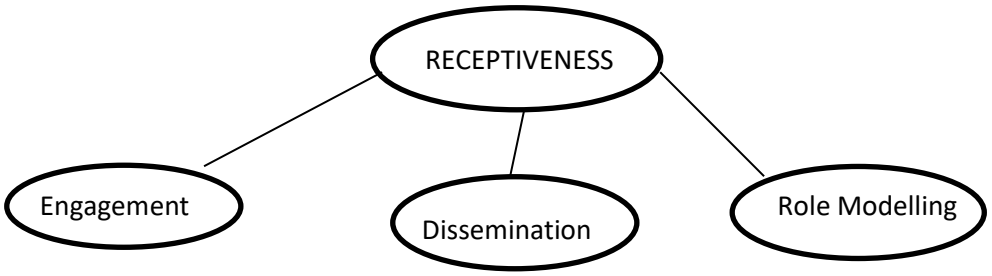


Figure 2. Receptiveness and its subthemes

Engagement

This subtheme draws together the active engagement that participants have shown towards CFA both professionally and personally.

Importantly, participants appeared engaged with the evidence base which resonated with their professional stance and the biological underpinnings of CFA.

Dissemination

Cascading information to colleagues is often a prerequisite of attending training; here, the drive of participants to disseminate CFA suggested that this was due to the strong level of engagement with CFA. Most participants were keen to cascade the information in a meaningful way that would convey some their learning and the impact of CFA on both their mentoring practice and other contexts.

Role Modelling

Participants described the importance of role modelling in nursing per se. Therefore role modelling aspects of CFA appeared to be an important part of mentoring and a demonstration of participants' engagement with the model.

AIM 3: What aspects of the programme itself were helpful and what needed changing?

LEARNING

This theme brought together some of the areas that were helpful and unhelpful within the programme. The subthemes were Group Learning; Space; Maintenance. Figure 3 provides a visual representation of the theme.

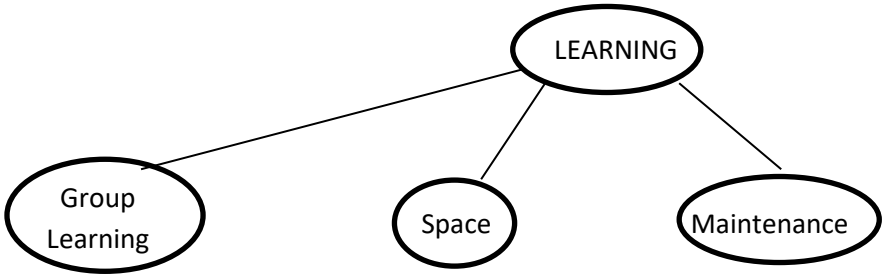


Figure 3. Diagram of the theme Learning and its subthemes

Group Learning

Trainers and participants noted two areas of learning as a group that seemed to aid their learning i.e. being in a group per se and the mix of disciplines.

(i) Being in a group

Both trainers and participants described a sense of cohesion within the group that enhanced the learning process e.g. sharing ideas with each other or from learning through others application of CFA.

(ii) Mix of disciplines

A unique feature of the programme which participants highlighted as enhancing their learning was the diversity of participants' nursing backgrounds e.g. participants described the uniqueness and novelty of training with other nursing disciplines and how this appeared to add to their overall learning experience. The difference in the professional disciplines of the trainers was also believed to enhance the training experience.

Space

Participants and trainers highlighted the importance of space to consider participants' applications of their learning as well as their values, how they manage difficulties and reflect on the practice of caring for others.

Participants who did not complete the programme confirmed their engagement with the engagement with the programme, but expressed a preference for more space between the two parts of the programme as their work/home situations limit their capacity to utilise learning opportunities.

Maintenance

Participants discussed the importance of maintaining their learning through on-going groups or refresher sessions to support their application of CFA. Other participants noted it would be helpful to have reading materials to help to supplement, consolidate and maintain their learning.

CONCLUSIONS/RECOMMENDATIONS:

The Key Findings:

1. The first two themes highlight that participants valued CFA as a model and were able to utilise CFA within their mentoring roles. This would suggest that CFA has a place in nurse mentor training.

   Participants and trainers provided clear accounts of the application of specific CFA concepts and skills to nurse mentoring. Specifically, mentors use of the three systems model (threat, drive and soothing) for themselves and with their mentees

e.g. recognising and managing the activation of the threat system. This may begin to address processes that impede mentee learning such as mentee shame processes (Bond 2009; Johnson 2012) when the threat system is activated.
Their engagement with and application of CFA, alongside their descriptions of role modelling CFA to students and colleagues may positively influence their working/practice learning environments (e.g. Buante et al., 2012; Epstein, 2012; Francis, 2013; Henderson and Tyler, 2011) therefore optimising student learning experiences.

2. The third theme highlighted areas participants identified as important to the learning process i.e. dedicated space and a mixture of nursing disciplines added a unique dimension to the process.
All participants and trainers highlighted the value of a formal way of maintaining their learning. Suggestions included on-going supervision, refresher sessions and/or a handbook which had not been included in the programme.

Recommendations:

The themes generated the following recommendations:

1. Building an evidence base for CFA to nurse mentoring through on-going delivery and evaluation of successive programmes such as, the use of quantitative methods to assess/measure changes in compassion towards the self and the mentee as well as changes in the mentoring process and practice learning environment.
2. Maximising Learning for future CFA programmes through maintaining a broad mix of nursing disciplines and the development of a maintenance programme. Further, all those involved in the programme highlighted difficulties with the amount of material presented on day 2, stage 1 of the programme and suggested this should distributed across the remaining days.
3. Maximising attendance within the programme through appropriate recruitment of well-informed individuals. This could be achieved by providing sufficient pre-course information to prospective participants.

It is hoped that these recommendations and the findings of this report will enable the development of an innovative programme to further strengthen the student-mentor relationship, improve opportunities for students to learn by enhancing the quality the practice learning environment and begin an evidence base for CFA to support the finding that CFA is a relevant approach to nurse training.

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Mandatory Appendices not referred to in the body of the thesis

Appendix AL. Chronology of Research Process

Date	Service Evaluation	Empirical Study	Literature Review
May - September 2014	Design of evaluation, semi-structured interview, data collection and transcribing		
September – October 2014	Thematic analysis, preliminary feedback of results for ECQ		
November 2014 – January 2015	Write up first draft		
February-October 2015	Review Draft	Design, development of vignettes, selection of measures and writing research protocol	
November 2015 – February 2016		Cohort 1 data	
April 2016 – October 2016		Data input, scoping for additional cohort, amendments to ethics	
November 2016 - April 2017		Cohort 2 data	
May 2017 – September 2017	Review draft	Data input	Scoping Literature Review and initial search terms
October – December 2017		Quantitative analysis, further amendment to ethics	
January-April 2018		Begin follow-up interviews Coding vignettes and Content analysis	Refining search terms with librarian
May 2018 – June 2018		Follow-up interviews and transcribing	Literature Search
June-July 2018		Follow-up interviews and transcribing	Review Papers and Quality Assessments
August-October 2018		Final follow-up interview, transcribing and thematic analysis	First complete draft
November 2018 – December 2019		First draft	
January - February	Review draft	Review draft	Review draft
March –April 2019	Final review and submission	Final review and submission	Final review and submission

Appendix AM. Author Guidelines for the British Journal of Clinical Psychology

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology and Registered Reports. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

All papers published in The British Journal of Clinical Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

The following types of paper are invited:

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- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

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2. Length

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- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
- All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before

'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

- All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.
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These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

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