Teaching Compassionate Mind Training (CMT) to help midwives cope with traumatic clinical incidents

Hollins Martin, CJ, Beaumont, EA, Norris, G and Cullen, G

10.12968/bjom.2021.29.1.26

Teaching Compassionate Mind Training (CMT) to help midwives cope with traumatic clinical incidents

Caroline J. Hollins Martin[1]

Elaine Beaumont[2]

Gail Norris[3]

Gavin Cullen[4]

[1]Caroline J. Hollins Martin, Professor in Maternal Health, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK, EH11 4BN, Email: c.hollinsmartin@napier.ac.uk

[2]Dr Elaine Beaumont, Psychotherapist and Lecturer in Counselling, School of Health and Society, University of Salford, Mary Seacole Building (MS3.17), Salford, M5 4WT. Email: E.A.Beaumont@salford.ac.uk

[3]Gail Norris, Senior Lecturer & Lead Midwife For Education, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK, EH11 4BN, Email: g.norris@napier.ac.uk

[4]Gavin Cullen, Lecturer in Mental Health, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK, EH11 4BN, Email: g.cullen2@napier.ac.uk

Correspondence
Caroline J. Hollins Martin, Professor in Maternal Health, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK, EH11 4BN, Email: c.hollinsmartin@napier.ac.uk

Teaching Compassionate Mind Training (CMT) to help midwives cope with traumatic clinical incidents

Abstract

This paper considers use of *Compassionate Mind Training (CMT)* to help midwives cope with traumatic clinical incidents. In this context, *CMT* is taught to cultivate compassion and teach midwives how to care for themselves as they would women, family and friends. The need to build midwives' resilience is recognized by the UK Nursing and Midwifery Council (NMC), who advocate that mental health coping strategies be embedded into midwifery curriculum. In this respect, *CMT* can be used as a resilience building method designed to help the midwife respond to self-criticism and threat-based emotions with compassion. The underpinnings of *CMT* involves understanding that people can develop cognitive biases or unhelpful thinking patterns co-driven by an interplay between genetics and the environment. Within this paper, the underpinning theory of *CMT* is outlined and how it can be used to balance the psychological threat, drive, and soothing systems. The 3-way flow of compassion is further discussed, which involves: (1) delivering compassion to others, (2) accepting compassion from others, and (3) providing compassion to self. To stabilize emotions and create self-soothing, *CMT* activities have been described that are designed to improve ability to cope and reduce perceptions of threat and danger. To contextualize application to midwifery practice, a traumatic incident has been used to illustrate how CMT can improve a midwife's compassion for self, quality of work life, and mental well-being. Overall, teaching *CMT* has potential to improve professional quality of life, reduce midwives' sickness rates, and potential attrition from the profession.

Key words: Clinical incident, compassion, Compassionate Mind Training (CMT), midwives, sick, trauma

Teaching Compassionate Mind Training (CMT) to help midwives cope with traumatic clinical incidents

Introduction

Compassion Focused Therapy (CFT) and *Compassionate Mind Training (CMT)* aim to help people cultivate compassion for self and others. *CFT* was created to help people respond to self-criticism and shame with compassion and self-supportive inner voices (Gilbert, 2005; 2009; 2010; 2014). *CFT* is a psychotherapy used in therapeutic settings (Kirby 2016), whereas *CMT* is a programme of contemplative and body-based practices that can be used in non-clinical populations to help people cultivate compassion (Gilbert, 2005; 2009; 2014). Over the past 10-years there has been an expanding body of evidence to support use of *CMT* to alleviate mental health difficulties and promote wellbeing (Beaumont & Hollins Martin, 2015; Leaviss & Uttley, 2015; Karatzias et al., 2019). In response, *CMT* is now being implemented in hospitals, prisons, schools, universities and businesses, which makes it appropriate for midwives to now consider its use.

To assist exploration of the *CMT* approach within midwifery practice, an emotionally challenging incident has been presented to illustrate application (*Box 1)*.

BOX 1

When people use the word compassion, they usually apply it to describe an act of kindness. Yet, at the core of compassion is bravery, with kind people not always having the courage to behave in compassionate ways. Gilbert (2009) describes compassion as a sensitivity to suffering in self and others and having the commitment to alleviate it, with his definition capturing two processes. First, it involves having the courage to engage with one's own or other peoples distress, as opposed to avoiding it. Second, it involves being prepared to acquire wisdom to behave appropriately when suffering occurs. It is important to be aware that humans are biological beings, who have a legacy of inherited genes, which are pushed and pulled by motives and emotions that have been socially shaped. With this in mind, *CMT* can be taught to cultivate midwives' compassion and help them cope with traumatic clinical incidents. In this context, *CMT* has the ability to reduce self-

criticising thoughts and equip midwives to care for self in the same way as they deliver care to women, family and friends.

Using CMT in modern midwifery supervision

It could be useful to include *CMT* within modern midwifery supervision models, with *CMT* used by the *Professional Midwifery Advocate* (PMA) as part of the *Advocating for Education and QUality ImProvement* (AEQUIP) model (NHS England, 2017), or the new *Scottish Clinical Supervision Model for Midwives* (Key et al., 2017). Both of these supervision models have restorative elements, which include examining experiences that have affected the midwife emotionally, with emphasis placed upon reducing stress and burnout which stem from emotional fatigue (Klimecki & Singer, 2012). The restorative component is designed to develop midwives' reflective skills and help them to better manage demanding clinical work (Sheen et al., 2014). The aim is to build resilience through *Reflecting* upon the event, examining how the midwife *Respond*ed and why, and help *Restore* emotions to a more comfortable place and build resilience to cope in similar future events.

Who should deliver CMT?

One question that you may be asking is, who should be delivering CMT to midwives? The answer is someone who has been trained, which could be the midwife's supervisor, manager, midwifery lecturer, Midwifery Advocate (PMA), or an independent practitioner. Each Health Board (HB) can develop its own system of delivery, with the essential being that the person chosen has been appropriately trained. This person should be a qualified *CMT practitioner*, with many courses available on the internet (e.g., see Compassionate Mind Foundation).

Analysing a scenario to contexualise use of CMT

In relation to the scenario in BOX 1, seven steps have been outlined that can be followed to help equip a midwife with skills to cope with trauma events in the clinical area (see *Table 1*).

TABLE 1

Step 1: Organise a meeting to analyse the midwife's experience

Post experiencing a traumatic clinical event, the thought of returning to work fills the midwife (Willow) with anxiety, and so the team organise a meeting for the midwife to meet with her (e.g., supervisor, manager,

member of the perinatal bereavement team, lecturer), to reflect upon the traumatic incident.

Davis and Coldridge (2015) describe low-mood, fear, distress, guilt, and withdrawal of some midwives who have experienced a traumatic incident in the clinical area. Akin to Willow, these midwives questioned their competence and described worry about whether they could have prevented the tragic outcome (Davies & Coldridge, 2015). Such responses are not unusual, with 15% of Swedish obstetricians and midwives reporting trauma symptoms from being placed in similar situations (Wahlberg et al., 2016). As such, clearly there is a need to build midwives' resilience, with the UK Nursing and Midwifery Council (NMC) advocating that mental health coping strategies be embedded into midwifery curriculum (NMC, 2019). In this context, building resilience involves the midwife developing coping strategies, along with teaching them how to respond positively and consistently in the face of adversity (Seery et al., 2010).

Step 2: Build resilience through self reflection and teaching the purpose of developing compassion for self.

Teach the midwife (Willow) how to self reflect and the purpose of developing compassion for self and others.

Self Reflection

One method of building resilience involves developing self-reflection skills (Grafton et al., 2010). Within the clinical incident described in *Box 1*, Willow's supervisor organises a meeting to help her recover from the trauma incident and build her confidence to return to work. The first step involved organising a meeting with Willow to reflect upon the trauma incident using Gibbs (1998) reflective model (see *Figure 1*).

FIGURE 1

Responding to suffering with compassion provides a restorative element (Beaumont & Hollins Martin, 2016; Key et al. 2019), whilst analysing the trauma incident using a reflective model will help the midwife (Willow) cope with similar future traumatic incidents (Sheen et al., 2014). During process, the supervision provided should involve a restorative and compassionate element (Key et al., 2019; Raab, 2014), with focus placed upon building resilience, cultivating compassion for one's own suffering and reducing trauma symptoms, stress, and potential burnout

(Klimek & Singer, 2012). Hence, it is important to carry out supervision in a safe protected space (Bishop, 2007).

There are 3 elements to building resilience. These include (1) *Reflecting*, (2) *Responding*, and (3) *Restoring* (Key et al., 2019), which involves *Reflecting* upon the traumatic incident (*Figure 1*), analysing how the midwife *Responded* and why, and using compassion to *Restore* emotions to a more comfortable place. To this effect, supervision involves examining what went right and wrong and what potential improvements to practice could be made (Key et al., 2019). As such, the midwife is not just reflecting upon the traumatic incident, but also taking a conscious look at their emotions and behavioural responses to increase understandings of self (Paterson & Chapman, 2013). It is important that the midwife (Willow) is taught to understand that all humans have a tendency towards repetitive self-limiting behaviours (Turetsky et al., 2011), with challenge to negative cycles of thinking and behaviour key (Helsing et al., 2008). An important part of reflection is to address any gaps between actual and good practice and provide affirmations for successful elements to build self-efficacy, self-esteem and confidence. At the end of each meeting, it is important to evaluate the midwife's views about what went well or otherwise.

Develop compassion for self

Compassion fatigue can be reduced by implementing strategies that activate neural pathways associated with compassion, empathic concern, positive feelings, and altruistic behaviour (Klimecki & Singer, 2012; Kim et al., 2020). Compassion "aims to nurture, look after, teach, guide, mentor, soothe, protect, and offer feelings of acceptance and belonging" (Gilbert, 2005, p. 217). Compassion is at the very heart of *CMT*, which in the incident described is used to help the midwife (Willow) reduce threat-based emotions and self-criticism. As part of process, there is a focus upon teaching the midwife to recognise cognitive biases and biological processes that are directed by genes and the environment (Gilbert, 2014).

Step 3: Teach the underpinning theory of Compassionate Mind Training (CMT)

Teach the midwife (Willow) the underpinning theory of CMT to help her generate a kind and self-supportive inner voice.

CMT or *Compassion Focused Therapy (CFT)* depending upon context, was developed by Gilbert (2009) in response to his observation that people high in shame and self-criticism often experience difficulty generating kind and self-supportive inner voices. The central therapeutic technique of *CFT* is *CMT*, which involves teaching the skills and attributes of compassion. *CFT* is used when the focus is upon a patient with a diagnosed psychological pathology (e.g., depression), whilst and in contrast, *CMT* is used in non-clinical populations to help people explore problematic patterns of cognition and emotions relating to anxiety, anger, shame, and self-criticism (Gilbert, 2009).

To date, *CFT* has shown itself to be effective at reducing trauma symptoms (Beaumont & Hollins Martin, 2015; Leaviss & Uttley, 2015; Karatzias et al., 2019), with a meta-analysis reporting large effect sizes for relationships between compassion and depression and anxiety and stress (Macbeth & Gumley, 2012). Surveys have also shown that self-compassion positively correlates with improved well-being (Neff et al., 2007; Van Dam et al. 2011), and reduced psychiatric symptoms, interpersonal problems, and personality pathology (Schanche et al., 2011). This evidence supports that developing interventions that cultivate compassion should work towards improving midwives' ability to cope with trauma, by reducing self-criticism and self-attack (Beaumont, 2016).

What the Literature says about CMT in midwifery practice

To date, only two papers have directly focused upon *CMT* in midwifery practice (Beaumont et al., 2016a&b). Beaumont et al. (2016a) used validated scales to measure student midwives' compassion for others, compassion for self, quality of life, mental well-being, and their association with compassion fatigue and burnout. Participants reporting high on self-judgement sub-scales, scored lower on compassion for self, compassion for others, and well-being, and scored higher on burnout and compassion fatigue. The main conclusion drawn by Beaumont et al. (2016a), is that midwives could benefit from learning to be 'kinder to self', which in turn could help them cope with the emotional demands of clinical practice. In response to these findings, Beaumont et al. (2016b) developed a *CMT* education model informed by evidence which shows that *CMT* is beneficial in populations who have experienced trauma, through reducing self-criticism and heightening compassion for self and others (Ferrari et al., 2019). This work is ongoing and has

potential to profoundly impact upon midwives' absence and attrition rates from midwifery practice.

To understand how compassion can be used to improve wellbeing, it is first important to understand the psychological model of threat, drive and soothing that underpin the *CMT* model.

The threat, drive and soothing systems that underpin CMT

Humans have 3 genetically programmed internal psychological systems (Gilbert, 2009).

(a) *The threat system*

The *threat system* directs attention to perceived danger, and when activated the person responds with anger, anxiety and negative thinking-feeling loops. Also, individuals high on self-criticism and shame have been shown to have dominant *threat systems* (Beaumont & Hollins Martin, 2016; Gilbert, 2009). In response to the incident portrayed in *Box 1*, Willow is filled with doubt, shame and self-blame.

(b) *The drive system*

The *drive system* motivates a person to pay attention to helpful resources that relate to doing, wanting, achieving, status-seeking, competitiveness, and avoiding rejection (Depue & Morrone-Strupinsky, 2005). When the *drive system* is activated the experiencer responds with joy emotions, which then proceed to reinforce associated successful behaviors.

(c) *The soothing system*

The *soothing system* stimulates physiological responses that promote calming, soothing, attachment, and interpersonal connection (Depue & Morrone-Strupinsky, 2005; Gilbert, 2014). Hence, cultivating a compassion filled internal and external environment should increase the midwife's (Willow's) feelings of safeness and social connection, at the same time as reducing symptoms activated by the *threat system* (Gilbert, 2014).

These systems thus serve vital roles in keeping people safe and experiencing the 'good things' in life. For example, satisfaction of a job well done, and maintaining health and well-being. However, the threat system operates on a 'better safe than

sorry' principle in order to fulfil its objective (Gilbert, 2009). This can lead to 'fight, flight or freeze' responses to perceived rather than actual threats, e.g., hearing a strange rustling sound walking home late at night, feeling frightened, and then realising it was just litter moving in the wind. Further, when ambitions related to the drive system are thwarted, for instance when something goes wrong in a professional context, the threat system can then be triggered, leading to self-criticism even if the person themselves is not to blame for the incident. The soothing system, meanwhile, is essential for our psychological, physiological and interpersonal well-being (Gilbert, 2009).

What is Compassionate Mind Training (CMT)

The aim of *CMT* is to balance the *threat, drive* and *soothing systems,* through developing compassion for self and others and reducing self-criticism. In *CMT*, compassion is viewed as comprising of a 3-way flow (Gilbert, 2014) between:

- Compassion for others (*compassion flowing out*).
- Compassion from others (*compassion flowing in*).
- Self-compassion (*self-to-self compassion*).

Part of developing compassion involves the individual being sensitive to their own distress and engaging with it in a non-judgemental way and teaching the midwife (Willow) how to activate her own *soothing system*. For example:

- Breathing exercises to slow the body down.
- Imagery, attention, mindfulness and memory training (to calm and soothe the mind).
- Method acting techniques (to practice being compassionate).
- Recalling events of giving and receiving compassion.
- Skills of engaging compassionately with emotions, thinking, and behaviours.
- Compassionate letter writing (to lesson shame, self-criticism & fear).
- How to deal with blocks to compassion flow.

To view an outline of a *CMT* teaching program (see Beaumont & Hollins Martin, 2016).

In relation to the incident described in *Box 1*, the goal is to:

- Develop the person's awareness of own suffering.
- Turn towards the person's suffering.

- Learn to engage with and not avoid the person's suffering.
- Help the person cultivate self-compassion towards own suffering.
- Know how to manage the person's suffering.

An outline of skills and attributes involved in providing compassion can be viewed in *Table 2*.

TABLE 2

Step 4: Teach CMT approaches that develop compassion

> *Teach the midwife (Willow) CMT approaches that will help her develop compassion for self and others, which can be used to help cope with future trauma events.*

In the incident in *Box 1*, Willow is questioning herself, is experiencing anxiety, is self-critical and worrying about returning to work. In this context, compassion-based interventions are used to help midwives (like Willow) develop self-efficacy, self-esteem, and confidence to return to work. Several examples of *CMT* approaches follow.

(i) Divert attention using a sound based mindfulness exercise

Divert attention to focus on breath, sound and body (Irons & Beaumont, 2017). The example in *Box 2* illustrates how sound can be used to anchor a person's attention.

BOX 2

(ii) Teach Soothing Rhythm Breathing (SRB)

Breathing exercises can trigger alternative feelings, behaviours, and thought patterns. Hence, activating the parasympathetic nervous system using *SRB* is used to regulate heart rate, soothe the mind, and calm the body (*Box 3*).

BOX 3

(iii) Use imagery to create a safe place

The person can be guided through an imagery exercise that cultivates the *soothing system* and 'creates a safe place' (*Box 4*).

BOX 4

(iv) Explore obstructive thinking?

Worry about returning to work and what peers are thinking has filled the midwife's (Willow's) mind with doubt, shame, and self-criticism. In attempts to diminish these negative thoughts, empathetic statements can be used to cultivate compassionate attention, thinking, and behavior. For example:

- Other midwives have experienced similar situations, and like you have found them hard to handle.
- It is completely understandable that you feel the way you do. This incident is upsetting, and it difficult to witness another suffering.
- Remember that your thoughts are not actual facts, and others may not view events as you do.
- Speaking to others about your feelings can help you come to terms with this traumatizing experience.
- The way you feel today will pass.
- We can teach you strategies to deal with this experience, which will help you cope in the future.

(v) Label upsetting emotions

Identifying and labelling of emotions can be used to develop *Emotional Intelligence (EI).* In this respect, *EI* is a person's ability to recognize emotions of self and others and being able to discriminate between different feelings and label them appropriately. Emotional interpretation guides a person's thinking and response behaviours in a given situation. Some useful prompts can be used to explore and label the midwife's emotions.

- Your threat system has been activated, which makes you predisposed to having 'biased' and 'all or nothing thoughts' (discuss) (i.e., good/bad; right/wrong). The situation is not black or white.
- When people experience intense emotions their heart rate rises, their voice reverberates, and they can often feel unwell or faint (discuss).
- Attempt to label your emotions (i.e., the 27 emotions captured by Keltner and Cowen (2017) include admiration, adoration, aesthetic appreciation, amusement, anger, anxiety, awe, awkwardness, boredom, calmness, confusion, craving, disgust, empathetic pain, entrancement, excitement, fear,

horror, interest, joy, nostalgia, relief, romance, sadness, satisfaction, sexual desire, surprise).

- Discuss thoughts associated with labelled emotions (e.g., “I cannot cope”, “What do others think of me”, “I cannot do this job”).
- What are your response behaviours? (e.g., wanting to hide away, avoid future incidents, or abandon the midwifery profession).

(vi) Carry out compassion for others exercises

Ask the midwife (Willow) to imagine listening to another who has experienced a similar traumatic incident. For example:

- What would you say to a friend who has experienced a similar incident and feels the same way you do? Now reverse this procedure and talk to yourself in this compassionate way.
- Write a compassionate letter to another midwife who is suffering post experiencing a traumatic incident? Now reverse this procedure and write a compassionate letter to yourself.
- Look into a mirror and practice talking to another midwife about their traumatic incident. When you are doing this, use a compassionate tone of voice, positive body language, and affirmative facial expressions. Now reverse this procedure and offer yourself the same compassionate conversation.

Step 5: Write a Pre, During and After (PDA) Plan to facilitate return to work

Write a PDA-Plan with the midwife (Willow) to help build self-esteem, self-efficacy and confidence to return to work.

As sports coaches encourage professional competitors to do, write a *PDA-Plan* with the midwife (Willow). For example, a footballer prepares for a match by rehearsing penalties and imagining scoring the winning goal. They also plan to eat particular foods, follow an exercise schedule, design a warm-up, and conduct psychological activities to ‘fire them up’ before a game, i.e., visualizing their team being awarded the gold cup. In a similar fashion, the midwife can be helped to write a *Pre-plan,* which includes time spent on each of the *CMT* approaches (see *Table 3*).

TABLE 3

In preparation for first day back at work, the *During-plan* can include supportive statements that the midwife can practice and repeat when fear related thoughts emerge. For example:

- Other midwives have progressed and grown after experiencing what I have. It is all just part of a midwives' job.
- The way I feel now will pass. Today and ongoing, I am going to enjoy my work.
- Fears are just thoughts in my head. I can cope, as I have coped many times before.

Also, the midwife (Willow) can carry an object in her pocket (e.g., a stone or meaningful piece of jewelry), which reminds them that thoughts are not facts and to be compassionate and kind to self.

In the *After-plan*, the midwife (Willow) can write a reflective compassionate letter to self, which includes praise for facing anxieties. To view a profile where the midwife can record their *PDA-plan* (see *Table 3*) (Irons & Beaumont, 2017).

Strengths and limitations of CMT

One strength of the *CMT* model includes development of an enhanced understanding of human distress both physically and psychologically, which has evolved over millions of years. A second benefit involves enhancing the receiver's understanding of their internal drive for social fairness, status, and pursuit of wealth. Together, these strengths diminish the idea that the person is responsible for their thoughts and feelings, which includes blame. One limitation of the *CMT* model involves an optimistic belief that a person can learn how to be more compassionate, which involves re-wiring the brain to become kinder, more content, peaceful, and accepting. Some people have greater aptitude to develop compassion, which is influenced by the quality of care they receive in their own social environment and brain plasticity, with younger brains more able to make new connections. A further limitation occurs when the midwife continues to exist in a threatening environment. Despite these limitations, providing *CMT* provides helpful ways of understanding threatening situations and can reduce self-blame when upsetting events occur.

Argument for adding CMT to the Restorative Supervision (RS) model

RS contains elements of psychological support, which include listening, supporting, and challenging the midwife to improve their capacity to cope, especially when difficult and stressful situations prevail (Proctor, 1988). *CMT* makes a further useful addition to the RS model for the following reasons:

- Gilbert (2010) argues that cultivating self-compassion can be the antidote to self-criticism. CMT may help midwives who experience self-critical judgement and self-doubt cultivate compassion for their own suffering.
- When self-criticism, anxiety, low-mood and/or self-doubt are holding the midwife back, or are leading to unhelpful behaviour patterns, *CMT* will help to counter these well-rehearsed patterns.
- *CMT* will help the midwife develop self-awareness of their self-criticism and self-doubt and learn methods of acknowledging these thoughts.
- The *CMT* practitioner can teach the midwife to understand human evolution, biology, and attachment theory, to help them make sense of why they worry, self-critique and experience stress, anxiety, and depression.
- The *CMT* practitioner can teach the midwife to understand the key emotion regulation systems and how *CMT* practices can be used to soothe and regulate an 'overactive' threat or drive system.

In addition to RS, practising *CMT* techniques will help the midwife develop more compassionate responses towards their self. Through activities that are specifically developed to activate the soothing emotion regulation associated with care and connection (e.g., mindfulness, breathing practices, and guided imagery) the midwife will learn self-care strategies that can be used ongoing throughout their life.

Step 6: Measure effectiveness of the CMT PDA-plan before and after using psychometric scales

Use psychometric scales to measure before and after improvements in the midwife's (Willow's) levels of traumatisation, compassion engagement, compassion for self, self-criticising and attack, professional quality of life, and mental well-being.

A midwife who has experienced a traumatic clinical incident, may be experiencing Post Traumatic Stress Disorder (PTSD). Hence, it is important to check for symptoms of PTSD or Complex-PTSD (CPTSD) using the *International Trauma*

Questionnaire (ITQ) (Cloitre et al., 2019). The ITQ is a scale that has been validated to diagnose PTSD and CPTSD in accordance with the ICD-11 (WHO, 2018). If symptoms of PTSD are present, the sufferer should be referred for appropriate diagnosis and treatment.

Other psychometric scales can also be used to measure effectiveness of the supervision meetings and the *CMT PDA-plan*:

- Compassionate Engagement and Action Scales (Gilbert et al., 2017): https://www.compassionatemind.co.uk/uploads/files/the-compassionate-engagement-and-action-scales.pdf
- Self-Compassion Scale (Neff, 2003): https://self-compassion.org/wp-content/uploads/2015/06/Self_Compassion_Scale_for_researchers.pdf
- Self-criticising/Attacking Scale (FSCRS) (22-items) (Gilbert et al., 2004): https://www.compassionatemind.co.uk/uploads/files/forms-of-self-criticising-attacking-and-self-reassuring-scale-fscrs.pdf
- Professional Quality of Life Scale (Stamm, 2009): https://proqol.org/uploads/ProQOL_5_English.pdf
- Short Warwick and Edinburgh Mental Well-being Scale (Tennant et al., 2009) https://www.corc.uk.net/media/1245/swemwbs_childreported.pdf

These questionnaires can be issued at 2-3 timepoints:

Timepoint One: At first meeting.

Timepoint Two: Post implementation of the *CMT PDA-plan* (which may be endpoint if scores are good).

Timepoint Three: Continued meetings until mutually agreed endpoint.

To view a summary of the described *CMT* approaches that develop compassion (see *Table 4*).

TABLE 4

Conclusion

This paper has described an intervention that supervisors, managers and midwifery lecturers can implement to facilitate a midwife to recover from experiencing a distressing incident in clinical practice. A *CMT PDA-plan* has been outlined that can be implemented to help traumatised midwives build resilience, cope with their

emotions and negative thinking, and build courage to face further similar events. In this paper, *CMT* has been described in a context that will help midwives who are questioning their ability to practice effectively and build their confidence to face future challenge. In this context, *CMT* activities have been proposed to help midwives cope with adversity, reduce perceptions of threat, and improve professional wellbeing. Embedding *CMT* into everyday clinical midwifery practice could markedly improve professional wellbeing, reduce abscense rates, and decrease levels of attrition from the profession. In relation to teaching midwives skills that enable them to care for their mental health during their career, it is important to introduce the *CMT* model early on and ideally during undergraduate degree programs. The author(s) of this paper have begun this work in their own universities.

References

Beaumont E (2016) A compassionate mind training model for healthcare practitioners and educators. *Healthcare Counselling and Psychotherapy Journal* 16(3), 22-27.

Beaumont E, Hollins Martin CJ (2015) A narrative review exploring the effectiveness of Compassion Focused Therapy. *Counselling Psychology Review* 30(1), 21-32.

Beaumont E, Durkin M, Hollins Martin CJ, Carson J (2016a) Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: a quantitative survey. *Midwifery* 34, 239-244.

Beaumont E, Hollins Martin CJ (2016b) Heightening levels of compassion towards self and others through use of compassionate mind training. *British Journal of Midwifery* 24(11): 3-12.

Bishop V (2007) *Clinical supervision in practice* (2nd Ed). Palgrave-Macmillan, Basingstoke (UK).

Cloitre M, Shevlin M, Brewin CR, Bisson JI, Roberts NP, Maercker A, Karatzias T, Hyland P (2019) The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and Complex PTSD. *Acta Psychiatrica Scandinavica.* DOI: 10.1111/acps.12956

Davies S, Coldridge L (2015) No man's land: an exploration of the traumatic experiences of student midwives in practice. *Midwifery* 31 (2015), 858–864.

Depue RA, Morrone-Strupinsky JV (2005) A neurobehavioral model of affiliative bonding: implications for conceptualizing a human trait of affiliation. *Behavioral and Brain Sciences* 28, 313–349.

Ferrari M, Hunt C, Harrysunker A, Abbott MJ, Beath AP, Einstein DA (2019) Self-compassion interventions and psychosocial outcomes: a meta-analysis of RCTs. *Mindfulness*. https://doi.org/10.1007/s12671-019-01134-6

Gibbs G (1988) *Learning by doing: a guide to teaching and learning methods*. Further Education Unit, London.

Gilbert P (2005) Social mentalities: a biopsychosocial and evolutionary reflection on social relationships. In Baldwin M (ed) *Interpersonal cognition* (pp 299–333). New York, NY: Guilford.

Gilbert P (2009) *The Compassionate Mind.* Constable, London.

Gilbert P (2014) The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology* 53(1), 6-41.

Gilbert P, Catarino F, Duarte C, Matos M, Kolts R, Stubbs J, Basran J (2017) The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care* 4(1), 4.

Gilbert P, Clark M, Hempel S, Miles JNV, Irons C (2004) Criticising and reassuring oneself: an exploration of forms, styles and reasons in female students. *British Journal of Clinical Psychology 43*, 31-50.

Grafton E, Gillespie BM, Henderson S (2010) Resilience: the power within. *Oncology Nurse Forum* 37, 698–705.

Helsing D, Howell A, Kegan R, Lahey LL (2008) Putting the development in professional developing understanding and overturning of educational leaders immunities to change. *Harvard Educational Review* 78(3), 437-465.

Irons C, Beaumont E (2017) *The compassionate mind workbook: a step-by-step guide to cultivating your compassionate self*. Constable Robinson, London.

Karatzias T, Murphy P, Cloitre M, Bisson J, Roberts N, Shevlin M, Hyland P, Maercker A, Ben-Ezra M, Coventry P, Mason-Robersts S, Bradley A (2019) Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis. *Psychological Medicine* 1–15.

Keltner D, Cowen AS (2017). Self-report captures 27 distinct categories of emotion bridged by continuous gradients. *Proceedings of the National Academy of Sciences*. 114(38), e7900–e7909.

Key S, Marshall H, Hollins Martin CJ (2019) The Scottish clinical supervision model for midwives. *British Journal of Midwifery* 27(10), 655-663.

Kirby JN (2016) Compassion interventions: the programs, the evidence, and implications for research and practice. *Psychology and Psychotherapy: Theory, Research, and Practice.* Advance online publication. https://doi.org/10.1111/papt.12104.

Kim JJ, Parker SL, Doty JR, Cunningham R, Gilbert P, Kirby JN (2020) Neurophysiological and behavioural markers of compassion. *Scientific Reports* 10, 6789.

Klimecki O, Singer T (2012) *Empathic distress fatigue rather than compassion fatigue? Integrating findings from empathy research in psychology and social neuroscience*. In Oakley B, Knafo A, Madhaven G, Wilson DS eds (2011) Pathological Altruism (pp 368–83). Oxford University Press, New York.

Leaviss J, Uttley L (2015) Psychotherapeutic benefits of compassion-focused therapy: an early systematic review. *Psychological Medicine* 45, 927-945.

MacBeth A, Gumley A (2012) Exploring compassion: a meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review* 32, 545-552.

Neff KD (2003) The development and validation of a scale to measure self compassion. *Self and Identity* 2, 223-250.

Neff KD, Kirkpatrick KL, Rude SS (2007) Self-compassion and adaptive psychological functioning. *Journal of Research in Personality* 41,139–154.

NHS England (2017) A-EQUIP a model of clinical midwifery supervision. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/04/a-equip-midwifery-supervision-model.pdf

Nursing and Midwifery Council (NMC) (2019) *Standards of proficiency for midwives*. NMC, London.

Paterson C, Chapman J (2013) Enhancing skills of critical reflection to evidence learning in professional practice. *Physical Therapy in Sport* 14(3),133–138.

Proctor B (1988) *Supervision: a cooperative exercise in accountability*. In Marken M, Payne M, eds (1997) Enabling and ensuring. National Youth Bureau and Council for Education andTraining in Youth and Community Work: Leister (UK).

Raab K (2014) Mindfulness, self-compassion, and empathy among health care professionals: a review of the literature. *Journal of Health Care Chaplaincy* 20(3), 95-108.

Schanche E, Stiles TC, Mccullough L, Svartberg M, Nielsen GH (2011) The relationship between activating affects, inhibitory affects, and self-compassion in patients with Cluster C personality disorders. *Psychotherapy (Chicago Ill)* 48, 293-303.

Seery MD, Holman EA, Silver RC (2010) Whatever does not kill is: cumulative lifetime adversity, vulnerability and resilience. *Journal of Personality and Social Psychology* 99,1025-1041.

Sheen K, Slade P, Spiby H (2014) An integrative review of the impact of indirect trauma exposure in health professionals and potential issues of salience for midwives. *Journal of Advanced Nursing* 70, 729-743.

Stamm BH (2009) Professional Quality of Life: compassion satisfaction and fatigue Version 5 (ProQOL). /www.isu.edu/~bhstamm or www.proqol.org.

Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, Parkinson J, Secker J, Stewart-Brown S (2009) The Warwick and Edinburgh Mental Well-Being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcomes.* 5(63), 1-13.

Turesky EF, Gallagher D (2011) Know thyself: coaching for leadership using Kolb's experiential learning theory. *The Coaching Psychologist* 7(1), 5-14.

Van Dam NT, Sheppard SC, Forsyth JP, Earleywine M (2011) Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of Anxiety Disorders* 25,123–130.

Wallbank S, Woods G (2012) A healthier health visiting workforce: findings from the Restorative Supervision Programme. *Community Practitioner* 85(11), 20–23.

World Health Organization (2018) The ICD-11 for mortality and morbidity statistics. Accessed at: https://icd.who.int/browse11/l-m/e.

Box 1: An example of a traumatic clinical incident

A newly qualified midwife (Willow) was caring for a couple having their first baby (Helena & Findlay). After 6 hours of labour, Helena progressed to second stage. After 10-minutes of pushing, the fetal heart descended into a continuous bradycardia. Willow prepared for a forceps delivery and 12-minutes later a baby girl was born with an Apgar of 1. An attempt to resuscitate was made, and after 25 minutes the baby was pronounced dead. The next day Willow phoned the birthing unit stating that she would be absent from her shift as she felt unwell, and 1 week later she still had not returned to work. Willow was experiencing repeated thoughts of self blame and anxiety, which was causing her to think about a career change. To reflect upon this event, Willow's supervisor, a delivery suite midwife, and a member of the 'Perinatal Bereavement Team' have arranged to meet with her.

In accordance with the Code of Conduct (NMC, 2018) pseudonyms have been used.

Box 2: Sound based mindfulness exercise

(1) Find a quiet and relaxing place to sit.
(2) Sitting comfortably in an upright position in a chair, focus on your body and just breathing in and out (around 30-seconds).
(3) After the initial 30-seconds, widen your attention away from your body and pay attention to the sounds that can be heard around you. Be receptive to each sound as it arises and disappears. You are 'in the now', simply attending to each sound as it happens (around 60-seconds).
(4) Select just one sound and be aware of the direction it arises from, its nature, character, volume, pitch, tone, and whether it is continuous or intermittent (around 60-seconds). Attempt to anchor your attention in this sound and describe its characteristics. When your mind wanders, keep drawing it back to this sound. Also, when distracted by thoughts, worries or concerns, attempt to bring your attention back to noticing the sounds around you again (around 60-seconds).
(5) Repeat activities (2) and (3).
(6) Now widen your awareness to what is happening in the room around you and bring yourself into the 'present moment'.
(7) Reflect upon how it felt to use sound to anchor your mind and attention.

(Adapted from Irons and Beaumont, 2017)

Box 3**:* **Learning to use *Soothing Rhythm Breathing (SRB)

(1) Find a quiet and relaxing place to sit.
(2) Sitting comfortably in an upright position in a chair, focus on your body and just breathing in and out (around 30-seconds).
(3) Notice the sensations present as you breathe in and out. If your attention becomes distracted, gently attempt to bring it back to your breathing without judging or criticising yourself.
(4) Paying attention to the flow of your breath, attempt to induce a calming *Soothing Rhythm* to your *Breathing* (*SRB*). *SRB* involves breathing, slower and deeper than usual, yet in a smooth, even and comfortable way. When you are distracted by thoughts, emotions, or external stimuli, gently draw your attention back to the calming quality of your *SRB*. It can be helpful to count your breaths from 1 to 5 as you do so:

- In-breath 1–2–3–4–5 seconds
- Hold 1 second
- Out-breath 1–2–3–4–5 seconds
- Hold 1 second
- In-breath 1–2–3–4–5 seconds
- Hold 1 second
- Out-breath 1–2–3–4–5
- Hold 1 second
- In-breath 1–2–3–4–5

(5) Continue this style of *SRB* for another 3 to 4 minutes, maintaining your attention on your breath. At around 5 minutes, widen your awareness to the whole room by listening for the sounds around you. Bring yourself into the present moment.
(7) Reflect upon your experience of engaging with *SRB*. What did you notice about your thoughts, physical sensations, and feelings?

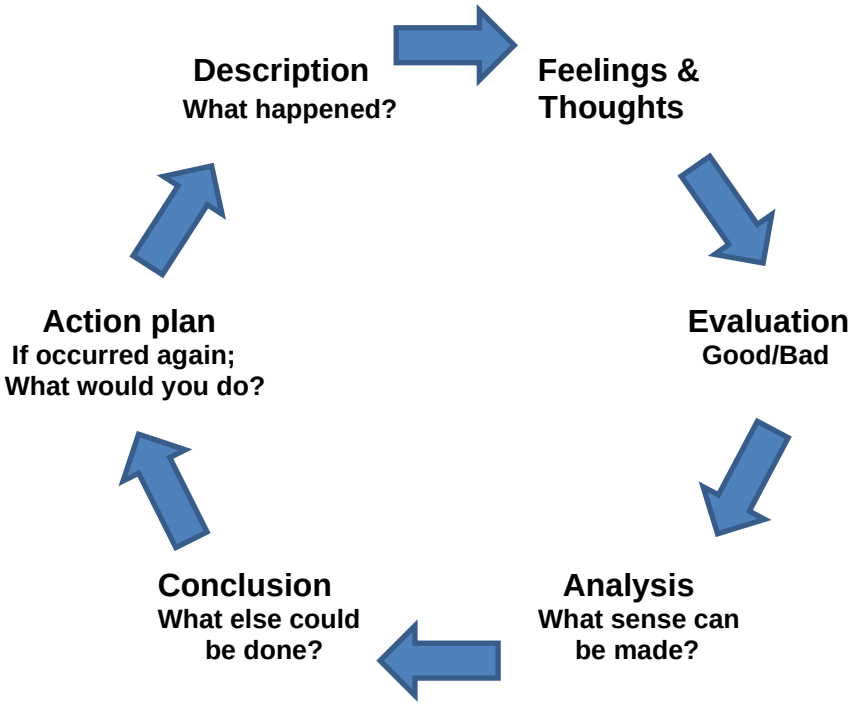
(*Adapted from Irons and Beaumont, 2017*)

Box 4: **Creating a safe place**

(1) Find a quiet and relaxing place to sit.
(2) Sitting comfortably in an upright position in a chair, focus upon your *Soothing Rhythm Breathing* (*SRB*).
(3) Conjure up an image of a place you consider to be sheltered and soothing (this safe place may be familiar or created).
(4) Mindfully pay attention to what you see in this image, e.g., colours, shapes, and objects (around 30-seconds).
(5) Notice sounds present, observing different qualities and how you are feeling (around 30-seconds).
(6) Notice any soothing or comforting smells that are present (around 30-seconds).
(7) Notice any physical sensations (e.g., touch, warmth of the sun, feel of the grass or sand beneath your feet (around 30-seconds).
(8) Is someone or an animal present with you (around 30-seconds)?
(9) Imagine that your safe place has an awareness of you. That it is welcoming you in, happy to see you, and wanting you to feel safe and calm (around 60-seconds).
(10) Consider what you would like to do whilst in this safe place (e.g., being still and content and 'being in the moment'). Alternatively, you are free to explore this place (e.g., walking, swimming, or playing a game).
(11) When you are ready, widen your awareness to the full room around you. Notice sounds and bring yourself into the 'present moment'.
(12) Reflect upon what it was like to visit this soothing place?

(Adapted from Irons and Beaumont, 2017)

Figure 1: Gibbs (1988) reflective model (Adapted from Gibb's, 1988)



Steps	Table 1: Actions designed to help midwives cope with trauma events in the clinical area
Step 1	Organise a meeting to analyse the midwife's experience.
Step 2	Build resilience through self reflection and teaching the purpose of developing compassion for self.
Step 3	Teach the underpinning theory of Compassionate Mind Training (CMT).
Step 4	Teach CMT approaches that develop compassion.
Step 5	Write a Pre, During and After (PDA) Plan to facilitate return to work.
Step 6	Measure effectiveness of the CMT PDA-plan before and after using psychometric scales.

Table 2: Outline of skills and attributes involved in providing compassion (adapted from Gilbert, 2014)

Compassionate attributes	**Compassionate skills**
Care for well-being: Develop a caring motivation and desire to relieve and turn towards suffering. *Sensitivity to distress:* Recognise and be attentive to both own and others' distress. *Sympathy:* Ability to be emotionally moved by feelings of distress, as opposed to disconnected from them. *Distress tolerance:* Tolerate difficult emotions by moving towards them, as opposed to avoiding suffering. *Empathy:* Tune in emotionally to another's suffering. *Non-judgement:* Step away from judgement, self-criticism, and disapproval.	*Attention:* Focus the mind on what is helpful and not harmful. Pay attention in the here and now. *Imagery*: Use imagery exercises to calm and stimulate the soothing system. *Sensory:* Utilise breathing exercises, vocal tones, facial expressions, and body postures to help regulate distress. *Reasoning:* Learn to reason in ways that are helpful, compassionate, and caring. *Feeling:* Learn to respond compassionately to emotions. *Behaviour:* Behave in helpful ways towards self and others (requires courage).

Table 3: **A Compassionate Mind Training (CMT) informed *PDA-Plan* (Irons & Beaumont, 2017)**

Traumatic incident	*Pre-Plan*	*During-Plan*	*After-Plan*
Date of meeting:	*Date of meeting:*	*Date of meeting:*	*Date of meeting:*

Table 4: **Compassionate Mind Training (CMT) approaches designed to assist staff to cope with traumatic clinical incidents**

(i) Divert attention using a sound-based mindfulness exercise'
(ii) Teach *Soothing Rhythm Breathing (SRB).*
(iii) Use imagery to create a safe place.
(iv) Explore obstructive thinking.
(v) Label upsetting emotions.
(vi) Carry out compassion for others exercises.
Write a Pre, During and After (PDA) Plan to facilitate return to work.