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<http://dx.doi.org/10.1177/00178969211008484>

Title	Exploring the impact of a compassion-focused therapy training course on healthcare educators
Authors	Raynor, G, Beaumont, EA, McAndrew, SL and Irons, C
Type	Article
URL	This version is available at: http://usir.salford.ac.uk/id/eprint/59912/
Published Date	2021

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Health Education Journal

1–12

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DOI: 10.1177/00178969211008484

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Abstract

Background: Stress, and particularly burnout, is a major problem among healthcare workers and can lead to high staff turnover and low patient/client satisfaction.

Objective: To explore the impact of 3-day compassion-focused therapy training on those delivering education to healthcare students. The underpinning premise was that the training course could potentially be replicated through the participants' work with students embarking on a career within the helping professions.

Design: Mixed-methods study, with the qualitative findings being presented in this paper.

Setting: Training course was delivered in one higher education institution in England.

Methods: In total, 44 healthcare lecturers attended the course, with 6 taking part in a reflective focus group.

Findings: The analysis highlighted four main themes: reassurance and increased knowledge, increased compassion towards others, self-compassion and empathy, and blocks to compassion.

Conclusion: Findings add to previous quantitative research findings showing that participants who undertook training were able to engage with their compassionate self and consider the importance of showing compassion towards the self and others in healthcare education.

Keywords

Compassion-focused therapy, healthcare education, mental well-being, qualitative research, self-compassion

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Introduction

Workplace stress is high in the healthcare workforce and has been associated with poor mental and physical well-being, increased staff turnover and compromised quality of care (Alenezi et al., 2019; Burton et al., 2017). In the light of these difficulties, it is important to find more effective ways of dealing with stress within the healthcare workforce. One approach to reducing stress is through cultivating self-compassion – compassion being a central concept within healthcare practice and a core value for those delivering care (Beaumont et al., 2016a). Compassion may be defined in a number of ways, but it always encompasses a sensitivity to suffering and distress, both in the self and others, with the aim of trying to do something about such distress (Gilbert, 2005, 2010, 2014).

Healthcare educators have a vital role to play in teaching self-compassion to enhance students' compassion towards others (Newton, 2010). In nurse education, lecturers with higher levels of self-compassion have been found to be more compassionate towards others (Gustin and Wagner, 2013). Similarly, in a sample of healthcare students, self-compassion aided well-being and management of emotional distress (Yarnell and Neff, 2013). Cultivation of self-compassion can lead to increased self-improvement and motivation, and improved patient care (Bramley and Matiti, 2014; Breines and Chen, 2012). This paper reports on findings from a course evaluation for health educators introduced to compassion-focused therapy (CFT) in a university setting. The course could be replicated through participants modelling what they have learned when working with students.

Compassion-focused therapy

A variety of training courses exist to help develop the skills and attributes of compassion. One approach, namely CFT, was specifically developed to address psychological problems underpinned by shame and self-criticism (Gilbert, 2005). The CFT model draws on insights from evolutionary theory, neuroscience, developmental psychology, attachment theory, emotional regulation and social motivational systems theory (Gilbert, 2009, 2010). The model suggests individuals can learn to develop compassion and balance emotion-regulating systems. Gilbert (2005, 2009, 2010) proposes that we have three emotion regulation systems:

- The drive or activating system (excitement, joy and anticipation) functions to help us pursue resources and move towards goals that may be advantageous to us.
- The soothing system (safe and connected) helps us rest and digest, bringing balance to the other two systems.
- The threat system is focused on anger, anxiety and disgust, alerting us to things that are threatening in the world. It motivates us to engage in a response that aims to protect and keep us safe.

Gilbert (2009, 2014) proposes that the threat system is activated during high levels of self-criticism and shame. The aim within CFT is to bring balance to motivation and threat systems by cultivating a compassionate system. An understanding of how mood regulation systems are balanced or sensitised can lead to a better understanding of the facilitators and inhibitors of compassion (Gilbert, 2009). When high levels of stress are experienced, negative self-judgement and emotions such as shame may interfere with our ability to reflect, problem-solve and integrate information. These thoughts, judgements and emotions trigger the threat protection system (Liotti and Gilbert, 2011).

This has relevance to well-being and the facilitation of learning, as having the ability to reflect in and on practice, solve problems and apply theory to clinical practice is a key requirement of all healthcare professionals. One potential solution for dealing with such stress may be to teach people strategies that cultivate compassion for self and others, and by so doing reduce self-criticism and the negative emotions often associated with it.

Key concepts

An important concept in CFT is the idea of an ‘old brain’ (physical reactions; heart racing, tense muscles, feelings of anxiety, anger) and a ‘new brain’ (self-doubt, self-criticism, rumination). The ‘old brain’ evolved over millions of years and shares a variety of emotions and motivations with other animals (Gilbert, 2009). However, humans also have the ability to think, reflect and observe, as well as have a sense of self-identify, with what can be considered the ‘new brain’. This can be a useful concept in understanding behaviour.

Another important concept to explore with reference to compassion is the notion of ‘flows’ of compassion. There are three ways in which compassion might flow, each of these having facilitators and barriers that impact their cultivation (Gilbert, 2014). First, compassion flows out; individuals can experience compassion in themselves and direct it outward towards other people. Second, compassion may flow in; individuals can experience receiving and accepting compassion from others. Finally, there is self-compassion, which involves generating and directing compassion towards ourselves (Gilbert, 2009, 2014).

CFT interventions that help assist the flow of compassion have been found to be beneficial with patients (Beaumont and Hollins-Martin, 2013; Beaumont et al., 2012; Beaumont et al., 2016a; Gilbert and Procter, 2006; Leaviss and Uttley, 2015; Mayhew and Gilbert, 2008). Similarly, CFT has been reported to be successfully used outside of psychotherapeutic settings, such as in acute mental health wards (Crawford et al., 2013) and schools (Welford and Langmead, 2015). Given current demands within healthcare delivery and the importance of compassionate care, it may be useful for staff to be supported in developing their skills to cultivate compassion for others, from others and for self. The provision of continuing professional development (CPD) courses to help staff develop self-care strategies could help healthcare professionals self-soothe and increase self-compassion in times of distress. Learning to compassionately respond to the self and others has the potential to help individuals cope with stressors and enhance their resilience (Whelton, 2000).

Against this background, the aim of this evaluation was to explore the impact and personal experience of a 3-day CFT training course on healthcare educators.

Methodology

The first two authors of this paper established the need for the course to increase participants’ knowledge and experience of compassion to facilitate compassionate education for healthcare students. The course developed integrated theory and practice, including an exploration of the significance of evolution and attachment theory within CFT, and the role played by the three emotion regulation systems (Gilbert, 2009). The experiential skills practised during the course were designed to increase motivation to practise compassionate activities towards the self and others. (see Table 1)

In total, 44 educators attended the course at the University of Salford in 2016. While all worked in academia, staff attending came from a variety of health professional backgrounds including adult, child and mental health nursing; counselling and psychotherapy; and midwifery. Their ages

Table 1. Compassionate mind experiential exercises.

Compassionate mind experiential exercises included	
Mindfulness and focused attention	Participants learnt to mindfully focus on the present moment without judgement
Soothing rhythm breathing	Participants were taught breathing methods that have been found to be associated with positive health outcomes and facilitation of frontal cortex
Compassion-focused imagery	A range of exercises, which focused on imagery were used throughout the workshop
Creating a safe place	Imagery was used to help participants create a place in their mind that provides a feeling of safeness and calm
Compassion as a flow	Participants explored 'compassion as a flow'. Compassion flows in three ways, from others to us, from us to other people and from and to ourselves
Developing the compassionate self	Method acting and imagery techniques were used to create and develop a compassionate self (a best version of themselves – 'me at my best')
Developing our ideal compassionate other	Participants created an image of an ideal compassionate other – an image of someone or something that has their best interests at heart, who is there to offer strength and support
Using compassionate self to explore and relate to different parts of ourselves (multi-self)	Participants explored different emotional (angry, sad, anxious) parts of themselves and used their compassionate mind and compassionate self to relate to these different parts
Using compassion to engage with self-criticism	Participants directed compassion to their inner critic
Compassionate letter writing	Participants wrote a compassionate letter to themselves. The letter focused on offering support, understanding and compassion

ranged from 25 to 60 years, and they had between 1 and 20 years of teaching experience. Of the 44 people who attended the course, 28 completed pre- and post-questionnaires.

Participants self-selected to attend the course and participate in the evaluation study. Ethics approval for the research was provided by the University of Salford. To evaluate the impact of the training course, a two-phase multi-method study was undertaken. The first phase involved a quantitative approach using pre- and post-test questionnaires, which were statistically analysed using mixed analysis of variance (ANOVA) (see Beaumont et al., 2016b). There was a statistically significant increase in self-compassion and a reduction in self-critical judgement between measures taken before and after the course.

Phase 2 of the study took a qualitative approach and involved a focus group conducted 1 month after course completion. This provided a more detailed narrative of participants' experience of the course and its impact on them. It is this aspect of the study that is presented here.

Purposive sampling (Palys, 2008) was used in this study. The 28 staff members who had engaged in the training and completed the pre- and post-test were invited to take part in the focus group. Six agreed to participate. Those taking part in it included one counsellor, one midwife, two adult nurses and two mental health nurses. No one withdrew from the group.

The focus group ran for 1 hour, was audio-recorded and was held in a university setting. Two key questions initiated the discussion: (1) What effect has the CFT training had on you? (2) How did the

CFT training affect your work with students? The facilitator of the focus group was an experienced group psychotherapist and researcher, with previous experience of facilitating focus groups.

Interpretive thematic analysis was used to identify and understand participants' responses (Braun and Clarke, 2006). Following transcription of the focus group recording by the first author, an inductive thematic analysis was developed. Coding was informed by the data (bottom-up), rather than a pre-existing theoretical lens (top-down). The approach involved exploring participants' experiences, meanings and realities. The first two authors independently analysed the transcripts with Braun and Clarke's six-phase guide supporting the analysis. In the first phase, the transcript was read to gain familiarity with the data. Then coding was developed using a system each author believed would highlight important facets of the data. Themes were then generated and reviewed to enhance inter-coder reliability (Gregory et al., 2012). Definition and naming of the themes took place.

Findings

The analysis highlighted four main themes: reassurance and increased knowledge, increased compassion for others, self-compassion and empathy, and blocks to compassion. Participants were assigned pseudonyms to protect confidentiality.

Reassurance and increased knowledge

Participants reported that they felt reassured by the principles and practice in the CFT model and that they were using some elements in their current practice. Evidence of this came from Anne who was a nurse:

You know I just needed that reassurance that what I was doing was within my limitations and was acceptable.

This related to reassurance about her educational practice. Others experienced an increase in theoretical confidence that reinforced compassionate practice. The theory on the course strengthened compassion where there was previously self-doubt. Brenda, who was also a nurse, said:

Now I've sort of got the reassurance that's not the easy option, it's me being compassionate. Whereas before I thought, maybe I'm a bit of a soft touch and they think they can get away with it. But I think no, that's the compassionate way to view things and when they start to talk about this going on, I was starting to think oh yeah, now I've got a theory to hang on to that then.

For these two participants, having been trained in CFT enabled them to remain compassionate, believing this was a correct and 'acceptable' way to interact with students. They were able to recognise that they were using compassion and appeared 'reassured' that theory supported them in its use. Other group members agreed with their views.

Increased compassion towards others

Participants discussed how they gained increased compassion towards students, colleagues and patients/clients in their clinical work and how this had been validated by the course. An example of this was given by Brenda:

In terms of the personal tutor role and as programme leader, as you know I had students to see during that week [of the course] and to be able to sit through a conversation with a student and know what I was saying and what I was doing was acceptable [was good].

Here, Brenda recognised how a compassionate approach had helped her communicate more effectively with students in her course leadership role. Being able to do this enhanced her esteem. Increased compassion towards students meant that for Clare (a midwife) she could spend more time understanding why things happen rather than just advising:

But I think importantly for the students, the ones not coming for supervision or someone is not listening they are going away and not doing as you advise. There is a reason why. There is always a reason why. And it's my role to find out what that is rather than going 'you've not done what I said', 'you've not taken what I have said on board'.

Here, the use of compassion enhanced empathy and personal connection through greater understanding of the students' situation. This was accompanied by a reduction in judgement and anger in response to non-compliance. It also extended to colleagues for Brenda:

I guess it's given me a reminder that compassion not only starts from ourselves, but it's extending from us and beyond and I guess that I have found, I have been more proactive with colleagues mainly, because part of my role is to do that with students anyway, but now also with colleagues.

This theme of compassion towards others extended to colleagues. It appeared that empathy, understanding and connection to colleagues via compassion were limited prior to the course and was enhanced. The compassionate flow to others that was discussed on the course also began to have meaning and connection for additional people at work in educational settings and with patients.

The theme of compassion towards others also connected for some participants and their clinical work. Christine (a mental health nurse) described how useful she found the three-system model of emotion regulation to understand the patients she worked with:

I think we should assume that every single patient we meet has a massive threat system. Because if you're in hospital, then it's inevitable, isn't it?

There was an understanding within the group that when patients are ill or in crisis, their threat system would be triggered. This above statement demonstrated clear empathy and compassion with the patients' state of mind. However, when forensic mental health settings were considered, this appeared to be more of a challenge. Christine stated,

When you are trying to understand people in forensic settings you know, people who have committed terrible crimes and the students often find that difficult, don't they? Now I can think, oh, they are old brain and it makes me wonder, whether their new brain has developed well.

Gaining insight into the threat-focused system and old brain was reported to help assist with empathy, as well as being useful to communicate these ideas to students and support them in their clinical placements. This was also deemed useful by Clare:

Women go very old brain when they have a baby. Some women react really badly in the labor room. But actually, it's easy to be compassionate because somehow there is no premeditation to it, you know they are in agony and you just let them do it. And you forgive them immediately.

Clare reported how she found it helpful to learn about the notion of an 'old brain' and a 'new brain', and that some of the emotional and behavioural responses are, from an evolutionary stance,

archaic. This was reported to assist in conceptualising behaviours in a different way to improve interpersonal relationships within healthcare settings. It was noted that compassion towards others and empathy was a stronger theme than self-compassion.

Self-compassion and empathy

Participants highlighted the role played by self-compassion and empathy. This was framed as a process of self-reflection and self-compassion and a sense of slowing down when experiencing stress. Ruth (a nurse) reported how the training had helped her deal with her own problems:

When I saw an email, that really initially made me see red, I didn't respond, I parked it. I thought about what we had learned on the course, and then dealt with it the next day in a very different way than probably I would have responded the day before. So, it's made me think about a number of occasions, both personally and at work, where I have responded differently.

Here, the ability to take some time to consider responses meant that Ruth was able to react with increased compassion. There was a connection here between enhanced self-compassion, which increased a practice of increased compassion to another staff member. This was reaffirmed by Clare:

If you get an email from someone, I used to have a knee jerk reaction, but now I respond, but without pressing reply, but park it and send it later.

Two aspects of the training, mindfulness and three-system model of emotion (also referred to as the 'traffic light' system), were also considered useful by Clare:

With the mindfulness thing, when they say stand back as an observer and say to yourself, that's an annoyed person there and just be kind to yourself. Say it's ok to be annoyed, the reason that I'm annoyed is because I'm so busy. I've got too many things to do. The traffic light system for me has had such a big effect and I watch other people and I think, they are in red, they are in amber, they are in green.

The training (especially the three-system model) was described as being useful to understand interpersonal processes and also to empathise with other people. Clare linked the use of this theory to move into a personal reflective space, utilising self-compassionate thoughts as a precursor to responding in a considered manner. Again, the use of a theoretical construct appeared to help in the compassionate reflective space that facilitated a different way to create meaning and avoid the threat system. The imagery and colours were important as shorthand.

As part of the training, staff were invited to create an ideal compassionate image (Gilbert, 2010) from which attendees could experience compassion flowing towards them and out to other people. Time and space to undertake this exercise were given, in the hope it would give permanence to this image as a coping strategy. The exercise was viewed positively within the focus group, and the imagery connected to a deeper internalised more compassionate self. Alicia (a counsellor) stated,

I instantly envisaged somebody quite famous who I have always had as a bit of a role model and that really worked. And I thought, yes when I get anxious I just think of this individual and how would she react and respond. I actually downloaded her autobiography as I wanted to know more about her and then look at the traits she had and how I could develop that in me.

Compassion and empathy were directed first towards others, and then participants brought these back to themselves. The focus on keeping compassionate others in mind meant that self-compassion and improvement could be enhanced with further learning and empathic connection. Christine described how her image helped her to manage difficulties:

It was a very religious image, kind of like Jesus floating down the street and I was in like a cozy coat with a wand that sparkles, you know like a kid's wand that goes . . . dring dring . . . And so, I have got this image now that's with me all the time, like in a stressful situation or trying to get to sleep, especially. I just see me and my friend like that floating down the street and going . . . dring . . . dring . . .

This was reported as a positive experience and a useful way to cope with stress:

I've been quite surprised at the effect of the image that was given. I could have created that, but no one ever asked me to create it. I wouldn't have thought or know how to even begin to do that. And I don't use imagery often, but that's really stuck and it's there. I feel like it's there forever now.

Participants spoke of their imagery of compassionate others that enabled them to turn to their self-compassion. There appeared to be a requirement that the facilitator invited them to do this. Although this theme focused on self-compassion, it seemed that this only occurred when directed by another person and was usually compassion-directed to others first and then back to the self.

Blocks to compassion

Blocks to compassion was a theme relating to communication, ethical issues and being 'perfectly compassionate'. During the focus group, compassion towards others was reported to already have had a firm focus on interactions with staff, students and patients. However, participants also discussed a block to receiving compassion through communication from other staff members. For example, Alicia discussed how a member of staff had spoken to her about being compassionate and had told her,

'You will be compassionate'. If you are told this, it doesn't work because it's failed before it's started. We could also be accused of that, telling the students you have got to be compassionate, but I'm not going to be compassionate to you. So, unless we are [compassionate] to them how can we expect them to learn to be compassionate to other people?

There is an acknowledgement here that people cannot be forced to be compassionate. Being aware of the way in which communication occurs is also likely to affect a person's ability to show compassion towards others. Alicia was told by another member of staff 'you will be compassionate', detracting from her motivation to show compassion. Alicia was also keen to point out that educators need to show compassion, as well as asking students to be compassionate in their care of patients or clients. This notion also extended to the participants' employing organisation. Participants agreed that they needed to receive compassion from leaders within their organisation to provide compassionate education. Alicia stated,

If the compassion of the whole organisation was different, would that then mean that individuals would be more able to be compassionate? Because they would be less fearful of the consequences that may come from the organisation.

Here, Alicia had developed a greater understanding about the process of compassion, and importantly how there needed to be a flow between receiving compassion from others and giving compassion to others and self. This was also agreed to be important by the other participants. Three participants discussed how compassion could conflict with their professional role as a registered nurse. Brenda stated that

I have got the public to protect and compassion goes to a certain degree. You have to think is this person fit for practice? And I think that really does conflict sometimes with this compassionate you. Because you have another role that is always indoctrinated into you; that you are a nurse and you want to care. So, that bit does cause some conflict sometimes.

As a nurse and lecturer, there are responsibilities towards the profession, and while compassion has its place in education and care, standards have to be met and the public protected. To achieve this, registered nurses have a duty to report anyone who may not be fit for practice (Nursing and Midwifery Council (NMC), 2018). Participants were keen to discuss how their professional responsibility conflicted with compassion towards others. If a student's professional practice was unethical or deemed to be 'bad practice', all participants agreed the student would have to be told and, if necessary, disciplined, in order to prevent further occurrence. However, the idea that this was without compassion was challenged by Ruth:

So, she has broken those rules, but how do we then deal with that compassionately? You can see what has happened, the reason she has done it, but the rules don't allow us to take any mitigating circumstances into account. You are either guilty or not guilty and then the penalties are applied. But I think it's then [you can be compassionate], how you then share that with the student.

Although judgements about clinical practice must be made, Ruth argued that empathy could be experienced, and compassion demonstrated, when communicating the outcomes of a fitness for practice hearing to the student. Brenda reaffirmed this position:

Ultimately we have to oblige and follow rules and regulations, but do it in an assertive, compassionate way.

Another aspect of the blocks to compassion theme was being self-critical for not being 'perfectly compassionate'. One example of this came from Clare:

I see it in you, you are all compassionate people, you say really compassionate things, I actually felt quite inadequate at the end, because it's quite hard to be compassionate all the time, isn't it?

This was an interesting reflection from Clare, since during the training it was stressed that it would be both impossible and unwise to try and be compassionate all the time. Clare's reflection appeared to be her perception of an ideal compassionate person being one who was compassionate all the time and, in comparison, concluded that she was inadequate, appearing to feel some guilt. Brenda offered an alternative view:

I didn't want to leave the session thinking I should be compassionate all day long, it would be part of the same sharp sword.

The sharp sword Brenda referred to represented the ability of being 'perfectly compassionate', but if unable to achieve this, a person would become self-critical. Participants talked of it not being

useful to put pressure on self to be compassionate all the time or to compare yourself to others who appear to have the ability to do this. Ruth stated,

We can't always be compassionate all of the time, but compassion makes you put your breaks on and become aware of what you are doing. I don't think it's human to be 100% compassionate.

This statement demonstrates how stopping, thinking and being aware of behaviour could provide some compassionate space and help to embrace this aspect of humanity.

Discussion

This study explored how participation in a CFT course affected healthcare educators and the impact this had on their work. While the results of quantitative aspects of the study are presented elsewhere (see Beaumont et al., 2016b), the emphasis in this paper is on the qualitative findings from the study. Our earlier quantitative work reported a statistically significant increase in self-compassion and a reduction in self-critical judgement. Focus group findings supported this apart from a degree of self-criticism for not being compassionate all the time, which was expressed by one person. While the emphasis of the course was on learning about the therapeutic model and its application to educational practice, attendees were also encouraged to take an 'inside-out' perspective in applying aspects of the theory and practice to themselves using experiential learning. Similar to Cronin and Connolly's (2007) study, the experiential learning aspect of the course was stressed. This was favoured by the focus group as it increased their compassionate practice towards the self and others.

With respect to knowledge and reassurance, participants felt encouraged and supported by Gilbert's model. Participants discussed how important it was as educators to model compassionate communication with students when teaching, when in a personal tutor role or as programme leaders. This is supported by Drumm and Chase (2010) and Hawks (1992) who warned against a hidden curriculum that unintentionally devalues the role of compassion when educators react in a non-compassionate way towards students. Also deemed important was the fact that educators should be treated with compassion within their organisations. This would enable them to receive compassion and express compassion towards others.

The increased compassion towards others theme showed how useful it was for participants to learn about the theoretical components of CFT. Doing so enabled them to understand and increase empathy towards the challenging behaviours that can sometimes be experienced in educational and clinical settings. Increased compassion towards others connected with self-compassion and empathy. Beaumont et al. (2016b) found that community nurses who had higher levels of self-compassion were less likely to suffer from burnout. However, much of the published literature and professional guidance on compassion and nursing focuses more on compassion expressed towards patients (NMC, 2018), with much less of an emphasis on self-compassion.

The blocks to compassion theme highlighted how ethical decisions can challenge the idea that being compassionate is more than just 'being nice' to people. When ethical decisions have to be made with the likelihood of negative consequences, the latter should be communicated compassionately. This supports the findings of Crawford et al. (2013) who also report how professional and organisational requirements can impact healthcare professionals' ability to be compassionate.

Limitations

There are a number of limitations to this study. First, the focus group design had some limitations due to social acceptability bias. Participants' awareness of being observed and monitored may have

made it difficult for participants to discuss how they struggled with self, or other, directed compassion. Moreover, only six people took part in the group, and self-selection bias may mean that these were those with a more favourable attitude towards the training offered.

The study has limited external validity as the findings are not readily generalisable but instead provide detail on the reported effects of the course. To enhance internal validity and trustworthiness, the authors kept diaries and had reflexive discussion about their beliefs and how these may have influenced interpretation.

Further research

Although participants undertaking the course reported increased knowledge about compassion, and increased levels of compassion post-training, they also acknowledged some challenges in relation to being compassionate. The latter needs further study. It would be useful to further explore the relationship between ethical decision-making and compassion. Further research could examine the impact of compassionate work environments versus a non-compassionate work environment and how this affects student experience and/or patient care.

Conclusion

Focus group discussion complemented previously published data on the impact of a CFT training course on healthcare educators. Those participating in the group were able to clearly articulate what was useful to themselves and how the training had enhanced their roles as teachers in higher education. Evidence generated through the focus group supported the idea that participants who undertook the training were able to engage more fully with their compassionate selves and reflect more generally on the importance of compassion in healthcare education.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

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