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OBM Integrative and Complementary Medicine

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Case Report

Employee Support During COVID-19 Using Compassionate Mind Training

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Academic Editor: Marianna Mazza

Special Issue: Compassion Focused Therapy (CFT) - New Insights and Outcomes

OBM Integrative and Complementary Medicine
2023, volume 8, issue 1
doi:10.21926/obm.icm.2301015

Received: November 15, 2022
Accepted: February 06, 2023
Published: February 17, 2023

Abstract

An individual's wellbeing at work is now recognised as key, particularly for those in challenging environment's such as health and social care. Focusing on the cultivation of (mindful) compassion has been shown to be an effective way of improving mental health. This service evaluation focused on a pilot drop-in group for council and NHS staff, informed by Compassionate Mind Training. It was facilitated during the COVID-19 pandemic, between April – August 2020. The group was evaluated by recording the number and characteristics of attendees and using a feedback survey focused on the acceptability of the group structure and content. Workload was a barrier to attendance. There were differences noted in terms of gender and area of employment of the attendees. The offer of a regular, short (30 minute) and virtual group during the working day seemed to facilitate participation. The group appeared acceptable as attendees indicated they improved their knowledge and understanding about group concepts and reported they had become more mindful and

compassionate in everyday life. Participants appeared to value the range of meditations offered and group resources. The facilitators were struck by the sense of community that emerged. The group could be used in future research as a stand-alone programme to support staff wellbeing or perhaps as one part of a wider approach to support the development compassionate organisations.

Keywords
Self-compassion; compassionate mind training; health care professionals; employee support; online intervention

1. Introduction

It is increasingly being recognised that supporting the wellbeing of employees at work is crucial. Across health and social care staff, emotional exhaustion and burnout are key issues, with high rates found within these populations [1]. Focusing on employee wellbeing has become even more important given the current context of COVID-19, which has put additional pressures on services. For example, in a cross-sectional analysis, keyworkers reported significantly higher depression and anxiety compared with pre-pandemic population norms [2].

One way of promoting staff wellbeing is through teaching various contemplative/meditative practices. One such well-researched approach is mindfulness, commonly defined as the awareness that arises from "paying attention in a particular way: on purpose, in the present moment, and nonjudgementally" [3]. Mindfulness was introduced into Western healthcare settings by Jon Kabat Zinn, who first developed the Mindfulness Based Stress Reduction (MBSR) programme for chronic pain [4], and then Mindfulness Based Cognitive Therapy (MBCT) [5] focused on relapse prevention in depression. Both MBSR and MBCT are group programmes that include a variety of different mindfulness meditations that focus on the body (e.g. a body scan, mindfulness of breath and mindful movement), a personal's external environment (e.g. mindfulness of sounds) and internal experiences (e.g. mindfulness of thoughts).

Since these original programmes were developed, research around mindfulness has grown significantly and its principles and practices have been incorporated into many psychological approaches such as Acceptance and Commitment Therapy (ACT) [6] and Compassion Focused Therapy (CFT) [7]. Mindfulness research has also expanded across a wide range of settings including mental health psychopathology [8] and within the general population, for example, supporting the wellbeing of adults in the workplace [9]. Of note, the results of a systematic review concluded that MBSR may help to improve some aspects of psychological functioning in employees, including reductions in emotional exhaustion, psychological distress, anxiety and depression [10]. Similar results were found in a meta-analysis of Mindfulness-Based Programmes (MBPs) in the workplace [11]. This study also highlighted that MBPs could improve employee wellbeing, compassion, and job satisfaction.

More recently (and in parallel to mindfulness) there has been a greater interest in how compassion, and in particular self-compassion, maybe beneficial for staff wellbeing. Self-compassion has consistently been found to be associated with better mental health and resilience

[12]. Compassion Focused Therapy (CFT) is an approach that aims to cultivate the three the 'flows' of compassion: to give compassion to others, to receive compassion from others, and to give compassion to ourselves (i.e. self-compassion). It takes an integrative, process-driven biopsychosocial approach, with influences from evolutionary psychology, broader psychological science and other schools of psychotherapy including attachment theory [13].

CFT includes Compassionate Mind Training (CMT) which involves psychoeducation and experiential exercises and practices, with an overall aim to help individuals develop a compassionate self-identity [14]. The psychoeducational components introduce individuals to compassion, defined as 'a sensitivity to the suffering of self and others, with a commitment to try to alleviate and prevent it'. There is a focus on the process of evolution as resulting in the 'tricky brain' which can get lost in thinking-feeling 'loops' between its 'old' and 'new' parts. Emotions are grouped according to their evolved function and summarised into 3 emotion regulation 'systems' (threat, drive & soothe). Threat-focused emotions are described as shaping the mind and body in different ways to the point that they could be thought of as different emotional 'selves'.

Key CMT practices include mindfulness to develop self-awareness, Soothing Rhythm Breathing (SRB) and compassionate imagery. Unique to CFT, SRB is a collection of breathing exercises aimed to bridge into the soothing system, providing a solid foundation on which to build the compassionate self through various imagery exercises.

The popularity and evidence-base for CFT for a range of mental health difficulties is growing [15]. There is preliminary evidence suggesting that CMT has benefits across a wider scope, as a way of promoting wellbeing within the general population [14], as well as within certain employment sectors, including with schoolteachers and support staff [16] and with certain healthcare professionals [17].

Since CMT training focuses on cultivating the three flows of compassion, it potentially has an important role in supporting healthcare professionals to provide more compassionate care to their patients, as well as supporting themselves to both give and receive care from their colleagues (and themselves) as they continue to work in extremely difficult contexts such as the NHS or social care. For example, training in certain Buddhist meditations, including with a compassion-focus, has been found to possibly increase altruistic orientation, a tendency to feel empathic concern for another person [18]. Furthermore, [19] showed that receiving compassionate support during critical incidents had a lasting positive effect on employees whereby they described both their colleagues and their organisation in more positive terms. Finally, CMT training specifically led to increases in self-compassion and reductions in self-criticism in a range of health care professionals [20].

Since the outbreak of COVID-19, there has been a focus on the use of online CMT interventions [21], including those designed with health care professionals in mind [22]. However, the authors are not aware of a group being developed that was informed by CMT in response to a global pandemic and delivered for staff online and specifically designed to be delivered as part of the working day.

The current service evaluation therefore focused on a pilot online group for staff during the height of the COVID-19 pandemic. Staff members worked for either the council or National Health Service (NHS). The first author worked in a community team for people with learning disabilities in London, England. The service was integrated with Adult Social Care (ASC) meaning that NHS and Local Authority (LA) staff worked at the same physical base and used the same electronic systems. Prior to COVID-19, the first author had run several 'introduction to mindfulness' drop-in groups for colleagues. Whilst in principle any individual from ASC was invited, only those within the same

building would usually attend. As the COVID-19 pandemic began to unfold, teams moved to remote working. The authors therefore developed an 'introduction to mindful compassion' drop-in group as an offer of support for colleagues during this incredibly challenging time.

2. Materials and Methods

2.1 Design

This was a service evaluation of a pilot drop-in group (thus, no ethical approval was sought). The group was evaluated in terms of the number and characteristics of attendees each week as well as the acceptability of group structure and content using a feedback survey that was completed following the last session.

2.2 Participants

Invites were sent to the mailing list that had been put together from previous mindfulness groups. The group was also advertised via email and using the staff LA intranet. After the groups began to run, the LA asked to advertise the group as part of their own workplace initiative called 'Wellbeing Wednesday'. Through word of mouth, the local NHS Trust also asked to offer the group to their staff as well.

Those interested in attending were asked to email the first author to be added to the group's electronic invites and associated mailing list. All attendees were sent an information' sheet which included key aspects about the group.

The characteristics of attendees in terms of sex and broad employment area was collected by the facilitators through a combination of ways: by meeting individuals in the group, observing attendee photographs used at work or with email signatures.

2.3 Group Structure

The group consisted of 15 weekly sessions which took place at lunchtime (1 pm). Sessions lasted for 30 minutes and were delivered over Microsoft Teams. It was an open group so individuals could join at any point during the fifteen weeks and attend as many sessions as they found helpful. Each session was therefore designed as 'stand-alone', although topics were built on week to week.

It was run by a Clinical Psychologist, and two co-facilitators (a Trainee Clinical Psychologist and an Assistant Psychologist). Each session consisted of two practices, each approximately 7-10 minutes long. The main facilitator provided relevant psychoeducation before each practice and then invited reflections about what attendees noticed. Some time was left aside for reflections and questions/discussion about the session content.

Practices were recorded live and uploaded into a Dropbox account for attendees to download if they wanted to develop their own self-practice. Following each session, the main facilitator sent an email summary to attendees with written resources, as well as a separate email to the whole mailing list with an outline of what was covered with a reminder to attend the next session.

2.4 Group Content

The group was considered to have three phases that built on each other: 1.) an introduction to mindfulness; 2.) mindfulness practices and Soothing Rhythm Breathing (SRB); 3.) SRB and introduction to compassionate imagery. A summary of the session content (and subsequent attendance) is included in Table 1. Mindfulness practices in the second phase were used to mark the beginning of the group and were therefore shortened to allow further time for the second main practice. The mindfulness practices and associated written resources were predominantly adapted from core practices used in Mindfulness Based Cognitive Therapy [23] and Compassionate Mind Training [24], but significantly shortened and adapted for the different context and purpose of the group. Compassion-focused practices were adapted from The Compassionate Mind workbook [25] and also drew from Paul Gilbert's 'Compassion, Safe Relating and World Change' lecture series [26].

Table 1 Outline of the group and the number of attendees at each session.

Session	Content	Main Practices	Number of attendees
1	Introduction to mindfulness.	Body scan A 'Breathing Space' to introduce the idea of building awareness towards different kinds of internal experiences	24
2	Mindful awareness of internal physical experiences. Developing a mindful attitude of curiosity & openness & the 'cycle' of mindfulness.	Mindfulness of the breath Mindfulness of the body	35
3	Everyday mindfulness as 'knowing what you are doing when you are doing it'. Its importance given the mind's negativity bias.	Mindful movement Mindfulness of sounds	29
4	Introduction to the 'tricky' brain and the 'loops' between our 'old' and 'new' brain. Emphasis on its 'not our fault' that we get 'lost' in loops and mindfulness can help develop distance from these loops.	A breathing space Mindfulness of thoughts	26
5	Overview of the 3 emotion regulation systems (threat, drive and soothing). Key aspects of the threat system's 'better safe than sorry' approach. Sympathetic (threat) versus parasympathetic	Mindfulness of the breath An introduction to SRB (Posture, facial expression, mindful breath, slowed breath)	25

	activation (soothing) Introduction to SRB practice to calm the threat system.		
6	Introduction to compassion – definition & why we need it (the inevitable suffering in life). The 3 systems – common pattern of activation at work (threat & drive). SRB as different from mindfulness & aim to embody groundedness & stability (not relaxation).	A breathing space SRB – part 1: Posture, facial expression, mindful breath, slowed breath	29
7	Why we need compassion continued – compassionate insights ('how much of this did you choose?'). Further psychoeducation about SRB – breathing rate, rhythm & depth.	Body scan (shortened) SRB – part 2: invitation to count the breath	30
8	Looking at compassion in more detail: the two psychologies, compassion as a motivation and the 3 flows.	Mindfulness of the breath (shortened) SRB – part 3: invitation to bring in one's internal voice/tone	28
9	Recap on compassion definition and the 3 flows. Introduction to using imagery.	Mindfulness of the breath & body (shortened) Compassionate memory (of receiving compassionate from another)	34
10	Recap on key aspects of SRB. Recap on the use of imagery & Developing a safe/welcoming place.	SRB with a focus on slowed breath (shortened) Safe/welcoming place imagery	28
11	Recap on key aspects of SRB. Developing the soothing system to build a 'solid foundation' for compassion. Developing a compassionate other as receiving compassion from another The key qualities of this image as caring commitment, wisdom & strength.	SRB with a focus on slowed breath (shortened) Compassionate Other image	37

12	Introduction to the idea of 'multiple selves' and the compassionate self-identity. Developing this part of oneself using imagery/method acting.	SRB – with a focus on one's internal voice tone (shortened) Developing the Compassionate self – considering how you would hold yourself, stand, speak, think, feel & respond to distress of self & others	39
13	Further exploration of the idea of 'multiple selves' and the compassionate self-identity. Developing this part of oneself using imagery/method acting – 'stepping into the shoes of'.	SRB – with a focus on counting (shortened) Developing the Compassionate self – imagining this part of you in front of you and then merging with it	43
14	Further exploration of the idea of 'multiple selves' and the compassionate self-identity – like the captain of a ship lost at sea. Practicing switching into our compassionate self when we are going through difficulties. Overview of the group.	SRB with a focus on slowed breath (shortened) Using the multiple selves to a (small) problem or worry and imagining the problem from the perspective of the angry, anxious, sad and compassionate self	30
15	Final practice to focus on the flows of compassion. Questions to the group – hopes for coming? Learnt/experienced? How take things forward?	SRB with a focus on slowed breath, alongside a reading of The Guest House by Rumi Short Loving-kindness meditation	33

2.5 Feedback from Attendees

Feedback was collected following the last session via an online survey that was devised specifically for this evaluation. It included quantitative rating scale questions such as: 'The drop-in sessions were helpful', 'I improved my knowledge and understanding about mindfulness and compassion' and 'The drop-in sessions helped me become more mindful/compassionate in my everyday life?' with the same rating scale of: 'strongly agree, agree, neither agree nor disagree, disagree or strong disagree'.

The survey also had open-ended questions which included: 'Did you practice any of the exercises outcome of the sessions? Please tell us about your experiences e.g. which you tried/how often/how you found them? Did you listen to the recordings/read the handouts?' Brief content analysis [27] was used to analyse the written answers to the open-ended questions (with inductive categories developed from the responses).

3. Results

Twenty-three attendees completed the feedback survey questionnaire.

3.1 Attendance

There were 120 individuals who attended at least one session (see Table 1). The average number of attendees per session was 31, with a maximum of 43 and minimum of 24. The number of sessions attended by an individual ranged from 1 to 15, with the average being 4 sessions. There were 46 attendees who attended 4 or more sessions and 23 attendees who attended 8 or more (i.e. more than half of the sessions). Of the 23 that completed the questionnaire, 22 answered the question about how many sessions they attended; they had on average attended 8 sessions.

Attendees sex and broad area of employment are broken down in Table 2. Attendees were made up of more females; in total 96 females attended at least 1 session and 41 (43%) attended 4 or more sessions. In comparison, there were 16 males and 4 (25%) of which attended 4 or more sessions. There were more attendees from the local authority compared with the NHS/Learning disabilities team and attendees from the former came from a range of different employment areas.

Table 2 Attendees broken down by sex, broad employment area and those that attended 4 or more sessions.

Sex	n	%	n (4 or more)	% of n attended 4 or more
Female	96	80	41	43
Male	16	13	4	25
Not known	8	7	1	13
Broad employment area	n	%	n (4 or more)	% of n attended 4 or more
Council				
Housing	27	23	10	37
Children's services	23	19	11	48
Adult social care	12	10	5	42
Finance	11	9	4	36
Environment	10	8	3	30
IT	3	3	3	100
Human resources	2	2	0	0
Transport	2	2	1	50
NHS/Learning disabilities	16	14	5	31
Not known	14	12	4	29

Twenty-two individuals responded to a question about barriers and facilitators to attendance. Two themes emerged. Firstly, a barrier was workload and other time commitments, including meetings and 'schedule conflicts'. One person noted that 'this can't be helped'. Secondly, the time of the sessions seemed to generally work. One person stated that 'the half hour is good as it enables me to take the time out'. Others stated that the time of the sessions was helpful as it 'was right in the centre of the day having had a busy morning to calm my thoughts', and also that around

lunchtime was preferable as it gave them 'permission to take part and not worry about having to answer emails'.

3.2 The Context of COVID-19

When asked for general reflections, several attendees referenced that the sessions provided a helpful space in the context of an increased workload and additional pressures from COVID-19. One respondent stated that the group was a 'solid safe base' to 'build compassion awareness and to release some of the pandemic tension which was burning me out'. Another indicated that the sessions were 'just a real time of peace in a really crazy time'.

3.3 Group Structure and Content

The majority of attendee's reported that they either 'strongly agreed' (n = 18, 78%), or 'agreed' (n = 4, 17%) that the drop-in sessions were helpful. The majority also reported that they either 'strongly agreed' (n = 13, 57%) or 'agreed' (n = 8, 35%) that they had improved their knowledge and understanding about mindfulness and compassion. When asked whether the drop-in sessions helped attendees become more mindful and compassionate in everyday life, a sizeable majority 'strongly agreed' (n = 10, 43%) or 'agreed' (n = 8, 35%). The vast majority of the attendee's said that they would attend a similar session in the future (n = 22, 96%).

Qualitative comments also indicated that the group had been helpful. One respondent stated that it had been 'such a positive thing'; another said that it had been 'life changing'. One respondent stated they had not expected to 'value the sessions so much' and that it felt like 'we shared a space and a sense of community'. There were also multiple requests for the group to be 'rerun', and a 'wish it could continue' and that 'it would be nice if it became a regular weekly event for staff'.

3.3.1 The Helpfulness of Practices

Twenty-one of the attendee's responded to a question about which practices they had found most useful. The responses varied, highlighting individual preferences for different practices. A number referenced that 'all' had been helpful, suggesting that the group content was acceptable to attendees. Several responses highlighted the helpfulness of 'breathing' practices, with specific reference to SRB.

3.3.2 Practice Outside of the Group

Of the twenty people who responded to a question about practicing outside of the sessions/use of resources, 14 indicated that they had practiced the exercises at some point outside of the sessions, whilst 6 had not. Ten responses stated that they had used the resources (handouts and/or recordings) to support this. Only a small number of responses included the frequency of practice, which varied from a daily to weekly basis.

3.3.3 Group Resources

These appeared to be useful. One respondent described the handouts as 'clear and very helpful to understanding the concept of the day'. Comments highlighted that the function of the resources

varied for different attendees, including allowing them to go through missed sessions, to remind them about the exercises, as well as remind them about the 'safety' of the live sessions.

3.3.4 The Facilitators

A theme emerged from responses about the facilitators. Some noted that '[the facilitator] was brilliant and so were [their] co-mentors' and that the 'facilitators all had a very calming presence'. One highlighted that ''[the facilitator] was able to explain complex theories in an accessible way'.

3.4 The Wider Impact of the Group

Following the group ending, positive feedback was received from several very senior members within the local authority. The group facilitators were also nominated as local 'Heroes' because the local authority had 'received so much positive feedback from colleagues and your sessions have helped so many staff pull through an unprecedented and challenging time'.

4. Discussion

4.1 Attendance

It appeared that the remote nature of the sessions allowed a greater number of people to attend, perhaps because barriers such as travel or limited office space were no longer an issue. A common barrier to attending was workload. Whilst perhaps not surprising, it is particularly pertinent as any initiative aimed at staff wellbeing would need to be carefully thought through so that individuals feel able to attend. This highlights the need for staff wellbeing to be considered at the organisational level as part of the development of compassionate leadership and organisations [28]. The British Psychological Society (BPS) recently published guidance on building a caring work culture outlining the need for a whole system approach to mental health and wellbeing at work with a focus on leadership, support and learning, organisational interventions and culture [29]. Thus, this kind of intervention may help to support and enable the development of a compassionate organisation working at the individual level, alongside a focus on team and leadership [30].

The group was advertised as an open group; however, it appeared that females were more likely to attend compared to males. It also seemed that females participated in a high number of sessions compared to males (as 43% of females attended 4 or more sessions, compared with 25% of males). Having a relatively consistent attendance from some group members likely helped bring a sense of shared understanding and cohesion. It is interesting to reflect that one of the facilitators was male and attended every session. However, this was clearly not enough to encourage males' attendance and, if the group were run again, careful consideration needs to be placed on this issue. The rate of premature male mortality is a current and ongoing issue in the UK and there are continued challenges with effective health promotion for men [31]. [32] summarise ways of improving access and outcomes of men within primary care including, for example, investment into outreach services for men in the workplace. Future research could explore the effectiveness of strategies to improve male group attendance for example, by recruiting a male 'champion' or using a tool to help employ a gender-sensitive approach in the planning, implementing and evaluation of the group [33].

In relation to employment area, 16 attendees were from the NHS/Learning Disabilities Team. As indicated, a number of these individuals were from the facilitators Learning Disability Team and

therefore individuals who were aware of similar groups that were run before the pandemic. It is promising to see that a 'word of mouth' process emerged whereby individuals from a range of council departments and services then requested to attend. The facilitators were more easily able to offer the group in this way because of the integrated status of the learning disability service. As well as this, it is important to recognize the receptivity of the council, which could have been linked to the fact that compassion was one of their 'visions and values'.

The relatively small number of attendees from the NHS trust is difficult to interpret. It is possible that there were other NHS employees within other integrated services in e.g. Adult Social Care or Children's Services who were using their council contact details. It is also possible that NHS colleagues joined as 'guests' and so are part of the 'not known' category. However, this small number possibly highlights the limitations of solely relying on a 'word of mouth' process at a 'grassroots' level, particularly within some larger organisations. It is also important to note that attendees who found out about the group in the later stages of the programme would have only been able to attend a smaller number of sessions. It is hypothesized that, if the group were run again in, for example, collaboration with the Trust's staff health & wellbeing initiatives, participation would increase.

4.2 Group Structure and Content

The 15-week programme seemed to be an adequate length of time, allowing attendees to try a variety of different practices. Whilst sessions were short (30 minutes), this seemed to help with attendance during the working day. Specific timings were set for each practice to ensure that sessions ended promptly, whilst facilitators also made themselves available after sessions for further reflections or questions.

Some dilemmas arose from the virtual nature of the group. In some sessions, there were distractions reported associated with work-related notifications or background noise. There were practical issues for facilitators such as deciding the best ways to devise a register and facilitate discussions following practices. An unexpected positive surprise was the chat function which allowed attendees to participate in discussion without speaking in front of a large group.

Being an open group, some attendees came to every session whilst others only attended one. The feedback suggested that the group protocol found the balance between introducing core practices to newer attendees, whilst also offering variety and the opportunity to build on skills for those who joined more regularly.

The set of practices appeared to be helpful, with particular reference to SRB, a core practice within CFT. SRB is thought to be one way to 'prepare the body to prepare the mind', to build a solid foundation to then connect with compassionate imagery exercises. With this in mind, whilst feedback within the group suggested that attendees who joined later in the programme found the compassionate imagery useful, this was not measured formally within e.g. the feedback survey. Future research could explore whether there are individual factors that contribute to someone's readiness or ability to engage in imagery techniques.

The resources appeared to be an important component of the group (summary emails, handouts and audio recordings), allowing for practice outside of sessions. However, there appeared to be several attendees who only took part in the exercises within each session with comments suggesting they came to 'switch off' from the stresses of daily life, rather than use the skills learnt to help cope

outside of the group. The importance of regular practice could therefore have been emphasised further. In CFT, practice is described explicitly in relation to neuroplasticity of the brain and the need to build new compassionate pathways and networks.

The final theme that was focused on was about the facilitators. The lead facilitator had run mindfulness groups for their colleagues in the past thus demonstrating the broader roles that a psychologist could take on within a team. As a Learning Disability psychologist there is also an emphasis on working indirectly with paid and family carers, to try to put them in the best position to help the individual that they are supporting. It is therefore likely that this gave the facilitators confidence with this broad model of helping people to 'put on their own oxygen mask first'.

The lead facilitator developed the group protocol during the very early stages of pandemic out of compassionate concern for their colleagues and desire to help. At this point in time, the pandemic itself was seen as a shared common threat which seemed to lead to a re-defining of what was meant by a 'colleague' – it was broadened to mean anyone in the same organization, even if from 'different teams'. The facilitators tried to embody this caring motivation with all elements of the group e.g. taking time sending and replying to emails with queries and reflections outside of the group, infusing them with warmth and with a recognition of the value of everyone particularly during this extraordinarily difficult time.

4.3 Creating a Compassionate Community?

The most surprising aspect of the group was that, through word of mouth, more attendees from different teams and services requested to attend. Over time, there appeared to be a strong sense of community and connectedness between attendees and facilitators. This is particularly positive given that the sessions were relatively short and run remotely and group cohesion has been found to moderate the negative effects of stress exposure and posttraumatic stress symptoms on negative nurse outcomes including 'compassion fatigue' and burnout [34]. One hypothesis in keeping with the CFT model is that the group supported individuals to move from a threat/competitive mentality to a caring affiliative mindset. Future research is needed to explore this hypothesis further using a collection of outcome measures to consider the groups impact on key constructs such as compassion fatigue, burnout, the three flows of compassion and wellbeing.

4.4 Limitations

This was a service evaluation and thus overall conclusions are limited. Pre and post measures were not collected. Given the wide offering of the group, it is unclear what proportion the level of attendance represents within the organisations.

Acknowledgments

The authors would like to acknowledge and thank a number of people: firstly, to all those who attended the group, secondly, to Dr Roman Raczka (Consultant Clinical Psychologist) for his supervision and support and, finally, Tumu Johnson (at the time of the group, Trainee Clinical Psychologist) for her help with facilitation.

Author Contributions

The first author led on developing the group structure and content (including facilitation), the service evaluation design, data analysis and manuscript. The second author supported with the group content (drafting certain scripts), data analysis and manuscript. The third author gave permission to use all of the group content and supported the revision of the manuscript.

Competing Interests

The authors have declared that no competing interests exist.

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