

INGA A. BOELLINGHAUS PHD

# CULTIVATING COMPASSION IN PSYCHOLOGICAL THERAPISTS: THE POTENTIAL OF LOVING-KINDNESS MEDITATION

Section A: Cultivating compassion in psychological therapists: A literature review on the role of mindfulness and loving-kindness meditation
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CANTERBURY CHRIST CHURCH UNIVERSITY

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**Summary of the MRP Portfolio**

**Section A:** summarises theory and research relevant to the role of compassion in the work of psychological therapists. Two approaches that are thought to cultivate compassion, namely, mindfulness meditation and loving-kindness meditation (LKM), are introduced and their potential for fostering compassion in therapists is explored. Following this, extant empirical studies examining the effects of mindfulness-based and loving-kindness interventions on compassion are critically evaluated. Limitations and gaps in the existing evidence base are discussed, and the need for further research, such as studies using LKM with therapists, is outlined.

**Section B:** presents a study using Interpretative Phenomenological Analysis to explore how therapists in training experienced a course of LKM. Twelve trainees took part in a six-session long LKM course, which was offered following a mindfulness-based cognitive therapy course. Semi-structured interviews were carried out post-intervention. Participants reported perceived benefits of practising LKM, such as increased compassion for self and others and enhanced clinical skills. At the same time, LKM was experienced as emotionally challenging. Implications for training, clinical practice, and further research are discussed.

**Section C:** summarises critical reflections on the process of conducting this research study, including the researcher's learning experience, implications for training and clinical practice, and further research.

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# Section A:
# Cultivating compassion in psychological therapists: A literature review on the role of mindfulness and loving-kindness meditation

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## Abstract

The ability to be compassionate towards others is a key component of psychotherapeutic work. Theories and research suggests that compassion towards others is grounded in the capacity to be compassionate and caring towards oneself. Studies have shown that therapists are at risk of high levels of stress which may impact on their psychological well-being and ability to be compassionate towards clients. Thus, there is a need for approaches fostering self-care and compassion in clinicians.

There has been increasing interest in approaches rooted in Buddhist traditions that are thought to enhance compassion: mindfulness and loving-kindness meditation. A critical review on studies using mindfulness-based interventions identified that there is encouraging though limited evidence for their role in cultivating self-compassion in health professionals. The evidence for effects of mindfulness-based interventions on compassion for others is more tentative. A review on loving-kindness interventions showed preliminary support for its potential to foster compassion. However, no study to date has used loving-kindness meditation with therapists.

Further research to address methodological limitations of the existing evidence base is needed, such as randomised controlled studies comparing mindfulness-based interventions with active control groups. Moreover, research on the effects of loving-kindness meditation on compassion and self-care in therapists is warranted.

# 1. Introduction

Arguably, the capacity to be compassionate towards others is key in psychotherapeutic work (Gilbert, 2005a). At the same time, continuous work with people in mental distress commonly leads to symptoms of psychological distress in clinicians which may lead to burnout or compassion fatigue (Figley, 2002; Hannigan, Edwards, & Burnard, 2004). Over the past decades, Western psychology has increasingly become interested in training programmes that are thought to cultivate compassion, such as programmes based on mindfulness meditation (Gilbert, 2005b; Kabat-Zinn, 1990). Although the majority of research on mindfulness-based training programmes has been carried out with people with medical or mental health problems (e.g., Baer, 2003), there has been growing interest in the use of mindfulness to reduce stress and increase self-care in mental health professionals (Shapiro & Carlson, 2009).

More recently, research has started to explore loving-kindness meditation (LKM), a traditionally Buddhist meditation which is commonly practised in the context of mindfulness (Tirch, 2010). LKM cultivates an attitude of unconditional love, kindness, and compassion for oneself and others (Gilbert, 2005b; Salzberg, 1995). Studies have explored its impact on psychological well-being and interpersonal relating (e.g., Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008) which may also bear implications for enhancing self-care and compassion in psychotherapists.

Within this context, it seems important to review the empirical literature on the role of mindfulness-based interventions (MBIs) and loving-kindness interventions (LKIs) in fostering compassion in therapists. Firstly, this review will introduce the concepts of compassion, mindfulness, and loving-kindness and will introduce theories relevant to the development of compassion and its role in caregiving. It will then explore the role of compassion in psychotherapy and its relationship with stress in

clinicians, arguing for the need of approaches fostering compassion and self-care in therapists. Following this, the potential of MBIs and LKIs to enhance compassion in clinicians will be discussed. Finally, the empirical literature on MBIs for therapists and other health professionals and LKIs will be critically reviewed, with particular emphasis on their role in cultivating compassion. Implications for future research will be discussed.

## 2. Conceptualising Compassion, Mindfulness, and Loving-Kindness

### 2.1. Compassion

According to Gilbert (Gilbert, 2005b) compassion "involves being open to suffering of self and others, in a non-defensive and non-judgmental way" (p.1). It further involves a cognitive understanding of suffering as well as the motivation and behaviour directed to relieve suffering (Gilbert, 2005b).

Gilbert (Gilbert, 2005b; Gilbert & Tirch, 2009) suggested that compassion consists of six components:

1. The motivation to care for oneself and others
2. A sensitivity towards distress and needs of oneself and others and an awareness of how threatening emotions can hinder such sensitivity
3. A capacity to being moved by feelings and distress of others (sympathy)
4. A capacity to tolerate distress in self and others
5. A capacity for and understanding of someone else's feelings (empathy)
6. A non-judgmental attitude.

All of these components are thought to form the basis of a "care giving mentality" (Gilbert & Tirch, 2009, p.106), such as shared by therapists.

Neff (2003) has focused in her research on self-compassion, which she proposes has three components: 1. being kind rather than critical towards oneself, 2. perceiving one's experiences not so much as isolated but rather as part of common humanity, 3. being aware and non-judgmental of one's experiences rather than over-identifying with them.

The definitions of Gilbert and Neff both suggest that compassion is created in an atmosphere of openness, awareness, and acceptance of experience, which are key features of mindfulness.

### 2.2. Mindfulness

In Buddhist traditions, mindfulness is seen as a path to overcoming suffering (Siegel, Germer, & Olendzki, 2009; Silananda, 1990), and it has become increasingly integrated into Western clinical psychology as an approach to teach helpful responses to physical, emotional, and behavioural difficulties (Bishop et al., 2004). Mindfulness has been described as a non-judgmental moment-to-moment awareness (Kabat-Zinn, 1994). Although it can be cultivated in a number of ways (Harris, 2006; Linehan, 1993), it is most commonly taught in MBIs, such as 8-week long programmes of Mindfulness-Based Stress Reduction (MBSR) (e.g., Kabat-Zinn, 1992) and Mindfulness-Based Cognitive Therapy (MBCT) (Segal, Williams, & Teasdale, 2002), which have shown to been beneficial for a range of mental and physical health conditions (Baer, 2003; Grossman, Niemman, Schmidt, & Walach, 2004).

In an attempt to conceptualise mindfulness and its key processes Bishop et al. (2004) proposed a two-component model of mindfulness. They suggest that mindfulness is a psychological process that regulates attention to focus on current experience. Such self-regulation of attention is thought to enhance awareness of mental events and to facilitate disengagement from negative cognitive strategies, such

as worry or rumination. The second component of mindfulness involves an attitude of openness, curiosity, and acceptance towards any arising experience. Bishop et al. suggest that such attitude increases tolerance of negative affect and reduces cognitive and behavioural avoidance, leading to a reduced vulnerability to psychological distress. Although studies have provided support for Bishop et al.'s model (Feldman, Greeson, & Senville, 2010; Jain et al., 2007; Kumar, Feldman, & Hayes, 2008), further research on the processes involved in mindfulness is needed.

### 2.3. The Relationship between Compassion and Mindfulness

There is conceptual overlap between compassion and mindfulness, in that both concepts involve a non-judgmental and accepting attitude. Whereas some have suggested compassion as a quality of mindfulness (Shapiro & Schwartz, 2000), others have proposed compassion as an outcome of mindfulness (Bishop et al., 2004; Gilbert & Tirch, 2009; Walsh, 2008). Tirch (2010) put forward mindfulness as a "context for the cultivation of compassion" (p.113) and referred to Buddhist traditions in which mindfulness is commonly practised before compassion-focused practices, such as LKM. Similarly, Gilbert (2010) suggested the practice of mindfulness as a preparation to more specific compassion-focused exercises, such as compassionate imagery.

Supporting Tirch's notion, research has shown that changes in mindfulness after an MBSR intervention were related with changes in self-compassion (Birnie, Speca, & Carlson, 2010) and that the relationship between mindfulness and well-being is partially mediated by self-compassion (Hollis-Walker & Colosimo, 2011). Neurophysiological studies have found that mindfulness meditation is associated with changes in structure and activity of brain areas associated with caregiving behaviour, compassion, and the experience of love (Cahn & Polich, 2006; Lazar et al., 2005; Tirch, 2010). However, all of these studies used a correlational design which does not

allow any conclusions about causality, and further research is needed on the relationship between mindfulness and compassion.

### 2.4. Loving-Kindness

The Buddhist concept of loving-kindness is closely linked to compassion (Gilbert, 2005b; Salzberg, 1995). Loving-kindness is traditionally practised in the context of mindfulness (Salzberg, 1995; Tirch, 2010) and taught in a meditation cultivating feelings of kindness, compassion, and care towards oneself and others. Loving-kindness has been described as an unconditional love without desire for people or things to be a certain way, an ability to accept all parts of ourselves, others, and life, including pleasurable and painful parts (Salzberg, 1995). Embracing the spirit of loving-kindness is seen as a path in overcoming negative emotions and in promoting connectedness with others (Salzberg, 1995).

Psychological research on loving-kindness is only just evolving and there is a lack of a theoretical framework around the concept and the effects of LKM. The only theory on LKM so far is the ‘broaden-and-build-theory’ by Fredrickson et al.(2008). The theory suggests that LKM increases positive emotions which then lead to increased personal resources and well-being. The authors provided preliminary support for their theory in a study which will be reviewed later.

# 3. Theories on compassion

The following sections aim to summarise theories relevant to the development of compassion and its role in caregiving.

## 3.1. The Development of Compassion

In his evolutionary model, Gilbert (2005a) proposes that the development of compassion is shaped by two affect-regulation systems: a threat-focused and an affiliation-focused system. The threat-focused system is thought to regulate safety-seeking behaviour, such as fight or flight responses, in the presence of perceived danger. To the contrary, the affiliation-focused system de-activates defensive emotions and behaviours and underpins feelings of safeness, including content and calmness. Gilbert outlines that the development of both systems is shaped by gene-learning-interactions. He particularly emphasises the impact of early attachment experiences on the development of these systems and the capacity to develop compassion. He proposes that a threatening or non-caring early childhood environment is likely to lead to a strong threat-system and weak affiliation-system. As a consequence, a person struggles to feel safe with themselves and others, resulting in a reduced capacity to be compassionate. To the contrary, early experiences of a responsive and loving caregiver are likely to result in a stronger affiliation-system and greater capacity for compassion.

Gilbert proposes that people with an underdeveloped affiliation-system can learn to become more compassionate. He and his colleagues developed compassion-focused mind training which draws on mindfulness and other techniques to foster self-compassion (Gilbert, 2010). Studies using this approach with clinical samples have shown an increase in self-compassion and decrease in self-criticism, depression,

anxiety, paranoia, submissive behaviour, and shame (Gilbert & Procter, 2006; Laithwaite et al., 2009; Mayhew & Gilbert, 2008). However, all studies had small samples sizes and no control group, limiting the conclusiveness of results.

### 3.2. Compassion and its Relationship to the Caregiving System

Extending Gilbert's (2005a) model, Gilath, Shaver, and Mikulincer (2005) provided a theoretical framework for understanding the relationship between compassion and caregiving behaviour, drawing on attachment theory. They proposed that "compassion is associated with what Bowlby called the 'caregiving behavioural system' – an innate behavioural system in parents and other caregivers that responds to the needs of dependent others" (p.121). This system is thought to be complementary to the attachment system. The attachment system is activated by perceived threat and leads to the need to seek safety from an attachment figure. Bowlby (1982) proposed that the activation of the attachment system inhibits functions of the caregiving system. Thus, Gilath et al. (2005), conclude that the "aim of the caregiving system is more likely to be achieved when a person is secure enough to allow for a focus on someone else's needs" (p.126).

This notion has been supported by studies showing that attachment security was positively related to compassion towards others and the capacity to respond to and tolerate distress in others (e.g., Belsky, Rovine, & Taylor, 1984; Miculincer & Shaver, 2001).

### 3.3. Summary

Compassion, mindfulness, and loving-kindness are overlapping but distinct constructs. It has been argued that compassion may be cultivated though mindfulness and loving-kindness. Developmental theories on compassion propose that the capacity for compassion is related to early attachment experiences and that the ability to be

caring towards others is related to the ability to feel secure in oneself. Thus, compassion towards others is grounded in the capacity to be compassionate to oneself (Gilbert, 2005a). The following section explores the role of compassion in therapeutic work, its relationship with stress in clinicians, and how compassion may be fostered through mindfulness and loving-kindness.

## 4. The Role of Compassion in Therapeutic Work

### 4.1. Compassion and the Therapeutic Relationship

The therapeutic alliance is a complex interaction influenced by the client, therapist, and external circumstances (Hardy, Cahill, & Barkham, 2007). Compassion or components of compassion, in particular empathy and warmth, have been viewed as key factors in establishing good therapeutic relationships with clients (Ackerman & Hilsenroth, 2003; Bennett-Levy, 2005; Elliott, Bohart, Watson, & Greenberg, 2011). Empathy has been described as the "ability of the therapist to enter and understand, both affectively and cognitively, the client's world" (Hardy, 2007, p.29). Findings from a meta-analysis have shown that empathy accounts for about 9% of outcome variance in psychotherapies (Elliott et al., 2011). It has further been estimated that the therapeutic alliance predicts about 30% of outcome variance, compared with 15% predicted by specific therapy techniques (Lambert & Barley, 2001). However, these results need to be interpreted with caution, given the multiple factors involved in the therapeutic relationship, the challenges of defining and measuring these by self-report, and the variable ways in which therapy outcome is assessed.

The following sections discuss how stress in therapists may impact on their ability to be compassionate with clients, as well as themselves.

### 4.2. Therapist Stress and its Impact on Compassion in Therapeutic Work

About 25-40% of practising psychologists in the UK reported significant psychological disturbance (Hannigan et al., 2004) and about 60% of therapists admitted having practised at times when they felt too psychologically distressed to work effectively (Pope, Tabachnick, & Keith-Spiegel, 1987).

On-going stress may lead to 'compassion fatigue', a concept introduced by Figley (2002), which has been defined as a reduction in "our capacity or our interest in bearing the suffering of others" (p.1434), in particular in work with traumatised individuals. Identified prevalence rates of compassion fatigue in mental health trauma workers are inconsistent though, ranging from 5% to 65% (e.g., Craig & Sprang, 2010; Wee & Meyers, 2002). This is likely to be related to the lack of an agreed definition of the construct and use of different measures, cut-offs, and populations.

Only a few studies have examined the effects of therapist stress on compassion for clients. An experimental study showed that videotaped therapist-client interactions were rated more negatively if the therapist showed symptoms of burnout (Renjilian, Baum, & Landry, 1998). However, the results of this study lack validity and generalisability since interactions were staged by actors and ratings of therapist attentiveness and empathy were measured with single items only. Another study found that self-reported stress in nurses was negatively correlated with their interpersonal sensitivity, including tolerance with patients and interpersonal warmth, as rated by colleagues and supervisors (Motowidlo, Packard, & Manning, 1986). However, conclusions are limited due to the correlational design of the study, and none of the studies examined the relationship between clients' perceptions of therapists and therapist stress.

### 4.3. Therapist Stress and the Role of Self-Compassion

Stress in clinicians may lead to symptoms of anxiety, depression, and burnout (e.g., Ackerley, Burnell, Holder, & Kurdek, 1988; Radeke & Mahoney, 2000), highlighting the need for self-care in therapists. According to Gilbert (2005a), stress and anxiety activate the threat-system and de-activate the affiliation-system that generates feelings of safeness and the capacity for self-compassion. Self-compassion can be viewed as essential in engaging in self-care in that it involves an awareness of one's suffering, an acceptance of one's own needs, and the motivation to meet those needs (Gilbert, 2005a). It seems therefore important to actively cultivate self-compassion in clinicians, particularly given its relationship with the capacity to be compassionate towards others (Gilath et al., 2005).

### 4.4. Summary

Studies have shown that therapists are at risk of experiencing high levels of stress. Theory and research have suggested that therapist stress may impact on the capacity to be compassionate and caring towards oneself and others, highlighting the need to cultivate compassion in therapists. The following sections examine the potential role of mindfulness and loving-kindness in fostering compassion in therapists.

## 5. The Potential of Mindfulness and Loving-Kindness in Cultivating Compassion in Therapists

### 5.1. Mindfulness

It has been suggested that training in mindfulness may enhance therapeutic skills related to compassion, such as taking a non-judgmental attitude, being present, attending to, and tolerating the distress of clients as well as arising feelings in the therapist (i.e., countertransference), and being empathic (Bruce, Manber, Shapiro, &

Constantino, 2010; Hick & Bien, 2008; Shapiro & Carlson, 2009). Studies have shown that therapist mindfulness was associated with more positive alliances as rated by clients and therapists (Wexler, 2006, as cited in Hick, 2008) and therapist-rated counselling self-efficacy (Greason & Cashwell, 2009), although conclusions are limited due to the use of correlational designs and self-report measures only.

Grepmair et al. (2007) conducted a randomised controlled trial (RCT) in which therapists in an inpatient service were allocated to a meditation course or no intervention. Clients of meditating therapists showed greater symptom reduction over time compared with clients treated by non-meditating therapists. The study provided robust support for an effect of therapist mindfulness on client outcome, although it suffered from small numbers of participating therapists (n=18) and the lack of an active control group and follow-up.

Randomised controlled studies have provided growing evidence that MBIs decrease psychological distress and symptoms of burnout in clinicians (Cloitre, Cohen, & Koenen, 2006; Jain et al., 2007; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007), which in turn may positively impact on their ability to be compassionate towards clients. The evidence is limited though since most studies did not use an active control group or follow-up assessments and used small sample sizes.

### 5.2. Loving-kindness

Given the focus of LKM to cultivate kindness and compassion for self and others (Salzberg, 1995), it presents a potential intervention to actively cultivate compassion in therapists and its use has been promoted by Shapiro and Carlson (2009) as a means to self-care. Moreover, the broaden-and-build-theory (Fredrickson et al., 2008) suggests that LKM promotes positive emotions and personal resources

which seems relevant for coping with stress and increasing self-care in therapists. However, compared with mindfulness, the use of LKM has received little attention and no study to date has explored its effects on mental health professionals, calling for future studies in this area.

### 5.3. Summary

There is preliminary evidence that therapist mindfulness impacts on the therapeutic relationship and therapy outcome and more robust evidence that MBIs reduce stress in clinicians which may increase their capacity for compassion. Given the need to foster compassion in therapists and the potential role of MBIs and LKIs in this, it seems important to review the current evidence base on this topic. Since no studies have yet used LKIs with health professionals, the following literature review will focus on the effects of MBIs on compassion in health professionals.

## 6. Literature Review on the Effects of Mindfulness-Based Interventions on Compassion in Health Professionals

Since only few studies used samples of therapists, the review also included studies using MBIs with other health professionals for whom compassion is similarly relevant to caregiving and who also suffer from high levels of stress and burnout (Moore & Cooper, 1996; Shapiro, Schwartz, & Bonner, 1998).

Studies were reviewed if they used outcome measures of self-compassion or compassion towards others, including measures of empathy, resulting in eight quantitative and four qualitative studies. Please see Appendix A for details on the literature search conducted and Appendix B for a summary of the studies reviewed.

## 6.1. Quantitative Studies

### 6.1.1. Studies measuring self-compassion as outcome.

All studies reviewed used the Self-Compassion Scale (SCS) by Neff (2003) as an outcome measure.

Two uncontrolled studies with clinical psychology trainees showed that participation in a MBI led to an increase in self-compassion scores (Moore, 2008; Rimes & Wingrove, 2011). Qualitative analysis of feedback questionnaires supported this finding and further suggested that participants felt more able to empathise with clients. Given the small sample sizes of these studies (n=17 and n=20, respectively), the generalisability of these findings is limited. Furthermore, results of the studies are difficult to compare due to the difference in MBIs used. Whereas Moore examined the impact of 14 10-minute long mindfulness sessions, Rimes and Wingrove evaluated an 8-week long MBCT course. In addition, conclusions are limited due to the lack of control groups.

Using a cohort-controlled design and larger sample size (n=64), Shapiro et al. (2007) examined the effects of an MBSR course on counselling students. The control group consisted of students taking part in psychology courses which had the same facilitator contact time as the MBSR group. Results showed that, compared with the control group, the MBSR-group showed an increase in self-compassion which was related to changes in mindfulness. Although the study provided stronger evidence than uncontrolled studies, students volunteered to take part in the MBSR course which may have biased the results.

This problem of self-selection was addressed by a RCT that allocated 40 health professionals into a MBSR group or wait list control (WLC) group (Shapiro, Astin, Bishop, & Cordova, 2005). Results showed that the mindfulness-group showed a

significantly larger increase in self-compassion compared with the WLC group (22% versus 3%). Although RCTs provide the most robust evidence, neither this study nor the one by Shapiro et al. (2007) employed an active intervention as control group, leaving it unclear if changes in self-compassion were due to the MBSR intervention. Moreover, none of the studies reviewed used follow-up assessments, thus is remains unclear how durable the changes in self-compassion are.

### 6.1.2. Studies measuring compassion for others as outcome.

Four studies used an uncontrolled pre-post design, measuring the impact of an MBSR or MBCT course on empathy. Three studies using the Interpersonal Reactivity Index (IRI; Davis, 1983) as an outcome measures did not find any changes in empathy (Beddoe & Murphy, 2004; Galantino, Baime, Maguire, Szapary, & Farrar, 2005; Rimes & Wingrove, 2011) whereas the study using the Jefferson Scale of Physician Empathy (Hojat et al., 2001) found a medium-size increase (d=0.45) in empathy (Krasner et al., 2009), leading to questions about the sensitivity of the IRI to change. Beddoe and Murphy attributed the absence of change to a ceiling effect and reported that baseline levels of empathy in participating nurses were 40-50% higher compared with non-nursing populations. Galantino et al. used a mixed sample of hospital staff including administrative personnel. It is likely that empathy plays a less important role in the work of administrators compared with clinical staff which may also have impacted on the outcome.

The study by Krasner et al. found that changes in mindfulness were positively correlated with increases in the empathy subscale of ‘perspective taking’ (r=.31). This study was the only one that conducted follow-up assessments, at 12 and 15 months, which showed that the increase in empathy was maintained over time.

However, the absence of control groups in all four studies limits the conclusiveness of findings.

Shapiro et al. (1998) used a matched-randomised control design in which 78 medical and premedical students were assigned to a MBSR or WLC group. Results demonstrated that empathy, as measured with the Empathy Construct Rating Scale (La Monica, 1981), increased in the mindfulness group compared with the control group. The MBSR intervention also included empathic listening exercises, so that it remains unclear which component promoted change. Furthermore, results are limited due to the absence of an active control group and follow-up.

The study by Rimes and Windgrove showed that the amount of home practice impacted on changes in empathy; however, the effects of home practice on outcome were only addressed by half of the studies.

#### 6.1.3. Summarising critique on MBIs with health professionals

Most studies reviewed used an uncontrolled design, self-report measures, self-selected samples, and had no follow-up assessments. Some studies further had small sample sizes. These methodological limitations limit the validity and generalisability of results. Despite these limitations, studies have provided encouraging evidence that MBIs increase self-compassion in health professionals and tentative evidence that MBIs increase empathy, supporting the notion of mindfulness as a context for cultivating compassion and its usefulness for therapists (Bishop et al., 2004; Hick & Bien, 2008; Tirch, 2010).

### 6.2. Qualitative Studies

Four qualitative studies explored the experience of therapists of a MBI (Appendix B). Three studies were conducted by the same research group (Christopher & Maris, 2010), examining the effects of a 15-week long course, including

mindfulness practice, Qigong exercises, and didactic material, on counselling students. The authors used content analysis on data from a focus group and journal assignments. Another study used thematic analysis on diaries of family therapy trainees about their experience of a MBI on their clinical practice (McCollum & Gehart, 2010). The studies identified an increase in participants' self-awareness, self-compassion, and compassion towards others, including clients. Participants in all studies reported benefits for their clinical practice, such as an increased presence in sessions, tolerance to sit with silences, and an increased ability to focus on interpersonal processes and the client's experience.

Drawing on Yardley's (2000) validity criteria in qualitative studies, all studies showed sensitivity to the context, in particular to the position of trainees. For example, all authors reflected on the ethical challenge that mindfulness was offered to trainees in the context of an evaluated training programme which researchers were actively involved with. One other limitation was that the study by McCollum and Gehart lacked information on the length of the MBI. All studies showed commitment in that they demonstrated an in-depth engagement with the material and sufficient transparency with regards to the process of analysis, and provided a number of quotes to ground identified themes in the data. However, the generalisability of results from qualitative studies is limited. Moreover, the interventions either consisted of multiple components (i.e., meditation and qigong) or were embedded in clinical seminars; thus, findings might not be transferable to other MBIs.

### 6.3. Summary of review on Mindfulness-Based Interventions

The review of the literature on MBIs for health professionals has shown encouraging although preliminary support for the hypothesis that mindfulness cultivates compassion in health professionals, including therapists. The evidence base

needs to be extended by research addressing the methodological limitations discussed. Given the limitations of the evidence base for MBIs, it seems of interest to extend the review to LKIs. Although no studies on LIKs have yet been carried out with health professionals, a review on other LKIs studies may shed light on the potential of LKM to cultivate compassion in therapists.

## 7. Studies on Loving-Kindness Interventions

A literature search was carried out (Appendix C) to obtain studies that evaluated LKIs. Studies were reviewed to examine the potential of LKIs to foster compassion. They were included if they evaluated the impact of LKM on compassion or related constructs as well as the impact on coping with stress.

In a RCT with psychology students, Weibel (2007) found that four sessions of LKM resulted in an increase in self-compassion and compassion for others. The study benefited from a randomised design and 2-months follow up which showed that changes in self-compassion were maintained. The design of the study suffered from a lack of an active control group though and the use of a relatively new measure of compassion for others (Sprecher & Fehr, 2005).

In an experimental laboratory study, Hutcherson et al. (2008) showed that a brief loving-kindness exercise increased positive feelings and feelings of connectedness towards strangers. Although the findings further support the notion of LKM as a tool for increasing social connectedness and compassion for others (Salzberg, 1995), their external validity is limited due to the artificial laboratory setting, and results cannot be generalised to other, longer LKM interventions.

Results from a neurophysiological study have suggested that LKM is related to an increased empathic response to social stimuli and ability for perspective taking (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008). The study compared people

experienced in LKM with novice meditators; therefore, changes between the two groups may have been due to other factors that differed between the two groups, rather than their experience in LKM.

Another neurophysiological study addressed this problem by randomising participants to either a LKM or health-discussion group (Pace et al., 2009). It was found that participants in the LMK showed a reduction in stress-related neuroendocrine and immune responses, indicating that LKM may facilitate coping with stress, a finding relevant to the apparent need in therapists to cope with stress (see above). However, the generalisability of these neurophysiological laboratory studies is limited and further research is needed to support these findings.

The most robust evidence for LKIs comes from a RCT in which Fredrickson et al. (2008) examined their broaden-and-built-theory. The authors proposed that LKM increases positive emotions which would impact on personal resources and well-being. Results supported the model in that individuals participating in a 7-week LKM-course experienced an increase in positive emotions over time which predicted an increase in resources, including mindfulness, self-acceptance, received social support, and positive relations with others. These resources, in turn, predicted life satisfaction and reductions in depressive symptoms. A follow-up study showed that resources gained were maintained 15 months after the intervention (Cohn & Fredrickson, 2010).

The studies did not identify any changes in compassion for others. However, compassion was measured by one item only which the authors acknowledged may have lacked validity. Another limitation of the studies is the absence of an active control group. It is further noteworthy that results showed an initial drop in positive emotions which did not improve until week three. This finding suggests that the

engagement in LKM might not be of immediate benefit or might even be challenging at first.

Potential difficulties of engaging in LKM have been identified in other studies. An experimental study found that whilst some people showed a brain response associated with positive emotions to a brief LKM, others did not, in particular those with a tendency to ruminate (Barnhofer, Chittka, Nightingale, Visser, & Crane, 2010). Another experimental study found that contrary to their hypothesis, LKM resulted in an increase of a supposedly maladaptive belief that happiness is related to the achievement of specific targets in life, which has been shown to be related to depression (Crane, Jandric, Barnhofer, & Williams, 2010). Although these studies have limitations, such as the use of only one 15-minute long LKM exercises, the findings resonate with clinical impressions that some individuals struggle to engage with LKM (Barnhofer et al., 2010) or interventions used in compassion-focused therapy work (Gilbert, 2009).

Recent studies have shown that highly self-critical individuals show a physiological threat response when trying to be more self-compassionate (Longe et al., 2010; Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008). Gilbert (2009) hypothesised that compassion-focused interventions may trigger feelings of grief about the lack of feeling loved and cared for in childhood and that individuals may hold negative beliefs about compassion (e.g., ‘I don’t deserve it’). Thus, further research on the experience of engaging with LKM or compassion-focused interventions is warranted.

In summary, studies have provided preliminary evidence that LKM has the potential to foster compassion for self and others. Further research is needed to

explore its effects and potential for cultivating compassion in therapists and other health professionals.

## 8. Summary of the Review and Suggestions for Future Research

The literature review has highlighted the role of compassion in therapeutic work. Theoretical models drawing on attachment theory have suggested that the capacity for compassion towards others is grounded in the capacity to be self-compassionate which is related to early experiences of attachment relationships.

Mindfulness has been put forward as a context for cultivating compassion and there is considerable evidence that MBIs reduce stress in health professionals. This is an important finding, since there is a need for self-care in therapists and since theory and research have suggested that stress is related to the capacity for care and compassion towards others. However, only three out of eight quantitative studies with health professionals have examined direct effects of MBIs on compassion in therapists. As highlighted in the critique of these studies, more rigorous research, such as RCTs, is needed, comparing MBIs with active control interventions and using follow-up assessments. Also, research may further develop measures of compassion other than empathy, for example the compassionate love scale (Sprecher & Fehr, 2005). Future research may also include observations by clients on their therapists, measures of the quality of the therapeutic alliance, or observer ratings of therapist behaviour in sessions, e.g. by ratings of video-taped material.

The theoretical framework for the development of compassion and its role in care-giving outlined in this review suggests that the capacity to be compassionate towards others is based on the capacity to be compassionate towards oneself. It is therefore surprising that studies on MBIs with health professionals have not examined the relationship between the two concepts. In fact, only one study measured both, self-

compassion and empathy (Rimes & Wingrove, 2011), but did not explore their relationship.

Furthermore, given the potential of LKM to increase compassion, it is surprising that no study to date examined the effects of LKM on compassion in therapists. Future research could compare MBIs with LKIs for therapists. Such studies may also shed more light on the differential effects of these two interventions, which seems relevant since both meditation practices share components, such as an attitude of acceptance and gentleness, whilst having a distinctly different focus. So far, only a few studies have compared the two interventions, using only very brief exercises in an experimental setting (Barnhofer et al., 2010; Crane et al., 2010).

The review has shown that there is emerging but tentative evidence that LKM increases self-compassion, compassion for others, and well-being. Clinical experience and research studies have suggested though that the engagement with LKM may be challenging and future research needs to explore these findings further. It seems therefore apt to explore how individuals experience the encounter with LKM. Crane et al. (2010), called for research that "may help to see more clearly the nature of destabilizing effects" of LKM and "to identify those individuals who are likely to need extra support to engage" (p.205). Knowing more about the destabilising effects of LKM would provide relevant information for further research and development of conditions that may facilitate the encounter with LKM and minimise its potential risks.

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INGA A. BOELLINGHAUS PHD

# Section B:
# Cultivating self-care and compassion in psychological therapists in training: The experience of practising loving-kindness meditation

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## Abstract

**Objectives.** Emerging research suggests that loving-kindness meditation (LKM) increases well-being and compassion whilst being difficult to engage with. Since there is a need to cultivate self-care and compassion in trainee therapists (TT), this study aimed to explore how TT experience a course of LKM.

**Design.** A qualitative design using Interpretative Phenomenological Analysis was applied in order to gain a detailed understanding of the experience of LKM and the meaning participants gave to it.

**Methods.** Twelve TT who had previously attended a mindfulness-based cognitive therapy course took part in a six-session long LKM course and were interviewed about their experience.

**Results.** Five master themes were identified 'Engaging with the practice', 'Impact on self', 'Impact on relationships', 'Bringing compassion into the therapy room', and 'Integrating LKM into life'. Participants perceived LKM to have led to increased self-awareness, compassion for self and others, and therapeutic presence and skills. At the same time, LKM was experienced as emotionally challenging.

**Conclusions.** LKM may be a useful tool for enhancing self-care and compassion in TT. Further research is needed to extend the findings and implications for the use of LKM with TT and other populations are discussed.

# Introduction

## Stress in Therapists in Training

A significant proportion of psychological therapists suffer from psychological distress and burnout (e.g., Hannigan, Edwards, & Burnard, 2004). Research has suggested that younger and newer health professionals are at particular risk to stress (Moore & Cooper, 1996; Skovholt & Ronnestad, 2003). Surveys with clinical psychology trainees in the UK have found that between 25% and 41% of trainees reported a significant problem with anxiety, depression, low self-esteem, or work adjustment (Brooks, Holttum, & Lavender, 2002; Kuyken, Peters, & Lavender, 1998), highlighting the need for self-care in trainee therapists (TT).

## Self-Care in Therapists and its Relation with Compassion

Self-care has been referred to as self-initiated behaviours that promote well-being (Bickley, 1998). It has been suggested that self-care in therapists involves self-awareness, self-regulation, and the ability to balance the needs of self and others (e.g., Baker, 2003; Brady, Guy, & Norcross, 1995). The ability to care for oneself has been viewed as related to the ability to be compassionate towards oneself (Gilbert, 2005). Compassion has been described as a non-judgmental openness to and understanding of the suffering of self and others, which involves the motivation and behaviour to alleviate such suffering (Gilbert, 2005). Neff (2003) suggested that self-compassion also involves a kind and less critical attitude towards oneself and recognising one's experience as part of shared human experience.

**The Development of Compassion and its Role in Caregiving**

A number of authors have developed theoretical accounts of compassion which are relevant to understanding self-care and caregiving in therapists.

Gilbert (2005) proposes that the capacity for compassion is related to the development of two affect-regulation systems: a threat-focused system which generates safety-seeking behaviour, and an affiliation-focused system which de-actives defensive behaviour and generates feelings of safeness. Gilbert argues that early attachment experiences of being loved and cared for promote the development of the affiliation-focused system, which enables a person to feel safe with themselves and to develop compassion. A non-caring environment in childhood would lead to an underdeveloped affiliation- and overdeveloped threat-system, resulting in a reduced capacity for compassion.

Gilath, Shaver, and Mikulincer (2005) provided a theoretical framework on the relationship between compassion and caregiving. Drawing on Bowlby's (1982) attachment theory, they proposed that caregiving behaviour is inhibited if a person feels insecure or anxious, i.e. if their own attachment system is activated. This notion has been supported by studies showing that attachment security was positively related to compassionate behaviour towards others (e.g., Belsky, Rovine, & Taylor, 1984; Miculincer & Shaver, 2001). Studies with health professionals have suggested that clinician stress may impact on their ability to be compassionate and caring towards clients (Figley, 2002; Motowidlo, Packard, & Manning, 1986; Renjilian, Baum, & Landry, 1998). The need to monitor and seek help for therapist stress, "health-related or other personal problems that may impair their own professional competence" is also highlighted in the Code of Ethics and Conduct of the British Psychological Society (BPS) (BPS, 2009, p.17).

In summary, fostering self-care and compassion in TT seems central both to prevent psychological distress and to maintain high quality of care for others.

## Cultivating Self-Care and Compassion in Therapists in Training

"Developing strategies to handle the emotional and physical impact of own practice" and managing self-care is one learning objective listed in the accreditation criteria for clinical psychology training programmes (BPS, 2004, p.13). However, as Christopher (2006) remarks, due to the demands of the curricula of clinical training "self-care is typically presented to the student as an individual responsibility" (p.496). More recently though, there has been a growing interest in the use of mindfulness-based interventions (MBIs) within clinical training programmes (e.g., Rimes & Wingrove, 2011).

### Mindfulness-based interventions for therapists in training.

Mindfulness is a traditional Buddhist concept which has been described as a non-judgmental moment-to-moment awareness (Kabat-Zinn, 1994); it is commonly practiced through meditation. The most widely used MBIs are Mindfulness-Based Stress Reduction (MBSR) (e.g., Kabat-Zinn, 1992) and Mindfulness-Based Cognitive Therapy (MBCT) (Segal, Williams, & Teasdale, 2002), which have shown to been beneficial for a number of mental and physical health problems (e.g., Baer, 2003). More recently, mindfulness has been suggested as a tool for increasing self-care and compassion in clinicians (Shapiro & Carlson, 2009; Tirch, 2010).

To date only four quantitative studies have examined the effects of MBIs on TT (Cohen & Miller, 2009; Moore, 2008; Rimes & Wingrove, 2011; Shapiro, Brown, & Biegel, 2007). The studies showed that MBIs led to reduced levels of stress, anxiety,

and rumination, and an increase in self-compassion, reflecting findings from studies with other groups of health professionals (e.g., Irving, Dobkin, & Park, 2009). However, the evidence base is limited. Three of the four studies used small sample sizes and uncontrolled designs. All studies relied on self-report measures only and no follow-up assessments were conducted. Moreover, a comparison of results is challenging, since the nature and lengths of MBIs varied significantly.

Four qualitative studies on MBIs with TT have reported that participants perceived an increase in self-awareness, self-compassion, and compassion towards others (Chrisman, Christopher, & Lichtenstein, 2008; Christopher, 2006; McCollum & Gehart, 2010; Schure, Christopher, & Christopher, 2008). Practising mindfulness was further experienced to lead to an increased presence in therapy sessions, tolerance to sit with silences, and an increased ability to focus on interpersonal processes and the client's experience.

In summary, there is encouraging though limited evidence that MBIs increase self-care and compassion in TT. The primary aim of MBIs is to cultivate a non-judgmental moment-to-moment awareness. Although the practice embraces a kind attitude towards any arising experience, it can be argued that it does not explicitly cultivate compassion for self and others, in comparison with alternative meditation practices, such as loving-kindness meditation (LKM). Thus, LKM may be an alternative or additional tool for cultivating self-care and compassion in TT.

## The potential of loving-kindness meditation in fostering self-care and compassion in therapists in training.

Loving-kindness is a Buddhist concept that has been described as unconditional love and an ability to accept all parts of oneself and others (Salzberg, 1995). It is seen

as a path to overcoming negative emotions and promoting well-being and connectedness with others (Salzberg, 1995). LKM actively cultivates feelings of kindness, compassion, and care towards oneself and others and its use has been suggested as a tool to enhance clinicians' self-care (Shapiro & Carlson, 2009). However, compared with mindfulness, psychological research on loving-kindness is in its infancy and no studies to date have been carried out with TT or other health professionals.

Studies with other populations have provided preliminary evidence that LKM increases compassion towards self and others (Weibel, 2007), social connectedness (Hutcherson, Seppala, & Gross, 2008), empathic response to social stimuli (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008), and a reduced stress reaction (Pace et al., 2009). The most robust evidence comes from a randomised controlled study which found that LKM led to increase in positive emotions over time which predicted an increase in personal resources, such as self-acceptance and positive relations with others; these resources in turn predicted life satisfaction and reductions in depression (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008).

Although these findings are encouraging, further research needs to address methodological limitations of studies, such as the absence of active control groups and reliance on self-report measures. Moreover, studies have suggested that the engagement with LKM may be challenging. For example, Fredrickson et al. (2008) found an initial drop in positive emotions in the first weeks of practicing LKM. Another study identified that people with a tendency to ruminate did not show a positive response to LKM (Barnhofer, Chittka, Nightingale, Visser, & Crane, 2010). These findings resonate with clinical observations that some clients struggle to engage in LKM or other compassion-focused exercises (Crane, Jandric, Barnhofer, &

Williams, 2010; Gilbert, 2009). Recent studies have shown that highly self-critical individuals show a physiological threat response when trying to be self-compassionate (Longe et al., 2010; Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008). Gilbert (2009) hypothesised that compassion-focused interventions may trigger painful feelings about a lack of care and love in childhood. Thus, further research on the experience of engaging with LKM or other compassion-focused interventions is needed (Crane et al., 2010).

**Summary and Research Aims**

There is encouraging but limited evidence that MBIs enhance self-care and compassion in TT. LKM explicitly fosters care and compassion and emerging studies have shown its benefits whilst highlighting potential difficulties in engaging with the practice.

Given the need to cultivate self-care and compassion in TT, it is surprising that no study to date has used LKM with TT or other health professionals. Furthermore, no qualitative studies have been carried out on LKM which could provide an in-depth understanding of how individuals experience LKM and possible challenges of the practice. This study aimed to fill these gaps by examining how TT experience a LKM intervention, in particular, whether they perceive LKM to impact on how they relate to themselves, others, and their clinical work.

## Methods

A qualitative research design seemed most appropriate for exploring how TT experience LKM. Interpretative Phenomenological Analysis (IPA) was chosen as method for analysis since it examines in detail how individuals reflect on their experience and the meaning they give to it (Smith, Flowers, & Larkin, 2009). IPA seemed best placed to analyse the meaning of trainees' experiences, whereas other qualitative methods focus on other areas, such as theory generation in grounded theory (Glaser & Strauss, 1967) or the societal discourse about a topic in discourse analysis (Potter & Wetherell, 1987).

This study occurred alongside a quantitative single-case design research project which will be prepared for publication independently. The researcher was a clinical psychology trainee in her second year of training. She had completed two MBCT courses and had an interest in the benefits and challenges of LKM.

### Participants

Twelve TT took part in the study, ten women and two men. Seven participants were attending a year-long CBT training and five were in their first of three years of clinical psychology training at a university in the UK. Participants were between 26 and 54 years old (Mean=37.3, SD=8.6) (Appendix D).

### Recruitment

The sample was recruited from trainee CBT-therapists and clinical psychologists studying at the same university. Only trainees who had previously attended a MBCT course were included in the study, to ensure familiarity with

mindfulness meditation practices which are viewed to facilitate the encounter with LKM (Kabat-Zinn, 2005). The group size was restricted to twelve participants to ensure enough space for discussion.

Thirty TT who had completed a MBCT course at the university were informed about the study and invited to participate (Appendix E and F). Twelve TT expressed an interest and attended an informative meeting where informed consent was obtained (Appendix G).

**Intervention**

The LKM intervention started 8 weeks after the MBCT course had ended. It consisted of six hour-long group sessions which were offered over the course of 8 weeks on the university campus. Sessions were led by the same person who had facilitated the MBCT course - a clinical psychologist and university staff member qualified in running MBCT groups and with experience of practicing LKM. All sessions included a 30-minute guided LKM practice followed by discussion about the experience of meditating, modelled on the format of MBCT sessions (Appendix H).

The guidance was derived from traditional Buddhist LKM but offered in a secular way; it consisted of five stages (Salzberg, 1995): Firstly, loving-kindness was directed towards the self, then a friend, a neutral person (e.g., the postman), a person one experiences difficulties with, and finally, loving-kindness was extended to all beings.

Participants were encouraged to practice LKM 25 minutes daily and were given a CD with guidance (Appendix I). The researcher took part in the LKM course to experience the intervention but remained silent during discussions.

### Interviews

Interviews were conducted within 6 weeks after the end of the course; two took place at participants' homes, two in work settings, and eight on the university campus. Interviews lasted between 52 and 85 minutes and audio recordings were transcribed for analysis.

### Interview Schedule

A semi-structured interview schedule was developed in consultation with research supervisors who are both experienced in facilitating MBCT groups. The questions aimed to explore a broad range of experiences of practising LKM. Topics included the experience of LKM practice and its perceived impact on the experience of training, personal and professional development, and participants' relationships with themselves and others. Possible benefits and challenges associated with the meditation practice were explored. The interview schedule was piloted with a clinical psychologist with experience of LKM before it was finalised (Appendix J).

### Ethical Approval and Considerations

Ethical approval was obtained from the university's Ethics Committee (Appendix K). Since the researcher attended her clinical psychology training at the same university, trainees from her cohort were excluded from the study.

Before setting up the study, five trainees from a previous MBCT course participated in an anonymous consultation about the study (Appendix L and M). Trainees' views were acted upon by offering the LKM course in a shorter format than the MBCT course and by giving particular attention to the fact that the facilitator was a university staff member and research supervisor. Participants were made aware of

this and encouraged to decide how much or in which way to share their experience. They were assured that any identifiable information would be removed from the data and data analysis. Finally, the study was conducted in line with the BPS code of ethics and conduct (BPS, 2009).

**Data Analysis**

Data were analysed using IPA and its principle of a 'double hermeneutic' (Smith & Osborne, 2003); the researcher was aiming to make sense of how trainees made sense of their experience of practising LKM. The first four transcripts were analysed using Smith et al.'s (2009) guidance on working with small samples to gain familiarity with the process of analysis. Each transcript was read and re-read and initial comments on content, linguistic patterns, and conceptual ideas were made. Themes were extracted and connections between themes explored before moving onto the next case. Smith et al. (2009) suggest that such detailed analysis is not feasible for each transcript when working with larger samples as in this study. Following their guidance, the analysis then focused on key themes emerging in the whole group, holding off cross-case comparisons until all cases were analysed. Themes were then examined for similarities and differences before being summarised in master and sub-themes.

**Quality Assurance Methods**

In line with Smith et al.'s (2009) recommendations, Yardley's (2000) principles of assessing validity in qualitative studies were used as a guide throughout the study. For example, the researcher considered the specific context in which the study was conducted by considering the ethical implications of the course being offered by a

university staff member. ‘Commitment and rigor’ (Yardley, 2000) was aimed for by following established IPA guidelines (Smith et al., 2009) and by examining data for inconsistencies. Furthermore, parts of the analysis were cross-checked by the external supervisor to ensure themes were grounded in the data.

Yardley (2000) further emphasised the importance of reflexivity. At the outset of the project, the researcher was interviewed by a fellow trainee about her preconceptions and experience of LKM (Appendix N). She further kept a reflective diary (Appendix O) and engaged in regular discussions with her supervisors.

## Results

The analysis revealed five master themes and 12 sub-themes, as illustrated in Table 1, which will be considered in the following sections (see Appendix S for initial codes).

**Table 1** Master themes derived from analysis

| Master themes | Sub-themes |
|---|---|
| Engaging with the practice | • Intellectual understanding versus experiential engagement<br>• Emotional response to practice<br>• Safety of practising<br>• Creating a personal practice<br>• The power of sharing |
| Impact on the self | • Self-awareness<br>• Self-compassion<br>• Self-confidence |
| Impact on relationships | • Awareness of self in relationships<br>• Compassion for others<br>• Social connectedness<br>• Overcoming interpersonal difficulties |
| Bringing compassion into the therapy room | |
| Integrating LKM into life | |

**Engaging with the Practice**

The first master theme reflects participants' experiences of engaging with the LKM practice and consists of the following sub-themes.

Intellectual understanding versus experiential engagement.

Participants found it challenging to intellectually engage with the concept and task of the LKM whilst experientially connecting with it. Some participants experienced the meditation as too structured or abstract:

'*It was (…) taking away from how I was feeling and it was just kind of trying to* think certain thoughts about, you know, it was really cognitive, really brainy, and I *couldn't connect with it*' (P9,5,11).[1]

It seemed that participants' previous mindfulness experience played a significant role in understanding and engaging with the practice:

'*The mindfulness is about (…) my own state, my own sort of (…) thoughts,* feelings, awarenesses, whereas the loving-kindness felt very *much about how I (…) cope and look and view and sort of view others, (…) and one definitely leads to the* other' (P6,7,20).

Experience in mindfulness was mostly seen as helpful in engaging with the LKM, for example 'in terms of the trying not to judge' (P4,33,30).

1 (…) Material omitted

[ ] Interpolation added by author for clarity

(Px,x,x) Participant number, page number, line number of transcript

However, one participant struggled to intellectually integrate the two practices which hindered their experiential connection with the practice:

*'I was feeling like I was trying to create something, or cultivate something, so* being quite active, whereas when I'm doing the mindfulness practice I'm not being *passive, but I'm not being active. (...) I was conceptualising the loving*-kindness as *creating (...) something, and that to me seemed to be (...) pulling in the opposite* direction to doing the mindfulness' (P5,1,19).

Emotional response to practice.

Most participants experienced parts of the practice as soothing or grounding. However, few reported predominantly positive feelings, such as being 'quite peaceful immediately after the practice and more physically relaxed' (P3,11,15).

For the majority of participants the meditation practice 'has been really intense' (P2,10,8) and brought up difficult feelings at times, such as anger, guilt, sadness, or anxiety.

For one person, thinking about the suffering of other people, 'how all these *people are walking around with whatever their internal struggle is (...) was just a really sad thought'* (P5,7,4). Similarly, another person stated feeling 'powerless to do anything about all the suffering' (P7,10,17).

For some, the practice triggered difficult past experiences:

'It went deep in my past and I was a bit shocked by that how, how I got to that *state. (...) It was really intense, (...) it brought up times, the relationship between me* and [parent], how it was difficult. *(...) I felt quite a lot of anger there (...) and as it progressed I felt quite drained afterwards'* (P8,10,8).

For this participant, the memories of the past seemed to have led to a dissociative state:

*'Part of the difficultly was to bring me back (…), I mean* I used my breathing as *my anchor to come back to where I was'* (P8,12,14).

For another person, the experience of meditating alone at home triggered feelings of isolation and not being cared for in the past:

'*It's associative (…) with times that I have bee*n self-soothing (...) just because *that's all there is available (laugh) to kind of (…) try and mend'* (P2,30,14).

Safety of practising.

Given its powerful emotional impact, the majority of participants experienced the meditation as personally challenging. 'It can feel a bit risky almost doing the meditation, um, doing something that's, that is so unsettling' (P5,8,15). For one participant, wishing themselves well felt '*wrong'* and like 'tempting fate' and triggered superstitious thoughts of a 'dangerous' quality:

'*I'm half thinking either this will be brilliant and (…) life changing and great, or (…) there might be some catastrophic health consequence or (…) something (…) more extreme happens as a result of trying this'* (P4,9,6).

Participants drew on a range of strategies to make the practice safe, for example using mindfulness when feeling unsettled:

*'Using the mindfulness techniques in a way just (…) makes me … that I'm feeling quite upset at the moment, but its ok, I'm just letting it be'* (P7,8,21).

Some participants assessed whether they had the emotional resources to practise and decided to avoid the meditation when they did not:

'*There's so much stress on training that sometimes it's too much so you're trying to avoid it rather than getting in to it. (…) I've also watched out when it was* safe for me to do it' (P9,8,8).

For some participants, personal therapy provided a space to reflect on issues arising in the meditation. One participant described how previous therapy helped them to encounter the practice:

'I think all that psycho-*dynamic therapy that I've had means that (…) there was nothing painful that came as a surprise because I've been there already'* (P3,5,5).

Creating a personal practice.

Participants described how they experimented with different meditation techniques to develop a meaningful LKM practice as they were encouraged to do in the guidance. Some strategies were chosen to overcome commonly reported obstacles during the practice, such as feeling tired or distracted:

'Focussing on a pictur*e of myself when I was feeling loved, that's what (…) provoked that sensation of being loved (…) and then occasionally [I] used the other* ones [verbal phrases] as well if I was kind of drifting off a bit' (P3,7,4).

Some participants created personal phrases: *'I would say certain phrases to do with what I wanted to be feeling like, what I wanted to be, what (…) sort of my* intention was for myself' (P10,19,19).

Others used imagery to get into a compassionate mindset. One participant imagined 'sitting in a fie*ld with the sun on my face'* (P5,5,1), another person imagined a 'garden loving-*kindness where you can (…) show people around the garden in your* heart' (P12,4,7).

Most participants described struggling to make time to practice which led to some people shortening the practise, or bringing on loving-kindness thoughts 'scattered throughout the day' (P10,12,13).

The power of sharing.

Most participants talked about the 'power of the group' (P6,23,7), of meditating together being 'quite special' and a motivating factor to practice. Sharing of the meditation was extended outside of the group by some participants who started to meditate with their partner or with one another, which seemed to increase a sense of connection:

*'We did a couple of practices together (...)* and [the colleague] said actually *[they] thought about me in one of [theirs] um and I think it's made me think about my colleague as well'* (P11,20,5).

Discussing the experience in the group seemed important in that participants felt supported in their struggles which appeared to have made engaging with the practice safer. 'What actually helped was other trainees in the group had felt in a *similar way and that was a bit um reassuring'* (P8,14,9). It further seemed that some participants were deeply affected by the experience of others:

'*I was kind of surprised that the power of (...) what I'd said, how that had affected [another trainee], so (...) the loving*-kindness had affected me to say something and [the other trainee] had been affected as well' (P12,20,1).

**Impact on the Self**

This theme refers to the changes participants perceived the LKM to have on themselves and contains the following sub-themes.

Self-awareness.

All participants reported that the practice made them more aware of their thoughts and feelings. One participant compared this process to the function of dreams: '*I think dreams are useful, just remind me what's in the back of my mind and so, it's a bit similar to that*' (P11,34,14).

One dominant theme was becoming aware of one's own self-critical and ruminative patterns:

'*All the kind of, um, self criticisms (…) that just bubble up (…)* – they're just too *gentle to properly notice most of the time. It's just like the shade of the lighting or something, but (…) this has been bringing it much more into my* immediate vision' (P2,15,20).

'*I have become aware of (…), you know, I ruminate, (…) hugely, so I suppose that's a big big big thing, and I think that's quite detrimental in some ways'* (P6,55,12).

For some participants, becoming more self-aware connected them with their own vulnerabilities:

'I felt more, just a bit more tearful and a bit more like easily upset about *things, like maybe things weren't so (…) deeply buried in me that were a bit more on* the surface, because I was sort of thinking about them during loving-kindness meditations' (P7,16,12).

A heightened sense of one's vulnerability seemed to be related to an increased awareness of stressors in training, coping strategies, and the need for self-care, as this participant described with respect to the impact of clinical work:

'*It just helped me realise and becoming aware and reflect on what's, what this type of work is taking from me and how exhausting it is and, (…) in order for me to* be kind to others I also need to learn to be kind to myself' (P9,20,5).

Self-compassion.

All participants talked about becoming more accepting of themselves, particularly of difficult feelings. Some participants felt that the practice helped in 'containing them [difficult feelings] in some way having more space around them' (P12,5,20) and that the practice was '*a way of feeling safe with (…) those feelings and* therefore experiencing them fully rather than suppressing them' (P3,29,10).

One person described how they felt able to embrace different parts of the self: 'I have positive and negative emotions, positive and negative habits, you know, and they're all me' (P1,38,10).

Self-acceptance seemed closely related to taking a kind and compassionate attitude towards oneself, particularly in response to self-critical thoughts:

'*I could very very readily think of situations where (…) I'd like cringed inside at something awful I'd said or done (…) that I felt quite ashamed of, and then I found* it quite powerful to be able to be gentle to myself and forgiving of myself' (P1,11,1).

Being kind to oneself was related to a distance from self-critical thinking, in that 'self-critical thoughts were a lot less self-critical' (P7,9,19).

One person compared this process to challenging negative thoughts in cognitive therapy:

'*It's a bit like CBT (…), if you're feeling a bit stressed or a bit hurt you might* get caught up and focusing on a negative thing, so [loving-kindness] sort of counterbalances that' (P11,21,5).

Being compassionate about feeling stressed about work and giving oneself permission to be 'a good enough student' (P4,9,34) and to 'take the pressure off' (P4,8,6) was a theme for most participants.

'*In the past I would have been quite (…) angry with myself for not being able* to cope and just get on with it, I think I was more a*ble to say, oh look (laugh) you're sad, you're under a lot of pressure and that's ok*' (P7,24,5).

Participants fostered kindness and compassion in different ways. Some used positive self-talk: 'I just got into a habit of being a bit kinder to myself and talking to *myself the way I'd want others to talk to me'* (P10,5,2). Others encouraged themselves to a better work-life balance and to engage in nurturing activities: 'Be kind to *yourself, go for a walk, do other things, (…) whatever it is you want to do*' (P4,10,2).

However, not all participants found it easy to be self-compassionate. For one person being self-compassionate felt uncomfortable and '*selfish'* (P4,13,5). In this case, the loving-kindness course felt like a '*permission (…) to try it out, and (…) the* idea of experimenting and just seeing what happens' (P4,30,9) seemed helpful for this person to question their negative judgments about being self-compassionate.

Another person found it very challenging to find self-kindness:

'*I (…) needed to stay with the struggle (…) and be compassionate for myself in the fact that I'm having this struggle, and really (…) staying with the struggle was,* was just really difficult' (P5,6,12).

For others, being kind rather than self-critical seemed to have triggered worries about becoming complacent:

'Mindfulness and loving-*kindness I don't want them to get in the way (…), I feel like (…) I might relax and rest too much, I feel like I need to (…) be more disciplined* as well, but it is just about getting the balance' (P11,35,6).

Self-confidence.

Half of the participants talked about starting to feel more secure in themselves. For one person, the practice had a profound effect in that they started to feel empowered to speak up to others to get their needs met:

'*I go 'actually that's not ok to treat me like that and actually it's perfectly justified for me to be really hacked off with that person'. (...) I was starting to (...)* find a bit of clarity, a bit of confidence, a bit of backbone' (P2,1,17).

Similarly, another participant described feeling more able to assert their needs:

'*I'm getting much better at saying no to friends, (...) [there is] something in terms of assertiveness in this as well in terms of what feels right (...) for me, yeah, all* part of taking care of yourself' (P4,22,26).

One person started to feel more confident in looking after themselves:

'*It made me feel (...) more safe with myself. (...) I can actually know what I need, (...) that I can do that [loving*-kindness] as a way of finding out what I need *(...) and that actually I do know how to be compassionate towards myself'* (P3,5,23).

However, for one participant, the practice triggered thoughts of self-doubt when they realised that self-compassion did not come easily to them:

'I just think I'm quite neutral, and I did find it really difficult to really sort of *foster the (...) compassionate side, for me (...) and (...) because it was really difficult to find that compassion for me (...) I started questioning whether I was really finding it for anyone else either'* (P5,3,17).

**Impact on Relationships**

This master theme refers to changes participants observed in their relationships related to the LKM. Similar to the master theme 'Impact on self', it contains sub-themes of 'awareness' and 'compassion'.

Awareness of self in relationships.

Participants talked about becoming more aware of how they relate to others:

'*I've started to notice some of my relationship patterns, like how I am with certain relationships'* (P7,3,12).

The meditation seemed to offer a space to reflect on and experience reactions to others:

'Noticing that I do have frustration towards some people when, a lot of the time *I (...) conceal that frustration in order to (...) superficially get on with them, but I don't really know what I'd do with that frustration, I just sort of ign*ore it, whereas the loving-*kindness sort of helped (...) to just sit with it and experience* it' (P7,5,6).

One person found it useful to become aware of their difficulty in feeling emotionally compassionate towards others:

'I see other people relating to each other in that [compassionate] way *sometimes, but I don't to most people. So it hasn't really changed that, but at least its* [the LKM] highlighted it' (P3,20,18). For this person, the meditation introduced a sense of what it is like to feel compassion: 'I had no sense of it before and now I have *a very vague sense of it'* (P3,23,22).

Compassion for others.

Participants described finding themselves more accepting of others:

'*Having spent quite a bit of time over the practising (...) thinking about [a* friend] *in a slightly different way, (...) like she is very different from me that sort of being accepting of the difference'* (P4,25,17).

*'[I] just kind of accepted [my manager] as a person, and the same with my supervisor (...) it seems like you're kinder about people's shortcoming sometimes* because you know you have shortcomings and you're kind about those, so why not be *kind about other people's shortcomings?'* (P9,25,12).

Connecting with a sense of 'shared humanity' (P5,20,18) seemed to help in finding kindness towards others:

'*Whatever difficulty I have with this person we're both human, this person* struggles too' (P5,20,18).

'*It just makes me less critical, less judgmental, less (...) in that kind of 'everyone's an enemy mode', (...) rather than they're just people, (...*) just like me' (P6,61,5).

Social connectedness.

Doing the LKM course increased the connection between participants: '*We've* kind of really bonded' (P6,25,4), described one person and another shared that participants reminded each other of being kind to themselves: '*If someone's stressed about something (...) we kind of say 'oh, loving-kindness"* (P4,27,16).

Participants talked about becoming more open to connecting with people on their training course, at work, or, as for this person, in their personal lives:

'You feel a bit closer to them and you're a bit more open to them when you go *to the gym, so now a lot of the (...) people that were my neutral people [in the LKM], (...) I kind of know them quite well now'* (P4,24,20).

'*It's (...) reminded me to be more open to* other people and meeting new people or being aware of them' (P11,26,15).

Some participants also started to feel safer in their relationships:

'*I feel more present in my relationship (...) slightly less on the back foot'* (P2,23,21). One person felt, 'that people were less of a threat' (P3,9,5) and more able to negotiate closeness in their relationships:

'*I (...) feel closer to [my parent] without feeling that [my parent] can sort of* have the negative impact on me that [they] used to be able to have if I got too close. So that's really positive' (P3,11,1).

Feeling more connected and safer in relationships also seemed to be related to the following sub-theme.

Overcoming interpersonal difficulties.

Participants talked about feeling more able to cope with difficulties in their relationships, for example overcoming negative feelings after an argument:

'*It helped me to (...) get over (...) angry feelings of the argument more quickly (...) and (...) see things from [my partner's] perspective*' (P1,30,3).

One participant talked about loving-kindness offering a way out of unhelpful patterns of blame:

'*Without it just being on one person's right one person's wrong, (...) that kind* of you-did-this-*thing, just knowing that there is some (...) way of stepping back from that I think it's he*lpful'(P12,26,8).

Another person described struggling with their supervision and gaining more perspective on unhelpful dynamics with their supervisor:

*'Instead of getting completely wrapped up in my own (...) sinking pit of my stomach I was able to (...) feel* ok enough to objectively observe what was going on' (P3,26,10).

Some participants actively used the LKM to cope with difficult relationships:

'*I think it's a really useful strategy to (...) support yourself in dealing with a difficult relationship (...) which I'm sure then helps the relationship, but on a (...)* self-*level it can help, I'm finding it can help to (...) break a pattern of keeping somebody as being 'oh just really annoying (...)', which is actually quite exhausting* for yourself' (P5,29,4).

For another participant, the meditation helped in overcoming interpersonal anxieties: '*I (...) recognise that I am anxious around people and am a bit more accepting of it so (...) I am trying not to fall into the pattern of just avoiding people* because I think that maybe th*ey don't like me'* (P7,13,6).

**Bringing Compassion into the Therapy Room**

The fourth master theme reflects how participants integrated compassion into their clinical work.

Participants actively encouraged clients to be more kind to themselves or found themselves being more compassionate towards their clients. Some participants described their therapy becoming 'more human and more authentic and less about techniques' (P1,23,12).

'*I can (...) be with clients not just on a[n] (...) instrumental level where you just* (*...) apply tools and skills and, just kind of more on (...) a different level where (...)*

*you're just (...) there together as people, sharing something that might be really* painful, and just stay with those feelings' (P9,26,23).

One person described using their own experience with struggle to 'develop *more, to allow more empathy for other people's struggle. (...) I feel like now I could (...), if I so chose to, contact that person's suffering (...) on a much more experiential* level' (P5,22,10).

Some participants felt that the experience of sitting with uncertainty in the meditation was similar to their experience in therapy sessions:

'*Not necessarily knowing what's going to come up and not judging it, just, sitting with whatever's there (...), it's sort of mirrored in th*e [therapy] room' (P4,18,18).

One participant thought about a client in their LKM to overcome their negative countertransference: '*That helped me (...) step back and sort of work through that* [negative countertransference]' (P11,24,10).

Participants talked about integrating their experience of loving-kindness with knowledge and skills gained from lectures and personal experience, and with skills of working in specific therapy models:

'*All that (...) validation that we do in CBT around understanding your* experi*ence and why we are the way we are, it (...) connects so well with that [loving-*kindness]' (P6,8,22). Another participant, working psychodynamically, felt that their loving-kindness experience reminded them to be gentle in uncovering clients' defences, 'that *the defences don't just come down if you're just banging away*' (P12,41,6).

Whereas quite a few participants used mindfulness techniques with clients, they felt hesitant about introducing loving-kindness exercises, like this person stated:

'*I'd be cautious* about it because I know how much difficult emotion it brought *up in me'* (P7,32,3).

**Integrating Loving-Kindness into Life**

The final master theme depicts how participants conceptualised their experience of the LKM course and how they integrated it into their lives.

For most participants, the LKM course seemed to be part of a journey to a more compassionate attitude or way of life:

'*It made me feel more confident (…) moving forwards in my life so that I can do that [being compassionate], and that it's something that I can practise and develop'* (P3,6,5).

Some participants described having internalised the loving-kindness experience as a new skill:

'*It belongs to me as a process now, like a way of (…) dealing with situations* that I could just give myself some tim*e out and spend some time doing that (…) its taken on its own life separate from the practice'* (P2,33,17).

Loving-kindness also seemed to be experienced as a resource, an 'alternative mindset' (P3,25,16), '*ethos'* (P9,23,21) or 'different perspective' (P12,32,7) participants could draw on. One person talked about having the 'potential to see people in fuller terms' (P5,30,11). Holding onto such compassionate mindset seemed to be powerful despite irregular practice:

'*I definitely didn't do anywhere near the* amount of practice you're officially *supposed to do, but (…) it would still be in my mind quite a lot in the day*' (P4,13,5), '*it's less about the practice and more about the philosophy*' (P4,34,11).

## Discussion

The aim of this study was to explore how TT experience a course of LKM. Findings suggested that participants experienced LKM as beneficial as well as emotionally challenging.

Participants reported becoming more aware of themselves, their thoughts and feelings, and their patterns of relating to others. This awareness also contained an awareness of one's own needs and vulnerabilities, including difficult feelings triggered by clinical work. Such increased self-awareness seemed to have enabled participants to be more accepting, compassionate, and caring towards themselves. For example, trainees reported being more able to distance themselves from self-critical thoughts, to cope with stress, or to engage in nurturing activities. These seem to be important findings, given the high levels of stress and pressure TT can find themselves under (Brooks et al., 2002). Moreover, the results strengthen preliminary evidence from other studies that found LKM to increase self-acceptance and self-compassion (Fredrickson et al., 2008; Weibel, 2007) and to be associated with a decreased stress response (Pace et al., 2009).

Participants further described becoming more accepting and compassionate towards others and feeling more socially connected, which supports previous research findings (Fredrickson et al., 2008; Hutcherson et al., 2008; Weibel, 2007). Some trainees reported feeling safer and less threatened in their relationships, which seemed to positively impact on their ability to cope with interpersonal difficulties.

With regards to Gilbert's (2005) theory on the development of compassion, one may argue that these findings suggest that practising LKM strengthened participants'

affiliation-focused system and, thereby, their ability to feel safe with themselves and others.

The experience of LKM also seemed to benefit trainees' clinical work. In particular, participants reported an increased capacity to be 'human', empathic, and to connect with and bear the suffering of their clients. Thus, LKM seemed to enhance skills which Gilbert (2005) proposed are key components of compassion and caregiving. These findings also support results from a neurophysiological study which found that people experienced in LKM showed an increased empathic response to social stimuli (Lutz et al., 2008).

Some participants described feeling more able to contain their own difficult feelings including those arising in clinical work. In line with Gilath et al.'s (2005) model, it could be hypothesised that the findings suggest that participants felt less anxious and safer within themselves, which might have enabled them to be more caring and compassionate towards their clients; however, due to the study's design, no assumptions about causality can be made.

It seems that the course of LKM impacted on skills that are seen as central in becoming a therapist. In his cognitive model of therapist skills development, Bennett-Levy (2005) proposed that the ability to become aware of and reflect on one's experience is central in integrating and developing therapy knowledge and skills in practice. With growing reflective skills, acquired therapy techniques become less important, allowing therapists to become flexible in their work and to develop a 'therapist identity'. It seems that such process of increased flexibility and therapist identity development may have been facilitated through LKM for some participants who described feeling more able to be themselves with clients and to rely less on

specific techniques. However, such change is also likely to reflect a general development of trainees during training.

Overall, participants reported benefits for their self-care and clinical work, which resonates with findings from studies on MBIs with TT (e.g., Christopher & Maris, 2010; Shapiro et al., 2007). Moreover, the theme of 'Integrating LKM into life' mirrors qualitative research on the experience of becoming more mindful in everyday life after an MBCT course (Mason & Hargreaves, 2001). Since the LKM course was offered after an MBCT course, it is likely that the previous experience of mindfulness also impacted on perceived changes in participants. However, participants perceived LKM as different to mindfulness in that it was seen as more specific to fostering compassion and interpersonal awareness.

Although findings supported the role of LKM in cultivating self-care and compassion in TT, they also highlighted the difficulties of engaging in LKM. Participants described their experience of LKM as emotionally intense and even unsafe and risky at times. Feelings triggered through the practice included sadness, anger, guilt, and anxiety.

The study provided a detailed account of participants' experience in engaging with LKM and, thereby, furthered the understanding of clinical observations that some individuals struggle to engage in LKM (Barnhofer et al., 2010). Findings supported results from a study which found that some individuals show a physiological threat response to compassionate imagery, in particular individuals with an insecure attachment style and high self-criticism (Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008).

Attachment theory has suggested that the experience of kindness and care from another, for example a therapist, can activate the attachment system and with it

memories of past attachment experiences (Gilbert, 2009; Mikulincer & Shaver, 2007). Similarly, it can be hypothesised that the experience of directing kindness towards oneself during LKM may trigger past attachment experiences, which may be painful if early caregiving experiences consisted of neglect or abuse.

Although LKM was experienced as challenging by most participants, they reported a range of strategies that enabled them to make the practice safe, such as using mindfulness skills, sharing difficulties in the group, and deciding when not to practise. However, further research is needed to explore the processes involved in engaging with LKM and other compassion-focused exercises.

**Limitations of Study and Areas for Future Research**

This study used a qualitative phenomenological approach which is primarily concerned with an in-depth understanding of human experience (Husserl, 1927) rather than generalisability of findings. However, it needs to be acknowledged that the study was carried out with a homogenous sample of TT from one UK university, who were predominantly White British and female. This may limit the transferability of results, the degree to which findings can be transferred to other populations and settings (Smith et al., 2009), including other group of health professionals or clinical samples. In addition, the sample was self-selected and there may have been particular reasons why trainees volunteered to take part in the study that may have influenced the results. For example, participants may have particularly struggled with being kind towards themselves. Another limitation is that all participants had previously attended a MBCT course, which seemed to have facilitated the encounter with LKM. It remains, therefore, unclear how LKM may be experienced without skills in mindfulness or how much the previous MBCT training impacted on the changes

observed by participants. In addition, no conclusions can be drawn about the durability of perceived changes.

Given that the findings from this study suggest benefits similar to those identified in studies using MBIs with TT, future quantitative studies could compare LKM with MBIs in order to establish differential effects of the two interventions. Studies may also use different groups of health professionals. In order to increase conclusiveness of findings, studies may use randomised controlled designs with follow-up assessments, measures of self-care and compassion, as well as direct feedback from clients or supervisors. Using measures of attachment security may shed further light on individual differences in engaging with LKM. Furthermore, qualitative studies on LKM with clinical samples may extend findings of this study. However, the challenges of LKM identified in this study sample warrant thoughtful safeguarding in conducting research with clinical populations.

Finally, results may be limited in that the LKM course facilitator was a university staff member and the researcher a fellow TT which may have discouraged participants from sharing personal experiences. However, the richness of the data indicated that participants felt able to be honest and to share positive as well as challenging aspects of their experience.

**Implications for Training and Clinical Practice**

The findings bear several implications for training and clinical practice. Given the need for fostering self-awareness, self-care, and compassion in TT, clinical training programmes may consider offering LKM as an option for trainees to further their personal and professional development. Offering LKM as an adjunct to a MBI seems important in making LKM a safer and beneficial experience. When offering a

LKM course, careful consideration should be given to the set-up. Allowing enough space for discussions of experiences seems particularly important given the challenging nature of the practice. Therefore, groups should be kept smaller, i.e. 10-12 participants, compared with the commonly larger MBSR/MBCT groups. Furthermore, it would be important to inform participants of possible adverse effects of the practice and to encourage them to look after themselves, e.g. by giving permission to disengage from the practice should it become too intense.

If randomised controlled studies confirmed the effectiveness of LKM, it could be offered to clinical populations. Since clinical samples are likely to find the practice even more challenging, the caveats mentioned above would be particularly important. It might be advisable to introduce the idea of loving-kindness within the context of MBIs, as is often done in all-day MBSR/MBCT retreats (Kabat-Zinn, 2005), and to gradually build up LKM exercises over time. This would allow participants to 'get a feel' for the practice and their response to it.

**Conclusions**

This study provided insight into how TT perceived their experience of engaging in LKM. Participants reported that LKM increased their awareness of how they relate to themselves and others, their ability to be compassionate and caring towards themselves and others, and their clinical practice skills. LKM was experienced as emotionally challenging and a range of strategies, in particular mindfulness skills, seemed to have made the practice a safer experience. Further research is needed to extend the findings, by using other populations and quantitative outcome measures, and by further examining processes related to the challenges of engaging with LKM.

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INGA A. BOELLINGHAUS PHD

# Section C:
# Critical appraisal

Word Count:
1999

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2011

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

1. **What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?**

Before I started my clinical training, I completed a PhD on psychological factors involved in the development and maintenance of posttraumatic stress disorder and depression after trauma. I worked in a research team on a large-scale prospective quantitative study, recruiting and interviewing trauma victims. I gained experience in managing and analysing large datasets, parts of which I used for my PhD. Having immersed myself in quantitative research and with no experience in qualitative methods, I was curious about carrying out this study using Interpretative Phenomenological Analysis (IPA). Moreover, my previous research was part of a larger project that was initiated and managed by a senior university professor, so that my knowledge about obtaining ethical approval and setting up a study was limited.

In conducting the current study, I learned about the process of consultation by asking a group of trainees about their views on my research idea, which proved helpful in thinking about the set-up of the loving-kindness intervention (LKI) and related ethical concerns, such as the facilitator also being a member of university staff and research supervisor. I realised that, although all data were anonymised, it would have been possible for the facilitator to recognise trainees by being exposed to transcripts, given that the group size was relatively small and that some trainees had shared their experience in the group. Consulting with my supervisors about how to manage these concerns was invaluable. As a result, participants were informed about challenges of the set-up of the LKI and how confidentiality of obtained data would be ensured. In addition, the facilitator was only exposed to short parts of transcripts.

Finally, identifiable information, such as gender or ethnicity of participants, was removed from the analysis and write-up to ensure confidentiality. Thus, the study has furthered my ability to reflect and act upon ethical issues arising in research.

Conducting a qualitative research project using IPA meant that I had to put my previous experience of hypothesis testing behind me. Instead, I learned to embrace an open and curious approach that involved a double-hermeneutic of me understanding and interpreting how participants made sense of their experience (Smith & Osborne, 2003). I learned how to develop and use a semi-structured interview schedule that covered a number of topic areas whilst leaving room for participants to share their own associations. Conducting a pilot interview and gaining feedback on it from my supervisors helped me to gain confidence in using this new approach.

I have further become aware of the challenge of having multiple roles as researcher, trainee, and therapist. During the interviews, I had to remind myself to remain in the researcher role when some participants became emotional; I responded in a sensitive way and checked whether participants wanted a break or to stop. Slipping into a more therapeutic stance, for example, by making emotionally deepening comments, would have been unethical, since participants had consented to a research interview and not a therapeutic contact. However, I experienced how important it is to think about the possibility of participants becoming distressed and to be prepared to cope with such distress appropriately. Additionally, I felt that being a fellow trainee of participants, although not in the same year group, was a challenge to my role as a researcher. Whilst I felt that informal contact with participants outside and within the LKI helped to build a rapport with them, I was also aware that some of the information disclosed during the interviews was quite personal. I felt that my

experience of being part of a reflective practice group with peers has helped me to hold this tension.

Finally, I have learned the importance of reflecting on and 'bracketing' my own experiences and preconceptions of loving-kindness meditation (LKM) throughout the research process in order to encounter the interviews and data analysis with an open mind (Smith, Flowers, & Larkin, 2009).

Given that this was my first qualitative research project, I would like to deepen my skills in IPA, for example, by analysing fewer cases in more depth or by using unstructured interviewing or focus groups. I also would like to gain experience in other qualitative approaches, such as grounded theory (Glaser & Strauss, 1967) or discourse analysis (Potter & Wetherell, 1987). Finally, I would benefit from gaining experience in using single-case designs, as I think it would be a useful methodology to answer specific questions without having to recruit large number of participants (Yin, 2009).

## 2. If you were able to do this project again, what would you do differently and why?

One key finding of the study was that participants experienced practicing LKM as emotionally and personally challenging. My supervisors and I had been aware of this potential outcome. In order to reduce the risks of engaging with the practice, we implemented a number of safeguards, such as restricting the group size to twelve participants to ensure more space for discussion and only including trainees with experience in mindfulness meditation. However, if I was to do the project again, I would consider offering the course in a longer format to allow more room for discussions, e.g., by offering 90-minute instead of 60-minute-long sessions. Although

trainees consulted about the study recommended shorter sessions, particularly with sessions being offered after teaching days, with hindsight, 60 minutes seemed too short at times for participants to engage with each other and to reflect on their experience. Although the sharing that did take place was experienced as supportive by participants, I wondered whether participants felt that the sessions were rushed at times and whether this had made sharing in the group feel less safe.

Some participants also mentioned that they did not know trainees from the other training course and that they wished more time would have been spent at the beginning of the course to get to know each other. I think this was a useful suggestion which I would implement in the future. If I had more resources, I would also have employed a facilitator unrelated to the university as this might have made sharing experiences in the group feel less conflicted for participants.

Finally, I would further consider a staggered introduction of the different stages of LKM as done by Weibel (2007), which might give participants more space to become familiar with the practice.

**3. As a consequence of doing this study, would you do anything differently in regard to making clinical recommendations or changing clinical practice, and why?**

The findings of this study suggest a number of benefits for participants of practising LKM, such as increased acceptance and compassion for self and others, whilst the practice was also perceived as emotionally intense. It seems therefore important to consider how LKM can be applied in training and clinical practice, so that the benefits of LKM are maximised whilst its risks are reduced.

One key implication is that participants should be informed about the practice being potentially upsetting and a number of strategies should be put in place to support participants in their encounter with LKM. In addition to considerations about the set-up of LKM groups mentioned above, it seems apt to encourage participants to look after themselves during the practice. Teaching mindfulness skills in advance seem to be beneficial in coping with arising difficult feelings during LKM. Similarly, it has been recommended to learn mindfulness skills before engaging in compassion-focused exercises (e.g., Gilbert, 2010) and LKM is commonly introduced during all-day retreats of MBSR or MBCT courses (Kabat-Zinn, 2005). If the findings of this study are replicated and LKM is offered to clinical populations, extra care may need to be taken in introducing the practice.

Whilst being challenging, LKM seemed to have offered participants an engagement with themselves and others that was seen as helpful and different to the effects of mindfulness meditation. In particular, participating therapists in training (TIT) perceived LKM to impact positively on their ability to reflect on themselves, to be kind and caring to themselves, to cope with demands of training, and to enhance their clinical skills with clients. Clinical training courses could consider offering LKM as an optional module in adjunct to a mindfulness-based intervention (MBI) to enhance self-care, personal and professional development, and reflective practice. It might further be beneficial to include teaching on self-care and compassion in the curriculum, which could embrace information and experiential exercises of mindfulness and LKM.

Finally, it would be worth exploring if LKM might be helpful in fostering compassion and preventing burnout in mental health teams. For example, it has been shown that a MBI with psychiatric inpatient staff increased team functioning and staff

and patient satisfaction (Singh, Singh, Sabaawi, Myers, & Wahler, 2006). The risk of burnout and stress is particularly high in such acute settings (Vredenburgh, Carlozzi, & Stein, 1999), and LKM may be an additional tool to increase well-being of staff and quality of patient care.

**4. If you were to undertake further research is this area what would that research project seek to answer and how would you go about doing it?**

A number of research ideas could be implemented to further the understanding of the impact of LKM on TIT and other groups of health professionals. A quantitative study with TIT could complement this qualitative research. The study would seek to answer whether a LKI increases self-awareness, self-care, compassion, and interpersonal relating in TIT and whether attachment style might moderate effects of LKM. A number of TIT could be invited to take part in LKM courses which could be offered at multiple university sites. Previous experience in mindfulness meditation could be a requirement for participating, as was the case in this study; alternatively, the LKI could begin with practicing mindfulness skills before focusing on LKM. A randomised control design should be employed in which TIT would be allocated to either the LKI or a control condition. Ideally, the control condition would entail an active intervention, such as relaxation training, to test if changes were due to LKM rather than unspecific intervention factors, such as group interaction or therapist contact. A number of quantitative measures should be completed pre- and post-intervention, and at a short and long-term follow up (e.g., 2 and 12 months). Measures would assess previous experience of LKM, perceived stress (Cohen, Karmack, & Mermelstein, 1983), self-criticism (Gilbert, Clarke, Hempel, Miles, & Irons, 2004), self-compassion (Neff, 2003), compassion for others (Sprecher & Fehr, 2005),

empathy (Davis, 1983), and interpersonal relating (Soldz, Budman, Demby, & Merry, 1995). The amount of LKM and alternative meditation practice should be monitored before and throughout the intervention including follow-ups to control for effects of home practice on outcome. A measure of attachment style (e.g., Carver, 1997) would be administered pre-intervention to examine whether it may moderate the impact of LKM. The data would be analysed using multivariate analysis of variance.

Another idea would be to conduct a similar randomised controlled study, comparing a LKI with an MBSR or MBCT intervention and non-active control group. The outcome of such study could shed light on the differential effects of LKM and mindfulness meditation. It could be hypothesised that the LKM course leads to a greater increase in compassion and improved quality in relationships compared with the MBI, though self-compassion is also integral to mindfulness practice (Tirch, 2010). However, participants in the LKI should still be taught basic mindfulness skills to support their encounter with LKM.

Finally, resources allowing, it would be valuable to obtain observer ratings of participants' interpersonal relating with colleagues and clients. For example, therapy sessions of participating TIT could be video-taped and analysed by blind external raters with regards to skills related to compassion, such as non-judgmental listening and expressions of empathy. Furthermore, ratings of perceived empathy and the quality of the therapeutic alliance could be obtained from clients. Finally, research might examine the effects of a LKI on communication, functionality, and staff satisfaction in mental health teams.

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INGA A. BOELLINGHAUS PHD

# Section D:

# Appendix of supporting material

A thesis submitted in partial fulfilment of the requirements of

Canterbury Christ Church University for the degree of

Doctor of Clinical Psychology

JULY 2011

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

## Appendix section A: Search strategy and outcome of literature searches on MBIs with health professionals

The following databases were searched up until week 2 in May 2011: Psycinfo, Assia, Web of Science, the British Nursing Index, Medline, and the Cochrane library. The search combined terms for 'mindfulness' with a number of terms for therapists and other health professionals (see Table 1 below). Abstracts of articles were screened and references of relevant articles and books were hand searched for further references. Only publications in English were included.

Quantitative studies were included if they evaluated a MBI with health professionals, and measured compassion as an outcome. Since compassion consists of multiple components, studies measuring related concepts, such empathy were included, resulting in 8 studies. In addition, 4 qualitative studies on MBIs with therapists were identified.

**Table 1 Search terms and number of studies identified through literature searches on MBIs with health professionals**

| Search terms used for mindfulness: | ‘Mindfulness’ OR ‘MBSR’ OR ‘MBCT’ | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Search terms used for health professionals which were combined with terms for ‘mindfulness’: | ‘Counsellors/ Counselors’ or ‘Therapists’or ‘Psychotherapists’ or ‘Clinical Psychologists’ | ‘Counselling/ Counsellor Trainees’ or ‘Therapy/Therapist Trainees’ or ‘Clinical Psychology Trainees’ | ‘(Mental-) Health Personell’ or ‘(Mental-) Health Staff’ | ‘Pro-fessionals’ | ‘Nurses’ or ‘Staff Nurses’ or ‘Student Nurses’ | ‘Social Workers’ | ‘Psychiatric hospital staff’ | ‘Psychiatrists’ or ‘Medical Personell/ Staff’ |
| **Databases searched** | **Number of studies identified** | | | | | | | |
| Psychinfo | 42 | 8 | 58 | Na | 7 | 8 | 1 | 20 |
| Assia | 19 | 0 | 0 | 15 | 4 | 3 | 0 | 1 |
| Web of Science | 40 | 3 | 2 | 27 | 22 | 4 | 1 | 2 |
| British Nursing Index | 0 | 0 | 0 | Na | 1 | 0 | 0 | 0 |
| Medline | 0 | 0 | 7 | Na | 6 | 0 | 0 | 0 |
| Cochrane | 5 | 0 | 8 | 10 | 12 | 0 | 0 | 0 |

Note. Na = Not applicable because the search term ‘Personell’ was classified and used instead.

**Table 1** Quantitative studies reviewed on MBIs with health professionals

| Authors | *N* | Sample | Research Design | Follow-up | Treatment group after drop out | Control group after drop out | Outcome Measures | Home practice measured | Results |
|---|---|---|---|---|---|---|---|---|---|
| Rimes & Wingrove, 2011 | 20 | Clinical psychology trainees | Pre-post design | No | *n*=20; 8-week MBCT course for stress reduction | | PSS, HADS, IRI, FFMQ, SCS, RRQ, MMQ | Yes | Increase in: mindfulness and self-compassion; decrease in: rumination; larger increase in self-compassion in first years; reduction in stress for first years only; reductions in stress correlated with reduction in rumination and anxiety and increase in empathic concern; amount of practice related to most changes; no changes in empathy, |
| Krasner et al., 2009 | 70 | Primary care physicians | Pre-post design | 12,15 months | *n*=68; 8-week course of 2,5 hours in mindfulness, self-awareness exercises, interview skills, didactic material | | FFMS, MBI, JSPE, PBS, MMBF, POMS | No | Increase in: mindfulness and empathy; decrease in: burnout symptoms and mood disturbance; increase in mindfulness correlated with increase in empathy and decrease in tension, depression and anger |
| Moore, 2008 | 17 | First year clinical psychology trainees | Pre-post design | No | *n*=10; 4 sessions of 10-min mindfulness meditation | NA | PSS, KIMS, SCS, Feedback Questionnaire | No | Increase in: KIMS subscale 'Observe'; increase in: self-kindness; no impact on perceived stress |
| Shapiro et al, 2007 | 64 | Master level counselling psychology students | Prospective, non-randomised cohort controlled study | No | *n*=22; 10-week-long stress intervention, including 8-weeks of MBSR | *n*=32; 2 control courses of psychology topics | MAAS, PANAS, PSS, STAI, RRQ, SCS | Yes | Decrease in: perceived stress, negative affect, rumination, state and trait anxiety; increase in: positive affect, mindfulness and self-compassion; changes in mindfulness predicted changes in rumination, anxiety, stress and self-compassion |

*Note.* Table continued on next page.

## Appendix B: Studies on MBIs with health professionals included in the review

| Authors | *N* | Sample | Research Design | Follow-up | Treatment group after drop out | Control group after drop out | Outcome Measures | Home practice measured | Results |
|---|---|---|---|---|---|---|---|---|---|
| Shapiro et al., 2005 | 40 | Physicians, nurses, social workers, physical therapists, psychologists | Randomised controlled study | No | *n*=18/10, 8-weeks MBSR (2h-sessions) | *n*=20 Wait list control | BSI, MBI,PSS,SLS, SCS | No | MBSR group showed a decrease in perceived stress and increase in life-satisfaction and self-compassion |
| Galantino et al., 2005 | 84 | Hospital employees (including administrative and care staff) | Pre-post design | No | *n*=69; 8 week-long MBSR (2 hour sessions) | NA | POMS_SF, MBI, IRI, salivary cortisol | No | Decrease in: emotional exhaustion; improved mood; no changes in empathy or cortisol levels |
| Beddoe & Murphy, 2004 | 23 | Undergraduate nursing students | Pre-post design | No | *n*=16; 8 week long MBSR course | | DSP, IRI, | Yes | Decrease in: anxiety; trends towards decrease in stress and overidentification with client's distress |
| Shapiro et al., 1998 | 78 | Medical and premedical students | Matched randomised design?? | No | *n*=36, 8 week MBSR plus didactic material and mindful listening exercises | n=37 | ECRS, SCL-90-R, STAI, INSPIRIT, Daily journal, evaluation packet | Yes | reduced state and trait anxiety, psychological distress and depression, increase in empathy and spirituality |

*Note*. NA = not applicable; MBCT=Mindfulness-Based Cognitive Therapy; MBSR=Mindfulness-Based Stress Reduction.
BSI=Brief Symptom Inventory (Derogatis, 1993); DSP=Derogatis stress profile (Derogatis, 1987); ECRS=Empathy Construct Rating Scale (La Monica, 1981); PSS=Perceived Stress Scale (Cohen, Karmack, & Mermelstein, 1983); FFMQ=Five Facet Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006); HADS=Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983); IRI=Interpersonal Reactivity Index (Davis, 1980); INSPIRIT=Index of Core Spiritual Experiences (Kass et al., 1991); JSPE=Jefferson Scale of Physician Empathy (Hojat et al., 2001); KIMS=Kentucky Inventory of Mindfulness Skills (Baer, Smith, & Allen, 2004); MAAS=Mindful Attention Awareness Scale (Brown & Ryan, 2003); MBI=Maslach Burnout Inventory (Maslach & Jackson, 1986); MMBF=Mini-markers of the Big Five Personality Factor Structure (Saucier, 1994); MMQ= Mechanisms of Mindfulness Questionnaire (in development, Rimes & Wingrove, 2011); PANAS=Positive and Negative Affectivity Schedule (Watson, Clark, & Tellegen, 1988); PBS=Physician Belief Scale (Ashworth, Willliamson, & Montano (1984); POMS-SF=Profile of Mood States-Short Form (Curran, Andrykowski, & Studts, 1995); RRQ= Reflection rumination questionnaire (Trapnell & Campbell, 1999); SCS=Self-Compassion Scale (Neff, 2003); SCL-90-R=Symptom Checklist 90-Revised (Derogatis, 1977); SLS=Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985); STAI=State Trait Anxiety Inventory (Spielberger, 1983).

**Table 2** Qualitative studies reviewed on MBIs with psychological therapists

| Authors | *N* | Sample | Intervention | Qualitative data | Method of analysis | Results |
|---|---|---|---|---|---|---|
| McCollum & Gehart, 2010 | 13 | Trainee family therapists | Integrated teaching of mindfulness into clinical seminars, including mindfulness readings and meditations, 2,5 hour long weeky sessions over semester (15-30 minutes mindfulness practice per session. | Journal assignments over semester on impact of mindfulness course on professional work and personal life - only effects on clinical practice were examined in this study. | Thematic analysis from constructionist framework | Increased presence in sessions, increased awareness of self and client's experience, ability to use awareness in therapeutic relationship, remaining centered in distressing sessions, increased calmness, slowing down, awareness and distance from inner dialogue, increased boundaries between sessions, balance between doing and being mode, increased compassion and acceptance of self and others. |
| Chrisman et al., 2009 | 31 | First and second year master level counselling students | 15 week-long course over one semester, twice weekly, 2-hour-long sessions (each including 75 minutes of mindfulness practice based on MBSR plus 15 minutes academic content plus qigong) | Journal assignment about qigong practice | Inductive content analysis | Increased awareness and acceptance of own experiences and body; increased self-compassion and confidence in relation to self and work with clients; increased awareness of body's needs; increased self-care in life-style; more open and less defensive attitude; increased focus/attention; increased presence with self/others; increased distance from negative thoughts; increased awareness of self-critic; being more able to let go of control/being perfect.<br><br>Impact on relationships: more awareness of relationship patterns (including countertransference); increased flexibility, increased awareness of impact of others on self.<br><br>Impact on client work: more comfort with silences; more focus on relationship/process; improved coping with own anxiety in sessions, more presence in room; more able to help clients identify inner critics, more able to contain emotions. |
| Schure et al., 2008 | 33 | First and second year master level counselling students | 15 week-long course over one semester, twice weekly, 2-hour-long sessions (each including 75 minutes of mindfulness practice based on MBSR plus 15 minutes academic content plus qigong) | Journal assignment about course experience | Inductive content analysis | |
| Christopher et al., 2006 | 11 | First and second year master level counselling students | 15 week-long course over one semester, twice weekly, 2-hour-long sessions (each including 75 minutes of mindfulness practice based on MBSR plus 15 minutes academic content plus qigong) | Focus group | Inductive content analysis | |

*Note*. Results of studies 2-4 are summarised as they reflect findings of the same intervention with overlapping samples.

## Appendix C: Search strategy and outcome of literature searches on LKM

The following databases were searched up until week 2 in May 2011: Psycinfo, Assia, Web of Science, the British Nursing Index, Medline, and the Cochrane library. The search used the term 'loving-kindness' in different spellings (see Table below). Abstracts of articles were screened and references of relevant articles and books were hand searched for further references. Only publications in English were included.

All studies that evaluated an intervention using LKM or examined the relationship between LKM and compassion were obtained.

**Table 1 Search terms and number of studies identified through literature searches on loving-kindness**

| Search terms used: | 'Loving-kindness' or 'Lovingkindness' or 'Loving Kindness' |
|---|---|
| **Databases searched** | **Number of studies identified** |
| Psychinfo | 61 |
| Assia | 11 |
| Web of Science | 19 |
| British Nursing Index | 0 |
| Medline | 15 |
| Cochrane | 0 |

**Appendix D: Participants' demographic information**

**Table 2 Participants' demographic information**

| Gender | Age | Ethnic background | Years of working in mental health | Time spent meditating per week | Previous experience of loving-kindness meditation |
|---|---|---|---|---|---|
| Female | 26 | White British | 4 | 15 | yes |
| Female | 31 | White British | 0,5 | 0 | no |
| Female | 31 | White British | 2,5 | 0 | no |
| Female | 32 | White British | 2,5 | 60 | yes |
| Female | 32 | White British | 8 | 0 | yes |
| Female | 33 | White British | 2 | 20 | no |
| Female | 34 | White British | 0 | 15 | no |
| Female | 42 | White British | 5 | 30 | no |
| Female | 51 | White British | 20 | 30 | yes |
| Female | 54 | White British | 29 | 30 | no |
| Male | 38 | Any other | 19 | 50 | no |
| Male | 43 | White British | 7 | 40 | yes |

## Appendix E: Participant information sheet

Salomons Clinical Psychology Programme
Department Of Applied Psychology
Broomhill Road
Tunbridge Wells, Kent TN0 3TG

**INFORMATION SHEET**

**Title of project: The experience of psychological therapists in training of practising loving-kindness meditation**

Names of Researchers: Inga Boellinghaus (Trainee Clinical Psychologist), Dr Fergal Jones (Clinical Psychologist) and Dr Jane Hutton (Consultant Clinical Psychologist)

You are being invited to take part in a research study. Before you decide whether to take part, it is important for you to know why the research is being done and what it will involve. Please read the following information. It answers some of the common questions that are asked about research projects. If you have any questions that are not addressed here please do not hesitate to ask me. Please take time to decide whether or not you wish to take part.

**What is the purpose of the study?**
Undergoing training as a psychological therapist can be a stressful experience. When facing academic, clinical, and potentially personal challenges, self-care may become an important but also challenging aspect of training. Research has suggested that interventions based on mindfulness meditation may promote self-care in mental health professionals by reducing stress levels and increasing well-being.

Loving-kindness meditation is closely linked to mindfulness meditation, but particularly encourages a more compassionate and caring relating to oneself and others. Although some studies have reported benefits of loving-kindness meditation, it has not been examined yet whether psychological therapists in training may find loving-kindness meditation beneficial. I am aiming to explore how psychological therapists in training experience loving-kindness meditation. In particular, I hope to find out how trainees perceive its impact on their training experience, professional relationships, as well as their personal lives.

**Why have I been asked to take part?**
You have been asked to take part in the study because you are a psychological therapist in training and you have previously attended a mindfulness-based cognitive therapy (MBCT) course. Having some familiarity with mindfulness meditation may make it easier to practise a different kind of meditation, i.e., loving-kindness meditation. However, principles of mindfulness meditation will also be revisited.

**Do I have to take part?**
It is up to you whether or not to take part. If you did decide to take part, you would be given a copy of this information sheet to keep. You would then be invited to an introduction meeting during which you have time to ask questions. You would then be asked to sign a consent form of which you would keep a copy. If you decided to take part, you would still be free to withdraw at any time and without giving a reason. If you decided to withdraw, or decided not to take part, this would not affect your training or employment in any way.

## Appendix D: Participants' demographic information

**What would happen if I took part?**
You would be taking part in a loving-kindness meditation course. The nature of the course is secular. The course would consist of five sessions lasting for 90 minutes. The sessions would be facilitated by Fergal Jones, who facilitated the MBCT course you attended. They would include practices of loving-kindness meditation and there would be space to discuss your experience in the group, if you wished. You will also be asked to practise loving-kindness in between sessions, on six days per week for about 30 minutes. You will be given a guided meditation CD to support your home practice and you will be asked to keep a brief diary about your practice. There would be no more than 16 participants in the course. The course would be held at Salomons on Thursdays after teaching (probably from 5.30pm to 7pm). The course would consist of four weekly sessions held on the 20th of May, 27th of May, 3rd of June and 10th of June and a final session on the 8th of July 2010. For some people, attending the course may involve coming to Salomons on a study day.

Before the course starts, you would be invited to an introduction meeting on the 7th of May 2010 during which you would be asked to fill in some questionnaires. The questionnaires would be about your previous experience of meditation, perceived stress levels, and about ways you relate to yourself and others. Filling in the questionnaires may take you up to 30 minutes. You would be asked to fill in a similar set of questionnaires at the first, fourth, and final session. On these occasions the sessions would last approximately 15 minutes longer than usual. Should you miss a session, I would send or email the questionnaire to you. Three month after the final session, I would contact you with a final set of questionnaires. I would either come to one of your teaching sessions or would post or email the questionnaire to you.

After the final session, I would ask you to meet with me for one interview. I am aiming to interview 10 participants. Should more than 10 participants want to be interviewed, interviewees would be selected randomly. The interview could take place at Salomons or I could visit you at home or placement if you preferred. The interview would be likely to take 45 to 60 minutes. I would ask you questions about your experiences of practising loving-kindness meditation. I would record this interview, so that afterwards I could write down what had been said and then think about this. This recording would be kept confidential (see below) and would be stored in a secure place.

**Would my taking part in this study be kept confidential?**
All information collected about you during the course of the research would be kept strictly confidential and only shared within the research team (myself and my supervisors who are named below) and a person employed to transcribe the interviews who would sign a confidentiality agreement. Questionnaires will be filled in anonymously. The transcripts of the interviews will be anonymised before they may be discussed with the supervisor who facilitated the course. Data would be kept locked away securely for ten years, and destroyed after this time.

The only occasion on which I might have to share something you said (e.g., by speaking with a GP) would be if you told me something that suggested there was a risk of harm to yourself or another person. In such circumstances, I would try to discuss the way forward with you first.

There is a challenge of attending a course with fellow trainees and a facilitator who is a member of staff at Salomons. While discussions during loving-kindness sessions focus primarily on experiences during the meditation practice, they may sometimes involve quite personal experiences too. Everyone on the course will be asked to agree to treat whatever is shared by other participants during the course with sensitivity, respect and discretion. Similarly, during the research interview, you will be encouraged to decide how much and in what way you would like to share your experiences.

**What are the possible benefits of taking part?**
Telling me about your experiences would help to find out whether loving-kindness meditation may be useful for psychological therapists in training. If this was the case, training courses may consider offering similar courses. Knowing about your experience would help to understand

potential benefits, but also challenges that might arise during loving-kindness practice. This information would be particularly valuable when considering offering a loving-kindness intervention to people who experience significant psychological distress.
Finally, the interview would give you a chance to reflect on your own experiences. Sometimes people find that talking about their experiences clarifies their own thinking or makes them think about things in a different way.

**What are the possible disadvantages of taking part?**
It is not anticipated that there would be any particular disadvantages of taking part. The questionnaires would mainly be about how you relate to yourself and others and most of the interview questions would be about your experience of LKM. However, practising loving-kindness meditation may at times evoke strong feelings in you. For some people, engaging in loving-kindness meditation may bring up feelings of self-criticism, anger, or sadness. Similarly, being asked about your experience in the interview may bring up some of these feelings. However, you may find that your previous experience in mindfulness meditation may help you to cope with such feelings should they arise.

**What if I felt upset during the loving-kindness meditation course or the interview?**
If you became upset during the course, you could talk to me or the facilitator about this and we could think about who it would be most helpful for you to talk to afterwards. If I saw that you were finding the interview difficult, I would check whether you wished to continue. If not, I could arrange another time to see you, or you could withdraw from the study if you preferred. I would ask you how you found the interview at the end, and if you had any questions. If you were distressed and had been struggling lately, we might discuss who you could seek support from.

**What will happen to the results of the research study?**
Once I have analysed the information from all interviews, I would invite you to a meeting during which I would present my findings. I am interested to hear what your thoughts on my findings are. I will then write up a report to be submitted as part of my training. I also hope to publish the results in a journal. You would not be identified in any report or publication. I might use anonymous extracts from what you said in the interview if you consented to this.

**What if there is a problem?**
If you had a concern about any aspect of this study, you are welcome to contact me in person, leave a phone message for me so I can call you back, or write me an e-mail (please see below). I would do my best to answer your questions.

**Who has reviewed the study?**
This research study has been reviewed by the Salomons Ethics Committee to protect your safety, rights, wellbeing, and dignity. The committee has given approval for me to carry out this project.

Thank you for taking the time to read this sheet and for your interest. I would recommend that you take your time to decide whether you would like to take part in this research. If you would like to take part or if you would like any further information about this study, please contact me via email or phone (see below). You are also invited to come to an introduction meeting on the *7th of May 2010 at 1pm in Hythe* during which there will be time to ask questions.

**Contact information:**

**Inga Boellinghaus**
**E-mail: iab4@canterbury.ac.uk**
**Phone: 01892 507673**

| | | |
|---|---|---|
| Inga Boellinghaus | Dr Fergal Jones | Dr Jane Hutton |
| Trainee Clinical Psychologist | Clinical Psychologist Lead Supervisor | Consultant Clinical Psychologist Co-Supervisor |

# Appendix F: Email invitation sent to participants

Hi Everyone

Apologies to be sending an email to those of you who aren't on the MBCT course -this email is for MBCT participants only, but I'm afraid I haven't had time to create a separate email list.

I thought it would be helpful to email with a summary regarding what I said about Inga's research in the session yesterday, as some of you weren't able to make it.

Details of Inga's research can be found in the attached information sheet. In brief, the research provides an opportunity to attend a shorter course on loving-kindness meditation, which can be thought of as aimed at developing greater self-compassion and greater compassion towards others. It is only open to people who have attend the MBCT course, as we feel that foundation is needed for it.

If you are potentially interested in attending then please let Inga (i.a.boellinghaus4@canterbury.ac.uk ) or I know (if possible within the next week, so we can have an idea of numbers).

Also, if you are potentially interested but the dates or time of day is not possible for you, still please contact either of us, as it may be that we decide to move the sessions to a time that more people can make. Finally, if you have any questions please let Inga or I know.

Thanks for considering this,

Fergal

_____

Dr Fergal Jones
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Canterbury Christ Church University,
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## Appendix G: Consent form

Salomons Clinical Psychology Programme
Department Of Applied Psychology
Broomhill Road
Tunbridge Wells, Kent TN0 3TG

# CONSENT FORM

**Title of project: The experience of psychological therapists in training of practising loving-kindness meditation**

Names of Researchers: Inga Boellinghaus (Trainee Clinical Psychologist), Dr Fergal Jones (Clinical Psychologist) and Dr Jane Hutton (Consultant Clinical Psychologist)

**Please initial box**

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason, without my rights as a trainee or employee of the NHS being affected. ☐

3. I am available on the following dates between 5.30pm and 7pm: 20th of May 2010, 27th of May, 3rd of June, 10th of June, and 8th of July 2010. Some of these dates may fall on study days. Over the period of the course, on six days per week, I will have 30 minutes free of other commitments, during which I could practise loving-kindness meditation. ☐

4. I understand I am giving consent to be interviewed and audio-recorded. Information about me will be kept confidential and not divulged to anyone else. The only occasion on which information may need to be shared with anybody **beyond the research team** would be if I said something that suggested there was a risk of harm to myself or another person. ☐

5. I give permission for short extracts from my interview to be used in the final report, and any subsequent journal publications and reports. These extracts will be anonymous, with all personally identifying information being removed. ☐

6. I understand that relevant anonymised data collected during the study may be looked at by individuals from Canterbury Christ Church University. I give permission for these individuals to have access to this data. ☐

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

| Name of Participant | Date | Signature |
|---|---|---|
| Name of person taking consent | Date | Signature |

## Appendix H: Overview of LKM intervention

**Session 1 (60 minutes):**

- Welcome and introductions
- Ground rules, including invitational nature of course
- Names and brief expectations of participants
- Brief context to LKM
- Setting up for practice, based on Track 1 of CD
- Opportunity for comments / questions
- LKM practice, based on Track 2 of CD
- Brief enquiry
- Home practice –both tracks, daily. Drop first track once familiar with practice.

**Session 2-5 (60 minutes)**

- Briefer setting up for practice, based on Track 1
- Longer LKM practice, based on Track 2, but more spacious as sessions progress
- Longer enquiry, including today's practice, home-practice and LKM in everyday life
- Home practice –continue as before. Don't need to use CD if better to do without. Web-link to a track with just bells to mark stages provided.

**Session 6 (45 minutes, as followed by measure completion)**

- Shorter LKM practice, based on Track 2 but much more spacious
- Longer enquiry and review: mainly focusing on what gained from course
- Thinking individually / in pairs about intentions to taking LKM forward.
- Ending.

## Appendix I: Script of CD with LKM guidance

{NB The sentences will contain pauses in them. Where pause is written there will be a longer pause.}

**TRACK 1**

This is a CD of a loving kindness meditation to accompany the loving kindness meditation course. There are two tracks. This first track contains some guidance about how to approach the meditation, and the second track contains the loving kindness meditation itself. Once you are familiar with the contents of this first track you may want to skip straight to track two.

The intention in loving kindness meditation is to offer yourself, and then others, kindness and love as fully as you can, moment by moment. Alongside this there is an intention to be as gentle and patient as you can be with whatever thoughts, feelings or sensations arise when you attempt this.

The meditation practice is divided into five stages. The meditation guidance on the next track will contain a reminder of these, so you don't need to worry about remembering them.

In the first stage, the invitation will be to offer yourself kindness and love, and to receive that kindness and love. There are different approaches to this, some of which may resonate more strongly with you than others.

One way can be can be to gently repeat one or more phrases to yourself, such as: 'May I be safe, may I be happy, may I be well.' The phrasing matters less than the resonance for you.

Pause

Another can be to connect with a felt sense of warmth or love towards yourself in the heart area, if that happens to be present.

Pause

Another can be to reflect on your qualities and connect with what you feel is good in yourself. For example, your might bring to mind something helpful you've done for yourself or someone else, or reflect on the things that you value about yourself.

Pause

And another can be bring to mind a mental picture or memory of yourself feeling happy and loved.

Pause

It is worth spending a few moments now reflecting on which approach, or combination of approaches, you will use in the meditation today …

whether it be using imagery or memories ….. connecting with the good in yourself …. connecting with a felt sense of warmth and love in the heart area ….. or gently repeating a phrase or phrases which are meaningful to you. Feel free to be creative If you decide to use a phrase then it could be helpful to choose some words now that resonate for you.

Pause

It is probably best to stick with the same approach, or combination of approaches, to offering love and kindness, throughout all stages of the practice today. However, it may be that you choose to experiment with taking different approaches on different days.

Pause

Turning to the second stage, the invitation here will be to shift the focus of your offering from yourself to a friend (or relative?). It advisable to choose someone who you don't have romantic or sexual feelings for. Strong feelings of attraction may make it more difficult to practise an attitude of love and kindness that is *unconditional*, unrelated to our wishes or desires..

It could be helpful to reflect now on which friend you'll choose for the second stage. If you choose to use phrases in your practice you may find it helpful to direct the phrases directly at the person, such as 'may you be safe, may you be happy, may you be well'.

Pause.

In the third stage, the invitation will be to shift the focus again, this time to a neutral person; that is someone who you don't have strong feelings about and perhaps don't know very well. Examples could be the postman, a shopkeeper or someone who you see on your way to work.

It could be helpful to reflect now on who you will choose as your neutral person.

Pause

In the fourth stage, the invitation will be to shift the focus to offering love and kindness towards someone who you have had some difficulty with or have some difficult feelings towards. For example, it could be someone who you feel irritated by or who you have had an argument with. If you are new to this practice then it is advisable to choose someone for whom the difficult feelings are relatively mild.

It could be helpful to reflect now on who you will choose for this fourth

stage.

Pause

In the fifth and final stage of the practice, you will be invited to offer everyone from the previous stages love and kindness at the same time, before you may choose to extend your offering of love and kindness to all living things.

Pause

Alongside offering yourself and others love and kindness, it is important to be as gentle and patient as you can be with whatever thoughts, feelings or sensations arise during the practice. If you find you are struggling with any of the stages, it is fine to go to a different stage that you find easier to practice..

Sometimes during the meditation we may experiences different sensations or feelings to those that we would want or expect. For example, it may be that we seem to experience very little emotional reaction when we offer ourselves or others kindness and love, or that we experience feelings of irritation, anger, sadness or something else. It can be easy to be critical of ourselves if this happens or feel in some way inadequate. However, it is common to have such experiences during this meditation. The practice is to work with whatever feelings may arise and they are absolutely fine from the point of view of the practice.

As with mindfulness meditation, there is no right or wrong in terms of what we experience. Rather, the invitation is to be as gentle and patient as you can be with whatever thoughts, feelings or sensations arise during the practice … perhaps inviting in the possibility that whatever you experience, moment by moment, could be OK.

Pause

If you are new to this meditation or are unsure about some of what has just been said then you might want to play this track again or you may want to see whatever feels best for you once you engage in the practice. If you feel ready to begin the practice, then just let the CD continue…

Pause

**TRACK 2**

So, preparing now for the loving kindness meditation by finding somewhere where you can sit or lie and are unlikely to be disturbed for the next 30 minutes or so.

And if you choose to sit then sitting on a chair or a stool or a cushion. If you are sitting on a chair and if it is comfortable to do so, sitting away from the back of the chair, so that your spine can be self supporting. If possible, sitting with your back erect so that the crown of your head is pointing towards the ceiling or sky, allowing your head and neck to be balanced on your shoulders, and placing your hands on your knees or in your lap in a comfortable way. And inviting your shoulders to be relaxed and dropped. As best you can, allowing your posture to embody a sense of wakefulness and alertness, and a sense of stability and dignity.

In this way our posture during practice can help embody the attitude that we can bring to our experience in each moment as it unfolds. An attitude of openness, awakeness and dignity.

Alternatively, if it seems kinder to yourself right now, then choosing to lie down. If it is comfortable to do so, lying on your back on the floor or on a mat, with a cushion to support your head and your arms out stretched by your side, and legs out stretched with feet falling away from each other. And if needed covering yourself with a blanket to keep yourself warm.

Remembering that the intention is to be as awake as you can be to your experience moment by moment, but also that if you notice that you've been asleep then this is opportunity to practice gentleness and patience.

Knowing also that if one of these postures is not comfortable for you then you can find another way of lying or sitting that provides you with some sense of ease.

So spending a few moments now bringing awareness to your body and posture and making any adjustments that seem helpful. And knowing that during the practice our posture can change, and that it's fine to readjust so that our posture continues to embody a sense openness of awakeness and dignity, as best it can.

PAUSE

And now, if you're willing , bringing attention to the breath. Perhaps bringing attention to sensations in the belly or chest, as they expand with the in-breath and contract with the out-breath… or perhaps to the passage of air in and out of the mouth or nose, noticing maybe the difference in temperature between the in-breath and out-breath. Or perhaps placing attention somewhere else, where the breath sensations are particularly accessible and vivid for you right now.

Pause

And if your mind should wonder from the breath, knowing that this is ok and is what minds do. Acknowledging this with as much gentleness and patience as is possible and then returning attention to the breath as best you can.

Longer Pause

And knowing that the breath will always be present during this practice, so if at any time your experience feels too strong or too overwhelming then one choice that is open to you is to gently return the focus of your attention to the breath.

But for now letting go of the breath and connecting with the intention of the first stage of this loving kindness practice: the intention to offer yourself kindness and love as fully as you are able, moment by moment, allowing yourself to receive your own love and kindness. and with intention to be as gentle and patient as you can be with whatever thoughts, feelings or sensations arise as you attempt this.

And remembering that for each of us there may be different ways of offering ourselves love and kindness … whether it be gently repeating a phrase such as 'may I be safe, may I be happy, may I be well' … or calling to mind images or memories of ourselves feeling warm and loved ... or connecting with the good in ourselves …. or reflecting on the thing we value about ourselves …. or connecting with a felt sense of warmth and love in our heart area.

Pause

If you haven't already done so, choosing now which approach you will take and beginning to offer yourself love and kindness, as best you can.

Pause

Knowing that there is no need to force anything or rush … perhaps treating the process of offering kindness and love like dropping a pebble into a pond … and watching the ripples its makes … before dropping in another offering. Receiving your own love and kindness.

Pause

And as best you can being open to whatever experiences arise moment by moment, with gentleness and patience.

Pause

It maybe that you feel nothing much during this practice … it may be that the mind wonders frequently … it may be that self-critical thoughts or feelings arise. … Knowing that all of these are normal, common responses and all part of what we can work with in this practice.

Pause

So, as best you can, offering yourself love and kindness, and being open to whatever you experience in response.

Pause

Remembering that there is no right or wrong in terms of experience… so, as best you can, greeting whatever you experience with gentleness and patience … before returning to offering yourself love and kindness.

Longer pause

And if it's a struggle to receive your love and kindness then perhaps just gently allowing in the possibility of being kind and loving towards yourself.

Longer pause

So as best you can offering yourself love and kindness, and being open to whatever you experience, moment by moment.

Longer pause

{Repeating similar phrases if needed, depending on how time goes.}

Longer pause

And now, if you wish, reconnecting with the breath for a few breaths now.

Pause

And remembering the breath will always be present to return to throughout this practice, if needed.

But now, if you're willing, bringing to mind someone who you feel warmly or friendly towards.

And as best you can holding them in mind as you begin gently offering them love and kindness.

Pause

Remembering that whatever you experience in response is ok from the point of view of this practice and can be met with gentleness and patience.

Longer pause

So, as best you can, offering a friend kindness and love, and being open to whatever you experience in response.

Longer pause

And if the mind should wonder, greeting that with gentleness and patience, as best you can, before returning to offering a friend kindness and love.

Longer pause

{Repeating similar phrases if needed, depending on how time goes.}

Longer pause

And now, if you wish, reconnecting with the breath for a few breaths now.

Pause

And remembering the breath will always be present to return to throughout this practice, if needed.

But now, if you're willing, bringing to mind a neutral person ... someone who you don't have strong feelings towards … perhaps someone you don't know that well … maybe a shop keeper or postman or fellow commuter …

And as best you can holding this person in mind as you begin gently offering them love and kindness … much like dropping a pebble into a pond watching the ripples …

Pause

As best you can greeting whatever you experience, moment by moment, with gentleness and patience, and inviting in the possibility that it could be OK.

Longer pause

So, as best you can, offering the neutral person kindness and love, and being open to whatever you experience in response.

Longer pause

And if the mind should wonder, greeting that with gentleness and patience, as best you can, before returning to offering the neutral person kindness and love.

Longer pause

{Repeating similar phrases if needed, depending on how time goes.}

Longer pause

And now, if you wish, reconnecting with the breath for a few breaths now.

Pause

And remembering the breath will always be present to return to

throughout this practice, if needed.

But now, if you're willing, bringing to mind someone who you have some difficulty with or have some difficult feelings towards. … If you are new to this practice then choosing someone for whom the difficult feelings are relatively mild.

And as best you can holding this person in mind as you begin gently offering them love and kindness … much like dropping a pebble into a pond watching the ripples …

Pause

As best you can greeting whatever you experience, moment by moment, with gentleness and patience, and inviting in the possibility that it could be OK.

Longer pause

So, as best you can, offering the person you've have some difficulty with kindness and love, and being open to whatever you experience in response.

Longer pause

And if the mind should wonder, greeting that with gentleness and patience, as best you can, before returning to offering this person kindness and love.

Longer pause

{Repeating similar phrases if needed, depending on how time goes.}

Longer pause

And now, if you wish, reconnecting with the breath for a few breaths now.

Pause

And remembering the breath will always be present to return to throughout this practice, if needed.

But now, if you're willing, bringing to mind all the people from the previous stages … including yourself … the friend …. the neutral person …. and the person you've had some difficulty with.

And, as best you can, holding these people in mind as you gently offer them all love and kindness.

Pause

## Appendix I: Script of CD with LKM guidance

As best you can greeting whatever you experience, moment by moment, with gentleness and patience, and inviting in the possibility that it could be OK.

Longer pause

So, as best you can, offering all these people kindness and love, and being open to whatever you experience in response.

Longer pause

And now, if you wish, widening the focus so that you include everyone in this room….., in this building.

Pause

And widening again, if you wish, to offer kindness and love to everyone in the villages, towns and cities surrounding you … and widening again to the whole country … and now, if you wish, offering love and kindness to all living beings, as best you can.

Long pause

And now, if you wish, reconnecting with the breath. Being present with the in-breath … being present with the out-breath … as best you can.

Pause

And in a few moment time the bells will ring to bring this period of practice to a close, but for now just noticing what affect, if any, these words are having on your experience.

Pause

BELLS x3

So bringing attention back into the room … and gently moving from your sitting or lying position in your own time ….

## Appendix J: Interview schedule

**Thank you very much for taking part in this research project and for agreeing to take part in this interview. The interview will last about an hour, depending on how much comes up and how far you are happy to talk about things.**

**I am really interested in what is has been like for you to take part in the LKM course. I am equally interested in good and bad experiences and things which you liked or not. So, I would like to encourage you to tell me about whatever your experience was like.**

**As I am also a trainee at Salomons, it might not feel comfortable to share some of your personal experiences with me. I would like you to share only as much as you are comfortable with or in a way that feels right for you. For example, some people might find it ok to share that they had upsetting thoughts but might decide not to share what these thoughts were about in particular.**

**It is also fine not to talk about some of your experiences. I would like you to be comfortable with what you share with me, ok?**

**Can I check with you again if it is ok for me to record the interview (go through confidentiality)? Do you have any questions? Shall we start?**

1. **Can you tell me what it has it been like for you to practice LKM?**

Possible prompts: What has come up for you during/after the practice (thoughts, images, feelings, bodily experiences)? Can you bring to mind a particular situation? How did you experience the different stages of LKM? What was different from practicing mindfulness-meditation?

2. **Do you think the course has affected how you experience your life as a trainee? Have you noticed any differences?**

Possible prompts: Have you experienced any differences in how you cope with stress or look after yourself (e.g., work/life balance, how to relate to assignments, challenges at placement, self-critical thinking)?

3. **How have you experienced your relationships with others on your training course or placement since practising LKM?**

Possible prompts: Did you perceive any differences that you think are related to practising LKM? Relationships with peers (e.g., possible tensions in year group, with individuals), with colleagues, supervisors, manager, clients (challenging or good relationships); How have your relationships changed? How do you feel about these changes?

4. **Has the course impacted on aspects of your personal life?**

Possible prompts: Have you noticed any differences in yourself as a person (e.g., how you relate to your experiences; success, mistakes)?Has it made a difference to how you experience your relationships with your

partner/family/friends? Has it made a difference on how you encounter people you don't know well? How have you balanced life and work (leisure time)?

***The next questions will be about things that you might have found challenging during the course and it is fine to share as little or as much as you feel is ok to share.***

5. **Have there been any aspects of the LKM exercises that you have found challenging?**

Possible prompts: What do you think has made it challenging for you (e.g., particular instructions, previous experiences)? Can you bring to mind a particular incident that was difficult to you? How did you experience making time for practice? How did you respond to these challenges? How have these challenges left you feeling?

6. **How do you think you may use the experience of the LKM course in the future?**

Possible prompts: In training/professional life? In your personal life? Which aspects of the course can you imagine to hold in awareness? Which aspects were less helpful? How do you think you may use LKM in the future? Has the course instigated other strategies that you may benefit from in the future?

**Appendix K: Approval letter from ethics committee**

Canterbury Christ Church University

Salomons Campus at Tunbridge Wells

Inga Boellinghaus
12 Gladiator Street
London
SE23 1NA

17 March 2010

Direct line 01892 507672
Direct fax 01892 507660
E-mail margie.callanan@canterbury.ac.uk
Our Ref MMC/V75

Dear Inga,

**Outcome: Full Approval**

Thank you for addressing the points raised by the Ethics Panel so thoroughly, we are pleased to offer you approval for your proposed study.

We look forward to receiving a short report on progress and outcome on completion of the research, in order to complete our file. The report should be the same one that is provided to your participants. Please note that any changes of substance to the research will need to be notified to us so that we can ensure continued appropriate ethical process.

We wish you well with your study and hope that you enjoy carrying it out.

Yours sincerely,

pp. C. Callanan

**Dr M. M. Callanan**
Chair of the Salomons Ethics Panel

Cc: Dr C Hogg
Mr C Albani
Dr F Jones

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Professor Michael Wright, Vice Chancellor and Principal

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Registered Charity No: 1098136

**Appendix L: Email invitation for consultation about research study**

Hi there,

I am emailing you because you have been taking part in the mindfulness-based cognitive therapy course earlier this year and I would like to ask you a favour.

I will be doing my IRP on the experience of Salomons trainees taking part in a loving-kindness meditation (LKM) course. The project is supervised by Fergal Jones and Jane Hutton. We are planning to offer the LKM course to first years after they attended a mindfulness course. The study would involve taking part in the LKM course, filling in some questionnaires at the beginning, end and follow up, and being interviewed by me at the end.

I am interested to know how you would have felt about taking part in such a project, if you had been approached after the mindfulness course you attended. Your input would allow me to consider possible needs and concerns that potential participants might have.

I would like to ask if you would be happy for me to send you a brief questionnaire in the post. This way, you can answer the questions anonymously and send it back to me in a prepaid envelope which I would enclose. I would then integrate your comments in the design of my IRP and would report the results of the consultation in my proposal.

If you are happy to take part in this consultation, please reply to this email with your address details, so I can post the form to you. Please feel free to decide not to take part by ignoring this email.

Thank you and best wishes,

Inga

## Appendix M: Consultation about study with trainees

Dear trainee,

Thank you for agreeing to take part in this consultation. It will be very useful for me to know what your thoughts and feelings about my potential research project are.

I have attached a form describing a possible outline of the project and asking you for your opinion.

Once you filled in the form, please post it back to me in the enclosed pre-paid envelope.

Thanks again and best wishes

Inga

## Appendix M: Consultation about study with trainees

Please imagine the following scenario:

After the mindfulness course you attended earlier this year, a second year trainee would have invited you to take part in their IRP research project. The project would be on the experience of loving-kindness meditation (LKM), a practice encouraging compassion for self and others.
You would have been given an information sheet explaining the study. The project would aim to explore potential personal and professional benefits of LKM for trainees. Previous research suggests that LKM may improve psychological well-being and interpersonal relationships. The findings of the project may also inform future research using a clinical sample.
The LKM course would involve you attending four to six sessions. The sessions would be one hour long and facilitated by Fergal Jones. The information sheet would state that Fergal Jones and Jane Hutton (Department of Psychological Medicine, King's College Hospital) would be the supervisors of the project.
The LKM group would consist of maximum 12 to 14 participants. If you decided to take part in the project, you would be filling in a set of questionnaires before the course, at the end, and at a follow-up. The questionnaires would ask about perceived stress and well-being, self-compassion and compassion towards others, interpersonal challenges you may experience, and ways you usually relate to others and yourself.
After the LKM course finished, you would take part in an interview about your experience of LKM. This interview would be carried out by the second year trainee.
The information sheet would explain that the data from your questionnaires and interview would not be identifiable in the write up. Whereas the trainee would be able to identify the questionnaires you filled in, they would not be identifiable to the research supervisors.
It would further be explained that you could withdraw from the project at any time without giving any reason.

I would like to invite you to answer the following questions

1. How would you feel about taking part in such project?

_____
_____
_____
_____
_____

## Appendix M: Consultation about study with trainees

2. Would you have any concerns about taking part? And if so, could you describe any concerns you may have?

_____
_____
_____
_____
_____

3. Is there anything that could be changed in the project to address your concerns?

_____
_____
_____
_____
_____

4. Do you think it would be reasonable to carry out such project with a group of trainees?

   Yes ☐

   No ☐

5. Do you think it could be useful to carry out such project with a group of trainees?

   Yes ☐

   No ☐

## Appendix N: Transcript of interview with researcher about assumptions and biases

Interviewer (I): Ok, so I guess it might be helpful to think first of all about how you first found out about mindfulness and loving-kindness, kind of your first introductions to it.

Researcher (R): Well my very first lesson was at a conference when I heard someone talking about it that this was a new thing, and I was intrigued about it. And while I was doing my PhD. I did a, I observed a mindfulness at the Maudsley, which was run with patients with chronic recurring depression. And I found it helpful just to deal with my own stress, to being more in the moment.

And I also found it helpful because I was seeing a lot of trauma patients at the time, and we had three hour long interview sessions with them and I actually found it helped me to be more present with them in the room, whereas beforehand there was a lot of going in and out and giving questionnaires and leaving the room, coming back. I felt quite distracted and quite scattered. So I guess I got a sense of how the mindfulness had the potential to change the therapeutic relationship of being with a client, although I wasn't a therapist at the time, but I felt a different connection. And I think it just helped me to kind of contain my anxiety, or to deal with my anxieties a bit better. And I started using in breathing spaces and mindfulness meditation, but also I found there was quite a lot discipline and I was struggling with that, and I still am, as much as I'm really attracted by it I kind of like I'm going in and out of it and I'm struggling with the discipline routine.

But, yeah, and then I went on to kind of run four or five group sessions with clients – they were meant to be led by mindfulness clients, it was meant to be like a Service User like project, but it really wasn't, it was I was there facilitating the mindfulness and just giving them a space to talk, which was quite an experience for me. But I just still feel even when I don't practice, and I haven't practiced for at least two or three months properly, I feel like it stays with me as an anchor, something I know I can have. And what I still feel like I really connect with is with being in the moment and being with my bodily symptoms, sometimes relating to the breath. And even just identifying when I feel like I'm really on autopilot, and I really identify much quicker how unhelpful it is and how sort of stressed I get. So I think that's a bit of the relationship that I have developed with mindfulness.

And the loving-kindness is really, I think, something that Fergal, when I was looking for an IPR, that Fergal brought up, and what I heard about was the Gilbert compassionate mind stuff, and I was interested in that because, I think personally there is a connection because I can be quite self critical and because I can really push myself in working very hard, which kind of can leave me feeling quite stressed. And I think that is a critical component in that, you know, 'if you don't do this you're not going to achieve' and 'you should push yourself', sort of. And I liked the idea of a more compassionate way of relating to myself, I think. Yeah, and I think probably it was related with a degree of perfectionism and trying to be kinder to be kinder just be more happy with what you can achieve, to be gentle with yourself. And I think that was also what I liked about the mindfulness that it cultivates that attitude. And it seems like the compassionate component is more focussing than that and like it was more of a, you know, more focus really. I liked that.

However, I also realised that I can remember this exercise that, you know, we did here together, it was a compassionate mind exercise and we were asked to go to a safe place, I was really struggling and I quite upset as well, so I think I have also experienced that it can be quite challenging to kind of create that safe space for myself, and that as a realisation has been a bit upsetting because it threw me back in to like 'why?', and yes I know the answers, but I think it's been quite an eye opener to really to see there is something I would like to give to myself but it doesn't come naturally to me. And when I read about the loving-

kindness and got more interested in it, and I listened to some CD's, I liked the idea of cultivating that and kind of helping me personally with that.

And also I think I'm quite a social person, and I quite liked the idea of the loving-kindness of connectedness of people, and that's kind of also what my work is about, being a psychologist you try to connect with your clients, to support them and help them and you have to work with other people. And I think also as a trainee on this course you have lots of people around. But I think I've also at times found it difficult to negotiate differences, to negotiate competition, envy, and even in supervisory relationships I found that when I actually started to see that person a bit more from a loving-kindness point of view, it's a human being and we're all human beings and that's something that connects us all, and the differences fall apart a bit more. It felt like there was less need for negative emotions around it, less need for anger or anxiety, how other people see me, you know.
So there's something attractive about the idea of loving-kindness to me that brings me closer to other people, or that alleviates some of the difficult feelings that I may have being among others. Yeah, I think it's a bit about overcoming difference and barriers. And potentially as well with clients, I think, to kind of nurture this idea of connection. I mean obviously there needs to be professional distance, but sometimes I guess it can be quite difficult to relate, you know. So I think that's what attracted me to this, but I think because part of my project is also looking at the challenges that arise. I think that probably makes sense to me because I feel like I have experienced them myself in my struggle with being kind to myself. Yeah, I mean that's probably where my interest has come from.

I: So you've kind of spoken quite a lot about basically you had some like kind of really positive – although you've experienced the challenges, overall, it sounds like it's been really positive. And you mentioned earlier about observing some groups, and I just wondered what the outcomes were of them, if you were aware of any outcomes of the groups that you were observing?

R: Well I think they did some quantitative measures with them, and I think I maybe listened to a presentation. I think overall it's been quite good outcomes in terms of BDI and anxiety and all of this and that. that, you know, it wasn't controlled by any means, so I'm not sure – well I think to be honest the outcome was, you know, that some people have really benefited from it. Other people have really felt 'it's not my cup of tea, I can't do it'. Some people will just take an attitude away, just like the mindfulness, the breathing spaces, and just work with that. But I think overall I had the feeling there was some sort of benefit in raising awareness about moment-to-moment and how we relate to our feelings and emotions, but I think the meditation component was in fact for everyone. You know, obviously some people also didn't like it. Yeah.

I: Ok. What led you then to actually choosing to do this as an IRP? Because obviously you've got your own experiences. What was that kind of extra step that made you want to actually carry out your IRP in this area?

R: I wanted to do an IRP which was about meaning, which is I think why I chose a qualitative topic and why perhaps, you know, I was quite happy with an IPA study, really to get to people's experiences and what it meant to them, and what it means to them. So I think one component was I wanted to do something qualitative about something that I can relate to, and that ticks both of the boxes. And I think that perhaps part of me wanted to connect with the meaning because I felt I was in a struggle to find meaning in my PhD. I very much got on a train that was already running when I started my PhD and I was trying to find the meaning, but I think I just about towards the end felt I had made it a bit mine. And I think that kind of drove me to, in this project, to kind of try to go a bit deeper. And I think for me there is also

something about, you know, there is something about attachment in there, relationships, and how you kind of manage to relate to yourself and to your feelings and your ability to soothe yourself, to be kind to yourself, which I think I'm interested in and which resonates with me, I guess.

I: So how do you think, now given everything you've spoken about so far, how do you think that's shaped your research questions?

R: I think, you know, I think I was trying with the research questions to kind of keep them very open, so that like that really positive/negative experiences can be talked about. I think it was important to include questions about challenges because that's also what has been shown in research before that compassionate, you know, programmes can lead to quite strong emotions or quite overwhelming emotions. I think well it has probably guided me a bit in that I expect, that there is a possibility of loving-kindness to intrude all areas in your life really because we are social animals so we relate to people in all kinds of ways, so whether it's at work, at home, in private, or the relationship with yourself, and I think that is what structured aswell the questions I came up with, plus the challenges. So I think that my experience has coloured them while I was trying to kind of keep them open to kind of see what comes from the participants.

I: Before collecting any data, what are your expectations from the results? What are you thinking will be the responses to your questions?

R: Well I kind of would expect that there's some discovery about oneself, how one relates to oneself. So I kind of think I expect positive and negative discoveries really, that there will be potentially the discovery of a benefit of relating more compassionately and more caring or loving to oneself, and to other people. But I do expect that people will find it challenging as well and that this might link to different ways of relating to the meditation course, you know. So I kind of feel like, to be honest, I think probably I would expect changes in relationships with colleagues at work, the way of dealing with conflict perhaps, or problems with particular people, because you're encouraged to also meditate on a difficult person you experience difficulties with, and I would imagine that this would change how you relate to that difficulty and conflict. I would expect changes in how you relate to yourself, and particularly as a trainee on a course, in relation to all the pressures that you're under. Perhaps also a bit of worry about that if you relate differently, if you're still able to perform. And I think then there's a whole area of private life, which I don't really know what will happen.

I: You say you don't know but/
R: Yeah, I guess/

I: You could always have a guess.
R: I guess there will be benefits, yeah, there will be benefits and that, yeah, how you deal with differences, and I think, for example, my relationship with my partner that if I think more in the loving-kindness way about our conflicts that it will be easier to be gentle and to kind of let go of some of the barriers that can get a bit rigid if you kind of feel a bit stuck perhaps. But I kind of expect that some participants will get in touch with potentially grief or potentially feelings of loss of what they didn't have, what they, you know, something that they couldn't connect with. I think practicing this is perhaps showing a need, or a wish to, nurture that area and perhaps that also shows there might have been a lack in nurturing of that area, and practicing it might trigger really the realisation a bit like, I guess, what I experienced. So I think that potentially it might come up.

## Appendix N: Transcript of interview with researcher about assumptions and biases

I feel I might be a little bit conscious or reflective about me not expecting that too much because it was my experience, and I guess because I would, you know, in my personal therapy I've done lots of links with my upbringing, my childhood, and I guess I'm quite aware of my experiences why it might have been struggling with the loving-kindness meditation, and I think I need to be a little bit cautious to bracket this when I'm doing the interviews because I think I might be quite receptive to someone hinting to something to similar but which might be quite different.

I: So how do you think in the actual process of the interview how will you manage bracketing that, and how will you manage wanting to possibly explore that further with the participant or, you know, when I suppose there's the possibility of kind of leading the interview down one way/
R: Yes.

I: So how would you be able to manage that in the moment?

R: Well I think a good way would be to try to have quite a mindful attitude whilst doing the interview to kind of try to be aware of my own emotions that come up, which might be an increased sense of connectedness that I perhaps all of a sudden might identify or have a feeling of identifying with a person that I then can put a little bit the alarm – not alarm bells – but, you know, kind of to really try to be very gentle in the prompting and kind of not to jump to any conclusions. I think it's just the self awareness I can bring to the interview, and I think just something like this today helps me being a more aware of it. I think a good idea would be as well to perhaps for me to write a diary or to speak some notes after each interview, so for example should that have happened, you know, which, you know, is probably not impossible and perhaps not even unlikely that I, you know, I'm interacting and having some influence on where things are going that I can reflect on that and learn about it for the next interview. So perhaps that's a good idea as well. Yeah, and I guess the other thing is perhaps also to – I guess I'm a little bit unsure as yet how to do the interview. I'm doing a pilot interview in two or three weeks time, but I'm a little bit unsure as to how much you try to really stick with your prompts or how much also you can sort of navigate a bit and further away and take the lead of someone. You know, I'm a little bit unsure about that so maybe it will be helpful in that pilot interview with someone who's done IPA studies to clarify that a bit.

I: Who are you doing the pilot interview with?
It's a clinical psychologist; it's a colleague of [supervisor]. She's done her IRP on mindfulness and she's practised loving-kindness before, so it's a clinical psychologist who's just qualified a year ago. So it will be a bit different anyway because she's not a trainee/

I: Yeah.

R: So I need to sort of/

I: That's what I was thinking. It might be worth exploring that a bit here in thinking about what she might be bringing to the pilot interview that would be different to what your participants might be bringing.

R: Well I think one thing is as well, I haven't met this person and I'm not likely to have contact, so there is a component, that I do know the other people, I know them face-to-face, I bump into them in the corridor, so I think there is an issue as well of, you know, confidentiality and how much people disclose. If you're comfortable to disclose – it might be similar with her, but I don't think I'm not as close to her. I mean obviously she would be

under different pressures as a trainee would be, and there are colleagues around for her but there isn't in a year group, and I actually think that our year group is quite an interesting source to learn about yourself because you have to negotiate lots of different things, you know, with it. Yeah, so I think that's quite different.

I: So how might you manage that?

R: Say again?

I: How might you manage that?

R: About the pilot interview being different.

I: Yeah.

R: I haven't really thought about it. Do you mean how I manage that in terms of transferring the outcome onto my schedule, or just interviewing her?

I: More about the transferability.

R: Well I mean having said that we originally thought as well that perhaps we could use one or two participants of my sample as pilots as well. I think what I can transfer from that interview is my interview style. I think it's quite helpful that you made me think of how I bracket my own expectations, or beliefs, so I feel like I could perhaps practise that. So I feel like I can take away or transfer the interaction. And I think try to kind of stick with the person's experience and be led by that, will probably be a key thing, I think. In terms of the questions, I think because she's practiced loving-kindness and meditation and she would have practiced it as well in a different way because obviously she hasn't done this 5 week/6 week course. She said she's done one day retreat and she's doing lots of mindfulness, so I'm already a little bit thinking well that's quite different, but perhaps she can still talk about the challenges of that and the impacts on her life of the particular loving-kindness meditation.

Yeah, so I think they're a lot of the things I could take away from it, but perhaps particular questions about the training, you know, won't be possible to – well, I could think perhaps depending on when she started it. Maybe she also started it when she was training, so maybe there's a bit of room as well to ask her about her training experience, or maybe she might still do some sort of training in a different context or so.

I: Ok. Another thing that I thought of as you were talking earlier is about exploring the challenges that people experience, and I just wondered if you'd had any thoughts, obviously before data collection, about how you might explore those challenges in terms of the actual write-up of the results? What would you kind of be hoping to do with them? Does that make sense?

R: How do you mean, in terms of the write-up?

I: Well, say that you identify x, y, z challenges, in terms of actually writing them up what do you think your motivations might be for pulling out and writing up certain challenges? What might you hope would be gained from doing that?

R: I think what could be gained from it is like a clinical awareness if you work with a group of people to be very sensitive around issues that would have come up for this group, so you could gain from it to maybe prepare people for those challenges. Maybe, I guess, I'm also

expecting that people will have found some ways of dealing with these challenges, and that will be helpful to learn about, what has helped or has not helped, and which you could then potentially give as guidance or as a lesson examples. And I guess also to kind of, depending on what the outcome is, to caution a bit more in the practice around certain things, because it will be interesting, where these challenges arise, whether there's a particular sort of stage of the loving-kindness meditation you could move sort of in stages or whether for some people there might be particular images, sentences or different feelings or, yeah, images that might have triggered strong emotions. Yeah, I think in the write-up as an outcome, you know, are the challenges that big that one should caution really for doing it with a clinical sample, or are they actually manageable and, you know, and what would be helpful.

I: And so on the flipside of that you've spoken about – my brain's gone absolutely dead!

R: Mine too! You've got all these clever questions!

I: Yeah, you spoke about wanting, or kind of the possibility, of raising awareness of loving-kindness as – I think you said that as one of your kind of motivations for wanting to do this as a research project. So I'm just wondering, again, kind of a similar question really but on the flipside, so the more positive responses that you get, what would you be hoping kind of, in an ideal world for example, what would you hope would your research paper would be able to be used for? How would you, you know – so I'm kind of looking at underlying motivations in that way/

R: Yeah.

I: And what would be your ultimate goal for this paper?

R: I think that a goal would be to – two goals really – one is to look at basically one intervention that could be offered to the trainees, because its specifically with trainees, to think about if people did find that helpful whether it could offered as part of a programme or part of an experience, for example here at Salomons where that could be offered regularly in adjunct to the mindfulness. Whether you could think about offering it to staff courses as well rather than just mindfulness, extending that. But also in terms of that it might inform clinical research to really think about whether it can say a little bit more about what exactly it is that felt challenging, the quality of the challenges and how people cope with it. And of course you can't transfer it to the clinical population but there might still be things that might be very relevant that might have come up and that we then could use to inform clinical studies with clinical populations on loving-kindness. Yeah, so that's really/

I: So given what you've just said about writing up both kind of the positives and the challenges, how do you think, just in terms of kind of using this to reflect, how might that influence how you interview people?

R: You mean that I possibly expect both to be present? Is that perhaps what you mean?

I: Yeah, it is about kind of expectations about what might come up, but I guess kind of we've just talked about kind of overall goals with an end published paper, and I guess I'm just trying to kind of raise awareness of/

R: Yeah.

I: How that could – again, I suppose it's about that leading down a certain way in the interview or/

## Appendix N: Transcript of interview with researcher about assumptions and biases

R: Yeah.

I: Selecting particular participants/

R: I guess, you know, there could be a danger in me kind of saying, you know, having the anticipation there were benefits but then there were challenges but they were dealt with, you know, sort of I could be tempted to achieve that narrative, whereas actually some people might have zero benefits and just challenges, or some people might actually have not experienced many challenges and maybe it just turns out that it will actually be quite a safe intervention, you know, for trainees who are not of clinical sample. So I think it really is about, yes, staying quite tentative and staying quite exploratory and not wanting to replicate, I guess, my experience, and awareness of that. Yeah. I find it quite challenging to think about what you kind of, you know, how – because I think the nature of the questions they're very carefully formulated that they are quite open and stuff/

I: Yeah.

R: So you kind of think 'oh, I've cautioned against it, but of course, you know, it might be quite implicitly or unconsciously to slip in.

I: And I guess I mean it's – I mean I think I kind of asked the question but just in a different way, because I think you kind of answered it earlier aswell, but I was tying to encourage you to think about a slightly different perspective of it or a slightly different issue that might come up. But I guess it does all come back down to bracketing and, like you said, making notes straight away afterwards and just kind of trying to be aware of/

R: Yeah.

I: Being aware of everything.

R: Well I guess I also feel like I do need to speak a bit about how to do the interview, what is ok and what isn't. I kind of feel like I haven't really thought a lot about it. I mean I won't be interviewing until August or something, so I've still got a bit of time, but yeah it would be helpful to think about.

I: I mean you say how you'll interview. What do you mean by that?

R: Well in terms of like how much you stick to your prompts and the questions/

I: Yeah, right/

R: And how much leeway you give, because the more leeway the more it is tempting to go down routes that you kind of confirm your hypothesis, I think, or confirm your own expectations of it. I think just keeping an open and curious mind about people's experiences and reminding myself of that.

I: I think it's quite difficult, isn't it, because I guess on one hand you're getting the person's – by letting them take their own route and following them on their route you're getting their true experience rather than trying to stick to an interview schedule/
R: Yeah.

I: But it does open up the risk of/
R: Yeah.

## Appendix N: Transcript of interview with researcher about assumptions and biases

I: Picking up on one thing they've said over something else/
R: Yeah.

I: And it could be, you knot, the most minute thing could actually/
R: Yeah.

I: Completely steer it in a different direction.
R: Yeah.

I: I'm just wondering, I mean I don't know if there would be any scope for it at all – I don't know how useful it would be – but in terms of being observed doing an interview, so for example when you go to interview the psychologist, or even a possible participant. Maybe, and I don't know how they'd feel about it, but maybe use like a video camera/

R: Yeah.

I: Well I suppose you would even pick it up on the recording, but I think that would – listening back to them afterwards before doing another interview, might – or even getting someone else to listen to them, because they might think 'well why did you ask this rather than that?'. That could be quite a useful thing to do.

R: And I think it's perhaps also how much you express excitement or interest. Do you know what I mean? Like whether I would express more interest if someone says 'yeah, I found it really difficult', and then it would make me upset or something, you know, I'm expressing verbally or nonverbally more of an interest into other, you know/

I: Yeah.

R: In to things that I can identify with. Yeah, it's a good idea with the camera, I think.

I: Because, yeah, I mean think about the kind of therapy situation really, like it doesn't even have to be an overt display of interest, does it, it could just be like a change in your body language when they talk about something/

R: Yeah.

I: Or something else, and I guess it's just kind of just really having to be aware/

R: Yeah.

I: Really really aware of what you're/

R: Yeah.

I: Portraying to the participant.
R: Yeah.

I: It's quite scary!

R: It is.

## Appendix N: Transcript of interview with researcher about assumptions and biases

I: I guess the only one on here that I haven't really looked – well we have touched on it, that was with your kind of the role of you being a trainee interviewing trainees. And I guess we did touch on it a little bit, but I was wondering if you wanted to talk about that a bit more because I think that could be quite a big factor.

R: Yeah. I will be taking part on the course aswell, on the loving-kindness course/

I: Ok.

R: As an observer/

I: Ok.

R: So I won't be discussing my experience aswell, but I'll be doing the meditation and exercises and stuff.

I: Can I just, sorry, explore that a bit more? I'm just wondering if that would be worth thinking about and how the participants might experience you being in the room as an observer not sharing your own experiences but then interviewing them on theirs.

R: Yeah, I guess potentially it could be perceived as maybe a bit unfair or – but it's a little bit – I think perhaps also it might be – well we thought about that it might be easier to just keep the boundary that I am there in a different role. It's my research project and if I offloaded my personal things in there I think it would be difficult to/

I: Yeah.

R: Then take quite a neutral stance, so I think – but it makes me think now that it would be good to clarify that as well what my role will be in these groups and to explain the rationale why I won't be sharing, you know, that I will be interviewing them but this is for me to have a similar experience to them that I know what their course was like and I have my own experience but because I will be interviewing them about it it will be easier, you know, if I keep in that role as a researcher as well as participant. So it's a bit of a funny dual role.

I: Yeah, I guess that's, yeah, quite another quite important thing to think about, because not only, you know, we've spoken about your previous experience but I didn't realise you were actually going to be sitting in on this one as well/

R: Yeah.

I: So you'll have a whole new wealth of experience from this actual course/
R: Yeah, that's true.

I: And how that's going to impact on everything, you know, everything we've already spoken about/
R: Yeah.

I: But it's going to bring a whole new level to it.

R: I think I really would need to kind of keep a diary for myself, you know, once the course starts, and to be quite disciplined about it. Perhaps I'm going to use a tape actually, something to just speak my mind and talk on a tape. Yeah, because it's true, I would be in a very different position when I do the interviews because I will have been through the same.

## Appendix N: Transcript of interview with researcher about assumptions and biases

I: And obviously at the moment you don't know what's going to come up for you when you go through this course/

R: Absolutely.

I: You could have a completely difference to your previous experiences/
R: Yeah. And also because I won't have the opportunity to talk about it, I can talk to my second supervisor, she offered that, but, you know, if there's something that comes up for me in the sessions, you know, I have to be quite contained about that.

I: So, yeah, it's thinking about having an outlook for that.
R: Yeah. Yeah, it's quite interesting because it felt like a bit of a quick decision. First I thought I shouldn't take part, and then it was like 'well but then you don't know what the course was like' and I was like 'oh, that makes sense'. And it was almost more that Jane, my supervisor, offered herself for when there is a conflict between someone disclosing something to me that was difficult because I'm part of Salomon's and like wouldn't want to speak to Fergal, or perhaps there could be also a meeting with Fergal, but again it's more difficult because he's supervising on the project. I mean I think I've got my personal therapy which I think will be helpful for, you know, processing stuff that will come up there, so I feel like I am actually helped anyway by someone external to Salomons where I could go to. And I think perhaps also me having a reflective diary or, you know, using what comes up for me aswell as part of the process would be helpful.

I: I'm just thinking, to kind of imagine it might be quite difficult when it comes to writing up to really, yeah, just that really holding that awareness of 'no, that was mine and that's what I heard from someone else'/
R: Yes.

I: And kind of being really clear.
R: Yeah, it's true. It is really true actually. I hadn't really thought, because, you know, it seemed so distant until you really get cracking on with it, but yeah I think that will be important. so maybe there's also something that, you know, if I'm, you know, keeping a diary and perhaps also answering these questions for me in order to tease out, you know, and to bracket those away from when I look at the transcripts of the participants.

I: And I guess that's the benefit of IPA because you, you know, you can acknowledge your own/
R: Yeah.

I: What you're bringing to it as well/
R: Yeah.

I: And that's kind of the whole focus/
R: Well I guess, yeah, I guess it's probably interesting because I'm just thinking though it would be worthwhile, but perhaps it might be even helpful to be interviewed – that I would be interviewed after the course before I do the interviews.

I: Before you do them, yeah.
R: Because, yeah, as you say it might be quite different then. But maybe I could just that in a diary aswell, you know. Yeah.

I: But I think that would be useful with the actual interview schedule that you're going to use/

## Appendix N: Transcript of interview with researcher about assumptions and biases

R: Yeah. I agree. That's a good point.

I: Is there anything else you wanted to cover/
R: No.

I: In this bit?
R: I don't think so.

I: I haven't obviously gone through all this now, but I think I'm/
R: Yeah, well I think that it's been really, yeah/

I: It's been/
R: I feel it's been quite helpful thinking about different things that I wouldn't of thought of myself just as, you know, with the diary, so/

I: Yeah, I mean I think it would be – I mean I'm more than happy to go through this with you now, but I think it would be more helpful after the course/
R: Yeah, I agree.

I: And I mean we have looked at your own experiences and how they've led. I mean I don't know if we've kind of had different ideas about what today was about maybe, but, yeah, kind of how your experiences have led to what you're choosing in your research questions/

R: Yeah.

I: And how that might affect how you're interviewing and writing up.
R: Yeah.

I: So I guess – I mean as I said I'm more than happy to do this now, but if/
R: No, I feel like we've covered as much as like I think is helpful really at this point, and I think it's a good idea for me to, you know, go through these before I do the interviews after I've done the course. No, so/

I: I'm wondering if it's – when are you doing it with the psychologist?

R: In three weeks or something. Yeah. What were you thinking?

I: No, I as just wondering about whether it would be useful for you to do it before you do it with her, or after, but I guess if you're doing that as an initial pilot/

R: Yeah.

I: Just to see kind of how it flows and how it works and/

R: Yeah.

I: How you're going to interview/

R: Yeah, absolutely.

I: Yeah, then there's a big gap there aswell, isn't there?

## Appendix N: Transcript of interview with researcher about assumptions and biases

R: Yeah. And that would be perhaps a chance as well to think about me practicing with Fergal and Jane, you know, just practicing with different people, and work on that and then – yeah. No, thanks [name].

I: Has that been helpful at all?

R: Yeah, very much so.

## Appendix O: Abridged research diary

### 9th of March 2010 – Reflective interview

Today, I was interviewed by a fellow trainee about my preconceptions about the research project. It was a very interesting experience and really got me thinking about why I had chosen this topic and what my experience and expectations are about the findings. I have never done this before, doing qualitative research, and I feel there is a lot to learn about this. To really think about how my experience may impact on how I conduct the research and interpret interview material…it seems challenging but very interesting.

### 23th of May 2010 – Start of LKM course and my experience of LKM

The LKM course has started, and I'm struggling with doing the meditation. The first time I did it in the course, it made me sad. I chose some personal phrases for me and it made me think of the things that I did not feel at times when I was growing up. Then I used some imagery like the ballet scene I danced with someone when I felt touched by the other person and seen and accepted and safe. And then I imagined encountering other people in the circle of light. And then I thought about my ballet teacher and her being dead now and I felt sad again. I also used a fellow trainee as a difficult person and it helped me a bit when I saw the person again. But I have felt quite stressed in general and found it hard to be kind to myself, instead of criticising and pushing myself to gain control. I have felt very out of control at placement and incompetent…

### 7th of July 2010 – End of LKM course

It will be the last LKM session tomorrow. It is exciting that I can start with the interviews soon. I have felt quite detached from the LKM at times, because I found it hard to do the meditation, to find or to make the time. But I tried to practise LK with that, although it seems like a bit of an excuse. It feels quite full on at times this summer with organising everything around the IRP and doing all the interviews, but I am sure it will get easier afterwards…maybe not though…

It has been very interesting to practise the interview schedule with another trainee and a clinical psychologist. It feels similar but different to clinical work interviews. Having to be non-evaluative, to be just enquiring and open, and it is all about the experience of the person. I have really enjoyed the two pilot interviews and actually got good feedback on it. The clinical psychologist said that she felt very comfortable and I had a nice style, so that is good. It will be good to get going.

### 26th of March 2010 – Interview 1

This was my first interview. I was nervous about carrying it out and felt like I was struggling to feel at ease. Perhaps this was also to do with the fact that there was a theme of indifference and disappointment about the LKM intervention. I realised that I was keen to hear about either positive or negative

experiences and that indifference or disappointment did not fit those categories which I thought I needed to be aware of in the following interviews.

**4th of November 2010 - Interview 2**

I was struck by the richness of experience this participant had in practising LKM, in particular how LKM was perceived to increase confidence and assertiveness. This was a complete surprise to me and I found it very interesting. There also seemed to be an experience of being caring as a therapist and a helpful person which might turn into resentment if one felt not cared for enough by others – this is something I felt I could relate to. I was touched by how deeply the participant had been touched by the LKM intervention. What brought up feelings in me was the notion of not being seen, feeling isolated in training. It made me think about that how one's feelings about being with others may be related to experiences in childhood. It made me think of the Gilbert model and the role of attachment experiences in being compassionate towards oneself and others.

The feelings of being on a training course and feeling like having to pretend that everything is ok all the time is familiar to me and triggers thoughts in me about what to share with whom in training and how hard it can be to seek support, even though it is so important.

**15th of July 2010 – Interview 3**

I remember that I was struck by how this participant experienced the LKM as mostly positive and had little struggle with it. This was contrasting to the previous interview and my experience. It made me think about how previous therapy had a preparatory effect on the experience of LKM and that vice versa LKM impacted on the therapy experience. This made me think about the context in which LKM is offered and possible recommendations for it. It seemed that the mindfulness experience beforehand was helpful in enabling an acceptance of struggle when it came up.

**16th of July 2010 - Interview 4**

In this interview, I was struck by the theme of ambivalence, of wanting to be more self-compassionate whilst being worried that something bad would happen if one did. It seemed that curiosity about this new way of relating and experimenting with it was a compromise that allowed the participant to try it out without feeling bad about it. This interview made me think about how powerful self-critical styles of thinking can be and how a LKM intervention may open new paths to people with such self-critical thinking. At the same time, self-critical thinking may hinder self-compassion, giving rise to more negative thoughts during and after the LKM.

I was grateful that this participant brought up the ethical dilemma with the facilitator being a member of staff. It made me think about how the setting of a LKM course is important to ensure safety, safety to do the LKM but also to talk

about the impact of it, particularly seeing that the impact was quite intense and emotional for some participants.

**29th of July 2010 - Interview 7**

This was a very emotional interview which touched me. The participant became upset in the interview and I was challenged to stay in my researcher role. I noticed that I was tempted to take the role of the fellow trainee and to reassure the participant, just as I would support my friends in my year group, but I managed to just be empathetic and to ask her if she wanted a break. I also encouraged her to share as little or as much as she like which seemed important given that the interview seemed to have touched on quite personal things.

I generally found it challenging that some trainees revealed quite a bit about themselves and their personal information and to then see them around in at university in different contexts. However, I think that having been in the reflective group is a bit similar – people share intimate things there and you learn how to deal with them with respect, sensitivity, and confidentiality.

I also felt that having been a part of the LKM course was essential in order to share and related to the experience of participants and to know about some of the struggles participants were talking about. I think in the debrief of this interview, I actually shared with the participant that also I found the LKM upsetting at times and challenging, maybe I wanted to make the participant feel safer in having shared their distress with me or maybe I wanted to let them know that it was ok to show vulnerability, that it was safe with me.

I also had the feeling that the interviews were a reflective space, that made participants think of things they had not thought about before. Maybe in some ways it was reflecting the process of the LKM itself, that it was not possible to know what it would be like and that some things evolved in the interview that were unforeseen and emotional.

**4th August 2010 – Interview 8**

I was struck by the intensity of the impact of LKM on this participant. It seemed like the LKM triggered an almost dissociative flashback experience of the past. The fact that the LKM may trigger past distress was not a surprise to me but that the quality of the experience was almost dissociative and that it was hard to come back to reality for this person was surprising to me and bit shocking. However, it seemed that again, the mindfulness was helpful in grounding the person which I feel is reassuring.

It does make me wonder though about the length of our sessions, that they were quite short and did not leave a lot of time for exchange. This participant and others have said that sharing in the group was helpful, but I think that the limited time was a limitation to this support.

During this interview, I found it was possible but challenging to stay in my researcher role. I felt I succeeded in it by being empathic but by staying on task in exploring the person's experience rather than wanting to help them with the impact of the LKM. On the other hand, I found myself asking a question related to the quality of memories. Thinking about this now, this question was clearly influenced by my background in PTSD research and it actually seemed not appropriate to ask this in this research context. I think I also asked about the severity of the memories that came up or how vivid they were which also felt like a deviation from the task. I noticed this once I had asked the questions and was then more able to focus again on the person's experience in an open way.

Sometimes I felt that the person was hesitating in saying that they found mindfulness more useful than LKM and it made me wonder about social desirability in answering my questions. I also realised that the person's understanding of LKM was embedded in a CBT-way-of-thinking and the language the person used to describe their experience was a bit like CBT language. This made me think whether training in CBT has a particular impact on how people experience their encounter with LKM.

The participant talked about tensions in the training peer group, a desire to be part of it as well as the desire to have enough distance to not get caught up in the anxiety of others peers. I think that being aware of these tensions can also be useful for working in teams and other settings.

**5th of August – Interview 9**

I found this interview challenging in that the participant very much saw LK and mindfulness as one experience on the one side, but on the other hand clearly favoured mindfulness. The conceptual nature of the LKM was perceived as a big challenge and as too abstract, but the idea of LK and the mindset was perceived as very valuable. Avoiding the LKM practice as time seemed to be a protection against the emotional impact of the practice. This seems important to consider when offering LKM in the future, that people look after themselves in the practice and that there are different things that can taken away from LKM.

## Appendix O: Abridged research diary

### 6th of August 2010 – Overall reflection on interviews carried out

I have done 10 interviews by now and I am glad it has been going well. The interviews have been very mixed. I certainly have become more relaxed in being flexible with the interview schedule and the enquiry. Sometimes I fell that people thought I expected to hear positive things or that me asking for perceived differences meant that they had to have had them. So I felt as though they experienced me as a bit suggestive at times. However, I did say that they may or may not have experienced a difference and that this is fine, but I am wondering if me being a fellow trainee with an IPR that needs to get done has made it harder for some to say that there were no effects. But then again, people did say that they perceived no changes in some areas and that seemed to have been fine too.

Some of the interviews have brought up very personal stuff, and once I felt very sad and the participant was crying. It was difficult to balance the interest in the quality of the upsetting experience with being aware that this was not therapy and to respect and to flow with the participants choice as to whether they wanted to say more about it or not. I also felt that some felt a bit guilty about not practicing more whereas others were ok about it. Being asked about it might have been difficult for some people and they may have compensated for it by saying more beneficial things about LKM.

I handled the debriefing of the interviews by asking participants what it was like to be interviewed. Most people said that it felt comfortable and ok and that it was interesting to think about things they had not thought about before. Some asked me after the interview what it was like for me. I felt that it was ok to share my experience at that point and shared that I had found LKM challenging in some ways because it can stir up difficult emotions in me, but also that I found it helpful in dealing with difficult relationships or new encounters which can become less threating with LKM.

I wonder whether me not practicing LKM much was some form of avoidance too…the grief it brought up for me about my upbringing…and my ballet teacher. I think the experience during LKM about my ballet teacher was influenced me to get a photo of one of my performances framed. I think it was a way of helping me to process my grief about her passing away so recently. So that was interesting that this somehow came out of the LKM for me.

Also, I found it interesting what participants said about LKM mixing with other experiences, i.e. therapy. I think I have found it helpful to have personal therapy in training and that I felt safe in encountering LKM and having a space to bring upsetting feelings.

I think that the encounter I had with LKM has helped the process of accepting that I am who I am and that others are human beings with their story too. Maybe that also helped me with some tensions in my family…

## Appendix O: Abridged research diary

### 7th of January 2011 – The process of analysis

In the meantime, I got my interviews transcribed and focused on my other assignments I had to do so that I have been feeling a bit disconnected from the research. But listening to the interviews again and reading and re-reading the transcripts really brought back the content vividly and I have enjoyed immersing myself in the data.

I started the interview process with a very long and what seemed rich interview. I was struck by how long it took me to make the initial codings and to try to make sense of what the participant was saying. It was great fun though and I felt that there was a lot of interesting things in the data. It was bit like listening to a client in therapy and trying to take in the whole picture whilst also having to pick up on specific details that were said.

I love the process of finding meaning in the data and interpreting it. It really means an involvement in the research and this is so different to doing a quantitative project like my PhD where you can just get lost in the data and almost forget that there are real people behind the numbers…

I just analysed my sixth interview. I have noticed that almost every participant has found the intervention intense, emotional, and challenging. This makes me think how relevant this research is in terms of precautions and safeguards regarding implementing LKM groups for trainees and in particular for clinical groups. It also makes me think about the type of person that goes into a career in psychological therapy and that often our own experience of vulnerability has led to a desire to help or care for others. LKM may then confront ourselves with our own vulnerability. LKM maybe is a bit similar to seeking personal therapy, that one needs to feel able to make space for reflecting on oneself and one's relationships; and that LKM is less of a stress management strategy. It almost made me think that it is helpful to have therapy when doing LKM which is what some trainees said, but that does not seem to be a strong selling point, does it? But I guess I don't have to sell it or want to sell it, I think it is just that I can see the benefits as did some of the participants and that just even the mindset of LK can help with day to day things.

### 12th of January 2011 – Reflections on confidentiality

The issue of confidentiality has come up in some of the interviews. I think with hindsight, I would have reassured participants that I would not show the entire interview transcript to the facilitator and that only short extracts and parts of the interview are being used in discussion and the write-up, so that the possibility of being recognised by the facilitator would be reduced. I think it would have been helpful if this was agreed and clarified at the beginning of research. In the meantime, I took part in a qualitative research project by a clinical psychologist which showed me what it is like to experience a concern about confidentiality myself. It made me realise how important it is to experientially engage with these ethical questions.

## Appendix O: Abridged research diary

### 26th of March 2011

There has been a five week break since my last meeting with my supervisors and I have not been able to work on my analysis due to other course assignments. This has been frustrating and it has taken me some time again to connect with the material. Having analysed all data now, I have collapsed the themes today, trying to cluster them in a meaningful way, reducing the amount of detail whilst trying to capture the breadth of varying experiences of participants. This has been challenging and I wonder how I will be able to convey the richness of the data in the results section. I am hoping that choosing varied quotes from different participants will help me with this.

On a personal level, I have noticed how tired and exhausted I feel, and how little time I have made for LK or mindfulness. It is helpful to remind me in these days of a more loving attitude towards myself. And also, when I get annoyed with other people, I have been able to draw on the experience of LK. However, I feel that I am in need of a booster. Sometimes I feel like a hypocrite, doing this research project on LK and not being practising myself. On the other hand, this is a dilemma that other trainees have shared with me in the research, the struggle to find a balance between being kind and loving whilst having to meet the demands of the course…maybe this is also why I am interested

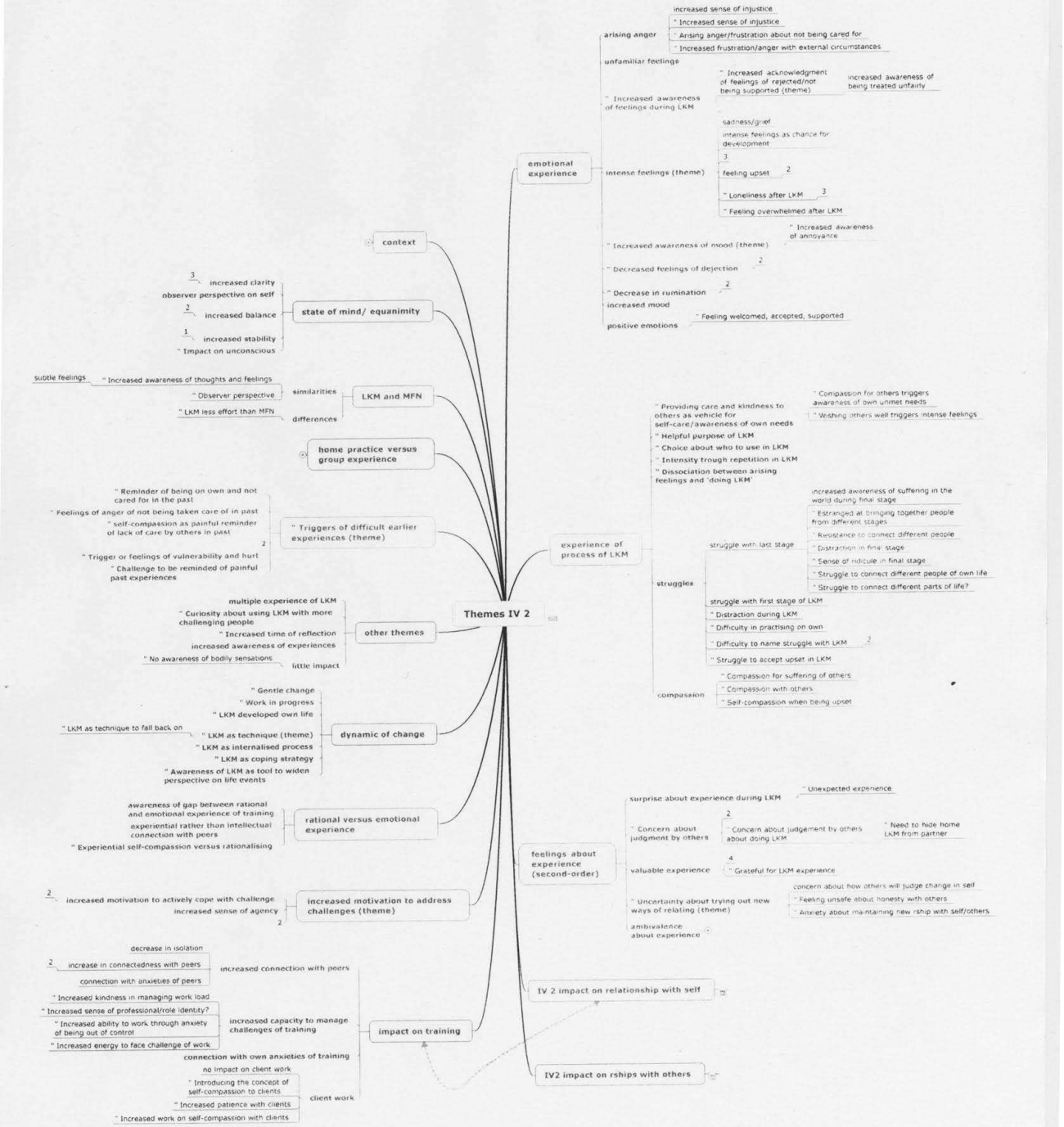
### 5th of May 2011 – Start of write up

I have started to write up the results. I am finding it very challenging to select which themes deserve more space. There is just not enough space in 4000 words to capture the richness of the data. I want to convey a good sense of the overall sample whilst keeping the individuals in mind. With 12 participants, this is not so easy. Thinking about each participant as a person, imagining their voice and face, was helpful in calling them to mind during the write up.

But it is also fun writing the results. I had to think back to my times of working in journalism when I was editing reports for the television, having to select quotes that fit with the narrative, the overall picture whilst adding something interesting. I hope that I will be able to find the right balance.

## Appendix P: Example of interview transcript and initial coding

# Appendix Q: Example mindmap on emerging themes for initial case



## Appendix R: Table of initial codes and their relationship with emerging master themes

| Master theme | Sub-theme | Initial themes related to sub-theme | Number of references |
|---|---|---|---|
| Engaging with the practice | Intellectual understanding versus experiential engagement | Intellectual understanding versus experiential engagement | 11 |
| | | Struggle to feel/connect with feelings | 11 |
| | | Loving-kindness abstract/conceptual | 5 |
| | | Struggle with structure | 5/2 |
| | | Loving-kindness as task | 2/1 |
| | | Integrating loving-kindness and mindfulness | 5 |
| | | Context of CBT training/cognitive language | 10 |
| | | Ease in practice over time | 6 |
| | | | 2 |
| | Emotional response to practice | Emotionally intense experience (e.g., upsetting, sadness, guilt) | 12 |
| | | Frustration/anger (with practice, about someone else, with self) | 8 |
| | | Disappointment | 5 |
| | | Confrontation with the past | 2 |
| | | Trigger of attachment patterns | 5 |
| | | Surprise about experience | 2 |
| | | Positive emotions | 7 |
| | | Grounding/containing | 6 |
| | | Relaxing/calming | 12 |
| | | Soothing | **5** |
| | | Warmth | 4 |
| | | Equanimity/balance | 4 |
| | | Increase in energy | 3 |
| | | Grounding of the body | 2 |
| | | Emotions in the body | 4 |
| | | Tension in body | 8 |
| | | | 2 |
| | Safety of practicing LKM | Loving-kindness feels risky/unsafe | 11 |
| | | Intensity of practice | 6/2 |
| | | Making the practice safe | 5 |
| | | Mindfulness as secure base | 8 |
| | | Avoidance of practice | 8/1 |
| | | Personal therapy as help with LKM | 4 |
| | | Negotiating safety in group | 3 |
| | | Groups as safe space/unsafe space | 2 |
| | | Embracing the challenge | 8 |
| | | Creativity/Developing a personal practice | 4 |
| | Creativity/Developing a personal practice | Obstacles to practice | 8 |
| | | Distraction during practice | |
| | | Negative thoughts/feelings as obstacles to practice | 9 |
| | | Tiredness | 7 |
| | | Struggle to make time for practice | 5 |
| | | Being kind to struggle with practice | 7 |
| | | | 6 |
| | The power of sharing | The power of sharing | 11 |
| | | Home versus group practice | 2 |

*Note*. Number of references refers to number of participants who referred to this theme. N/N refers to the number of participants who referred to this theme and the number of participants who contradicted this theme.

## Appendix R: Table of initial codes and their relationship with emerging master themes

| Master theme | Sub-theme | Initial themes related to sub-theme | Number of references |
|---|---|---|---|
| Impact on the self | Increased awareness of self | Increased awareness of self | 12 |
| | | Increased awareness of negative thoughts and feelings/self-criticism | 11 |
| | | LK as space for self/reflection on self | 11 |
| | | Increased awareness of own needs | 10 |
| | | Connection with own vulnerability | 7 |
| | Self-compassion | Self-compassion | 12 |
| | | Increased self-acceptance | 7 |
| | | Increased acceptance of difficult feelings | 6 |
| | | Increased self-compassion/kindness | 12 |
| | | Taking care of the self | 7 |
| | | Distance from negative thoughts/self-criticism | 10 |
| | | LK as counterbalance to self-critical voice | 5 |
| | | LK as counterbalance to low mood | 3 |
| | | Reduction of difficult feelings | 2 |
| | | Decreased rumination/worry | 7 |
| | | Struggle with self-compassion | 8 |
| | | LK as permission to be kind to self (struggle with self-care, guilt) | 8 |
| | | Trying out a new self | 6 |
| | | Curiosity | 4 |
| | | Ambivalence/Concern about the new self | 5 |
| | Context of demands of training | | 12 |
| | | Context of stress in training | 12 |
| | | Context of fear of failure/pressure to achieve/being judged | 11 |
| | | Context of self-criticism | 11 |
| | Managing stress/demands of training | | 10 |
| | | Increased awareness of stress/coping with stress | 6 |
| | | Increased capacity to manage challenges of training | 8 |
| | | Putting less pressure on self/permission to be good enough | 7 |
| | Increased confidence | | 6/1 |
| | | Increased assertiveness/sense of control | 4 |
| | | Increased trust in self/feeling safe in self | 2 |
| | | Increased confidence/self-esteem | 6/1 |

*Note*. Number of references refers to number of participants who referred to this theme. N/N refers to the number of participants who referred to this theme and the number of participants who contradicted this theme.

## Appendix R: Table of initial codes and their relationship with emerging master themes

| Master theme | Sub-theme | Initial themes related to sub-theme | Number of references |
|---|---|---|---|
| Impact on relationships | Increased awareness of self in relationships/relationship patterns | | 11 |
| | | Increased awareness of self in relationships | 11 |
| | | Awareness of being the helper | 5 |
| | | Increased awareness of difficulties in relationships | 7 |
| | Compassion for others | | 12 |
| | | Increased acceptance of others/differences in others | 8 |
| | | Increased compassion for others | 12 |
| | | Difficulty to feel genuine compassion with difficult person | 11 |
| | | Sense of shared humanity | 6 |
| | | Increased ability to seek support/share vulnerability | 1 |
| | Increased social connectedness/openness with others | | 12 |
| | | Increased social connectedness/openness | 12 |
| | | Decreased defensiveness/increased safety | 6 |
| | | Negotiating contact with peer group | 10 |
| | | Awareness of value of relationships | 3 |
| | Overcoming interpersonal difficulties | | 11 |
| | | Overcoming interpersonal difficulties | 11 |
| | | Increased choice in relationships /widened view on relationships | 8 |
| | | Challenging old patterns of relating | 6 |
| Bringing compassion into the therapy room | Bringing compassion into the therapy room | | 11 |
| | | Increased awareness of therapeutic relationship | 4 |
| | | Increased humanity/connection/compassion in the therapeutic relationship | 8 |
| | | Passing on experience/teaching compassion | 7 |
| | | Increased confidence as a clinician | 2 |
| | Integrating LK with other areas of personal/professional development | Integrating loving-kindness with other areas of personal/professional development | 9 |
| | | Mutual interaction between LKM and personal therapy | 3 |
| | | Integrating loving-kindness with personal experience/development | 7 |
| | | Course models loving-kindness in university context | 2 |
| Integrating LKM into life | | LK as mindset/philosophy/impact on day to day | 12 |
| | | LK as internalised potential | 10 |
| | | LK as work in progress | 7 |
| | | The power of subtle changes | 3 |
| | | LK as new skill/tool/technique | 9 |
| | | LK as new skill/tool/technique | 9 |

*Note*. Number of references refers to number of participants who referred to this theme. N/N refers to the number of participants who referred to this theme and the number of participants who contradicted this theme.

## Appendix S: Example quotes for sub-theme 'Emotional response to practice'

| | | |
|---|---|---|
| Anger/ frustration | P2,1,5 | I felt angry quite often and it's been, um, I think its been quite healthy. (...) what's been happening is that I get to that stage and I go 'actually that's not ok to treat me like that and actually its perfectly justified for me to be really hacked off with that person'. Um, and that's what what was happening, I was starting to actually find...a bit of clarity, a bit of confidence, a bit of backbone (laugh), a bit of, um...passion. |
| | P5,5,8 | A lot of the time I experienced a lot of frustration with doing the practice. |
| | P5,18,21 | I've quite often got sort of frustrated with the practice. |
| | P9,3,20 | It's just quite frustrating to do, to try and, you know, bring someone to mind and bring, and then see the whole world. |
| | P9,5,8 | And trying to think nice thoughts about people that maybe I dislike or had difficulties with, that was really, it's really hard, it's really hard to do. Um, and then trying to think nice thoughts about the whole world, how do you do that? It's just, it's just really hard. |
| Emotionally intense experience | P2,10,8 | It has been really intense sometimes, and I have cried… |
| | P2,27,7 | I got really upset a few times. Um, and I don't think that's necessarily a bad thing, um, at all. Um, I'd have probably felt some lower level of upset about those things anyway. (…) at the end of the session I was – because I I mainly practice on my, lying on my bed, um, and at the end of the session I just kind of curled over and sobbed a bit and just felt really kind of overwhelmed. |
| | P4,8,25 | I guess what I'm worried about is that deep down on some level I I might be quite anxious about the idea that I'm being kinder to myself and that maybe, um, that that will come out in my physical health or something that actually I, that I'm kidding myself in a way. |
| | P5,1,3 | I've found it very intense, and I'm just weighing up whether to say more intense than I would have thought, but I don't know if that's true. |
| | P5,9,12 | I mean I think it's a really intense experience, or it has been for me and maybe it's because I've approached the meditation with the idea of finding compassion through acknowledging struggle. |
| | P5,7,4 | I kind of thought how all these people are walking around with whatever their internal struggle is, was quite a, it was just a really sad thought, yeah, that was, and like having that kind of thought has made me feel quite sad now really. |
| | P7,1,7 | It did bring up some sort of upsetting and difficult emotions. |
| | P7,7,6 | It does bring up quite intense upsetting feelings as well sometimes when I kind of practice and bring my [parent] to mind. |
| | P7,10,17 | … bringing to mind all images of people who are suffering and people around the world who sort of don't have the kind of things that I have and who are struggling and…sort of bringing that to mind and trying to offer loving-kindness and sort of having feelings like I feel so powerless to do anything about all the suffering. |
| | P7,18,14 | …during the difficult stage I'd sometimes get a little bit tearful. |
| | P8,10,5 | One of the session I found quite emotional yeah, um that it brought up quite a lot of memories in the past, you know, so to date I'm still kind of struggling what, what it was about um things went quite deep it went deep in my past and um I was a bit shocked by that how, how I got to that state. |
| | 8,11,20 | It was really intense, um the actual sort of it brought up times, the relationship between me and [parent], how it was difficult um then I started sort of going on initially I started blaming [parent], I felt quite a lot of anger there towards [parent] and er as it progressed I felt quite drained afterwards, that afterwards I felt quite drained having had gone |

## Appendix S: Example quotes for sub-theme 'Emotional response to practice'

| | | |
|---|---|---|
| | | through what was going on there, and this was when we were sitting there my mind had drifted towards there. |
| | 8,22,5 | With LKM it's quite intense personal, so that's something I'm finding it's personal. |
| | 9,11,11 | When I was trying to think of my family (…) and I see them so little that, you know, I started to feel guilty that, you know, I don't call them enough or I don't see them enough, and those are just too difficult to think about. |
| | P9,7,3 | I came in touch with some feelings that were there, obviously, but it was just so strong that I was crying. |
| Grounding, relaxing, containing experience | P3,6,19 | I think it made me feel safe and relaxed and more peaceful I think after afterwards as well. |
| | P3,11,15 | I've always felt quite peaceful immediately after the practice, more so that like even while the practice would be quite a struggle, I generally feel better afterwards, um, and more physically relaxed. |
| | P6,1,18 | It's been quite a soothing experience. |
| | P6,16,23 | So it wasn't always quite, always grounding and soothing, but it became that way, so yeah. (…) But it was quite holding. So, yes, it was grounding. Yeah, and soothing...but not always. Not at the beginning. |
| | P10,23,21 | Um so it was more, it was self-soothing first and foremost and then and then it was something compassionate towards other people. |
| | P11.31.19 | I suppose it's like a sort of controlled space, you know, the practise to, it really doesn't matter, um, if you feel a bit tearful. |
| | P11,14,1 | Well it helped, you know it helps me sort of perhaps be more aware that I'm physically tense and and that it actually does help relax me. |
| Positive emotions, feelings of warmth | P4,2,26 | Where you're thinking about someone that you really care about, that bit is quite, I find that bit quite nice, quite a pleasant thing to be once I'd got through the first bit, and quite often find myself smiling or laughing because I'd, you know, be thinking about people that make me happy and the neutral person really, um, a real – that was maybe even like my favourite one, because there was just something nice when I think about somebody who doesn't know that you'd be thinking about them and that kind of, something quite nice about that. |
| | P5,5,20 | I've done, probably a smaller number where I've felt quite good after the meditation, um, like somewhere I've felt felt a real, um, like warmth in my heart, um, and felt a sort of real sort of contentment. |
| | P5,18,10 | The warm heart feeling at some points when I'm feeling like I'm in touch with a sense of compassion. |
| | P6,2,12 | I've often felt kind of quite refuelled, quite sort of energised by it, and it's, rather than drained, you know, so so that's been really good, which, so it's good. So it was mostly positive. |
| | P7,17,14 | I actually found that bringing a positive person to mind was usually quite a warm and nice experience. Yeah I did find that quite positive, and, yeah, it was quite nice actually to sort of feel that connection to someone that close to you, sometimes I'd bring one of my best friends to mind and I don't see her that much any more so actually that was quite nice sort of…having that connection with someone that I'm very close to who isn't in my life day to day. Yeah, so that was quite an easy and more enjoyable stage. |
| | P7,18,11 | Sometimes I'd get quite a warm sort of feeling around my heart chest area when I was connecting to the positive person…sometimes I'd fall asleep and get very very relaxed and maybe fall asleep. |

## Appendix S: Example quotes for sub-theme 'Emotional response to practice'

| | | |
|---|---|---|
| Trigger of past | 2,29,18 | I think that's been my tendency in fact is to justify and understand and be caring and thoughtful and kind to other people and to myself, and actually what that ultimately, you know, the amount of time I've had to do that in my life when actually I've done it because there hasn't been anyone else on the planet who's known what my circumstances are have cared, have sort of been there for me. Um...and so...it's such a tendency of mine at those times that – its still comforting (laugh) somehow. Compassion towards other people, compassion towards myself, it's comforting. Um, but as a necessity somehow, if that makes any sense? |
| | 2,30,14 | It's a associative, I guess, with times that I have been self soothing or just because that's all there is available (laugh) to kind of, er, try and mend I guess. Um, but that said, I think that's in that given moment separate from that doing the practice as a whole has been, um, welcoming, accepting, um, supportive. The whole process actually feels more, yeah, far less isolated, far less (pause). That's one of the things that I find difficult with the recording is when I, when I really start to notice it as a recording, you know, if if there's something about the volume or the speakers or something that leaves it just feeling like a recorded tape without the person behind it, then that feels very different from when I think of it as the person saying those things. It feels like a different process between the two. Um, and the former feels kind of, I feel more isolated and the latter I just feel is kind of warmth of/<br><br>*When someone is guiding you live, like in the group or, is that/*<br>Or, when I'm playing the CD?<br><br>*Yes.*<br>Um, there can just be a difference in something about the speakers or the sound/<br><br>*Yes.*<br>Or something that can just, um, make me more aware that this is just a recording on a CD, there are thousands of these recordings on thousand of CD's that I could, that I may or may not be listening to and nobody actually knows or cares, where as when I connect to the voice as a warm person saying these things and reflecting much more on how that feels in the group situation, that makes it quite a different experience.<br><br>*And in what way different that its/*<br>Um, that...um, that they're completely different in fact and and one just feels lonely and isolated and alone and unsupported and striving and self soothing and and trying and striving. And the other just feels on safe ground in a relaxed enjoyable environment where it's easy to see things straightforwardly, um, and with life and love and laughter and warmth and friendship and whatever else, and they just feel quite distinct. |
| | 4,32,14 | Um, and maybe thinking a little bit about my childhood, like trying to make some sense of why it might be particularly, um, hard to be kinder to myself. So like just, um, putting it in some context I guess. |
| | 4,29,8 | I *guess I was wondering whether you can say a bit more about this sort of this feeling about, and that feeling a bit risky or wrong or a bit* |

## Appendix S: Example quotes for sub-theme 'Emotional response to practice'

| | | |
|---|---|---|
| | | *dangerous and/*<br><br>I don't know, you can link it to critical parents sort of kind of what impact that might have had on you or, um, and then, and perhaps then therefore how you are with yourself. Um, I think I did link it to my childhood at one point (laugh), yeah, in my mind. Yeah, so kind of, er, in terms of sort of not, I think it was quite a kind of culture in our family not not to big things up, not to be arrogant, not to be big headed, not to, so so not to, so and I think in a way maybe I've translated that in some way in to not deserving, or, er, I don't know, because I definitely have this sense of, and then that's kind of made me interested in the idea then do I think I need to get that from other people and not from myself, so then do I need kind of kindness. |
| | 7,10,10 | *And, again, you know, its fine to not to talk about it but I want you to say as much or as little as you like…or do you think its made it challenging for you…kind of was it something about the particular instructions or about past experiences or the nature of the relationship*.<br><br>The nature of the relationship. Like when I brought my [parent] to mind or sort of other people I had difficulties with in the past. |
| | 8,10,5 | One of the session I found quite emotional yeah, um … that it brought up quite a lot of memories in the past, you know, so … to date I'm still kind of struggling what, what it was about um things went quite deep it went deep in my past and um I was a bit shocked by that how, how I got to that state/<br><br>Yeah, I mean I'll share it with you, what would happen basically as I started going into my past around the relationship with my [parent] … and what was going on there was he's he is passed away but my relationship with [parent] as well, I mean [parent] was quite authoritarian, quite um quite aggressive … so I had gone in that state … and um then I felt how did I actually get to that there and I hadn't been thinking about this at all.<br><br>It was really intense, um … the actual sort of it brought up times, the relationship between me and [parent], how it was difficult um … then I started sort of going on … initially I started blaming [parent], I felt quite a lot of anger there towards [parent] and er as it progressed I felt quite drained afterwards, that afterwards I felt quite drained having had gone through what was going on there, and this was when we were sitting there my mind had drifted towards there.<br><br>I mean part of the difficultly was to bring me back to get back to, I mean I used my breathing as my anchor to come back to where I was, I found it really difficult to actually come back.<br><br>It felt like a battle er to be dealing with that and finishing it off, cause there was a lot of emotions there, one was around um sadness, anger, frustration, and everything else was there and to actually come back to 'ok that's in the past'. |

**Appendix T: Publication guidelines of journal chosen for publication**

# British Journal of Clinical Psychology




Edited By: Gillian Hardy and Michael Barkham

Impact Factor: 1.697

ISI Journal Citation Reports © Ranking: 2010: 43/102 (Psychology Clinical)

Online ISSN: 2044-8260

## Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

• Papers reporting original empirical investigations

• Theoretical papers, provided that these are sufficiently related to the empirical data

• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

• Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

## Appendix T: Publication guidelines of journal chosen for publication

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjcp/. The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective,

Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Supporting Information

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Further information about the process of peer review and production can be found in this document: What happens to my paper?

## Appendix U: Summary of research for participants and the ethics committee

### 'Cultivating self-care and compassion in psychological therapists in training: The experience of practising loving-kindness meditation'

#### Research Context

A significant proportion of therapists in training (TIT) suffer from psychological distress, highlighting the need for self-care in TIT (e.g., Brooks, Holttum, & Lavender, 2002). Theory and research have suggested that the ability to be caring and compassionate towards oneself is related to the ability to be caring and compassionate towards others (Gilbert, 2005). Moreover, professional guidelines emphasise that therapists in training need to develop self-care skills to ensure responsible clinical practice (British Psychological Society, 2008; 2009). Thus, fostering self-care and compassion in TIT seems central both to prevent psychological distress and to maintain high quality of care for others.

Loving-kindness meditation (LKM) is a traditionally Buddhist approach that fosters compassion for self and others (Salzberg, 1995). Emerging studies evaluating LKM have found preliminary evidence for an increase in compassion and well-being (e.g., Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008; Weibel, 2007). However, clinical observations have shown that some individuals experience difficulties with engaging in LKM practice (e.g., Crane, Jandric, Barnhofer, & Williams, 2010).

#### Research aims

This study aimed to examine how TIT experience a course of LKM, including its benefits and possible challenges. In particular, the study aimed to explore whether TIT perceive LKM to impact on how they relate to themselves, others, and their clinical work.

#### Methods

Twelve TIT took part in a six-session long LKM course, which was offered following a mindfulness-based cognitive therapy course. Semi-structured interviews were carried out post-intervention and data were analysed using Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009).

#### Results

Five master themes emerged in the analysis. They are summarised below.

**Engaging with the practice**

Some participants struggled to emotionally connect with the LKM practice, describing the practice as too abstract or structured. For most participants, their previous experience in mindfulness meditation facilitated the encounter with LKM. However, the majority of participants also experienced the LKM practice as emotionally intense and personally challenging, which left some participants feeling unsafe and vulnerable at times. Participants used a number of strategies to manage these challenges; mindfulness skills, deciding when to practice, and sharing experiences with others were seen as particularly helpful.

## Appendix U: Summary of research for participants and the ethics committee

### Impact on the self

Participants reported becoming more aware of their thoughts and feelings, including self-critical thoughts. Furthermore, participants described getting in touch with feelings of vulnerability and a need to be caring and kind towards themselves. All participants expressed becoming more accepting and compassionate towards themselves, allowing them to be less self-critical and more self-caring. About half of the participants further described feeling more confident and secure in themselves.

### Impact on relationships

Participants reported that they felt practising LKM had increased their awareness of how they relate to others and had led to them becoming more accepting and compassionate towards others. Furthermore, participants expressed feeling more socially connected and safe in relationships, which enabled them to overcome interpersonal difficulties more easily. These interpersonal changes were seen to be relevant to participants' private as well as professional lives.

### Bringing compassion into the therapy room

Participants described how their increased awareness of compassion impacted on their clinical work. Some reported actively using compassion-focused interventions with clients whilst others perceived more changes within themselves as therapists. For example, some participants described feeling more 'human' and 'authentic' with clients, more attuned to their clients' suffering, and more able to tolerate uncertainty in therapy.

### Integrating LKM into life

For most participants, the LKM course seemed to be part of a journey to a more compassionate attitude or way of life. Participants described an 'ethos' or 'mindset' of loving-kindness that had become a valuable resource in their lives. For some, LKM had become a concrete strategy to use in coping with difficult situations.

### Implications for training, clinical practice and future research

Given the need for fostering self-care and compassion in TIT, the findings of this study suggest that clinical training programmes may consider offering LKM as an option for furthering personal and professional development of trainees. Since LKM was also experienced as emotionally intense, it will be important to inform future participants about the potential challenges of the practice and to consider carefully how to offer LKM. Previous experience in mindfulness seemed to be helpful in managing difficult arising feelings. Therefore, LKM could be offered after or within a mindfulness-based intervention. In addition, small group sizes (i.e., 10-12 members) are recommended to ensure space to discuss arising experiences. Particular caution seems warranted when introducing LKM to clinical populations.

Further research is needed to establish the benefits of LKM on self-care and compassion and to examine the challenges involved in LKM. Methodologically sound quantitative studies, such as randomised control studies, would be instrumental in providing robust evidence that could inform the use of LKM with clinical samples.

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