COMPASSIONATE CARE IN IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES SERVICES: A GROUNDED THEORY APPROACH

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A special thanks to my family and friends for helping to keep things in perspective. Particularly, thanks to Katie for her friendship and assistance with this research.

Most importantly, my gratitude and love to Matthew, my husband, for his endless love, patience and encouragement.

Dedication: To God in whom I find my strength.

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Compassion has inspired interest across the centuries, attracting definitions from different disciplines and, more recently, leading to the development of theoretical models of understanding and therapeutic modalities. Aspects of the NHS constitution include compassion as one of the six Cs outlined as core values: care, compassion, competence, communication, courage and commitment (Department of Health, 2015). Similarly, the Improving Access to Psychological Therapies (IAPT) manual (2018) incorporates compassionate care. IAPT is one of the main providers of primary mental health care in the NHS UK, and although compassion has been prioritised by the IAPT agenda it has not been investigated within these services.

The current study addresses the question "What is the process of compassionate care in IAPT services?" It also aims to generate knowledge about the facilitators and inhibitors of compassionate care in IAPT. Semi-structured interviews were conducted with 12 qualified clinicians. This study adopted a critical realist position, which informed the Grounded Theory methodology.

A new conceptual model was generated: *Enacting Compassionate Care in IAPT Services*. The five corresponding categories are *Possessing Core Attributes and Skills of Compassion, Building an Interpersonal Connection, Meaningful Response to Suffering, Conditions Nurturing Compassionate Care* and *Conditions Hindering Compassionate Care*. The main findings propose that enacting compassionate care is a dynamic process encompassing aspects that are individual, relational and behavioural. It involves clinicians employing core attributes and skills, to build a connection with patients and to respond to their suffering in a meaningful way. The findings have also highlighted the importance of reviewing service procedures, as well as the structural and emotional resources made available to nurture compassionate care. The limitations of this study and recommendations for future research are discussed.

1 INTRODUCTION

This thesis presents a Grounded Theory analysis of qualitative data based on the views of qualified clinicians about the conceptualisation of compassionate care in Improving Access to Psychological Therapies (IAPT) services in the United Kingdom (UK).

1.1 Key Terminologies

People accessing physical and mental health care in the UK, and other countries such as Australia and the United States of America, are often referred to as “patients”, “clients”, “service users” or “survivors”. Researchers have shown that there is no unified agreement, from the perspective of people who are accessing services, on the most appropriate term (Costa, Mercieca-Bebber, Tesson, Seidler & Lopez, 2019; Simmons, Hawley, Gale & Sivakumaran, 2010). Therefore, the researcher has not favoured a particular term and uses a variety of terms interchangeably in accordance with how people accessing services were referred to by clinicians or researches discussed in this thesis.

A variety of terms are used throughout the thesis to refer to the people who are providing health care. However, in order to avoid confusion, all those working in IAPT on a therapeutic capacity are referred to in this research as “clinicians” though they may have different training and working titles. Further information about the role of clinicians in IAPT is provided later in this chapter. Other terms and abbreviations are explained throughout the thesis.

1.2 Chapter Overview

This chapter outlines the main theoretical understandings, frameworks and therapeutic models of compassion. The chapter also presents the relevant NHS policies, the context of IAPT and its relationship with compassionate care at present. Further, the chapter presents a narrative review of the literature, which informs this study’s research question and aims.

1.3 Definitions of Compassion: Religion, Science and Humanities

The term “compassion” is rooted in centuries of interest and an integration of knowledge that crosses different disciplines and schools of thought. The initial ideas of compassion are primarily rooted in Eastern cultures, with the notion of compassion spanning religious, philosophical and scientific writings (Strauss, Lever Taylor, Gu, Kuyken, Baer et al., 2016).

Etymologically, Von Dietze and Orb (2000, p.168) noted “the English version of compassion has been around since the 14th century, a word derived from the Latin *com* (together with) and *pati* (to suffer), literally to suffer with”. Compassion has been similarly described by the Oxford Dictionary (2018) as sympathetic pity and concern for the sufferings or misfortunes of others.

Across religions, compassion appears to connote a deep connection and empathy for one’s own or another’s suffering, inspiring the motivation to act and alleviate that suffering (Von Dietze & Orb, 2000; Welford, 2012; Wiklund Gustin & Wagner, 2013). In Buddhism, the Dalai Lama (1995) defines compassion as openness to the suffering of others, guided by reason and wisdom, embedded in an ethical framework concerned with the selfless intention of freeing others from suffering.

Abrahamic faiths also incorporate the term compassion within their writings. In early Christian texts, the concept of compassion is contained in the Aramaic word *racham*, meaning, “to love, pity, and be merciful” (Burnell, 2010, p. 1). Christians are urged to be compassionate towards one another: “Finally, all of you, having compassion for one another; love as brothers, be tender hearted, be courteous” (1 Peter 3:8, New King James Version). For some Christian researchers, the drive to offer compassion has been defined as a calling from God which all must exert (O’Brien, 2001; Uustal, 2003). Similarly, Islam sees the sentiment of compassion as the ability to feel with the other, as expressions of the interconnected oneness of all human beings, reflecting the oneness and unity of God (Al Quran 2:178).

The evolutionary perspective suggests that compassion underpins the motivation for caring behaviour (Carter, 1998; Gilbert, 1989), and affiliative behaviour (Depue & Morrone-Strupinsky, 2005). In Goetz, Keltner and Simon-Thomas' (2010) systematic review of the evolutionary origins and functions of compassion, the term was clustered with "sympathy", "empathy" and "kindness". Neuroscientific studies have found a positive relationship between kindness, compassion, the healing process and recovery from mental health problems (Fehr, Sprecher & Underwood 2008; Hamilton, 2010). A neurological study described compassion as unique and multifaceted, with processes influencing affective and physiological experiences, and behavioural patterns motivating engagement and action with the intent to help others (Klimecki, Leiberg, Ricard & Singer, 2014). These findings suggest that compassion is a key component to the social behaviours that have continued throughout the evolution of the human race.

Different therapeutic models share the view that compassion is a crucial aspect of clinical interaction. The necessity of unconditional positive regard is emphasised in the humanistic perspective (Rogers, 1961), the development of a capacity for concern is central to Kleinian object relations theory (Froggett, 2002) and the necessity of affiliative relationships is central to the attachment theory of John Bowlby (Dunbar, 2010; Pilgrim, Lloyd-Jones & Rees, 2009). Sociological developments characterise compassion, for both individuals and collectives, as an obligation to read a scene of distress in order to help and support another (Berlant, 2004).

The aforementioned views of compassion suggest that a range of intrapersonal and inter-relational characteristics are necessary for it to occur. And yet, while the notion of compassion is evident across disciplines, religions and therapeutic perspectives, a definition within mental health care has not been established.

1.4 Theoretical Frameworks of Compassion

The definition of compassion from different disciplines influences various sectors of society, which include moral and ethical developments in the justice system, the provision of education and healthcare (Douglas, 2010). The theoretical frameworks of compassion in healthcare will be described below. These have been influential in guiding understanding of people's difficulties and have resulted in the development, and subsequent application, of therapeutic care.

1.4.1 Multi Dimensions of Compassion

Studies will be presented to show that there are multiple dimensions to compassion, and a variety of concepts and attributes seem to be crucial components.

1.4.1.1 Compassion for self and others: Neff (2003) stated that compassion could be experienced in multiple directions, including towards the self and others. MacBeth and Gumley's (2012) meta-analysis showed an association between self-compassion and different mental health presentations; a link that has since been widely accepted in the academic community (Wiklund Gustin & Wagner, 2013). However, there is a lack of consensus about the conceptualisation of compassion for others (Neff & Pommier, 2013).

Providing a detailed account of these different dimensions is beyond the scope of this thesis, but it is important to acknowledge that different dimensions are often linked to compassionate care in the healthcare system (McPherson, Hiskey & Alderson, 2016; Pettit, McVicar, Knight-Davidson & Shaw-Flach, 2019; Simmonds, 2015; West & Chowla, 2017); therefore being relevant to clinicians and patients within the context of IAPT which might encompass compassion both to self and to others.

1.4.1.2 Mindfulness and empathy: Compassion is also associated with mindfulness and empathy, although these terms have often been mistakenly used interchangeably within the literature of Western cultures (Mills & Chapman, 2016). Empathy has been defined as a component of compassion which allows connections to another person's distress but does not involve the motivation to reduce that distress (Neff & Pommier, 2013). In mindfulness practice, compassion is suggested as both a personal quality and an outcome received and experienced by others (Germer, 2009). Mindfulness is regarded as a passive method oriented towards relating to an inner experience, and involving acceptance of the present moment. By contrast, compassion is specific to an experience of suffering or distress, directed towards self or others and involving the motivation to reduce suffering (Kabat-Zinn, 2003; Neff, 2003a; Neff & Dahm, 2014).

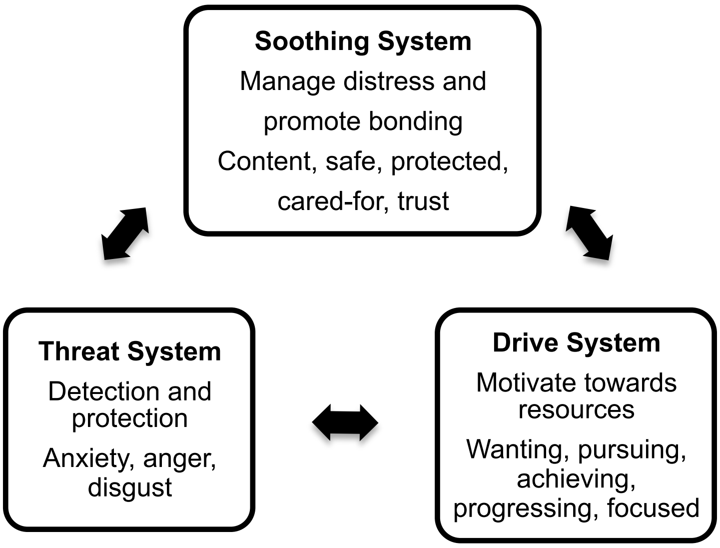
1.4.1.3 Five-element concept: Strauss et al.'s 2016 literature review led to a five-element concept of compassion to self and others. These elements are: recognizing suffering, understanding the universality of human suffering, feeling for the person suffering, tolerating uncomfortable feelings, and being motivated to act to alleviate suffering. Gu, Cavanagh, Baer and Strauss (2017) found support for the elements of compassion to others but not for the self-compassion, as reported by Strauss et al.'s (2016). They concluded that instead of five elements, only four elements were necessary for self-compassion because tolerating uncomfortable feelings was not required, and that further investigation on this element was required in other settings.

1.4.1.4 Six attributes of compassion: Paul Gilbert (2009) described compassion as the courage to descend into the reality of human experience with a deep awareness of the suffering of another coupled with the wish to relieve it. His work highlights human beings as a profoundly social species who depend on the safety, care, support, affection and encouragement of others to survive and thrive. Gilbert (2010) claimed compassion consists of two aspects: the ability to be motivated to engage with difficulties and the ability to focus on what is helpful. Following from this, Cole-King and Gilbert (2011) suggested that compassion is a complex combination of six attributes: care for wellbeing, sensitivity, sympathy, distress tolerance, empathy and non-judgement, and acceptance of oneself and others. These attributes are distinct but interconnected within a context of emotional warmth.

1.4.2 The Compassionate Mind Approach

Gilbert (2005) developed the multimodal Compassionate Mind Approach to understand factors that influence compassion. The Compassionate Mind Approach encompasses three systems, which are outlined in Fig 1 below based on Gilbert's (2005) affect regulation systems model. These systems respond to one another, and a blockage or interruption in one area, such as goals in the drive system, can trigger the activation of another, such as the threat system. This could result in difficulties with cognitive, emotional and psychological processes. The “soothing system” is associated with emotions of wellbeing and safety, a drive for attachment and affiliation. It allows individuals to be present, socially connected and compassionate towards themselves and others (Neff, 2003a). This approach has provided the foundation for several therapeutic models encompassing compassionate care. These will be outlined in the following sections of this chapter.

Figure 1. Emotion Regulation Systems adapted from Gilbert (2005).



1.4.2.1 Compassionate Mind Approach and therapeutic models: Gilbert (2014) suggests that a history of childhood adversities overdevelop the threat system; this can lead to chronic shame and self-criticism, which are found in different psychological presentations. Brain connections in early development are strengthened by repeated experiences, supporting Gilbert’s suggestion that repeated trauma can establish particular patterns of response to be more ingrained (Gerhardt, 2014).

Gilbert (2014) considered compassion as central to mental health “recovery” by helping to develop a sense of purpose, meaning and hope. He suggested that the required compassionate attributes can be developed through

Compassionate Mind Training that involve behaviour, reasoning, sensation, feeling, attention and imagery. With Compassionate Mind Training, the soothing system can be strengthened to help bring the systems into balance, reduce distress and increase compassion. Compassionate Mind Training assumes individuals have the ability and power to change; whereas a critical perspective would argue that the ability to change is constrained and enabled by social context and power (Fox, Prilleltensky & Austin, 2009; Smail, 2005).

While Compassionate Mind Approach considers the influence of the external environment on the person, the approach remains individually focused. Therefore, its cross-cultural relevance is unclear; collectivist cultures may emphasise interconnectedness to others, which is associated with the soothing system, while individualistic cultures tend to value achievement and competition, which are associated with the drive system (Welford, 2012).

Gilbert (2010) also established Compassionate Focused Therapy, which endeavours to help individuals engage with difficult inner experiences by working with experiences of inner warmth and safeness to aid the development of self-soothing skills and a more compassionate self-identity. Beaumont and Hollins (2016) suggest that Compassionate Focused Therapy describes Compassionate Mind Approach processes and theory.

Research evidence for Compassionate Focused Therapy suggests its effectiveness in treating eating disorders (Goss & Allan, 2014; Kelley, Vimalakanthan & Carter, 2014), strengthening resilience (Klimecki et al., 2014) and increasing self-reflection while reducing rumination, stress (Leaviss & Uttley, 2015; Samaie & Farahani, 2011) and self-criticism (Gilbert, Clarke, Hermel, Miles & Irons, 2004). A randomised controlled trial has shown significantly greater improvements in levels of compassion, reductions in depression and perceived social marginalisation in people with a diagnosis of schizophrenia when receiving Compassionate Focused Therapy plus treatment as usual rather than treatment as usual alone (Braehler et al., 2012).

In summary, there have been centuries of interest, many definitions of compassion from different disciplines and different schools of thought, as well as the development of theoretical models of understanding. Based on the theoretical definitions of compassion, the broad consensus presents compassion as a mental state and orientation for action (Crawford, Brown, Kvangarsnes & Gilbert, 2014). In clinical practice, given the positive connotations linking treatment approaches focused on compassion, such as Compassionate Focused Therapy, to positive outcomes for people in distress, the term is still very much of interest today. Therefore, it also features in the context of healthcare policies in the UK and in IAPT services as outlined below.

1.5 Compassionate Care and Policy Context in the UK

The UK policy context emphasises the importance of compassionate care and the responsibility of services and clinicians to be providing compassionate care in their settings. According to the National Advisory Group on the Safety of Patients in England (2013), compassionate care is what patients want and need. Gilbert and Leahy (2007) have argued that being compassionate towards others should be a requirement for NHS clinicians providing psychological interventions.

In the UK, policies have emphasised that high-quality care should be as safe and effective as possible, and patients should be treated with compassion, dignity and respect (Darzi, 2008). The Department of Health (DOH) (2012) defined compassion as “how care is given through relationships based on empathy, respect and dignity, and is central to how people perceive their care.” Care without compassion has been deemed unethical, dangerous and complacent at best and criminal at worst, often leading to mistakes and poor outcomes (Care Quality Commission, 2010).

Francis (2013) stated that abusive incidents in Stafford hospitals were a story of appalling and unnecessary suffering wherein patients had received suboptimal care, and that potentially 1,200 patients had died due to a lack of compassion, among other failures. These findings have prompted policymakers to question the preparedness of clinicians for the challenging environment in which they practise (Sinclair, Norris, McConnell, Chochnov, Hack et al., 2016). The Francis Report made recommendations to improve compassionate care in the NHS and to implement system-wide standards, guidelines, protocols and staff training schemes, such as values-based recruitment and a “Compassion in Practice” e-learning programme (Francis, 2013; DOH, 2012; Mills, Wand & Fraser, 2015).

Furthermore, to build a culture of compassionate care across all healthcare settings, the NHS constitution includes compassion as one of the six Cs outlined as core values: care, compassion, competence, communication, courage and commitment (DOH, 2015). The Compassion in Practice strategy outlined a key element of its vision and strategy to make the values of the six Cs real and visible to patients and the public. However, Flynn and Mercer (2013) have argued that these concepts are difficult to define and operationalise, which reduces services’ capacity to implement them fully into training and support for healthcare workers and providers.

1.6 Improving Access to Psychological Therapies Services

The IAPT programme was launched in 2008 and aimed to increase the availability of psychological treatments in primary care services within the NHS as recommended by the National Institute for Health and Care Excellence (NICE). IAPT services originally offered talking therapies to adults presenting with common mental health difficulties, including depression and anxiety disorders. According to the Mental Health Statistics for England briefing report in 2017, over 1.4 million people were referred to services annually. IAPT continues to receive government investment, and the range of ages and conditions treated within the IAPT program has expanded (Clark, 2018).

Treatment in IAPT can be delivered individually or in groups, in person, over the telephone or via computer programmes, and uses a stepped care approach which is shown below in Table 1. Step 2 interventions are provided by Psychological Wellbeing Practitioners (PWPs) and are based on the guiding principles of CBT, often following detailed protocols referred to as guided self-help. Step 3 interventions are delivered by clinicians with accredited Cognitive Behavioural Therapy (CBT) qualifications. NICE has established a protocol that outlines which interventions should be provided for certain mental health presentations. However, following this guidance is at the discretion of services, and some may not follow this exact model.

Table 1. IAPT's Stepped Care Model

IAPT's Stepped Care Model		
Step 3 High Intensity IAPT Service	Depression, mild, moderate and severe	CBT Interpersonal Therapy (IPT) Behavioural Activation (BA)
	Depression mild to moderate	Counselling, couples therapy
	Panic Disorder	CBT
	Generalised Anxiety Disorder (GAD)	CBT
	Social Phobia	CBT
	Post Traumatic Stress Disorder (PTSD)	CBT, Eye Movement Desensitisation and Reprocessing (EMDR)
	Obsessive Compulsive Disorder (OCD)	CBT
Step 2 Low Intensity IAPT Service	Depression mild to moderate	Computerised CBT (cCBT), Guided self-help, BA, Exercise
	Panic Disorder mild to moderate	cCBT, Guided self-help, pure self-help
	GAD mild to moderate	cCBT, Guided self-help, pure self-help, psychoeducation groups
	OCD mild to moderate	Guided self-help
Step 1 Primary Care and IAPT Service	Recognition of problem	Assessment Watchful waiting

1.6.1 Potential Influences on Compassionate Care in IAPT

The compassion of clinicians working in IAPT has been shown to significantly reduce when negative appraisals of clients occur and the clinician's threat system is activated (Teater & Ludgate, 2014).

Mills and Chapman (2016) suggest that compassion for oneself or others is influenced by an appraisal of whether compassion is deserved, which could influence IAPT clinicians' compassionate care to both themselves and their clients, who may trigger their drive, threat or soothing systems. Such a suggestion is substantiated by research in neuroscience showing that during the activation of the threat system, the ability to respond compassionately to another person is significantly limited (Russell, 2014).

Although the government claims to be focused on delivering evidence-based practice through IAPT, it is argued that the increasing evidence from psychological and neuroscientific research about the importance of providing therapeutic approaches that offer key strategies to promote compassion has not been taken into consideration (Baer & Huss, 2008; Gilbert, 2005; Hayes, Strosahl & Wilson, 1999). Thus, limiting compassionate care provided in these settings.

1.6.2 Compassionate Care and IAPT Services

IAPT has core accreditation standards that need to be met by clinicians, which include "treating people with compassion" (Farquharson, Cohen-Tovée, Palmer, Hodge & Hildreth, 2017, p. 11). Interestingly, the IAPT manual (2018, p. 64) instructs IAPT services to provide a "balance of effective and efficient service with compassion". Additionally, the Care Quality Commission (2010, p. 66) includes domains of "recovery focused compassionate care", and "a culture of shared and compassionate leadership providing high levels of support to staff". However, it is not yet established how compassion is understood within IAPT services and how treating people with compassion is practically translatable, assessed and praised within services.

Hamilton, Hicks, Sayers, Faulkner and Larsen et al., (2011) evaluated patients journey from referral to after treatment follow-up within three IAPT services in

London. Information from four focus groups and a paid expert advisory panel helped to develop a survey that was completed by 116 participants. Researches followed up with 20 semi-structured telephone interviews. Participants reported key principles for patient care satisfaction including, a relaxed atmosphere helping to minimise the stigma of accessing support, having contact during waiting times, feeling safe talking to a clinician and receiving patient-centred support to address their needs. Also, as IAPT offers a limited number of sessions, participants reported wanting clear communication and preparation about the end of therapy to avoid distress. Participants also wanted to connect with others accessing the service and the opportunity to get involved in service development.

Hamilton et al.'s study gathered data from London only, and thus findings cannot be generalised to different locations. Also, participants wanting to partake could have been influenced by gratitude to the clinician, thus inflating positive outcome. Further, opinions of people using online or telephone therapy is likely to raise other themes, but this was not investigated. Notably, of all the elements that were identified as key principles of care, compassion was not one of them. This reiterates the need for investigation of compassionate care in IAPT services, both from the perspective of clinicians and patients.

In Spandler and Stickley's (2011) review paper on compassionate care in current mental health policy and practice, they noticed key elements of compassion includes the recognition it operates through social relationships shaped within specific social and cultural systems. They argued that services such as IAPT adopt a language of ‘recovery’ imposing preconceived definitions and expectations of what recovery ‘should’ be, making it unclear what is necessary to encourage compassionate and hope-inspiring practices. It would appear from their paper, that current mental health policy and practice does not prioritise the development of such context. They suggest that compassionate care requires consideration beyond its expression from an individual clinician, through relationships, cultures and conducive environments.

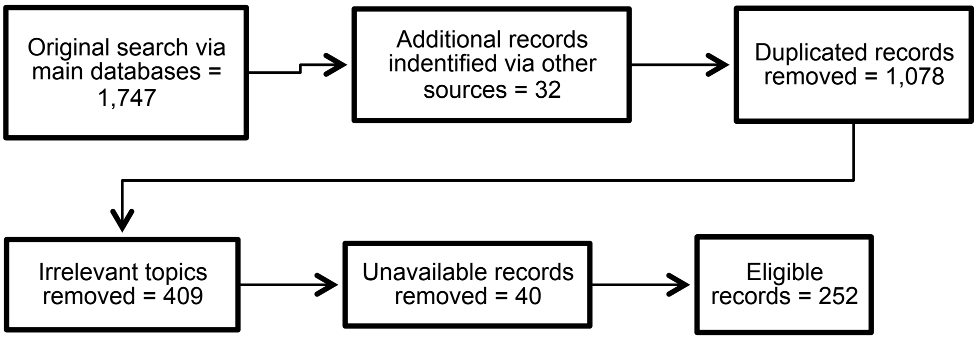
To summarise, despite prioritisation of compassionate care by the IAPT agenda in its documents, policies and accreditation standards, there is no clear evidence in practice of the understanding and processes of compassionate care within these services. Therefore, a richer understanding of the definition and the process of compassionate care in healthcare, particularly in IAPT as one of the major providers of primary mental health care in the NHS UK, seem necessary. A literature review (see below) helped to clarify the existing and requiring knowledge in this field.

1.7 Literature Search Strategy

A literature search was conducted on the following databases: Scopus, PubMed, EBSCO, PsycINFO, PsyArticles, CINAHL, Academic Search Complete databases and Google Scholar. The search was conducted from 2009 (the year after IAPT services were established) to the present. Only studies written in the English language were included. The initial specific search for compassionate care and IAPT did not produce any results, so terms related to compassionate care and healthcare were used with Boolean operators AND/OR (Appendix A).

The literature search originated 1,747 records consisting of documents focused on compassionate care in various healthcare services, with adult populations only. Relevant papers were initially identified through reading the title and the abstract. Citation searches were conducted on particularly relevant papers to enable the identification of other relevant literature. An extract of how papers were classified can be found in Appendix B. The results of the literature search are presented below in Flowchart 1. A total of 252 studies were reviewed, and relevant literature will be presented throughout the thesis.

Flowchart 1. Literature Search Exclusion Process



1.8 Conceptualisations of Compassionate Care in Healthcare Settings

Conceptualisations of compassionate care are presented from the perspectives of professionals, patients and their families across different healthcare settings.

1.8.1 Professionals Conceptualisation of Compassionate Care

Two studies explored compassion from the views of the same group of 20 mental health practitioners (i.e. Consultant Psychiatrists, Ward Managers, Ward Sisters, Nurses, Nursing Students and Healthcare Assistants) in two acute inpatient facilities in the Midlands, UK. In the first study, Brown, Crawford, Gilbert, Gilbert and Gale (2013) used constructionist discourse analysis and showed that compassion was conceptualised as an attitude of mind that was simultaneously practical. The authors concluded that compassionate care unfolds and becomes attuned over the trajectory of healthcare provision. Participants in their study drew from two repertoires. The practical repertoire evoked behavioural aspects, such as playing games with patients; deemed helpful for patients to disclose their concerns so that workers could attempt to help. The second repertoire related to practical organisational constraints to compassionate care, such as increased workload.

In the second study, Crawford, Gilbert, Gilbert, Gale and Harvey (2013) conducted a corpus-assisted discourse analysis of the interviews. They reported interviewees frequently used words contained within a 28-word item, researcher-developed lexicon of compassion attributes. However, it showed that much of the language used by participants was devoid of the affective elements. As reported in the first study, participants language often referred to the organisational barriers to providing compassionate care, including time, targets and processes that resembled a “production line”. The void of affective language found in this study differs from other studies emphasising that compassionate care was described as affective elements and part of the interactions between patient, clinician and their family (Lloyd & Carson, 2011, Stoter, 1995; von Dietze & Orb, 2000). This is not to be assumed that participants were not compassionate; rather, it may be understood that focus on organisational barriers might have limited their abilities to express compassionate care through affective language.

In Papadopoulos, Taylor, Ali, Aagard, Akman et al.'s (2015) study 1,323 nurses from 15 countries completed the International Online Compassion Questionnaire. They reported a shared understanding of compassion involving actions such as being there and getting to know the patient. Participants from Cyprus, UK and the Philippines defined compassion as "empathy and kindness", whereas nurses from Israel, Colombia and Spain defined compassion as "deep awareness of the suffering of others and a wish to alleviate it". The difference in the conceptualisation among countries suggests there are cultural differences in the definition of compassion, which is supported by their conclusion that such characteristics were assumed to influence compassionate care. Similarly, the importance of compassionately recognising a patients' diversity in various healthcare settings to promote better health outcome has been supported in other studies (Bleiker, Knapp, Morgan-Trimmer & Hopkins, 2018; Singh, King-Shier & Sinclair, 2018).

Bickford, Daley, Sleater, Hebditch and Banerjee's (2019) analysis of nine interviews and two focus groups of 23 medical and nursing students identified three themes within compassion: connection, care and respect for patient's humanity and dignity. Compassionate care was described as the ability to connect with the patient and understand their situation, showing kindness, being motivated to help and responding to suffering. It also involved listening, demonstrating a non-judgemental approach and seeing the person as an individual beyond the illness. Similar findings have been established in other healthcare settings and from the perspectives of workers and patients. These are discussed below.

In a Norwegian study, Kvangarsnes, Torheim, Hole and Crawford (2013) identified relational connection, respect and the ability to see patients as unique individuals as being key components of compassionate care in respiratory care settings. Support for the latter two components has been shown in other healthcare settings (Adamson, Pow, Houston & Redpath, 2017; Sanghavi, 2006; Schantz, 2007). These findings suggest there are similar views of the definition of compassion across disciplines of healthcare professionals, settings and countries. Providing individualised care, respect for others, and treating others with warmth and empathy were also important components of compassionate care in both pre-qualification and registered health and social care professionals in the UK (Bray, O'Brien, Kirton, Zubairu & Christiansen, 2014). However, it was not clear in the study by Bray et al.'s whether qualified professionals and students differ in their views.

1.8.2 Patients Conceptualisation of Compassionate Care

The perception of care by patients is seen as one of the most important factors for restoring confidence in NHS care (DOH, 2012).

Lloyd and Carson (2011) conducted group interviews with 30 mental health patients in the UK. Compassionate care was conceptualised as a collaborative relationship aiming to support recovery through presence and persistence, with patients being valued as a person, respected for their individuality and values, and being treated with dignity. It was also a crucial factor in establishing trust with professionals. Compassionate care involved listening to patients and putting their views into practice. However, the nature of the group interview might obscure voices less comfortable to share individual aspects of compassionate care in front of the group. Therefore, individual views of compassion may have been missed.

Bramley and Matiti (2014) interviewed 10 UK-based patients in a hospital and found that a caring nursing attitude and communication influenced their experience of compassionate care. Smaller gestures of compassion, such as a nod or a smile, were adequate to start an important nurse-patient relationship. Interestingly, studies with clinicians have described compassionate care similarly, including being motivated by a caring attitude, communication, honesty and fairness (Armstrong, Parsons & Barker, 2000; Skaff, Toumey, Rapp & Fahringer, 2003).

Recently, Wittkowski, Hare and Gilham (2019) investigated the experience of compassionate care for 15 patients on an acute perinatal psychiatric ward, using the Repertory Grid Technique. Participants perceived that compassionate care was based on how staff managed stressful situations, adhered to professional boundaries and showed flexibility in their care. However, the Repertory Grid Technique has been criticised for its short verbal labels, which may have neglected the richness of figurative language used by interviewees (Yorke, 1983), making it difficult to generalise these findings. The authors suggested that the perception of receiving compassionate care implicated women in feeling better about their mental health problems, although this has not been investigated.

To investigate patients' views of compassionate care different approaches have been used, including groups, individual interviews and a repertory grid. Conceptualisation of compassionate care from the patients' perspective appears to include workers' inherent qualities, as well as their intent to help. It also appears to involve active communication and collaboration through a respectful relationship. However, there may be unique aspects of compassionate care within different mental health settings, such as IAPT.

1.8.3 Workers, Patients and Families Conceptualisation of Compassionate Care

In the West Midlands, Kneafsey, Brown, Sein, Chamley and Parsons (2016) carried out a focus group with 45 academic staff, students, clinicians and patients. Participants defined compassion as a combination of emotion, values and motivation to act to help others. Behaviours linked to compassion included the motivation to understand others' needs, actions to alleviate suffering, empathic communication and kindness. This combination of components of compassion is evident in other studies of nurse and patient views of compassionate care in clinical settings (van der Cingel, 2014). Moreover, wider organisational challenges were considered by participants as systemic processes within the workplace which may inhibit their ability to provide compassionate care in healthcare settings.

Potential barriers to compassionate care discussed in the study by Kneafsey et al.'s were also discussed in a UK study exploring conversations in Schwartz Rounds in a range of health settings, discussing the social and emotional challenges of caring for patients (Goodrich, 2016). Respect for a patient's individuality was described as essential to compassionate care. While participants in the rounds felt that small acts of compassion do not take up time, it was the feeling of "pressure" which prevented them from the ability to feel that they want to give compassionate care. Additionally, findings from Goodrich

(2016) also supported the importance of communicating medical information clearly to patients as a way of ensuring compassionate care, as well as non-verbal communication such as eye contact. Many acknowledged that top-down pressure reduced their motivation to provide small acts of compassion. The study was carried out in different settings and the sample comprised of only 10 patients compared to 35 professionals, therefore, there is potential that individual perceptions may have been subsumed or overwhelmed by the perceptions of the professionals. Also, some participants might find it difficult to discuss personal and sensitive issues in a group, which in turn can influence the output data (Silverman, 2013).

A Canadian study (Smith-Macdonald et al., 2019) explored compassion from the views of 117 participants, including residents in long-term palliative care, their family and clinicians. Thematic analysis of the data from focus group resulted in five interrelated themes which support the idea that compassionate care is multidimensional and dependent on a composite of virtues, intentions, relational skills and intentionally deliberate actions on the part of the clinicians.

1.8.4 Measuring Compassionate Care

Early attempts to measure compassionate care have used quantitative scales to measure characteristics such as warmth, pleasantness and sensitivity and whether it plays a role in decreasing rates of patient anxiety (Fogarty, Curbow, Wingard, McDonnell & Somerfield, 1999). Limitations of specificity of the term compassion have led some authors to suggest that descriptive accounts of compassionate and uncompassionate practice are preferable to quantitative measures (Burnell & Argan, 2013, Dewar, 2012, Watson, 2008).

Sinclair, Russell, Hack, Kondejewski and Sawatzky (2017) reviewed nine studies that measured compassion using quantitative measures including the Compassion Care Competence Scale, Compassion Scale, Compassionate Care Assessment Tool ©, SCCCS™, and the Compassion Practices Scale. Limitations of these instruments were evident: a lack of generalisability to specialist healthcare services, reduced reliability and validity, reductionism of the experience and scoring burden. These limitations have been raised in other studies, and it has been argued that without an agreed operationalised definition of compassion, quantitative measures will always have constraints (Grimani, 2017; Watson, 2008; Papadopoulos & Ali, 2015). In support of this view, it has also been concluded that quantitatively measuring compassionate care may lead to a type of market-driven approach to healthcare, which offers artificial care rather than a genuine concern for patients (Bradshaw, 2009, Paterson, 2011; Spandler & Stickley, 2011). Nonetheless, efforts to evaluate compassionate care points to the unmet necessity of first understanding compassionate care and its processes in clinical practice in different settings, in order to then assess it.

In the literature presented thus far, both similarities and differences could be observed in how compassionate care is conceptualised. It became apparent that most studies have conceptualised compassionate care as a combination of professionals' innate or embodied qualities, a relational space whereby communication and a respectful connection and relationship are developed, and actions aiming to provide care that is tailored to the individual. Differences and limitations mostly related to findings that require further investigation – for instance, whether cultural background, status of professional qualification (e.g. qualified or pre-qualification), the type of setting in which patients are being treated and or their particular problem, influences how compassionate care is conceptualised. Also, it was not always clear from the literature whether conceptualisations of compassionate care gathered within group settings represented the views of all the different professionals, clients or family members taking part in the study.

1.9 Facilitators and Inhibitors of Compassionate Care

Facilitators and inhibitors of compassionate care have also been investigated within different care settings from the perspective of clinicians, patients and their families.

1.9.1 Facilitators

The literature presents a range of potential facilitators of compassionate care, including gathering feedback from patients about their care (Lown, 2014), clinicians' self-care (Barnett & Cooper, 2009; Boorman, 2009; Health and Care

Professions Council, 2016), regular supervision (Haslam, 2015), compassion for both self and others (Beaumont & Hollins Martin, 2016; Fernando & Consedine, 2014; Russell, 2014; Vivino, Thompson, Hill & Ladany, 2009), clinicians' personal faith (Tierney, Seers, Tutton & Reeve, 2017), having personal experiences of compassion (Graber & Mitcham, 2004) and revisiting training programmes (Dev, Fernando, Kirby & Consedine, 2019; Hendry, 2019; Hunter, McCallum & Howes, 2018; Shea & Lionis, 2017). Compassionate organisation is discussed below as a theme that recurrently featured in the literature.

1.9.1.1 Compassionate organisation: The topic of compassionate organisation is prominent within the literature as a potential facilitator of compassionate care. It has been argued that compassionate organisations can support staff's contentment, motivation, wellbeing, creativity and facilitates compassionate care towards patients (Amos & Weathington, 2008, Cole-King & Gilbert, 2011; Fernando & Consedine, 2014). Tehranineshat, Rakhshan, Torabizadeh and Fararouei (2019) stated that for a compassionate organisation to support compassionate care, a collective effort between policymakers, managers and healthcare providers is required. Other authors echoed this view and suggested rethinking organisational design through initiatives involving policymakers, patients, clinicians and service leaders (Crawford, Brown, Kvangarsnes & Gilbert, 2014; McSherry, Timmins, Vries & McSherry, 2018).

In Canada, Cochrane, Ritchie, Lockhard, Picciano, King and Nelson (2019) studied four health care organisations that adopted compassionate care as an explicit priority. Each organisation created a unique culture of compassionate care according to their needs and goals. Collectively, they identified compassionate concepts such as 'compassionate care is mandatory', 'compassion and engagement are mutually supportive', 'compassion is strengthened by community connections', and 'a culture of compassion drives performance improvement'. They also suggested best practices such as communication and staff training on key principles of compassionate care. Communication also appears key to compassionate care in Goodrich's (2016) study previously discussed.

Further, Cochrane et al.’s study suggests that compassionate organisations can lead to improved outcomes of quality and safety, patient experience, employee engagement and financial performance. The study also suggested that compassionate organisation starts from senior leadership. There is a link between supportive leadership enabling the development and preservation of compassionate care (De Zulueta, 2015; Zamanzadeh, Valizadeh, Ragmani, van de Cingel & Ghafourifard, 2017).

The “Building and Strengthening Leadership – Leading with Compassion” project led by the NHS England (2014) suggested that a multifaceted approach targeting individual, management, team and organisational levels is needed to sustain compassionate care. The project also suggests that organisations should listen to the experiences of patients and staff, clearly define values in behavioural terms and incorporate these values into practice. The research also highlights the need to show staff that they are valued, as this enables staff to act compassionately.

1.9.2 Inhibitors

Inhibitors of compassionate care are varied and include factors such as a lack of clinical supervision and a lack of support to manage the workload (Killian, 2008; Morse, Salyers & Rollins, 2012; Rupert, Miller & Dorociak, 2015; Skovholt & Trotter-Mathison, 2011). The two most frequently found factors are organisational threat and clinician burnout, which are presented below.

1.9.2.1 Organisational threat: It has been argued that organisations with discourses of insecurity about failing, meeting targets and fulfilling the need to audit clinical work intensively inhibit compassionate care in healthcare settings (Burnham, 2013; Chalice, 2007; Cole-King & Gilbert, 2011; Crawford et al., 2013; Henshall, Alexander, Molyneux, Gardiner & McLellan, 2018).

The UK’s DOH says that staff are required to have “professional instincts for compassion”, which has been criticised by some authors because there is an underlying implication that compassionate care is an individual’s responsibility (Cummings & Bennett, 2012, p.12). This individual focus means that practitioners, or their respective professional bodies and training programmes, are sometimes blamed for a failure in compassionate care (Collins & Long, 2003; Gilbert, 2009; Khatri, Brown & Hicks, 2009; Tierney, Bivins & Seers, 2018). It also overlooks the need for organisations, not just individuals, to be charged with upholding the provision of compassionate care. Mannion (2014) argues that threats and exhortations to professionals are likely to have limited results and perverse effects, and attention should shift to the organisations and system arrangements by, for example, focusing on the needs of the patients and clinicians alike.

Further, addressing organisational threat is assumed essential by the King's Fund (2017) in order to promote a culture of learning rather than blame, fear and bullying. This could create psychological safety at work, allowing staff to speak out confidently about errors and implement change to address specific threats in their work environment. This is an important consideration given that staff are more likely to experience lesser job satisfaction when they feel that organisational threat constrains them from acting compassionately (Cole-King & Gilbert, 2011; Maslach et al., 2001).

1.9.2.2 Clinicians burnout: Burnout is conceptualised as a syndrome involving emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach, 1982; Maslach, Jackson & Leiter, 1996). The continuous engagement with patient's problems is thought to lead to burnout, compassion fatigue and vicarious trauma, and to challenge the clinicians' ability to maintain compassionate care in the long-term (Figley, 2013; Stamm, 2010).

Rupert et al. (2015) hypothesised that mental health staff were specifically vulnerable to burnout because their work involves a unique combination of client and service-related stressors. A survey on the sources of burnout for NHS mental health professionals, among them IAPT clinicians, included an excessive focus on targets, an increased volume and complexity of cases, extra administrative demands, unpaid hours and a lack of resources (Rao, Bhitani, Dosanjh, Clarke, Hacker Hughes et al., 2016). These include the composition of pertinent aspects of IAPT services such as high workload and the focus on meeting targets to demonstrate client recovery (Jackson, 2019; Scott, 2018).

Using the Oldenburg Burnout Inventory, Westwood, Morison, Allt and Holmes (2017) estimated that working in IAPT for longer than two years, overtime and many hours spent on the telephone with patients increased the odds of burnout. The inventory predicted over two-thirds of PWPs and half of CBT therapists suffering emotional exhaustion and disengagement. This indicated the highest levels of burnout among the mental health workforce. A reduction in telephone workload and an increase in clinical supervision were both identified as helpful strategies to reduce burnout. Conversely, compassionate support at work for clinicians has been shown to increase collaboration, feelings of pride and gratefulness (Dutton, Worline, Frost & Lilius, 2006), lower staff turnover rates (Grant, Dutton & Rosso, 2008) and a reduction in burnout (Saab, Drennan, Cornally, Landers, Hegarty et al., 2019).

It appears from the literature that both mental and physical health services are faced with various facilitators and inhibitors of compassionate care. Facilitators combined efforts from clinicians' individual behaviours, such as looking after their physical and mental wellbeing, support from supervisors and compassionate leaders, and the responsibility of compassionate organisations. Similarly, inhibitors of compassionate care also involved organisational elements, such as job insecurity, high workloads and a lack of resources and support. These related to an increased risk of clinician burnout, diminishing their potential to care compassionately. Additionally, a key inhibitor of compassionate care comes when the organisation itself is operating on a threat mode, suggesting it is particularly important to avoid placing the responsibility solely on individual clinicians, and instead to review and implement organisational design that is conducive to fostering compassionate care.

1.10 Models of Compassionate Care

Researchers have started to focus on developing explanatory models of compassionate care in different healthcare settings.

1.10.1 Three Components Model of Compassion

Way and Tracy (2012) gathered longitudinal data from 96 hospice workers, by observing and/or interviewing. They developed a model of compassion with three components: recognising suffering, relating to individuals in suffering, and reacting to suffering. The latter was described as the overarching component of compassion. Compassion was associated with communicative actions and concluded that workers could be trained to enhance their compassionate care. Their study also suggested that providing compassionate care was associated with self-worth and appreciation for the work. While high in ecological validity due to its observational data, there is a deficit in explanations of how the mechanisms of the model are facilitated and how they differ in terms of being intuitive, cognitive or behavioural in nature in these settings. Also, the model was developed in American for-profit organisations, making it difficult to generalise the findings to NHS services, particularly mental health services like IAPT.

1.10.2 The 7 Cs Model of Compassion

Dewar and Nolan (2013) explored the types of relational knowledge that underpins compassion among older people (n=10), staff (n=35) and relatives (n=12) in the UK. They used a range of methods including participant observation, interviews, storytelling and group discussions, analysed by process of immersion crystallisation with staff as co-analysts. They developed a “7 Cs model” of compassionate, relationship-centred care based on “appreciative caring conversations”. The key components are connecting emotionally, to remain curious, collaborative, able to compromise, considerate of others’ perspectives, being courageous, and to actively celebrate when practices have promoted compassionate care. Key attributes to promote compassionate care include awareness of vulnerability and suffering, relating to the needs of others, preserving integrity and acknowledging the person behind the illness.

Findings from this study are consistent with literature and theory related to the importance of “knowing the person” to enable meaningful interactions between patients and professionals (Dewing, 2004; McCormack, 2004; Nolan, Brown, Davies, Nolan & Keady, 2006; Walsh & Kowanko, 2002; Zolnierek, 2014). However, the research provides a collective representation of compassion that is generated from nurses, inpatients and their families. As a result, it is difficult to establish specifically, from whose perceptions the key themes originate, and which, if any, could relate to IAPT services.

1.10.3 Enabling the Flow of Compassion Model

A multicentre research by Tierney, Seers, Tutton and Reeve (2017) used a constructivist Grounded Theory methodology to explore what compassionate care meant to 36 NHS clinicians for Type 2 diabetes patients. They created a model based on “flow” that can be affected by a complex range of interpersonal and organisational “defenders” (realistic work-related goals and expectations) which resulted in improved patient health and practitioners’ role. By contrast, “drainers” (competing demands on time and resources) emphasised the need for structural and interpersonal factors to be considered beyond the individual responsibility of the clinician. The study stated that professionals had differing amounts of experience. This may have interfered in the data – for example, their personal level of experience in the role may have influenced how they perceive or manage drainers. The idea of compassionate care flowing through the organisation and being defended or drained by different factors is an interesting concept that may be experienced by IAPT clinicians. The research presented in this thesis helps to clarify this within the IAPT context.

1.10.4 Patient and Healthcare Providers Model of Compassion

1.10.4.1 Patient model: Sinclair, McClement, Raffin-Bouchal, Hack, Hagen et al. (2015) interviewed 53 adults diagnosed with advanced cancer in palliative care in Canada, on the nature of compassion. A model was generated, which defines compassion as a virtuous response that seeks to address people’s suffering and needs through a relational space and action. The study has shown that caregiver compassion was preceded by virtues. Virtues were described as noble qualities embodied in the character of the caregiver: genuineness, love, honesty, openness, care, authenticity, understanding, tolerance, kindness and acceptance.

Patient reports indicated that compassionate care had the power to ameliorate physical, emotional, spiritual, familial and financial problems, although these potential outcomes were not empirically investigated. Nonetheless, this extends previous knowledge focused only on the disease or disorder that could be positively ameliorated. Further, a lack of compassion was identified based on the absence of caregiver virtues or competing vocational motivators that usurped caregiver virtues. This led to a detrimental effect on the caregiving relationship, often exacerbating suffering. The authors conclude that compassion, as experienced by patients, requires Healthcare providers to invoke their disposition along with their clinical proficiencies to have an optimal effect in connecting to patients and alleviating their suffering.

1.10.4.2 Healthcare providers model: To validate and further inform the compassion model developed from patients perspective, Sinclair, Hack, Raffin-Bouchal, McClement, Stajduhar et al. (2018) also explored compassion from the view of 57 frontline and peer-nominated exemplary compassionate healthcare providers working in different palliative care settings. The study largely mirrored the patient model of Sinclair et al. (2015), with virtues delineated as the primary motivator of compassion and describing compassion as a virtuous, intentional response through relational understanding of a person and action to ameliorate their suffering. Other researches have indicated that clinicians' compassion and the desire to help are innate and can be further awakened, developed and nurtured (Kalish, Dawiskiba, Sung, & Blanco, 2011; Lutz, Brefczynski-Lewis, Johnstone, & Davidson 2008; Tierney et al., 2017).

According to healthcare providers, compassion was not a systemic form of caring, but an intentional, discerning and targeted modality. Other researchers also reported that compassion is not coincidental but involves choice (van der Cingel, 2014; Zamanzadeh, Valizadeh, Rahmani et al., 2014). The model also suggests that compassion may be conceptualised through personalised patient care by acting on an acquired in-depth understanding of the person being cared for. This idea is supported by psychology research (Gilbert, 2014) and research on private sectors of Psychotherapy (Vivino et al., 2009).

A novel finding from this study was that healthcare providers identified their own responses towards the identified challenges of compassion to work pressures, as significant inhibiting factors for compassionate care. However, it was not considered insurmountable but would require a review of policy, practice, education and research to support healthcare providers' compassion.

Moreover, participants were nominated by peers who viewed them as compassionate healthcare providers. This method of sample selection could have resulted in selection bias which may have influenced the findings (Ellis, 2013). Also, these studies were conducted in Canada within palliative care; both the healthcare system and patient needs differ from the context of NHS IAPT services. As such, a question arises to whether these findings would be adaptable in IAPT.

Models presented in this section are compatible with previous literature describing virtues-based compassion and its relationship with improved patient health and clinicians' role (Armstrong et al., 2000; Bray et al., 2014; Horsburgh & Ross, 2013; Rigoni, 2007; Skaff et al., 2003; van der Cingel's, 2011). While there are clear commonalities between the models, these have been based on data from physical healthcare settings outside of the UK; it may be difficult to generalise these models to NHS practices and recommendations for further research seems appropriate.

1.11 Chapter Summary

This chapter has presented the main theoretical understandings, frameworks and therapeutic models of compassion from a range of disciplines. It also outlined the relevant NHS policies, and IAPT context relating to compassionate care. Further, the chapter discussed conceptualisations of compassionate care from the views of people receiving care, their practitioners and families, within a range of physical and mental health settings in various countries.

Findings from the literature conceptualises compassionate care as involving clinicians' virtues and volition, empathy, clear communication and collaborative work respecting patient's values and individuality – a relationship that allows getting to know more about the person rather than just their presenting difficulties, and wanting to alleviate suffering and acting to help the person. Definitions of compassionate care from patients, their families and professionals have shown to be similar. Nonetheless, research findings also pointed to a dynamic concept with intricate components that are still being established and defined within clinical research.

Moreover, although where possible the researcher incorporated studies from the UK within mental healthcare, most of the literature available is based on physical healthcare from researches outside the UK. This limitation also applies to models of compassionate care that have been generated outside of the UK. Therefore, it is not possible to generalise its findings directly to the NHS or to the IAPT primary care mental health context, due to the potential differences in organisational processes, resources and care provision. In spite of the limited research available for mental health care conceptualising compassionate care in the UK, the topic is the focus at present of many policies, including within IAPT services, indicating both its importance and the need for further investigation. The present research addressed the gap in the literature regarding clinicians' conceptualisation in primary mental health care, IAPT services in the UK.

1.12 The Current Research Question and Aims

Prior to this study, researchers have not explored the conceptualisation of compassionate care in IAPT despite the increasing acknowledgement of the importance of compassion in mental health care and the fact that IAPT is one of the main providers of primary mental health care in the UK. A lack of definition for compassionate care in IAPT may mean the current IAPT guidance is tentative, not founded in the perspectives of providers or receivers of care in those settings, and difficult to implement. Exploring clinicians' perspectives of compassion may lead to an understanding of specific important aspects of care within IAPT which are not yet recognised.

This research aimed to answer the following question:

1. What is the process of compassionate care in IAPT services?

This research has also addressed the aim to generate new knowledge about the facilitators and inhibitors of compassionate care in IAPT.

It is hoped that findings from this research may add to the understanding of the nature of compassionate care within IAPT services, contributing to useful strategies for supporting the cultivation and appraisal of compassionate care in those settings.

Conceptualising compassionate care within IAPT can offer a new understanding to guide clients on what can be expected, clinicians on what should be offered and policymakers on what to implement and how to prevent disruption to compassionate care. In addition, accessing research in this area may help to empower clinicians to understand and meet organisational expectations of compassionate care, rather than having to strive towards an undefined, and thus potentially unachievable, task.

2 GROUNDED THEORY

2.1 Chapter Overview

This chapter will provide a description of the study's epistemological stance and a detailed rationale for the chosen methodology.

2.2 Epistemology

The quality of qualitative research can be improved by attending to epistemological issues which refer to the theory, validity and scope of knowledge (Thompson & Harper, 2012). Epistemological positions concern both epistemology and ontology and are placed within a realist-relativist spectrum (Stevenson & Cooper, 1997).

Epistemology considers the extent to which knowledge of the 'real world' is reliable and valid (Willig, 2012). Ontology is the study of the way in which reality exists or comes into being (Harper, 2012). Ontological questions, therefore, tend to address "how things really are" and "how things really work" (Guba & Lincoln, 1994 p. 108). There are a variety of positions that fall within the spectrum between realism and relativism. The realist perspective on ontology asserts that there is an external reality that can be objectively and accurately measured. The relativist position asserts the opposite in that there is not an objective external reality but, subjective reality that is created through subjective interpretations (Henwood & Pidgeon, 1992).

2.3 Epistemological Stance

2.3.1 Critical Realism

The position of critical realism proposes the stance that a 'true' external world exists, but it cannot be investigated objectively (Archer, Bhaskar, Coller, Lawson & Norrie, 2013; Bunge, 1993; Burman & Parker, 1993). Rather, the research is subjective because the researcher cannot be separated from their personal and wider social, political and historical context (Danermark, Ekstrom,

& Jakobsen, 2001; Drake, Lovejoy, Pratt, Rogers, Santayana, et al., 1920; Oliver, 2011).

A critical realist position is in direct contrast with naïve realism that adopts the position that there is an unmediated relationship between the data that is generated during research and reality (Burr, 2003). Charmaz's (2006) constructivist position adopts the stance that underlying structures result in observable phenomena of data offered as interpretations by researchers. Constructs that can be identified in the data are hypothesised to reflect structures in the real world whilst acknowledging that different researchers might have different interpretations.

Willig (2013) describes the stance of critical realism as a combination of a realist desire to better understand what is really going on in the world, whilst recognising that any data generated will be limited due to the subjective nature of interpretation and understanding. Therefore, ideas, practice and theoretical notions can only be offered as an interpreted portrayal rather than an exact measure of the world. Thus, all aspects of the analysed data for this study will remain within the context from which it was generated and will remain as an informative account of the experience of working within IAPT, and not a direct reflection of the participants' reality or of an underlying 'true' concept.

The critical realist position considers phenomena to exist independent of an individual at the level of events and experiences but also at a deeper level that may not be observable. The researcher has a responsibility towards, and influence on, the generation, study, interpretation and reporting of the data (Willig, 2013). In this study, an exploratory position was adopted towards participants' social worlds and the way in which they report their views during the process of the research. In accordance with this epistemological stance, the study considered how compassionate care is conceptualised by considering whether there are common experiences between the descriptions of those who are working in the context of IAPT.

The researcher’s position and how it might influence the research process is described in more detail in the following chapter that outlines the process of Grounded Theory methodology.

2.4 The Appropriateness of a Qualitative Methodology

Quantitative approaches to research often operationalise constructs and variables so that they can be tested either directly or indirectly. In contrast, qualitative approaches may focus on delineating experiences without preconceived ideas or a need to operationalise the concepts or variables under investigation (Smith, Bekker & Cheater, 2011). A qualitative approach was deemed suited to this study as it can provide an opportunity to carry out more in-depth research of ideas, narratives and concepts to develop and deepen understanding (Thompson & Harper, 2012).

A qualitative approach was also considered suited to this study as it has been described as having the ability to contribute to rethinking, or deconstructing, some of the underlying frameworks and assumptions that are related to policies, services and national guidance for practice in mental health (Smith, Bekker & Cheater, 2011). These aspects of qualitative research were pondered by the researcher as pertinent for the context under investigation.

2.5 Choosing a Methodology

Different qualitative methodologies were considered during the initial planning stages of this study. Options included Thematic Analysis, which identify and analyse patterns of meaning to illustrate important themes in relation to a phenomenon (Braun & Clarke, 2006). Interpretative Phenomenological Analysis was also considered, which is a methodology whereby participants’ views of a particular phenomenon are understood in a dynamic process between themselves and the researcher (Smith & Osborn, 2007). The third methodology considered was Discourse Analysis, which studies language and how it is used to provide systems of meaning that reflect on wider social, political and cultural contexts (Wetherell, Taylor, & Yates, 2001). Whilst each methodology has its own merits, they often focus on the discourse and specific language used in describing a phenomenon (Larkin & Thompson, 2012). This suggests that these methodologies were not the most appropriate to use for this piece of research aiming to develop a theoretical framework.

Grounded Theory was developed to help researchers develop theories to describe and conceptualise the views, actions and experiences of people within their social contexts (Glaser & Strauss, 1967). This method aims to inductively produce theoretical frameworks from contextual data, such as interviews using a process of coding that leads to the formation of categories. The relationship between these categories is considered and used to develop a theory or conceptualisation of people's experiences (Charmaz, 2000). Therefore, this methodology was considered the most suitable to provide an opportunity to develop a theory of compassionate care situated in the context of IAPT services from clinicians' perspectives.

2.5.1 Grounded Theory Methodology

Grounded Theory was originally developed by sociologists Glaser and Strauss (1967). The original framework combined the perspectives of positivism and pragmatism to 'ground' the research in the data through a set of inquiry procedures. Through these procedures, new theoretical frameworks could be constructed to explain particular phenomena of interest, rather than relying on analytic constructs or categories from pre-existing theories (Charmaz & Henwood, 2008). Grounded Theory refers both to the method and to the theory as the end product of the process (Willig, 2008).

Since the conception of Grounded Theory, Glaser and Strauss have taken divergent directions in research, particularly with reference to its use within different procedures and epistemological frameworks (Charmaz, 2000). However, it is argued that all Grounded Theory approaches share central characteristics retaining consistency. These characteristics involve an abstract theory of action, interaction, and processes derived by the researcher, and grounded in participants' viewpoints from which a new theoretical framework is generated (Charmaz, 2009; Creswell, 2009; Oliver, 2011).

Grounded theory is suitable for a wide range of open-ended research questions that focuses on processes and meanings within a particular context. This was another reason why this methodology was chosen for this study; it provided an opportunity to develop an understanding of the social processes of compassionate care in IAPT. This was important because it was the participants’ experiences within the workplace, which helped to narrate some of the complex decisions and dilemmas they encountered in clinical practice regarding compassionate practice.

3 METHOD

3.1 Chapter Overview

All procedural aspects of the study regarding the sample and ethical considerations are presented in this chapter.

3.2 Recruitment Strategy

In order to generate interest and increase uptake, the researcher employed different methods of recruitment. For example, the participant invitation letter was posted on UK-based online platforms for mental health clinicians, including those working in IAPT services (Appendix C). With this method the researcher hoped to recruit clinicians from a wide range of geographic locations. However, no one responded to the online invite. Implications of recruitment strategies are discussed in the discussion chapter.

In addition to posting the invitation letter online, Atkinson and Flint's (2001) snowballing strategy was adopted. Drawing on personal contacts, including the researchers' fellow trainee Clinical Psychologists, the participant information letter was circulated by email and requested that they share this with others.

A strategy used by the researchers to increase accessibility and feasibility was to offer face-to-face, Skype or telephone interviews; all participants preferred a face-to-face meeting. The participants contacted the researcher by email or a telephone number used for the study. A convenient date, time and location for the interviews were agreed between the researcher and participants.

3.2.1 Inclusion and Exclusion Criteria

Inclusion criteria for the study were:

- Qualified clinicians currently working directly with clients in a therapeutic role (face to face, online or telephone) in an IAPT service in the UK.
- Being available to be interviewed during the analysis period.

Exclusion criteria for the study were:

- Clinicians who do not work directly with clients in a therapeutic role, but only indirectly, for example, in a managerial only role.
- Clinicians under training and not yet qualified.

3.3 Participants Profile

Twelve people were recruited and interviewed. The sample composition reflects different clinical professional roles within IAPT. These included four CBT Therapists, four PWPs and four clinical service managers who were either Clinical Psychologists or CBT Therapists supervising other clinicians and working therapeutically with clients.

Seven of the participants ranged from 26 to 35 years old, four of them ranged from 36 to 45 years old, and one participant ranged from 46 to 55 years old. Ten of the participants were female, and two were male. Six of the participants identified themselves as White British, three as Black British, two as Asian British and one as White European. There was a variety of religious and non-religious identification which includes six participants identifying themselves as spiritual, two as Muslins, two as Christians and two as atheists.

Eight participants were working full-time, and four were working part-time. Five of the participants have been working in IAPT for a minimum of three years and less than six years; another four participants have been working in IAPT for 10 years or more, and the remaining three participants have been working in IAPT for at least one year and for less than three years. Participant’s working regions are within different mental health Trusts in London.

Participants’ demographic information was extracted from the demographic questionnaire (Appendix D) completed at the time of the interview; the details of which are presented in Table 2 below.

Table 2. Participants Demographics

Name	**Gender**	**Age**	**Ethnicity**	**Religion**	**Role**	**Employ-ment Type**	**Years in IAPT**	**Working Region**
Alisha	Female	26-35	Asian British	Muslim	CBT Therapist	Full-time	3 to 6	London
Eva	Female	36-45	Asian British	Muslim	CBT Therapist	Full-time	3 to 6	London
Sarah	Female	26-35	Black British	Spiritual	CBT Therapist	Full-time	3 to 6	London
Dante	Male	26-35	Black British	Spiritual	CBT Therapist	Full-time	3 to 6	London
Natasha	Female	26-35	White British	Spiritual	PWP	Full-time	1 to 3	London
Daisy	Female	26-35	White British	Christian	CBT Therapist	Full-time	3 to 6	London
Maia	Female	26-35	White European	Spiritual	PWP	Full-time	1 to 3	London
Tosin	Female	26-35	Black British	Christian	PWP	Full-time	1 to 3	London
Susan	Female	46-55	White British	Spiritual	Clinical Psychologist	Part-time	10 or over	London
Monica	Female	36-45	White British	Spiritual	Clinical Psychologist	Part-time	10 or over	London
Rose	Female	36-45	White British	Atheist	CBT Therapist	Part-time	10 or over	London
Mark	Male	36-45	White British	Atheist	Clinical Psychologist	Full-time	10 or over	London

3.4 Semi-structured Interview

3.4.1 Interview Schedule

During the preliminary literature search, the key area identified that required further investigation was the conceptualisation and process of compassionate care in IAPT. Therefore, the interview scheduled was developed with these areas in mind.

The interview schedule included broad and open-ended questions to avoid forcing data into preconceived categories (Charmaz, 2004). The initial interview schedule was composed of seven main questions and various prompts (Appendix E) aiming for the interview to be flexible and responsive as suggested by Charmaz (2014).

3.5 Process of Interviewing

Although treatment sessions and research interviews are significantly different, the researchers drew on therapeutic skills in an attempt to build an empathic and respectful rapport with each participant, and encourage disclosure. This is considered essential in exploring qualitative data (Charmaz, 2006; Coyle & Wright, 1996; Rogers, 1951; Safran & Muran, 2000).

3.5.1 Data Generation

In Grounded Theory, the term data generation is preferred over the term data collection, in relation to the interactional process between researcher and participant (Charmaz, 2000). Data generation and analysis were conducted concurrently.

3.6 Pilot Interview

Pilot interviews are recommended in order to test and develop the draft interview schedule, identify any pitfalls and to ensure a smooth process and implementation (Charmaz, 2006). The interviewee provided helpful feedback; the process of the interview was comfortable, but the initial question “what does the term compassionate care bring to mind?” was difficult to answer due to the wording. In response to feedback from the interviewee, the question was reformulated with a new opening question; “thinking about your role in IAPT, what does compassionate care mean to you in this context?” (See Appendix F – Revised Interview Schedule). The data from the pilot study was not included in the study.

3.7 Transcription

Interviews were transcribed verbatim by the researcher using an adapted version of the transcription conventions described by Parker (2005) (Appendix G). During this process identifiable information was removed, and participants were assigned a pseudonym. Due to the time constraints of the Doctorate and participants availability, the first three interviews were transcribed at the same time, within a week after the interviews had taken place. The subsequent interviews were transcribed before interviewing the next participant. As suggested by Starks and Trinidad (2007), this process allows for inquiry about any emerging ideas that had not previously been considered.

3.8 Data Analysis

Charmaz’s (2014) guidelines to data analysis were followed, and each stage of the process is outlined below. An abbreviated version of Grounded Theory was used for the research, which is appropriate when Grounded Theory methodology is used to analyse data generated with limited time for the analysis in between interviews (Willig, 2013). This form of Grounded Theory was also chosen because the interview schedule could not always be adapted in response to previously generated data due to the time constraints of the project.

3.8.1 Systematic Coding

There were four stages to the coding process: initial, focused, theoretical and diagramming.

3.8.1.1 Initial coding: Initial coding is described as a simple, provisional process whereby the researcher remains close to the data. This involved coding line-by-line on each transcript, assigning descriptive labels to instances of phenomena, highlighting actions, and drawing attention to processes and meaning. This style of coding is carried out by breaking it into separate properties, defining actions these properties rest on, implicit actions and meanings, making comparisons within and across data and identifying any gaps (Charmaz, 2005).

3.8.1.2 Focused coding: Focused coding was the second distinct stage where previous codes were considered, and the researcher focused on the most frequent and potentially significant aspects of the data. Inclusion and exclusion of tentative categories were decided by examining which codes provided the most analytical sense for the theoretical framework. The data was frequently returned to enabling the researcher to remain close to the data and to test the seemingly significance of codes.

3.8.1.3 Theoretical coding: this stage provides precision and clarity to identify the relationships between categories developed in focused coding. Theoretical coding conceptualizes how codes are related, forming categories towards a theoretical direction.

3.8.1.4 Diagramming: Diagramming was used throughout the process of data generation and analysis to provide visual representations of the categories and their connections. This aided coherent links between the stages of coding and the latter stages of the analysis (Charmaz, 1995).

3.8.2 Constant Comparison

Constant comparison was used during all stages of analysis, looking for differences and similarities within and across transcripts, capturing instances of variation within the emerging theory. This stage aided the movement between the different stages of coding and allowed categories to be refined, resulting in the development of a theory grounded within participants' accounts (Mills, Bonner & Francis, 2006).

3.8.3 Theoretical Sampling, Saturation and Integration

Theoretical sampling involves the process whereby the researcher continues to sample and code until variances in the data are no longer identified and 'theoretical saturation' is achieved (Morse, 1995; Willig, 2008).

The process of theoretical saturation can theoretically be infinite, as changes in perspective are always possible (Glaser & Strauss, 1967). Therefore, in most cases, theoretical saturation is an aspiration for researchers using Grounded Theory rather than a reality (Willig, 2013). This was the case in this research due to the time constraints of the project.

The final stage of analysis involved theoretical integration. This helped the researcher to develop a consistent 'story' that had explanatory power and depth, accounting for participants' experience.

3.8.4 Timing of the Literature Review

To minimise the influence of existing theoretical knowledge, some grounded theorists argue that literature reviews should be conducted after the analysis is complete (Resnik Mellion & Moran Tovin, 2002). A full literature review for this final report was conducted after the analysis. However, the researcher was required to develop a detailed research proposal, which included a partial literature review, to be completed in the initial stages of the research process. Therefore, the analysis may have been influenced by the researcher's prior knowledge. This will be discussed further in the final chapter of the thesis.

3.9 Memos

Memos helped the researcher to record each stage of the analysis, as well as decisions that were made during the process of the study (Willig, 2008). According to Tweed and Charmaz (2012), memos ought to consist of the researcher's ideas, feelings and attitudes towards the data as it is generated. This is to help researchers to become immersed in the data throughout the research process, and to bring new ideas about the research to attention.

Advanced memos were written at different stages between the processes of data generation, analysis and report writing. This process helped to trace the changes as the researcher developed the categories and to consider the processes involving what the participants were or were not saying or doing (Charmaz, 2006).

3.10 Ethical Considerations

3.10.1 Ethical Approval

Ethical approval was obtained from the University of East London Ethics Committee (Appendix H and I). The research was developed and conducted within the British Psychological Society Codes of Human Research Ethics (2014).

3.10.2 Informed Consent

Informed consent was gained by asking participants to read the information sheet, sign and return a consent form for the study (Appendix J). Before starting the interview, participants were given another opportunity to read the information sheet and to ask questions. The researcher used Rosenblatt's (1995) processual consent during the interviews by asking questions such as: "Would it be ok if I ask more about that?" This allowed participants to reassess their consent given prior to the interview, and then decide whether to answer the questions being asked.

3.10.3 Confidentiality

In order to maintain confidentiality, all interviews were recorded onto a password protected recording device used solely for the purposes of the research. These recordings will be stored securely for a maximum of five years and then permanently deleted in accordance with the code of human research ethics (British Psychological Society, 2014). Results from questionnaires and transcribed interviews were stored on a password protected computer which could only be accessed by the researcher. If required, supervisors and examiners can also have access to the full data set, upon request.

3.10.4 Risk

It was felt by the researcher that interviews for this research were unlikely to cause significant distress that participants would need support after the study. However, any research topic can potentially be sensitive (Lee, 1993). Therefore, the researcher acknowledged that distress could arise and that skills developed through clinical and research interviews could be utilised to manage any such distress.

Deception did not feature in the study, and participants were routinely debriefed following interviews. Participants were made aware that breach of confidentiality might be necessary if there was a concern about anyone's safety. The researcher asked the following questions to develop a safety plan with participants: "How will I (the researcher) know that you want to stop the interview or skip a question, or that you may find it distressing and need help?" All participants reported being able to tell me in case they wanted to stop the interview. The researcher did not need to breach confidentiality at any stage of the research process.

A lone working policy was verbally agreed with the Director of Studies. The researcher agreed to inform the Director of Studies about scheduled interviews and any risk to ensure the safety of the researcher and of the participants. The researcher met with the Director of Studies on different occasions to update on the progress of the interviews.

3.11 Evaluating the Quality of the Research

The quality of the research was evaluated using the principles developed by Spencer and Ritchie (2012) and is presented in the critical review section of the thesis.

4 ANALYSIS AND FINDINGS

4.1 Chapter Overview

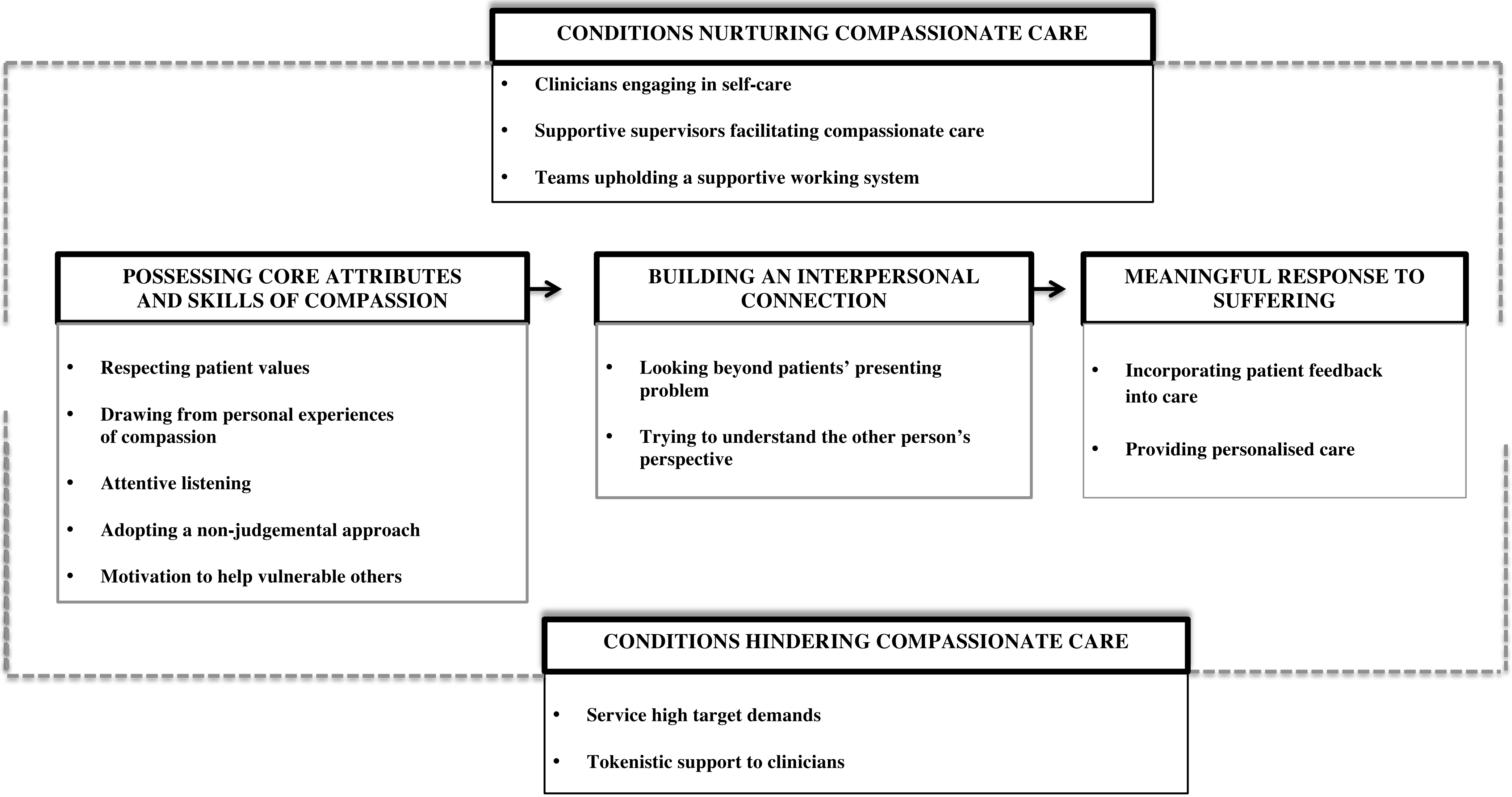
This chapter outlines the findings from the Grounded Theory analysis and presents the conceptual model Enacting compassionate care in IAPT Services. The process of analysis is described in the Methods chapter and comprises four stages: initial coding, focused coding, theoretical coding and diagramming. Based on the research analysis, the theory described in this chapter and presented through the model most adequately represents the participants' perspectives. The researcher acknowledges no single model can fully characterise the entirety of participants' narratives.

4.2 Enacting Compassionate Care in IAPT Services: Model Overview

Enacting compassionate care in IAPT refers to processing, acting on and implementing compassionate care into practice. The developed theory demonstrates a dynamic process between all those relating to IAPT in any capacity. It proposes that enacting compassionate care in IAPT involves individual, relational and behavioural aspects. These aspects described clinicians' conceptualisation of compassionate care as clinicians possessing compassionate attributes and skills that lead to building an interpersonal connection with patients and enables clinicians to offer a meaningful response to patient suffering. Clinicians' enactment of compassionate care in IAPT can be nurtured or hindered by the service contexts within which they work.

Although the model is comprehended dynamically in its processes, diagrammatically it is presented in Figure 2 with a degree of linearity for the purposes of clarity. The model is composed of five categories with 14 corresponding subcategories, which represent overlapping contexts that influence how compassionate care can be enacted in IAPT. Each category and its subcategories are presented in a table and followed by an explanation supported by participants' quotes.

Figure 2. ENACTING COMPASSIONATE CARE IN IAPT SERVICES



4.3 Possessing Core Attributes and Skills of Compassion

Possessing Core attributes and skills of compassion refers to the first essential aspect required by clinicians in the process of enacting compassionate care in IAPT. There was a consensus between participants that clinicians have different professional and personal experiences, therefore their overall individual attributes and skills may vary, although core attributes and skills are crucial to all clinicians. Rose described how important it is for clinicians to possess the core attributes of compassion to help her care for patients, and that compassionate care can be further enhanced through practice and training.

> *Rose: People are different, have varied life experiences… but all clinicians need to have some core compassionate attributes to bring these to the therapeutic role as an essential part of caring for others. These can be enhanced in practice and training but must exist already.*

There was also a consensus by participants about the core compassionate attributes and skills that clinicians must bring to their caring role to help them be effective at delivering compassionate care. Each of these are represented in the subcategories presented in Table 3 and discussed in turn.

Table 3. Category: Possessing Core Attributes and Skills of Compassion

Subcategories
• Respecting patient values. • Drawing from personal experiences of compassion. • Attentive listening. • Adopting a non-judgemental approach. • Motivation to help vulnerable others.

4.3.1 Respecting Patient Values

This subcategory starts to hone the specificity of the components of compassionate attributes clinicians have and enact in practice. In this section, clinicians identified an attribute, which could have been developed in different circumstances or stages in life, as significant to the process of learning how best to treat others. Respecting patients values by acknowledging their individuality was viewed as paramount in clinical practice in IAPT. Clinicians perceived this to help them keep sight of the humane interaction that must be offered. Daisy described this below.

> *Daisy: Like me, probably most people working in the field, are going to respect patient values and what makes them different, their stories and their suffering, to keep it a humane interaction.*

Eva described the importance of respecting others when there are additional responsibilities, such as time constraints or administrative tasks that must be fulfilled as a clinician.

> *Eva: I'm putting all the important skills together from a personal and professional sort of must-haves some of it is natural to the clinician, you value other people's values, and that helps to approach patients with respect, even when you have a lot to do, like the admin in IAPT that takes a lot of your time.*

Sarah described how respecting others is human nature whilst also being an essential part of her work with patients who are referred to IAPT for mental health care.

> *Sarah: I think it [compassionate care] is human, everybody has some level of it, and it is key in therapy when trying to show respect and good care for people.*

Alisha commented that respecting patient values was an important attribute to facilitate the enactment of compassionate care because asking for help may have been difficult for patients.

> *Alisha: An important attribute to therapists is respect for the client, as in not treating them differently because they came asking for help, but including their uniqueness and values as an important part of compassionate care.*

4.3.2 Drawing from Personal Experiences of Compassion

The participants identified the ability to draw from their personal experiences of compassion as an essential skill in the process of enacting compassionate care in IAPT. Participants were able to draw parallels between their experience of receiving help from others and their clinical practice when helping others. Daisy described how her experience of receiving compassion from another person has helped her to be compassionate towards patients.

> *Daisy: When thinking about compassion for others, I think about the compassion I received, and what that has done for me, like, I felt respected; and I bring the whole of me to the job, my skills and experiences and that's how it should impact on my job positively.*

Skills used in therapeutic relationships can be enhanced when a clinician remembers their experiences of receiving compassionate care and the positive impact it can have. Tosin and Dante said that by drawing on their personal experiences was a helpful way to relate to their patients compassionately.

> *Tosin: I can use my own life experiences to be more informed in how others feel and what they might need to feel care for compassionately.*

> *Dante: You [the clinician] have experiences in your personal background that helps you to relate or understand the difference compassionate care makes. So you can tap into that knowledge and feeling when you are in sessions with people.*

4.3.3 Attentive Listening

Attentive listening refers to the skill of paying close and undivided attention to patient narrative of their stories and presenting complaints. Clinicians can demonstrate this by reflecting back to the client their understanding of the presenting problem, including fine details using the patient's own words. Clinicians recognised attentive listening as an important skill in IAPT due to specific aspects of the service context, such as large caseload and a managerial focus on targets. Eva described how attentive listening could enable compassionate care in IAPT to ensure each patient's unique story is heard and attended to.

> *Eva: We hear many stories, as we see a lot of people. It's important to listen attentively as people tell their stories. You know you are being compassionate when the patient feels heard.*

Susan described how compassionate care requires attentive listening that should be prioritised over the service context constraints such as having lots of patients to see.

> *Susan: Offering that time to listen to them, so they feel like they have someone for that time, and that is a key part of compassion that can't drop because we are so busy with large caseloads.*

Clinicians also described the importance of attentive listening as a core skill because services often require them to follow protocols or scripted methods of assessing patients' mental health difficulties. Attentive listening can compensate for the loss of meaning that can often occur as a result of using standardised tools. Attentive listening enabled clinicians to ask additional questions that were appropriate in helping them understand their patient, which, in turn, facilitated their compassionate response towards them.

Alisha described how she would ask additional questions to demonstrate she was listening attentively to help the patient feel cared for compassionately.

> *Alisha: When I am in the room using skills like good listening, rather than just asking a question to tick a box as it can happen in IAPT, they can sense being cared for compassionately.*

Rose explained the importance of attentive listening by outlining potentially detrimental consequences of the patient not feeling respected if compassionate care was absent from an interaction with a patient.

> *Rose: It can't be just about the forms we have to complete. There is a strong narrative from patients wanting to be heard, so this is core for clinicians to offer as part of compassionate care. So when people are not listened to, they might think that we are not respecting them.*

Attentive listening was particularly important when working with patients who had negative experiences with other mental health services. The requirements of IAPT services, such as using standardised protocols and tools, was thought to potentially exacerbate experiences of rejection from mental health services. Susan reflected on how she felt attentive listening was a way of facilitating compassionate care for those who had previously felt rejected from services.

> *Susan: Patients who had difficult experiences of services might experience IAPT as rejecting them, not compassionate and unhelpful if they don't feel listened to.*

4.3.4 Adopting a Non-judgemental Approach

Participants described how adopting a non-judgemental approach when working with patients was another core attribute. Rosie described how she was able to put her judgements of the patient aside to enable compassionate care in IAPT.

> *Rose: You keep judgmental ideas aside; it is part of clinicians' attributes that helps with compassionate care.*

A non-judgemental stance is equally as important as other core attributes to help clinicians engage with their patients. Mark and Dante described how all of these attributes helped to enact compassionate care in IAPT.

> *Mark: In the process of making those key attributes available to engage with the person, you don't view clients as the problem and instead provide non-judgemental care.*

> *Dante: Compassionate care involves being non-judgmental and giving people space to make sense of problems.*

Pre-existing judgements could prevent clinicians from being hopeful and make providing compassionate care in IAPT more difficult. Experiences that challenged these pre-existing ideas helped to remind clinicians of the importance to remain non-judgemental so that they could be more compassionate towards patients.

Alisha was challenged by her preconceptions and learnt that a non-judgemental approach is essential in IAPT care where contacts can be brief and therapy protocolled.

> *Alisha: I had a client who was an ex-offender, and I made a lot of assumptions pre-empting that I couldn't do a piece of work with him because what we offer is quite established and brief sometimes. But I was completely wrong; he was just a person and deserved a non-judgemental approach, and that is what I needed to remember.*

A non-judgemental stance indicated that clinicians supervised by a participant were delivering compassionate care. Monica noticed this when her supervisees language was non-judgemental in prioritising patients as part of their compassionate approach.

> *Monica: I observe supervisees compassionate care when I notice the use of non-judgmental words, prioritising the patient.*

4.3.5 Motivation to Help Vulnerable Others

Participants described how difficult it would be to provide compassionate care in IAPT if the motivation to help vulnerable others were absent even when all other core attributes and skills were present in a clinician. This is because without the motivation to help, the other attributes and skills alone might not lead to acting on alleviating patient’s suffering; although participants described being motivated it did not necessarily led to measurable outcomes, but the desire to help was an act of compassion.

Alisha described how it was possible to be compassionate when the motivation to help others was present despite there being barriers to providing practical support to the patient.

> *Alisha: You know, if you have the right approach and you care for the person, and above all, you want to help that person, even if sometimes you can’t do what you want to help, but the fact you want to. You see, that matters, you are being compassionate.*

Dante described how crucial the motivation to help vulnerable others was to provide compassionate care.

> *Dante: By going through the first stages of engaging with that person, it is compassionate to feel motivated to help them. Otherwise, what would be the point if you don’t feel like helping?*

Susan described motivation to help vulnerable others, as one of clinicians’ main driving force to relate to others and care for them.

> *Susan: Having a sense of care for those most vulnerable, it is one of the main driving force for the clinician.*

4.4 Building an Interpersonal Connection

Building an interpersonal connection between clinicians and patients refers to an essential stage in the therapeutic process whereby clinicians feeling motivated to help vulnerable others and invest in getting to know the patient holistically. Daisy stated the fast-paced nature of working in IAPT could sometimes be a barrier to building connections with patients. Despite this, she emphasises building an interpersonal connection, which helps her to be compassionate.

> *Daisy: IAPT work is really fast-paced, and sometimes it's quite hard to invest in those relationships. I emphasise it because it is what connects you to patients, otherwise, how can you be compassionate if you didn't really build that?*

Mark stressed that building a connection with patients is something he considers crucial before attempting to help them. He also believes an interpersonal connection is what patients mostly remember, and feel helped by as something integral to them.

> *Mark: One of the main things to achieve by being a compassionate clinician and trying to help that person is to build a connection first. Usually is what patients will remember, and we know through research this connection helps them.*

As exemplified by Dante, open and collaborative conversations are related to the process of getting to know the person and building a connection with patients, in a fast-paced working environment.

> *Dante: Whilst working in a fast-paced environment, I try to have open and collaborative conversations to know the person and start building that one to one connection.*

Table 4. Category: Building an Interpersonal Connection

Subcategories
• Looking beyond patients presenting problems. • Trying to understand the other person's perspectives.

4.4.1 Looking Beyond Patients Presenting Problems

Looking beyond patients presenting problems is classed as important in order to contribute to the enactment of compassionate care in IAPT. This requires clinicians to have an interest in seeking to find out more about the different aspects that completes the person. This enables clinicians to consider different historical and social factors, their strengths and narratives of successes rather than focusing only on their presenting problem.

According to Dante, looking beyond patients presenting problems and diagnosis and getting familiar with the whole person helps him to feel more connected with the person.

> *Dante: When you get to connect with the person, you are not just aware of their problems in terms of the diagnosis, you know, but also getting to familiarise with them as a whole person. Like I said before, it just feels a bit more connected to them, is the only way I can explain it.*

Susan commented that compassionate relationships help her to see beyond patients presenting problems.

> *Susan: The sort of compassion in those relationships will take you to a more holistic view of who is in front of you.*

Rose described how she looks beyond patients presenting problems by considering different aspects of the person, including their strengths. This allows her the opportunity to better understand the person before trying to help them.

> *Rose: Before you try to intervene, you start seeing all the aspects of that person, the problem as well but also their strengths. Whatever you do after to help becomes more humane I guess, because you kind of know them a bit more.*

For Monica, looking beyond patients presenting problem is a key aspect of the job. This was facilitated by maintaining openness in her thinking and considering the patient as more than a problem to solve, including the different aspects of who the person is.

> *Monica: You have to be open to seeing more than just a problem, to consider all about that person, who they are, and that is your job and a more compassionate approach.*

4.4.2 Trying to Understand the Other Person's Perspectives

For clinicians trying to understand the other person's perspectives is a means to disarm themselves from being fixed in the idea there is only one explanatory narrative about the nature of the person's distress. Instead, it involves allowing the patient to convey their understanding of their difficulties and incorporate that insight into clinician's understanding.

Alisha and Maia emphasised that the process to understand the other's perspective involves a shared experience of allowing the patient to convey the problem without imposing clinicians' views.

> *Alisha: You won't get clients experiencing compassionate care without giving them the chance to tell how they see things and them adding that to your knowledge of the problem.*
>
> *Maia: You don't impose your views on them; it is a shared process that you are constructing together, as you give the person room to help you understand things from their perspective.*

As demonstrated by Daisy, understanding the other person's perspective leads to strengthening the interpersonal connection discussed in the previous subcategory and is vital to the enactment of compassionate care. This helps Daisy to make better sense of the problem to then consider how best to support the patient.

> *Daisy: Um, uh, I suppose the emphasis on building connections with people, for me. It is because it takes you to understand their problem from*

> *their way of making sense of it. And then it starts to make sense and guide you in how to progress from there and helps with the relationship.*

4.5 Meaningful Response to Suffering

Providing a meaningful response to suffering is deemed possible when clinicians employ their core attributes and skills of compassion and invest in building an interpersonal connection with patients. This category explains a dynamic and shared process whereby clinicians' knowledge of the support available together with patient's feedback about the care they receive can influence a meaningful response to patient suffering.

Sarah states that a meaningful response to patient suffering requires that clinicians employ all their attributes, skills and knowledge to take action in the best interest of the client.

> *Sarah: Compassionate care requires putting all your skills and knowledge of the person together and then trying to look after their needs in a way that is meaningful to them.*

Table 5. Category: Meaningful Response to Suffering

Subcategories
• Incorporating patient feedback into care. • Providing personalised care.

4.5.1 Incorporating Patient Feedback into Care

In order to provide a meaningful response to patients suffering, it is fundamental to incorporate patient's feedback into care as they are considered stakeholders of the care provided. Patients are therefore in a strategic position of providing feedback not otherwise accessible, as described by Rose.

> *Rose: Patients are key stakeholders that provide feedback that isn't captured in the data collected routinely. We need that to check if we are doing things right.*

Incorporating patients feedback into care can be done in different ways, including via organised forums, qualitative written feedback and directly requesting feedback in therapy sessions. Daisy viewed a patient advisory group as a channel to give patients a voice and to make herself and the service aware of how to improve treatment.

> *Daisy: The patient advisory group gives them autonomy to say, this was my experience, this is what I think would be better. It helps to be aware of things that we might not know impact on our clients. So they're the ones that can teach us how to improve.*

Maia explained how she first listens to patient feedback, which informs her on how to proceed with treatment.

> *Maia: You listen to their feedback and start thinking about treatment options that best fit patient's difficulties, and then you can act on that and offer something.*

Mark strongly suggested that services risk lacking compassionate care unless clients are actively involved in providing feedback that helps to review their individual treatment and service provision as a whole.

> *Mark: As a service we need to be seeking peoples unvarnished opinions and add that in their care, or you risk missing the point of compassionate care.*

4.5.2 Providing Personalised Care

To offer personalised care in the context of this study means to seek to act in devising care that is specifically suited to the patient needs. Considerations to peoples' individuality include their abilities, personal cultural background, as well as other factors that are important for the person, for example, ethnicity and socio-economic status.

Tosin described that only by considering patients' background, she is able to respond in compassionate ways.

> *Tosin: You have to consider where they're coming from to personalise things because the person is not from a textbook. You need to have intentions to do what is most helpful, by responding with actions that are compassionate.*

According to Maia and Eva, seeing the patient as a unique individual and not as another number into treatment is considered important in personalising patient care.

> *Maia: If the person is just a number, something has gone wrong because it is meant to be all about them and seeing who they really are, not only their problems.*
>
> *Eva: Being compassionate will combine seeing the person as a person, not just a number or a problem to solve but also seeing the positive aspects of them.*

Natasha found it difficult to admit the possibility of considering the patient just as another number rather than taking a genuine interest in them, seeing them as a person with difficulties, weaknesses and strengths.

> *Natasha: The amount of people that we see, you do get to a place where it's just another appointment, another call. I really don't want to say this out loud but just another number. To care compassionately, you need to take a genuine interest in every client seeing them as a person, with difficulties, weaknesses and strengths.*

Clinicians acknowledged that one type of treatment is not suitable for all patients. Rose mentioned that services do vary in what they offer, and therefore the client group they are able to serve. Yet, clinicians must value and act upon the opinions of those to whom the service is there to serve, instead of offering unsuitable care.

> *Rose: There are times when we’re turning clients away because they don’t fit the criteria and that message doesn’t sound like you care, although it might be just that the service can’t meet the client’s needs, and they won’t benefit from what we offer. So trying to think about what we can offer realistically is probably an example of compassionate care because we're thinking about the best fit for a client.*

Due to the closing or change in criteria of some community services, at times, IAPT clinicians struggle to find the right support for the client when IAPT does not offer a suitable type of care. Mark and Susan described that when faced with this situation, it appears to be a struggle both for clinicians and patients.

> *Mark: There aren’t many partners services available in the community for us to count on, meaning that people might not get the service they need.*

> *Susan: Some services don’t operate anymore so there’s very little provision out there and some people don’t get the treatment they should get.*

Daisy talked about a conflict experienced whilst working in a service whereby depending on the patient’s presentation, her only option is to suggest paid organisations for support. Daisy felt that despite having connected with the client’s difficulties and wanting to help, she was unable to provide a meaningful response to their suffering.

> *Daisy: I suppose action is needed to make compassionate choices for their care, but sometimes patients don’t meet threshold for any service because of how we are classifying them and I don't think that’s compassionate. Because I might then suggest they pay for a service elsewhere when they came to the NHS in the first place. Ideally, you can’t*

> *have the same rules for all people; you need to think case-by-case, but sometimes, that can't be done.*

4.6 Conditions Nurturing Compassionate Care

This category represents a macro view of the importance of compassionate care being nurtured in IAPT services in order to be enacted by clinicians. In this context to nurture compassionate care refers to a combined effort between all IAPT staff in encouraging the development, maintenance and delivery of compassionate care.

According to Mark, compassionate care can help to avoid clinical failures. He also adds this is only possible when all those within the system are responsible for their part in the collective responsibility of nurturing and delivering compassionate care to self and others.

> *Mark: Um, and that's when, you know, lots of failures that happened in some services due to lack of compassion can be probably avoided around the overarching notion of each one taking some responsibility and nurturing that compassion for themselves and others, with help from others and in the system.*

Table 6. Category: Conditions Nurturing Compassionate Care

Subcategories
• Clinicians engaging in self-care. • Supportive supervisors facilitating compassionate care. • Teams upholding a supportive working system.

4.6.1 Clinicians Engaging in Self-care

Clinicians pointed out to the importance of self-care. Different dimensions of self-care in clinicians' personal and professional life involved physical, psychological, social and spiritual.

Clinicians' self-care was deemed important for Natasha. Firstly due to the nature of the therapeutic work; which can be emotionally draining. Secondly, due to the many organisational and administrative tasks to be accomplished in IAPT, that can interfere with self-care and deplete clinicians wellbeing. Natasha added that self-care can be guided by personal interest and performed on her own or with others. Natasha believes self-care helps her to be compassionate towards patients.

> *Natasha: It can be draining on us the stories we hear every day and all we need to do admin wise on top of the clinical work. So engaging in self-care is a responsibility we have as clinicians to replenish us by doing things like, resting, connecting with your spirituality or being with friends, so we can be compassionate to patients.*

Similarly, for Eva, engaging with self-care can nurture her compassion as a clinician and restore balanced wellbeing whilst carrying on with the required administrative tasks in IAPT.

> *Eva: We are being compassionate therapists, but sometimes because of all the other things we do, like admin, wow, it can be a bit much, so we need to engage with things that balance it out for us. Whatever you like doing, maybe exercise, so you restore your own wellbeing.*

As part of engaging in self-care Sarah declared important knowing when to ask for help from senior colleagues with aspects of the work, which can impact on her psychological wellbeing. In addition, Sarah stated it is not always easy to ask for help as she strives to accomplish the many tasks designated by the service.

> *Sarah: Part of looking after ourselves as therapists is to know when to say, ok, I need to stop, slow down or ask for help, this rhythm is not good for me. But I know it is not always easy to do because you have so much on your plate and want to do things well.*

4.6.2 Supportive Supervisors Facilitating Compassionate Care

As well as the clinicians' responsibility to nurture compassionate care by engaging in self-care, participants stated that supervisors have a key role in nurturing clinicians' enactment of compassionate care in IAPT. Supportive supervisors were described as approachable, understanding and helpful. They are perceived by clinicians as compassionate towards them as professionals and people, and therefore facilitates clinicians' endeavour to provide patient care that is compassionate.

Susan recalled a time when she was experiencing difficulties in her personal life, and she received support from her supervisor. This led her to adapt her working hours in a way that she could continue to work for IAPT and enact compassionate care.

> *Susan: There was a time in my life when I had personal difficulties going on and my supervisor was approachable and understanding, and I was able to change my working hours and it made a big difference for me being able to stay at work and be compassionate towards patients.*

Similarly, Sarah recalled her supervisor being interested in helping her when she was going through difficulties in her personal life. This allowed Sarah to have work balance and be compassionate.

> *Sarah: When I was swamped with issues in my personal life, my supervisor was interested in helping me so I could have the right balance to do my work compassionately.*

Dante said that supervisors can be supportive by being attuned to clinicians' difficult roles and needs, as this directly impacts on their compassionate care towards patients. He suggested that supervisors should ask specific questions about how he is.

> *Dante: I think compassionate care comes into supervisors acknowledging our difficult roles and the importance of supporting our wellbeing, they can just check in with me by asking directly how I am doing.*

Tosin noticed that her supervisors showed an interest and care about Tosin and her work. This leads Tosin to feel encouraged to care for patients.

> *Tosin: I get the sense in supervision by the questions she asks, how I am doing? If I need help? That she cares about me, and the work I do. It encourages me even more to care for patients.*

Alisha felt that when supervisors are being compassionate and supportive, it helps her to gain new perspectives of her clinical efforts, which is essential to enact compassionate care in IAPT when being busy with different tasks.

> *Alisha: I didn't know how to work with that client, but I was trying to be compassionate and it made a difference to get that compassion and support from my supervisor. It helped to get perspective when doing so many things.*

Through reflections in supervision, Daisy felt reassured by her supervisor's support and believes this nurture compassionate care towards herself and towards patients.

> *Daisy: I think it's important to make time in supervision, to reflect, which helps me to feel reassured and be more compassionate towards myself and my clients.*

Eva praised regular supervision in IAPT as a means of being helped to reflect on the work and receiving support to enact compassion towards others.

> *Eva: What I really appreciate in IAPT that is different from other roles I had in mental health care is that when you need help to think about a patient, you get support from the supervisor, and that’s vital to practice compassionately.*

Congruent with what supervisees have said, some supervisors such as Dante and Monica have demonstrated awareness that clinicians require their support as a person who is also a professional in order to nurture compassionate care. This involved acknowledging and attending to clinicians emotions and hurdles relating to their work, as well as acting on their feedback.

> *Dante: My supervisee was understandably upset and anxious. The first thing I did was to show compassion towards her, just like being understanding, so she knew that I was there to help. I’ve also reassured her that she'd done the right thing.*

> *Monica: As a supervisor, I think about compassion towards my supervisees as people doing such hard work, their needs and how to support them by responding to their feedback when things aren’t right... so they can support others.*

4.6.3 Teams Upholding a Supportive Working System

Teams upholding a supportive working system is a subcategory expressing the importance of developing and adopting a similar mind-set as a way of working to understand the need for compassionate care to flow in different directions within IAPT. This is evidenced by Mark’s quote.

> *Mark: From the perspective of the management team, it’s the supportive way we work that upholds compassionate care within the system. It’s something about everyone holding the same supportive stance.*

Monica noticed that a similar mind-set adopted in the IAPT service where she works helps with awareness of their human limitations and also helps to uphold a supportive environment that facilitates compassion both for staff and patients.

> *Monica: There’s a way of thinking in the system we all adopt as a team that is compassionate towards one another, so creates a supportive environment, so we are aware that we are humans and work with difficult clients or have our personal difficulties*

In Dante’s experience, a supportive working system aligned with staff’s ways of thinking and actions helps him and his team to nurture compassionate care.

> *Dante: Part of why we are good at that [compassionate care] is because we retained a supportive system that resonates with how the service and the people in it think… and everyone gets involved with it as a way of working.*

Further, in order to uphold a supportive working system, there are specific requirements to be undertaken as a group and as individuals. Sarah thought it requires thoughtfulness about workers and clients and compassionate care being available between professionals and patients alike.

> *Sarah: … it can be about the whole system being thoughtful of patients and colleagues and that being in line with nurturing that compassion for all.*

Moreover, being connected with the team and having open conversations about clinical difficulties and good practice was understood by Susan to help nurture compassionate care as a team.

> *Susan: It probably comes back to having those open conversations with the team when things go well and when things go wrong, and learn from that how it helps with compassionate care.*

Rose mentioned that leading by example in modelling compassionate decisions helps to uphold compassionate care. She describes that team support in difficult times can help to maintain and enact compassionate care. This is facilitated by honest recognition of their strengths and shortcomings as a team, and dealing with the difficulties by making joint and supportive decisions.

> *Rose: Sort of leading by example, when modelling decisions about care, our team is supportive to each other, and even when we're up against it, we still manage to provide compassionate care. I think partly there is recognition about what is wrong with the system, naming it and not necessarily making kind of really reactive decisions but supportive ones.*

Monica said that a supportive working system could be attained through good relationships and connections within the system.

> *Monica: Sort of the compassion within all relationships and supportive connections within the system that leads to this overall helpful thing about the service.*

Maia described that supportive relationships within the team positively affects her feelings of connectedness and levels of confidence in delivering clinical work. This was particularly poignant in order to maintain compassionate care.

> *Maia: When you have access to sources of support in other members of the team, you are more likely to feel confident about the work you are doing. When people are working robotically, they might feel like they're managing on their own. Then, I think we do lose compassion at times.*

Natasha has noticed an opportunity and the need for learning from others in different ways, including reflective practice. She believes this can be inspirational to nurture and change her practice in more compassionate ways.

> *Natasha: Discussing experiences in reflective groups is helpful to grow in your practice; also listening to my colleagues being compassionate on telephone assessments is inspiring.*

4.7 Conditions Hindering Compassionate Care

Similarly to the category presenting “conditions nurturing compassionate care” the category “conditions hindering compassionate care” represents a macro view of how the enactment of compassionate care can be hindered in IAPT services. In the context of this study to hinder refers to barriers making it difficult for compassionate care to be enacted by clinicians working in IAPT. The conditions presented in this category are ‘service high target demands’ and ‘tokenistic support to staff’. These hindering conditions are understood as structures, rules, procedures and unbalanced responses from services to clinicians needs.

Rose described how she and other clinicians must be creative and abide by IAPT’s rules and procedures to secure funding, which is crucial for the service’s existence. For instance, it is necessary to demonstrate through routinely used measures that patients have had a positive treatment outcome.

> *Rose: We have to be creative to show results in ways that count, like really making sure staff are coding things right on the system as it can impact on funding.*

As services are put to tender endeavouring to maintain their existence, Susan talked about feeling the pressure to produce the right results required by commissioners, but in a way that suit her as a clinician.

> *Susan: We have to find ways to be commissioned and make it work for us as well. Obviously, we have to do the measures and work hard, making sure we are producing the right sort of results. So there’s pressure to demonstrate our effectiveness in order to sort of carry on, especially now that services are put out to tender.*

Table 7. Category: Conditions Hindering Compassionate Care

Subcategories
• Service high target demands. • Tokenistic support to clinicians.

4.7.1 Service High Target Demands

Service high target demands are explained as an evident hindrance to the process of enacting compassionate care in IAPT. This subcategory represents a process whereby participants tried to make sense of their concerns relating to impediments to their compassionate practice.

Mark described having to meet high target demands and demonstrate results as expected, regardless of whether or not he agreed with the established structures, rules and procedures.

> *Mark: I think a lot of the sort of more explicit goals and objectives of a service are about waiting times, recovery rates and numbers into treatment. So sometimes those rather more concrete, measurable objectives become elevated to a point of being the entire service project because of funding. Although I don't think it should be this way, we have to focus on that.*

Monica did not think the way outcome results are demonstrated always reflect the work carried out with the patient. Still, she tries to balance service's procedures and demands whilst also providing compassionate care that is not always accounted for in treatment outcomes.

> *Monica: It is not a great rule, because some clients don't easily get better in a way that we can show the 'right' results the service wants to see. Um, they might have benefited from seeing you but the PHQ-9*[1] *scores might not change, we can only try to do what the service wants and do a good job for the client, like offering compassionate care even if that can't be seen.*

As per Eva, the fast-paced nature of services, large caseloads and long waiting times into treatment are described as a hindrance as she aims to prioritise compassionate care. Eva also thinks these factors can negatively influence patients levels of distress and their perception of being cared for compassionately.

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[1] Patient Health Questionnaire 9 routinely used in IAPT to assess symptoms of depression.

> *Eva: We have large caseloads, and when people are waiting a long time for therapy, it's a bit of a difficult conversation to have with patients because we call them, but we're still saying to them, you need to wait three more months. I bet that doesn't sound very compassionate. Maybe if they don't have to wait for that long, their level of distress would have been contained.*

Daisy considered it a complex dilemma to maintain high access rates into treatment in IAPT and thoughtfully personalise care for each patient. This dilemma makes her feel less compassionate.

> *Daisy: Obviously working with a high volume of patients, it can sometimes be, you know, a barrier to us thinking personally about what's going to be helpful to that patient in each and every interaction. Facing this complex dilemma makes me feel less compassionate.*

Whilst endeavouring to meet the service high target demands, Susan and Eva described making a conscious effort to prevent them from affecting compassionate care to patients.

> *Susan: We're being pulled in a lot of directions, but that can't be at the cost of operating in compassionate ways.*

> *Eva: We need to keep alert about where we are investing our efforts, and checking if that isn't getting in the way of offering a compassionate service.*

Maia linked increased demands about access rates to achieve targets, directly with a vulnerability of losing compassionate care.

> *Maia: Um, so I think it's like the service demands and the way the service is structured can be a hindrance to compassionate care in terms of just the sheer volume of people we need to get through the door. It requires the right balance, or we get vulnerable to losing that compassion.*

Monica noted that her service has a helpful approach in helping each other as they work under stress and pressure to meet service demands. She stresses that a helpful environment promotes the possibility of finding a balance between meeting targets and prioritising good care for patients.

> *Monica: There is a lot of pressure placed on us on the job, so whilst we are focusing on our demands, I think within our service we help each other, and we manage to strike a good balance between hitting targets and still looking after people well.*

Mark acknowledged that some of IAPT’s rules and procedures, such as the type of therapy and access rates, can be rigid and therefore a hindrance that makes staff feel pressurised and compassionate care effortful. However, whilst trying to achieve targets, he finds it helpful to maintain thoughtfulness and to attend to clinicians and patients’ specific needs adapting the support required for clinicians to enact compassionate care and for patients to have a compassionate experience of the service.

> *Mark: I think IAPT can be stereotyped as rather rigid with the number of sessions and type of therapy, targets for access rates… that is not always conducive to compassionate care, but it helps to be thoughtful, recognising clinicians and patients’ specific context they are acting from and adjusting the work in a way that is consistent with needs as well as the content and fidelity requirements of a model and the system.*

Monica described how working flexibly and empowering clinicians to adapt their practice can be helpful whilst meeting high targets demands.

> *Monica: Of course people are expected to do a certain amount of work, but they need to be trusted and empowered to make choices about how they structure their time, while still maintaining that compassion, rather than having too much rigidity that can come with the way the service is, which I think makes people feel closed in.*

Sarah engaged in a reflective dialogue as an attempt to bridge what she perceived as an incongruous task at times.

> *Sarah: What's my aim for the sessions? Is it to be nice? Help the client to feel better? And have strategies that are going to help them long term? Or am I just trying to get into reducing their scores on the questionnaire so the service looks good? That's not compassionate care.*

Sarah also highlighted that demands on time relate not only to patients potentially receiving a less optimal quality of care, but it is also detrimental to staff. This is because despite trying to do her best, she finds it hard to have perspective on how well they are working.

> *Sarah: I can't give people that level of compassion because I have no time to think. You do your best. I think that's the nature of IAPT, there are so many targets, you know, that you just can't really get that perspective. People start giving compassionate care to their own detriment. Some IAPT is not set up for people to deliver the level of compassion that you want to give or that is needed having to see six patients a day.*

Alisha and Susan expressed discontentment, as for them reaching high target demands also meant that targets would continue to increase, without the necessary support in place to achieve them or to feel accomplished.

> *Alisha: When IAPT does a good job in showing results, targets get higher and add pressure for the next year, so it never settles.*

> *Susan: It feels like it's getting harder to balance it all because every year the number of people we are expected to see increases.*

4.7.2 Tokenistic Support to Clinicians

Meeting high target demands whilst trying to offer compassionate care, demands adequate support to clinicians. This last category represents clinicians' needs for balanced support instead of a type of support that does not help with their difficulties. Balanced support in this context relates to a position of equilibrium between different structures, rules, procedures and people (e.g. leaders, staff and patients) within a system. This category emphasises that clinicians operating under the condition of receiving tokenistic support are less likely to successfully enact compassionate care in IAPT.

Dante expressed what he believes to be an imbalance between service high target demands and the support received from the service, which is not conducive to helping others compassionately.

> *Dante: How do you fit in compassion when that competes against recovery data and all those other kinds of operational things? We certainly need the service to know what we are up against and help us in the right way so we can carry on helping others compassionately.*

Sarah described a time when she required balanced instead of tokenistic help as she struggled to be compassionate.

> *Sarah: Last year I struggled to be compassionate and felt out of my depth with so many complex cases and service demands, it is ridiculous. I need help from the service that matches my needs as a therapist.*

Tokenistic support to clinicians was characterised by one-off events that did not match their needs. Monica described how tokenistic support did not contribute to her wellbeing or the enactment of compassionate care in IAPT. Instead, she expressed her needs for thoughtfulness to match the support provided with her needs.

> *Monica: To offer some ice cream to staff once a year, ok it is nice and makes them happy in the moment, but is that what we need? Does it make a difference in me feeling cared for or better able to care for people? Help needs to be thoughtful thinking about what I need to make a difference.*

Tosin commented on the fact that tokenistic support for staff has short-term rather than long-term effects. She believes a more consistent approach could be helpful towards her wellbeing and her enactment of compassionate practice.

> *Tosin: If it is just tokenistic support like a one-off mindfulness session, it doesn't help me in the long term with wellbeing or work that I want to do compassionately. I need something more consistent with our needs, like a regular space to boost wellbeing even if it is mindfulness.*

Tokenistic support was also indicated to have the potential to offend as people might feel insulted by the disparity between support received and what is needed. Daisy commented on feeling disrespected when her needs (e.g. resources) as a clinician are not appropriately addressed. She believes addressing this can contribute to a happier work stance and improved quality of care.

> *Daisy: I feel disrespected because there is no point in just doing something nice from time to time. We need to address real needs, for example, resources to work happily and deliver good care.*

As a manager, Rose noticed that tokenistic support to staff can be perceived as unfair and does not lead clinicians to feel supported and valued by the service.

> *Rose: Sometimes the service get things done for the team, but it is not what the team needs to carry on feeling supported to do the work. People don't like that; they don't feel valued.*

Clinicians entrusted managers and team leaders to be attuned to when adequate support to staff is required, but tokenistic support is being offered instead. Maia suggested they should keep in mind the levels of distress she is exposed to and seek her feedback.

> *Maia: It helps me when seniors focus on staff's needs and wellbeing, helps me to manage the responsibilities and keep sane. Leaders should*

> *always consider the level of distress that we're exposed to and ask about how we might be experiencing the service.*

As a manager, Susan agrees with Maia that seeking clinicians' feedback and acting on them can help clinicians feel supported and cared for.

> *Susan: I think people come to work and want to feel supported, cared for. So as a leader, I need to be sensitive to this, and when there's a problem, do something about that and act on their feedback*.

Mark describes as a human element noticing staff's difficulties and looking after them adequately.

> *Mark: What I do as a manager is to help people manage, rather than letting their problems be an additional stressor for them. There's this general practical human element of noticing when they are not ok and finding out by checking with them what would help so we can look after each other.*

Rose also reflected both from the perspective of being managed in a helpful way and managing other members of the team. She believes adequate support positively influences competence and confidence to provide compassionate care, as well as reduce staff turnover.

> *Rose: As a manager, it's also about thinking of staff needs and supporting them to feel competent and confident to provide compassionate care for their clients. Because when staff is looked after well not tokenistically, you get people like myself who have stayed here for so long. Otherwise, you get high staff turnover that is never helpful.*

5 DISCUSSION

5.1 Chapter Overview

This chapter discusses the results of the study in the context of the research question, aims and relevant literature. A critical review of the research, implications for clinical practice, limitations and directions for future research are subsequently presented.

5.2 Review of the Research Question and Aims

IAPT services are one of the main providers of primary mental health care in the UK. Despite this, compassionate care had not been investigated in IAPT, and most of the previous researchers have explored compassionate care within physical healthcare and lesser within mental healthcare. The current study addressed the question “What is the process of compassionate care in IAPT services?” from the perspective of qualified clinicians working in IAPT. This research has also addressed the aim to generate new knowledge about the facilitators and inhibitors of compassionate care in IAPT.

5.3 Review of the Model: Enacting Compassionate Care in IAPT Services

This research employed a Grounded Theory methodology to generate an empirically informed model that defines compassionate care and its core elements. The developed theory proposes that compassionate care in IAPT involves individual, relational and behavioural components. Based on participants’ accounts in this study, compassionate care has been described as a process whereby clinicians possessing compassionate attributes and skills facilitate the development of an interpersonal connection with patients whilst offering a meaningful response to patients suffering. It is also understood, through the theoretical model, that compassionate care in IAPT is a dynamic process between all those relating to the service, including professionals in different roles and people accessing IAPT services. This process has separate elements, yet overlapping contexts that influence how the enactment of compassionate care in IAPT services can be either nurtured or hindered.

5.3.1 Possessing Core Attributes and Skills of Compassion

Clinicians discussed bringing individual attributes and skills that could contribute to the enactment of compassionate care. Clinicians have also identified core attributes and skills associated with compassionate care, desirable to all clinicians. These attributes and skills could be innate or have been acquired through different life experiences. Correspondently, Sinclair et al.’s (2018) Healthcare Providers Model of Compassion was centred on the idea of clinicians possessing virtues as the primary motivator of compassionate care.

IAPT clinicians understood these attributes and skills as fluid, and as such, they could be enhanced through awareness of compassionate care being raised in training and opportunities to reflect on compassionate practice at work. Therefore, it seems that whilst it is important for clinicians to possess core attributes and skills of compassion, IAPT clinicians understood these could be nurtured and developed through for example on-going training, reflections and clinical practice.

The perspective of having attributes and skills that can be further enhanced and developed is similar to that of Smith-Mcdonald et al.’s (2019) study with residents, family members and clinicians in palliative care; and in Bray et al.'s (2014) study; where a range of health professionals and pre-registration nurses indicated that for as long as the ability to be compassionate existed in them, it could be further developed. Similarly, in Vivino et al.’s (2009) study, psychotherapists reported their understanding of compassionate care as innate, and that it could be further awakened.

5.3.1.1 Respecting patient values: Respecting patient values was regarded by participants as an attribute whereby they consider what matters to patients in life. Participants discussed that respecting patient values was particularly important to keep in mind in the context of IAPT where, at times, clinicians’ lack of time and resources at work, might impede exploration and prioritisation of patients values believed essential to devise a meaningful treatment. This finding is also similar to other studies showing that mental health professionals considered respecting patients' values as a crucial component of compassionate care (Sanghavi, 2006; Spandler & Stickley, 2011). This outcome has also been found in physical healthcare with clinicians reporting that compassionate care must involve respect for patient individual hopes and values (Kvangarsnes et al., 2013).

5.3.1.2 Drawing from personal experiences of compassion: Indirect and direct experiences of compassion in both personal and professional settings where understood by clinicians in this study to help them provide compassionate care in IAPT. Some of the examples provided by participants about their personal experiences of compassion were across a variety of contexts: illness, family upbringing, personal development, preclinical education, faith and observing clinical examples of compassion in practice. Being able to draw from personal experiences of compassion was described as an individual skill that helps to understand patients' needs. This is because clinicians in this study discussed being able to internalise these experiences of compassion to make themselves more compassionate clinicians. This possibility is supported in Gilbert's (2009) Compassionate Mind Approach, whereby being able to internalise compassion might facilitate self-compassion and compassion for others. This suggests that experiencing compassion could aid in the ability to provide compassionate care to patients in IAPT.

Possessing this skill to enact compassionate care reflects findings from studies with patients as they identified clinicians ability to use personal experiences of compassion as a key contributor to the capacity for compassionate care in clinical practice (Bramley & Matiti, 2014; Crowther, Wilson, Horton, Lloyd-Willimas, 2013; van der Cingel, 2011). Moreover, researches investigating the views of students and qualified clinicians in physical health settings (Graber & Mitcham, 2004; Sanghavi, 2006), and in mental health settings (Vivino et al., 2009) have also found this to be a significant skill to facilitate compassionate care, as clinicians were able to understand how patients could be feeling and what could help alleviate their suffering.

5.3.1.3 Attentive listening: Paying undivided attention to patient's narrative of their stories and presenting complaints was also identified as a core skill in the present study. According to clinicians, this helped them to be attuned to the patients narrative of the problem rather than their own. They think it may also help patients to feel care for compassionately, as the clinician is not the only person talking but rather providing a space for patients to feel heard.

Day's (2015) thematic analysis study with 77 UK-based nurses also supported the importance of listening as a compassionate skill. Likewise, other studies that gathered patients' views on compassionate care have also reported that when patients are feeling listened to, it appears to implicate in them reporting a positive experience of care that is compassionate (Armstrong, Parsons & Barker, 2000; Bramley & Matiti, 2014; Kret, 2011; van der Cingel, 2011; Way & Tracy, 2012).

5.3.1.4 Adopting a non-judgemental approach: Participants suggested that adopting a non-judgemental approach could be enacted through the use of non-judgemental language and being mindful about clinicians' own preconceptions of how a person who has received a diagnosis may present, and whether they will be able to help. Participants' account indicated that adopting a non-judgemental approach could be helpful in IAPT in order to engage patients into treatment collaboratively. Adopting a non-judgemental approach was also understood as a way to allow patients to freely make sense of their difficulties. In addition, this approach would help clinicians avoid seeing patients as only a problem to solve, and thus seeing patients holistically, which was described as an approach more aligned with compassionate practice.

Similarly, other studies with healthcare professionals have also shown the importance of a non-judgemental approach and recognising the patient as being separate from their presenting illness as an important aspect of providing compassionate care (Bickford et al., 2019; van der Cingel, 2011). Relatedly, studies with patients have reported that clinicians communicating with a judgmental attitude, pity or making false assumptions are not seen as compassionate (Lloyd & Carson, 2011).

5.3.1.5 Motivation to help vulnerable others: Being motivated to help vulnerable others was described by participants in this research as a hallmark of compassionate care. A clinician added that having the motivation to help vulnerable others is a driving force to relate to others and care for them. This was identified as the most important component under the category 'Possessing Core Attributes and Skills of Compassion". Participants described that without this attribute compassionate care in IAPT may not bridge a link between clinicians using all attributes and skills, to invest in building a relationship with people to then be able to help them.

The Three Components Model of Compassion in a USA hospice (Way & Tracy, 2012) and the Healthcare Providers Model of Compassion in palliative care in Canada (Sinclair et al., 2018) have also highlighted motivation to help as a vital component conceptualising compassionate care from clinicians' perspectives. Additionally, there are similar thoughts for this aspect of the current research from previous research outlining motivation to help others seen as vulnerable as crucial to the foundation of the patient-carer relationship in both the UK and Europe within different healthcare settings (Badger & Royse, 2012; Bramley & Matiti, 2014; Bickford et al., 2019; Kneafsey et al., 2016; Kret, 2011; Sloan & Deery, 2017; van der Cingel, 2011). Therefore, it is likely that as described in the present study, the motivation to help vulnerable others is a key component to facilitate clinicians compassionate care within IAPT.

5.3.2 Building an Interpersonal Connection

Building an interpersonal connection marked a critical stage in enacting compassionate care in IAPT. Clinicians described employing their core attributes and skills, investing in getting to know patients and connecting with them, before attempting to help. Connecting and relating to vulnerable human beings implies a level of reciprocity and interdependence emphasised as the nature of compassion in the present research and previous studies (Bickford et al., 2019; Paulson, 2004; Sabo, 2011; Sanghavi, 2006). Similarly, in Sinclair et al.'s (2018) model healthcare providers conceptualised compassion as connecting through a relational understanding with the client's suffering and promoting change through action.

5.3.2.1 Looking beyond the presenting problem: Participants reported seeking to gain a holistic understanding of the patient when trying to look beyond their presenting problem. This was described as a helpful factor to build an interpersonal connection. This is consistent with findings within research (Bramley & Matiti, 2014; Goodrich, 2016; Lloyd & Carson, 2011; Papadopoulos et al., 2015) and the theoretical literature emphasising the importance of 'knowing the person' within caring relationships (Dewing, 2004; McCormack 2004; Nolan et al., 2006; Perry, 2009; Walsh & Kowanko 2002; Zolnierek 2014).

Furthermore, studies have shown that even the most transient of contacts between clinicians and patients (Chochinov, 2007; Safran & Muran, 2000) even in services with high patient throughput (Dewar & Nolan, 2013) can reflect an orientation towards a supportive connection. This might suggest that, in itself, brief therapeutic encounters offered in IAPT should not impede building an interpersonal connection as part of the process of compassionate care.

5.3.2.2 Trying to understand the other person's perspective: In this study clinicians said they try to understand the other person's perspective by allowing the patient to convey their understanding of the problem without imposing clinicians' views or preconceived ideas about how they feel, or what the impact of the problem might be. Participants thought that trying to understand the patient's perspective strengthened the interpersonal connection. Similarly, Dewar and Nolan (2013) 7 Cs Model of Compassion was centred on appreciative conversations. Patients, their families and relatives identified trying to consider the perspective of the other person essential to the care of older adults. Similarly, in Sinclair et al.'s (2015) patient study, gaining an understanding of the person was discussed as an integral component of compassionate care.

Trying to understand the other person's perspective was also described to help clinicians to make better sense of patients difficulties before considering how best to support them. Similarly, studies investigating the views of patients have argued that patients who felt that their clinician understood their perspective had experienced a more positive overall care; which may be linked to receiving compassionate care (Attree, 2001; Thorne, Kuo, Armstrong, McPherson, Harris & Hislop, 2005).

5.3.3 Meaningful Response to Suffering

Participants in this study communicated that providing a meaningful response to suffering was deemed possible when clinicians employed a dynamic and shared process of working with patients collaboratively. This would involve firstly employing their attributes and skills, as well as building an interpersonal connection with patients. And then by having a clearer understanding of their needs, clinicians would be able to revise their previous understanding of the patient's difficulties, regarding what might be a meaningful response to each person's suffering. Only then clinicians would feel better equipped to respond with actions that may alleviate suffering.

Responding to suffering as part of compassionate care has featured in many studies, including the models of compassion described in this thesis. For instance, in Sinclair et al.'s (2015) patient model of compassion, patients emphasised a relational space and action based on clinicians virtuous response to suffering.

5.3.3.1 Incorporating patient feedback into care: This was identified as an essential element of compassionate care when trying to offer a meaningful response to suffering. A participant stressed that services risk lacking compassionate care unless clients are actively involved in providing feedback that helps to review their individual treatment and service provision as a whole. Echoing the views of clinicians in this research are studies and documents showing links between services that regard the patient as an equal contributor to their care, where their opinions are sought and valued; and the provision of care that is perceived as compassionate (Adamson, 2013; DOH, 2008; NHS, 2014).

Moreover, Smith, Gentleman and Conway (2019) assessed nurses' experience of the Valuing Feedback NHS development programme of compassionate practice. Nurses found reflecting on patients' feedback helpful. They reported requiring support to plan, undertake and initiate practice development based on feedback. It can be suggested that similarly IAPT clinicians are also likely to need support to incorporate patient feedback into care.

5.3.3.2 Providing personalised care: Participants accounts appeared to be linking many of the attributes, skills and relational aspects of compassionate care described in previous categories in order to personalise care. For example, clinicians in the current study perceived compassionate care to involve attentive listening, accounting for and respecting patients' values and seeing them beyond their problems in order to provide adequate support. Also, participants believed that only by having an interpersonal connection with patients where all perspectives were considered could personalised care be provided. In Sinclair et al.'s (2018) Healthcare Providers Model of Compassion it was shown that only through an in-depth understanding of the person they could provide personalised care, deemed as an essential part of compassionate care. Other studies have shown that patients and clinicians described as key relational factors of compassionate care 'not assuming how people want to be cared for' (Dewar & Kennedy, 2016) and 'engaging the patient as a person with individualised needs' (Badger & Royse, 2012; Bray et al., 2014; Fernando & Consedine, 2014; Lown, Rosen & Marttila, 2011).

When trying to personalise care to meaningfully respond to patient suffering, it is often assumed patients will get better from their psychological difficulties as a result of treatment. As discussed by Hayes et al. (1999), patient 'non-recovery' after treatment, as assessed by standard measures to a specific diagnosis, tends to be related to the therapist's failures in delivering treatment or the client's levels of severity or engagement, rather than the theoretical unsuitability of the framework to the individual. This suggests that in practice, IAPT clinicians may encounter the dilemma of whether to use a specific therapy approach commissioned to services or to use a more idiosyncratic approach to make sense of people's difficulties and provide personalised care; even though this might not be accounted by routinely used measures of outcome. Another dilemma is that due to each service location, provision of care available within IAPT or via partner organisations in the community may vary and, therefore, the client group they are able to serve. Yet, clinicians in this study have shown that working collaboratively with patients helped to personalise care as much as possible, despite limitations of theoretical approaches and resources.

5.3.4 Conditions Nurturing Compassionate Care

To nurture compassionate care refers to a collective responsibility between all those relating to IAPT services in any capacity to develop, maintain and deliver compassionate care.

5.3.4.1 Clinicians engaging in self-care: Self-care is defined as “being mindful of and carrying out positive practices routinely towards one’s emotional, relational, spiritual and physical needs” (Wise & Barnett, 2016, p. 210). In the present study, self-care was specified within physical, psychological, social and spiritual domains. These are the same domains proposed in Malinowski’s (2014) review of the USA literature. IAPT clinicians linked self-care to an increased ability to care for others. There are links between clinicians’ self-care and experience of wellbeing at work and their ability to provide safe care to patients (Boorman, 2009; Dawson, 2009).

In psychology, self-care is stated as an ethical requirement to practice (Health and Care Professions Council, 2016). Although participants in this study identified their shared responsibility to engage in self-care, it is important not to take an individualised view of self-care to avoid justifying blaming of the individual for not coping with unmanageable pressures (Norcross & Barnett, 2008; Pakenham, 2015). Moreover, as mentioned by participants in this study, Barnett and Cooper (2009) also suggested that creating a culture of self-care should be considered the responsibility of the individual, the profession, and the employer. Compassion Focused Therapy has also been implicated in supporting staff to cultivate compassion whilst helping to reduce the impact of the stress of doing so. Compassion Focused Therapy would help clinicians imagine the experience of the patient, formulate what they could do to support their physical and emotional needs, and the relief the patient may feel when their needs are attended to (Cole-King & Gilbert, 2011).

5.3.4.2 Supportive supervisors facilitating compassionate care: As proposed by the model, according to participants' accounts, IAPT supervisors may have the opportunity to facilitate compassionate care by being attuned to clinicians' needs. Clinicians also described that a supportive supervisor could offer reassurance and provide a reflective space that could help clinicians gain new perspectives of their clinical efforts. Also, from the view of some clinicians, supervisors who listen and act on clinicians' feedback were thought to aid work balance, which was perceived as essential to enact compassionate care in IAPT when clinicians are busy with different tasks. Increased clinical supervision and support to manage the workload have been associated with lower levels of burnout in clinicians (Killian, 2008; Morse et al., 2012; Rupert et al., 2015; Skovholt et al., 2011). This could be a helpful strategy to nurture compassionate care in IAPT.

Moreover, the Compassionate Mind Approach could be used to illustrate the process of supervision as both a risk and a protective factor against issues that might hinder the enactment of compassionate care in IAPT. For example, supervisors perceived as threatening may activate a clinician's threat system. This can lead to a reduced willingness to disclose vulnerabilities in practice, and as a result, clinicians may not receive the appropriate support. Equally important, this could interfere with the provision of compassionate care. Further, supervisors who can show vulnerabilities and model compassion to self and others might normalise clinicians' difficulties, improve clinicians wellbeing and confidence in providing compassionate care (Beaumont & Hollins; Firth-Cozens & Cornwell, 2009; Martin, 2016).

5.3.4.3 Teams upholding a supportive working system: In the present study, clinicians described that on its own wishing to provide compassionate care was insufficient to ensure this transpired; clinicians needed to work with similarly minded colleagues that supported them to do this. This is also evidenced in Tierney et al.'s (2017) model Enabling the Flow of Compassion, where NHS clinicians conceptualised compassionate care as needing to be present in all aspects of the services and amongst professionals responsible for supporting the flow of compassion. In turn, this helped clinicians to care for others compassionately. Compassionate leadership in teams is also thought to help improve compassionate care and innovate service design (King's Fund, 2017).

Supportive working teams have shown to buffer the depleting effects of wider organisational pressures. Thus lowering clinicians' levels of stress, and improving clinicians' emotional capacity to be compassionate towards others (Carter & West, 1999; Lyubovnikova et al., 2015; West & Markiewicz, 2016). Conversely, teams operating in a threat system instead of a supportive working system may favour imposing detrimental working cultures rather than collaboration, thus exacerbating clinicians levels of stress and hindering compassionate care (Cole-King & Gilbert, 2011). Conversely, studies have shown that professionals with access to supportive peers and supervisors felt more valued, and this increased their sense of maintaining a positive work atmosphere, achievement, enthusiasm and teamwork (De Lange & Chigeza, 2015; Ohrt & Cunningham, 2012; Sui & Padamanabhanunni, 2016).

5.3.5 Conditions Hindering Compassionate Care

Participants conveyed that conditions hindering compassionate care represent a macro view of organisational factors. Compassion and organisational research articulated that organisational factors could hinder compassionate care. For example, when workers perceive the factor of organisational threat, by being continually informed about financial restrictions, it can lead to job insecurity and could influence clinicians' ability to provide compassionate care (Gilbert, 2009). Another perceived organisational threat that can hinder compassionate care in IAPT relates to organisations frequently dealing with pressures towards self-examination, accountability and reporting structures in order to prove its worth (Warwick, Meade & Reed, 1975).

Authors have suggested that accountability is shared with governments and organisations that design the spaces and contexts for compassionate engagements to occur between patients and practitioners (Crawford & Brown, 2011; Cummings & Bennett, 2012; Francis, 2010; Nijboer & van der Cingel, 2019; Tierney et al., 2017). It can be argued that compassionate leadership also plays a key role in clinicians compassionate care. For instance, compassionate leaders can ensure agreed rather than imposed objectives, based on a shared understanding of the work context faced by the team. This approach would differ from a leadership style that only focus on target-driven outcomes that appear to have limited success (Ham, 2014).

5.3.5.1 Service high target demands: As described by clinicians the fast-paced nature of work in IAPT, large caseloads and long waiting times into treatment could be a hindrance that makes staff feel pressurised and compassionate care effortful. As a result, patients might receive a less optimal quality of care. In addition, participants also indicated that high target demands could be detrimental to staff morale and wellbeing. Comparably, in Brown et al.'s (2013) and in Crawford et al.'s (2013) studies, mental health professionals' perspectives on compassion predominantly focused on organisational barriers with multiple references to targets as a hindrance to compassionate care. Likewise, Tierney et al.'s (2017) model Enabling the Flow of Compassion described "drainers of compassionate care" as many competing target demands that hindered NHS clinicians' delivery of compassionate care to patients with type 2 diabetes. "Defenders" were linked to realistic work-related goals and expectations.

Service high target demands is an important consideration as the nature of the therapeutic work can be emotionally costly for mental health professionals resulting in compassion fatigue, vicarious trauma and burnout (Figley, 2002; Sim et al., 2016; Thompson, Amatea & Thompson, 2014). As previously discussed, PWPs and HI clinicians have forecasted the highest levels of burnout among the mental health workforce (Westwood et al., 2017), which are linked to a reduction in the provision of compassionate care (West & Dawson, 2015; Rizq, 2012; Scott, 2018).

5.3.5.2 Tokenistic support to clinicians: Participants discussed that tokenistic support was a disparity between the support provided and clinicians' needs. Instead, it was indicated that adequate support to clinicians could result in long-term positive effects such as a sustained motivation to provide compassionate care. Clinicians reported that services taking a non-tokenistic approach to support clinicians require thoughtfulness and consistency, and could positively influence competence and confidence to provide compassionate care, as well as reduced staff turnover. Whereas positive outcome would not be possible if the necessary support were not in place to achieve high target demands, provide compassionate care and to have a sense of accomplishment at work.

Goetz et al. (2010) argued that mental health professionals might feel anger towards a system perceived to have influenced their distress by limiting their resources and by only providing inadequate support that does not match their needs. Therefore, considering the research findings, unravelling the contexts within which different approaches are effective in IAPT services could contribute to devising adequate support that nurtures compassionate care within services.

Also in this study, clinicians associated tokenistic support with not feeling valued, respected and understood by others in the service. Related to clinicians views in this study, Dutton et al. (2014) argued that feeling valued is not a given in organisations; rather, it is something that is either created or destroyed, by the workplace interactions. This also relates to the views of IAPT clinicians in this study, where they conveyed the need for teams to uphold a supportive working system that can nurture compassionate care.

5.4 Critical Review

This section provides a critical evaluation of the research and different aspects of reflexivity. Willig (2008) argues that the criteria of reliability, validity and generalizability used to evaluate quantitative research cannot be meaningfully applied to qualitative research. Spencer and Ritchie (2012) developed a set of guidelines to evaluate qualitative research which is based on principles they believe underpin different conceptualisations of what can be deemed as good quality qualitative research: contribution, credibility and rigour. These guidelines have been used to evaluate the research presented in the thesis.

5.4.1 Contribution

Contribution refers to the relevance of the research to theory, clinical practice or to the lives of individuals involved in the study. It can be argued that the present research has made a significant contribution to the literature because compassionate care in IAPT had not been studied in comparison to other healthcare settings. This is despite IAPT being one of the main providers of primary mental health care in the UK. The research contributes to the theoretical understanding of compassionate care by developing a model from direct reports of participants working clinically in the field; which provides substantial ecological validity for the presented findings.

Additionally, following the interviews, a number of participants reported anecdotally that they found the topic pertinent to their place of work and clinical practice. Some participants have also said the interview had evoked thoughts about their compassionate stance as a mental health professional. This suggests that the study has potentially made a contribution to individual clinicians.

As IAPT continues to expand and recruit more clinicians to support different age groups with different therapeutic approaches, findings from this study may contribute to consider timely service implementations. For instance, it could contribute to raise awareness of compassionate care during training and supervision, as well as routinely gathering patient feedback on their experiences of compassionate care. This may help to provide an opportunity for professional development through reflective practice opportunities. Services considering these suggestions may allow for compassionate adaptation in clinical practice.

Notably, this study presents tokenistic support to clinicians as an area that in the past has not been frequently reported or represented in other models of compassion. This contributes to an understanding of what might inhibit compassionate care specifically in the context of IAPT services, as well as what could be changed to nurture compassionate care.

On a wider scale, this finding could contribute to the revision of IAPT policies to reinforce compassionate care and the necessary individual support to clinicians and the required parameters for a supportive working system that nurtures compassionate care. In turn, a supportive working system could also contribute to a reduction in clinician burnout and the high level of staff turnover that has been previously identified in IAPT as an issue (Westwood et al., 2017).

5.4.2 Credibility

Credibility refers to whether the research's claims are supported by evidence forming a clear link between data and findings. This study has demonstrated credibility by providing extracts of raw data as part of the Analysis and Results chapter, where the claims are grounded in data excerpts from participants interviews. Also, the Methods chapter describes how the data has been categorised and added to become part of the outcome reported in the Analysis and Results chapter. Further information, such as the full transcripts or recordings, can be provided upon request.

5.4.3 Rigour

Rigour relates to whether the study was conducted safely and deemed methodologically valid and transparent. The Methods chapter demonstrates how data generation and analysis has been conducted in a systematic way. The Analysis and Results chapter provides a detailed and coherent narrative of how the analysis was conducted. An example of an analysed piece of text is included in Appendix K. Also, written memos helped to maintain rigour by considering the impact of the researcher's role, as well as values, ethical and theoretical orientation.

5.4.4 Transparency and Reflexivity

Theories that are generated from data are inherently influenced by the researcher's experiences and, therefore, transparency and reflexivity are considered an integral part of the research process (Charmaz, 2014; Parker, 2005; Patton, 1990). The researcher used reflexivity through memo writings throughout the research process; an example of these is provided in Appendix L. Personal, professional, epistemological and methodological reflections are presented below to provide evidence of reflexivity throughout the research process.

5.4.4.1 Personal and professional reflexivity: Research transparency and reflexivity also include outlining the researcher's personal relevant characteristics and history that might have influenced the study (Thompson & Harper, 2012; Willig, 2001).

The researcher was transparent about having worked in IAPT services prior to training as a Clinical Psychologist. This previous experience has influenced the researcher’s interest in the study due to a degree of familiarity with IAPT’s clinical context. However, it was not assumed that clinicians being interviewed would have the same experiences to those of the researcher. As suggested by Coyle and Wright (1996), memos were used to help maintain reflexivity on this stance, thus separating preconceived ideas from the analysis guided by the clinicians’ accounts.

At times, participants seemed to seek reassurance from the researcher that they could relate to their perspective, particularly when describing the more difficult aspects of working in IAPT. The researcher was aware of wanting to engage in reflections with participants but decided not to share personal views during the interview. It is believed that adopting this stance has enriched the researcher and participants’ experiences as participants could share their perspectives freely as otherwise, this could have interfered with the data generated.

As an NHS employee, fortunate to be exposed to different services prior to and during training, the researcher witnessed different difficulties faced by service leads, clinicians and patients. Despite this, the researcher has also worked in service contexts whereby clinicians’ maintained motivation to offer compassionate care whilst also managing systemic problems. These were inspiring experiences for the researcher. These scenarios and experiences have encouraged the researcher to investigate compassionate care within one of the main providers of mental health services in order to help better understand and support compassionate practice.

The researcher is personally interested in providing compassionate care to people seeking help for mental health difficulties and believes this is enacted through their clinical practice. In future, the researcher endeavours to maintain their ethical responsibility to contribute to the development of compassionate practice, whilst also remaining interested in, and questioning the different agendas (e.g. political) that might influence compassionate care in the NHS.

5.4.4.2 Epistemological and methodological reflexivity: Willig (2013) recommends reflection on the epistemological and methodological assumptions of a study, enabling consideration of what has been enhanced or obscured by the approach taken. This study adopted a critical realist position, using this to inform the Grounded Theory methodology. The rationale for adopting a critical realist position is presented in the Methods chapter. By adopting this position, the researcher acknowledges that the participants could take differing perspectives on compassionate care.

While this study's critical realist epistemology and Grounded Theory methodological framework were purposely chosen as the best fit to answer the research question, a different approach could have given the study's process, analysis and conclusions a different emphasis. For example, a phenomenological approach could directly connect with participant's experiences (Larkin & Thompson, 2012). Thus, emphasising emotional responses, which is an aspect that could have been missed by the presented model. Moreover, the model developed in this research may only present one view of what could potentially be multiple realities of how compassionate care is facilitated.

A social constructionist epistemological stance and a discourse analysis methodological approach could have elicited novel views on compassionate care. A social constructionist position may have focused on participants making sense of how the concept of compassionate care is socially construed and spoken about within IAPT (Harper, 2012). A discursive approach could have focused on unpacking common terms that are used to describe similar experiences (Potter, 2004). This could have contributed to an even deeper understanding of the meaning of words used by participants relating to interpersonal processes and systems of meaning (Coyle, 2000; Willig, 1999).

Discourse analysis might have pointed to a relationship between discourses, institutions, power and resistance that might take place between systems relating to IAPT clinicians (Parker, 2002). Also, it could help to examine and deconstruct services' dominant discourses and elicit alternative understandings, concepts and practices that can be engaged politically and socially as a form of action towards change (Harper, 1995). Consequently, exploring the subtle ways in which clinicians might have been subjugated by dominant discourses and practices to then increase reflexivity and raise consciousness, stimulating more competent and empowering professional practices (Willig, 1999).

Methodologically, the researcher had to deviate from only conducting a literature review after the analysis was complete as it is normally expected in Grounded Theory to minimise the influence of existing theoretical knowledge (Resnik Mellion & Moran Tovin, 2002). This was not entirely possible due to having to carry out a partial literature review for the research proposal as required by the university. This, in conjunction with the researcher's experience of working in IAPT, could have influenced the analysis and the subsequently developed model. Also, an abbreviated version of Grounded Theory was utilised in this study due to time limitations of a Professional Doctorate. While measures were taken to ensure that quality was maintained in the coding process, use of the full version could have allowed for a more in-depth exploration of the data and potentially a more elaborated theory.

5.5 Implications for Clinical Practice

Implications and recommendations for clinical practice are discussed below, followed by suggestions for potential areas of future research.

5.5.1 Individual Practice

This study does not attempt to make prescriptive recommendations that infer there is only one way of providing compassionate care; rather it attempts to provide an all-encompassing social process that conceptualises compassionate care from the perspectives of clinicians interviewed at a particular point in time.

Clinicians may find it helpful to reflect on their individual social process and enactment of compassionate care in relation to the theory this thesis presented. This may help them to consider how and when they incorporate different aspects of compassionate care to enhance their practice. An emphasis has been placed on the complex dynamic between clinicians wanting to provide compassionate care and inhibitors and facilitators of compassionate care within services. Therefore, individuals could consider the support they may need individually in order to nurture compassionate care and manage hindrances to compassionate care. This is similar to the recommendations outlined by Dewar and Nolan (2013), who suggested space and support is required to allow for self-reflection in the process of compassionate care.

As previously emphasised, it may be difficult for clinicians to enact compassionate care when they are facing difficulties; heavy workloads, tokenistic support and lack of organisational resources. Self-care was highlighted as something practitioners must engage with in the process of nurturing compassionate care. It is important, however, that clinicians wellbeing is not the sole responsibility of the individual, and cannot be used as a reason to blame clinicians for being unable to cope with increased pressures of working for the NHS.

5.5.2 Teams

This study draws attention to the importance of the role of teams in supporting an atmosphere that is conducive to compassionate care. It may be useful for teams to create a space to consider how best to ask and offer support when facing hindrances to compassionate care. Drawing from examples given by participants in this study, teams may also consider areas such as supervision, and a time to acknowledge and praise examples of compassionate practice. Participants mentioned that awareness and open dialogue within teams could support reflective practice and promote ideas of how to apply compassion successfully into practice. “Open dialogue can also allow for good sustainable, solutions to emerge to rethink the moral climate that is needed within services to support compassionate care” (De Zulueta, 2013, p. 89).

Lee and Miller (2013) described an environment conducive to facilitating compassionate care where employers provide time, encouragement, space and permission for self-care, and engaging and learning from others. This could be particularly helpful for a supportive working system in IAPT where consistency and proportionate responses to clinicians needs are prioritised so they can reflect upon their role in creating compassion within the wider culture of the organisation.

5.5.3 Systems

As discussed in this thesis situating the problem with individual clinicians and expecting them to implement compassionate care in practice would represent a rather simplistic view of the issue. It is most realistic and constructive to focus on the overall design of healthcare organisations, which have often influenced compassionate care (Crawford et al., 2013). Building on the participants' accounts of how the system may nurture or hinder compassionate care, service leaders might benefit from establishing regular consultation with staff. Regular consultations could aid a better understanding of how best to value clinicians and support their overall wellbeing and clinical practice. This suggestion is in line with an NHS England (2014) paper about compassionate leadership, which emphasised the need for organisations to listen to staff and make it clear they are valued within the wider organisation.

According to the data in this study, it could also be helpful for IAPT services to develop or make use of available strategies to incorporate patient feedback. This could effectively support the organisation to prioritise gathering, reflecting on and meaningfully acting upon patient feedback that could contribute to a better understanding of how to provide compassionate care. Attention is also needed to evaluate the impact current prioritisation of efficiency and measurable outcomes in IAPT could have on clinicians' wellbeing, and consequently on the care they provide. As discussed by Grawitch, Ballard and Erb (2015), it is insufficient and ineffective to address coping with stress and distress without addressing the underlying causes.

5.6 Limitations and Implications for Future Research

Twelve participants took part in this study and provided demographic information on their age, gender, ethnicity, spirituality, type of role of qualified clinicians, type of employment (i.e. full-time or part-time), years working in IAPT and working region in England. This information was used to describe the participants' characteristics. It was beyond the scope of this research to draw out the relationship between data and participants demographics, thus only brief observations were made. For instance, the information relating to participants' gender reflected the unequal gender balance within therapeutic professions, as only two males took part in the study. This is similar to the gender imbalance of Clinical Psychologists reported by the British Psychological Society (2016). Also, this research only considered the perspectives of qualified clinicians. It could be useful to investigate trainees' views and whether it would differ from those of qualified clinicians, given the different lengths of experience in their role.

The researcher hoped that by advertising the study online clinicians from different geographical locations would be reached. Also, by offering various ways in which clinicians could be interviewed the researcher hoped to have increased uptake from different regions in England and to have avoided potential bias arising from characteristics of local services and their particular systems. However, only clinicians from services in London showed an interest in participating in the study. This may have influenced the data towards a particular direction given potential regional similarities such as experiences of funding which could differ, for example, from services in rural areas with potentially different work pressures. Data could also have been influenced by the fact that only clinicians with an interest in the subject were more likely to partake, potentially inflating the importance of the concept in practice.

Spencer and Ritchie (2012) noted that different schools of thought vary in their assertions about qualitative research having generalizable relevance beyond its participants, settings or contexts. Some argue that wider inference is not possible using qualitative research (Schwandt, 1997; Stake, 2000). Others assert that it can offer inferential generalisation (Lincoln & Guba, 1985). Another suggests that it can provide representational generalisation (Ritchie & Lewis, 2003). Yet, another states that it can provide theoretical generalisation (Strauss & Corbin, 1998). Nonetheless, although this study does not intend to generalise its findings to other IAPT services as the researcher acknowledges that different services may have different needs and strengths it aspires to hold wider theoretical informative significance that might contribute to further research and clinical practice in other IAPT settings.

The researcher acknowledges the potential impact of broader factors within different interacting systems and contexts that can influence compassionate care. This is opposed to individualising the difficulties in enacting compassionate care in IAPT by focusing solely on clinicians or internal hindrances at an individual and service level. Thus avoiding locating both the problem and the responsibility for change in clinicians' alone. Different interacting factors are exemplified in the Figure 3 below as an added level to the model 'Enacting Compassionate Care in IAPT Services' generated from clinicians' accounts and discussed in this thesis. In the further developed version of the model the researcher adopted a broader systemic overview considering difficulties as situated within the relationships between clinicians and systems (Bronfenbrenner, 1979; Dallos & Stedmon, 2014).

The broader systemic perspective guided understanding of the way in which different systems related to IAPT may interact with clinicians' compassionate care. For example, the researcher considered macro-level influences such as social factors, neo-liberal cultures, the current governmental and political climate and the impact of austerity measure on the NHS. These aspects are thought to inform service development as well as clinicians' sub-culture, beliefs, working environment, access to resources and ability to care for patients compassionately.

Another area of consideration is the overall design of IAPT as a national organisation that might unfavourably influence the enactment of compassionate care. This is particularly of concern when the organisational design prioritises efficiency and measurable outcomes for commissioning and funding purposes, instead of therapeutic domains. Binnie (2015) proposes top-down adjustments to lessening the emphasis placed on outcome measures and targets at the commissioning and policy level. Such adjustments could support the enactment of compassionate care in IAPT services by equally focusing on different areas discussed in this thesis.

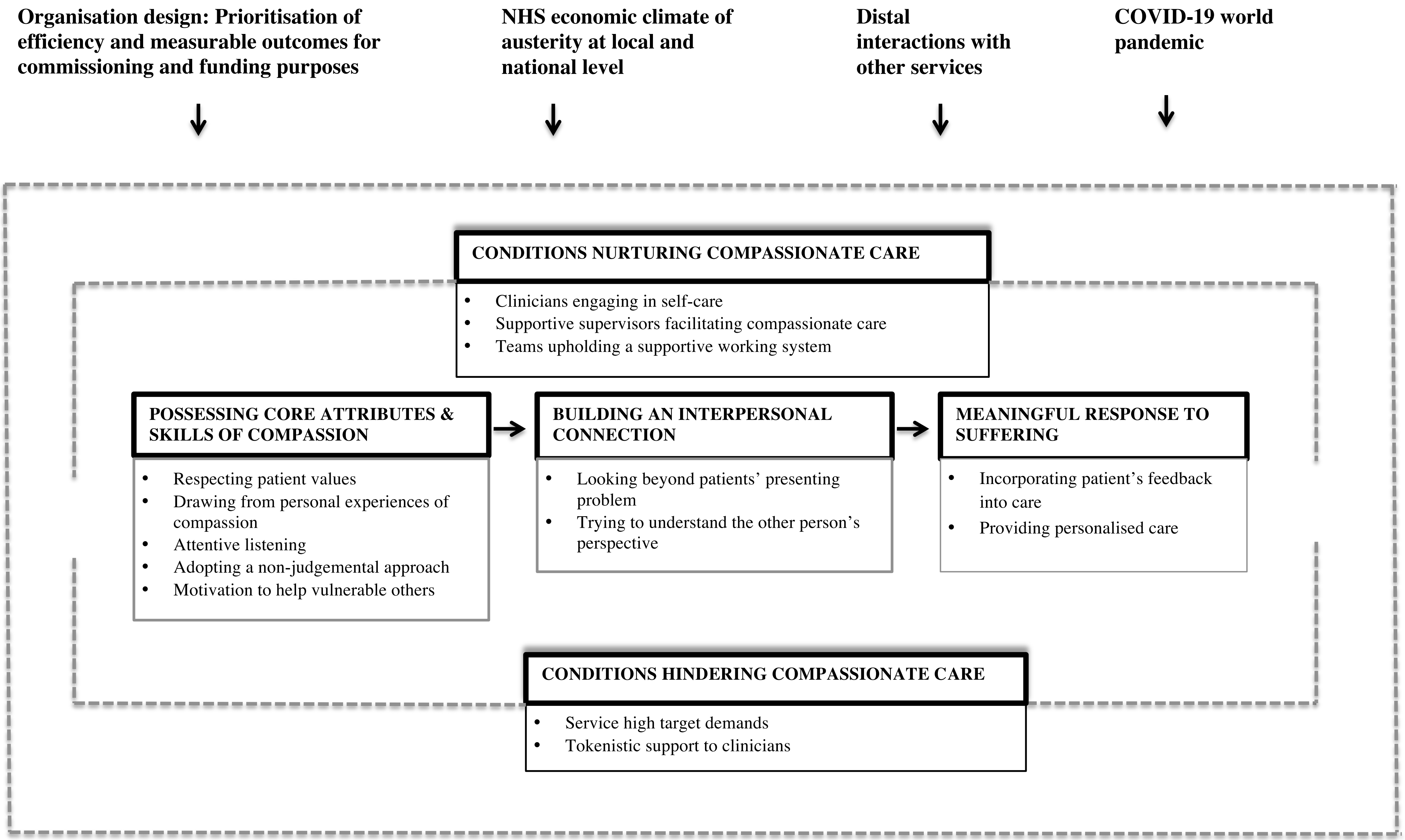
Moreover, influences at a distal level such as the GP and partner organisations, or social services may interact with IAPT clinicians when looking after the same patient. The nature of these distal interrelations can influence clinicians' perceived lack of access to resources and support from the care system. In turn, resulting in a sense of reduced autonomy, powerlessness, decreased ability to work compassionately and negative outcome for patients. Future studies on compassionate care in IAPT could include holding a professionals meeting to clarify the systems awareness of clinician’s difficulties with the inhibiting factors to compassionate care in IAPT, and a supporting plan.

Future research could also investigate the aforementioned contexts that shape the interpersonal terrain in which clinicians practice takes place; including whether there are other wider systemic influences that could affect policy change and service delivery.

Furthermore, IAPT may face an increased demand for resources in order to support an even larger volume of people; those affected by the COVID-19 pandemic. Meeting these demands will require adequate funding and preparation from services and clinicians to deliver compassionate mental health care (Pfefferbaum & North, 2020). Future UK studies could investigate the context of increased demand and compassionate responses in IAPT. Thus knowledge, learning and strategies used could be compared to how other locations may have understood and rectified these areas of concern.

By adding a broader level to the original model the researcher highlighted the importance of thinking systemically about compassionate care in IAPT. It pointed to the need to consider factors influencing the original model and how it can be sustained and developed in services facing different pressures. The researcher appreciates that these reflections might not capture the entirety and complexity of the dynamics in relationships through which clinicians define themselves, their actions and/or relate to social structures. Instead, these reflections are a starting point for future considerations.

Figure 3. ENACTING COMPASSIONATE CARE IN IAPT SERVICES – WIDER INTERACTING FACTORS



5.6.1 Patients Conceptualisation of Compassionate Care in IAPT

The researcher acknowledges that only by incorporating the perspectives of clinicians and patients could a more comprehensive understanding of compassionate care be obtained. Hence, in parallel to this study, another researcher has interviewed patients on their views of compassionate care in IAPT and developed a theoretical model of explanation (Alonso Soriano, 2020). Findings from the patient study generated five categories: distress, receiving a humanising response, receiving a dehumanising response, conditions facilitating or inhibiting the humanising response and response dependent outcomes.

The outcome from the patient study reflected various aspects within the findings presented in the current research with clinicians. For example, in the patient study, a humanising response was obtained by striving to understand the individual, through a relationship and acting to meet their needs. This process is similarly illustrated in the theoretical model 'Enacting Compassionate care in IAPT Services' as discussed throughout the thesis. Another example is illustrated under the facilitators or inhibitors of the humanizing response in the patient study. These include individual, relational, systemic and contextual domains. These domains are similar to findings in the presented study with clinicians proposing that compassionate care involves individual, relational and behavioural components that might be nurtured or hindered by different factors discussed in this thesis. A detailed comparison between the models could be a future consideration as an attempt to further validate findings from both studies and better inform theory, clinical practice and IAPT service's design.

5.7 Conclusions

The researcher followed a Grounded Theory methodology to conceptualise compassionate care in IAPT from clinicians' perspectives. A new conceptual model was developed: Enacting Compassionate Care in IAPT Services. The model depicts the domains and conditions that best accounts for the process of compassionate care in IAPT, but it acknowledges that compassionate care cannot entirely reflect nor be reduced to these domains and conditions.

The main findings indicated that enacting compassionate care is not necessarily a simple process. It requires clinicians possessing core compassionate attributes and skills such as motivation to help others seen as vulnerable and connecting with patients through an interpersonal relationship before responding to their suffering in a meaningful way.

The present research highlighted the importance of the structural and emotional resources made available to clinicians in order to nurture their compassion towards patients. It proposes the review of policies and guidelines to incorporate the concept of compassionate care in supervision, clinical development and IAPT processes, in order to support working spaces for compassionate care to thrive. Consequently, in services where compassionate care thrives, it could foster on-going service development, improved patient experience of care and employee wellbeing and retention.

In conclusion, nurturing compassionate care was understood as a systemic and dynamic process, rather than an individual formulaic or linear process. This emphasised the importance of combined efforts from all the different IAPT stakeholders: those in the position of planning care, as well as those providing care and equally important those receiving care. These different stakeholders could collaborate to a shared commitment to review service provision that is conducive to compassionate care. This could also provide an opportunity to recognise and celebrate compassionate practice.

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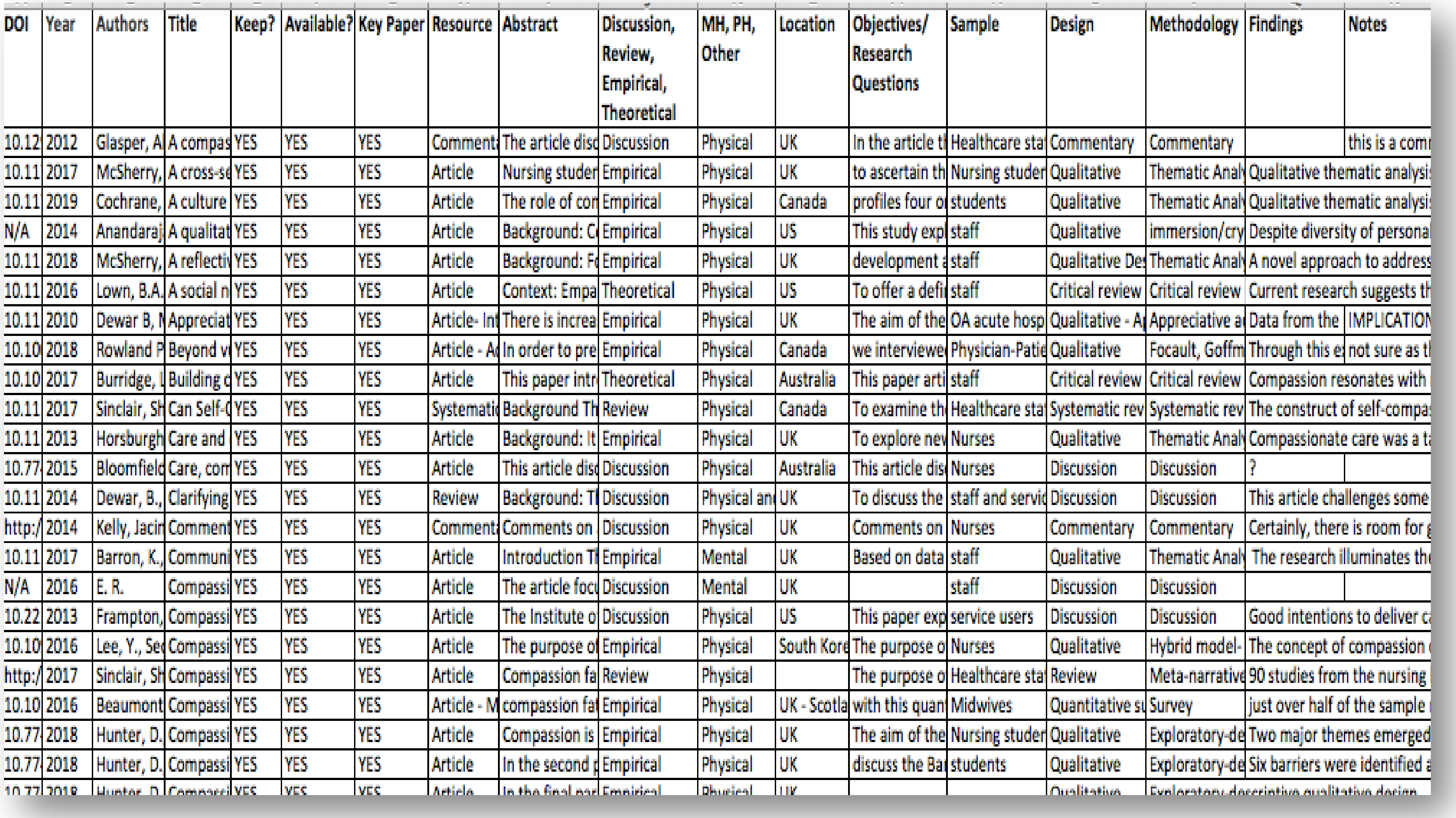
APPENDICES

Appendix A: Literature Search Terms

COMPASSION	STAFF	CLIENTS	SERVICE
Compassion	Clinician	Client	NHS
Compassionate care	Clinical Psychologist	Patient	National Health Service
	CBT Therapist	Service User	IAPT
	Cognitive Behavioural Therapist		Improving Access to Psychological Therapies
	PWP		
	Psychological Wellbeing Practitioner		
	Mental Health Staff		
	Counselling Psychologist		
	Counsellor		
	Practitioner		
	Therapist		
	Mental Health Professional		

Appendix B: Classification of the Literature Search



DOI	Year	Authors	Title	Keep?	Available?	Key Paper	Resource	Abstract	Discussion, Review, Empirical, Theoretical	MH, PH, Other	Location	Objectives/ Research Questions	Sample	Design	Methodology	Findings	Notes
10.12	2012	Glasper, A	A compas	YES	YES	YES	Comment	The article disc	Discussion	Physical	UK	In the article t	Healthcare sta	Commentary	Commentary		this is a com
10.11	2017	McSherry,	A cross-se	YES	YES	YES	Article	Nursing studer	Empirical	Physical	UK	to ascertain th	Nursing studer	Qualitative	Thematic Analy	Qualitative thematic analysis	
10.11	2019	Cochrane,	A culture	YES	YES	YES	Article	The role of con	Empirical	Physical	Canada	profiles four o	students	Qualitative	Thematic Analy	Qualitative thematic analysis	
N/A	2014	Anandaraj	A qualitat	YES	YES	YES	Article	Background: C	Empirical	Physical	US	This study expl	staff	Qualitative	immersion/cry	Despite diversity of persona	
10.11	2018	McSherry,	A reflecti	YES	YES	YES	Article	Background: F	Empirical	Physical	UK	development a	staff	Qualitative Des	Thematic Analy	A novel approach to address	
10.11	2016	Lown, B.A.	A social n	YES	YES	YES	Article	Context: Empa	Theoretical	Physical	US	To offer a defi	staff	Critical review	Critical review	Current research suggests th	
10.11	2010	Dewar B, N	Appreciat	YES	YES	YES	Article- Int	There is increa	Empirical	Physical	UK	The aim of the	OA acute hosp	Qualitative - A	Appreciative a	Data from the	IMPLICATION
10.10	2018	Rowland P	Beyond v	YES	YES	YES	Article - A	In order to pre	Empirical	Physical	Canada	we interviewe	Physician-Patie	Qualitative	Focault, Goffm	Through this e	not sure as t
10.10	2017	Burridge, L	Building c	YES	YES	YES	Article	This paper intr	Theoretical	Physical	Australia	This paper arti	staff	Critical review	Critical review	Compassion resonates with	
10.11	2017	Sinclair, Sh	Can Self-C	YES	YES	YES	Systemati	Background Th	Review	Physical	Canada	To examine th	Healthcare sta	Systematic rev	Systematic rev	The construct of self-compa	
10.11	2013	Horsburgh	Care and	YES	YES	YES	Article	Background: It	Empirical	Physical	UK	To explore nev	Nurses	Qualitative	Thematic Analy	Compassionate care was a t	
10.77	2015	Bloomfield	Care, con	YES	YES	YES	Article	This article disc	Discussion	Physical	Australia	This article dis	Nurses	Discussion	Discussion	?	
10.11	2014	Dewar, B.,	Clarifying	YES	YES	YES	Review	Background: T	Discussion	Physical an	UK	To discuss the	staff and servic	Discussion	Discussion	This article challenges some	
http:/	2014	Kelly, Jacin	Comment	YES	YES	YES	Comment	Comments on	Discussion	Physical	UK	Comments on	Nurses	Commentary	Commentary	Certainly, there is room for	
10.11	2017	Barron, K.,	Communi	YES	YES	YES	Article	Introduction T	Empirical	Mental	UK	Based on data	staff	Qualitative	Thematic Analy	The research illuminates th	
N/A	2016	E. R.	Compassi	YES	YES	YES	Article	The article focu	Discussion	Mental	UK		staff	Discussion	Discussion		
10.22	2013	Frampton,	Compassi	YES	YES	YES	Article	The Institute o	Discussion	Physical	US	This paper exp	service users	Discussion	Discussion	Good intentions to deliver c	
10.10	2016	Lee, Y., Se	Compassi	YES	YES	YES	Article	The purpose o	Empirical	Physical	South Kore	The purpose o	Nurses	Qualitative	Hybrid model-	The concept of compassion	
http:/	2017	Sinclair, Sh	Compassi	YES	YES	YES	Article	Compassion fa	Review	Physical		The purpose o	Healthcare sta	Review	Meta-narrative	90 studies from the nursing	
10.10	2016	Beaumont	Compassi	YES	YES	YES	Article - M	compassion fa	Empirical	Physical	UK - Scotla	with this quan	Midwives	Quantitative s	Survey	just over half of the sample	
10.77	2018	Hunter, D.	Compassi	YES	YES	YES	Article	Compassion is	Empirical	Physical	UK	The aim of the	Nursing studer	Qualitative	Exploratory-de	Two major themes emerged	
10.77	2018	Hunter, D.	Compassi	YES	YES	YES	Article	In the second	Empirical	Physical	UK	discuss the Ba	students	Qualitative	Exploratory-de	Six barriers were identified a	
10.77	2018	Hunter, D.	Compassi	YES	YES	YES	Article	In the final par	Empirical	Physical	UK			Qualitative	Exploratory-descriptive qualitative design		

Appendix C: Participant Invitation Letter and Information Sheet

Compassionate Care in Improving Access to Psychological Therapies Services: A Grounded Theory Approach

Are you currently delivering psychological interventions as a qualified clinician in an adult IAPT service? If so, I would like to invite you to contribute to this research on compassionate care in IAPT. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I? My name is Valéria Lupes de Souza and I am studying for a Professional Doctorate in Clinical Psychology at the University of East London. As part of my studies, I am conducting this research.

What is the research about? The topic of compassionate care is highly relevant and emphasised in all areas of the National Health Services. However, there is no research that has explored compassionate care within IAPT services. This study aims to explore compassionate care in IAPT from clinicians' perspective and inform service provision.

Why have you been asked to participate? You have been invited to participate in my research as a qualified professional working clinically in IAPT and therefore, actively delivering psychological therapists as part of your role. I would like to talk to qualified clinicians including clinical psychologists, counselling psychologists, psychotherapists, family therapists, Cognitive Behavioural Therapists, High Intensity therapists and Psychological Wellbeing Practitioners to help me explore my research topic.

I emphasise that I am not looking for 'experts' on the topic I am studying. You are invited to discuss your understanding of compassionate care, how it emerges and what factors might facilitate or hinder compassionate care. You will not be judged or personally analysed in any way and you will be treated with respect. You are free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

- If you agree to participate, please send a reply to xxx@study.email indicating your interest and availability. I appreciate that you might be busy, so according to your preference the interview can take place in person in a private room at the University of East London, in an appropriate venue of your choosing or via Skype.
- When a suitable date and time is agreed we will meet. I have some questions/topics prepared in advance. However, I aim to have an open conversation where you can talk freely about the topic in question.
- I estimate that interviews will take up to 60 minutes.
- Our conversation will be audio recorded to help me to study the content of our conversation at a later stage.
- I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Confidentiality

Your identity and safety will be respected at all times. Only your anonymised data will be used in the research. However, based on our conversation, if I believe that you, or someone else, might not be safe, then I will have to share this information and your details with other professionals who may be able to help.

You can stop the interview at any time, and you do not have to answer all questions asked. At the end of the interview, I will allocate some time for you to ask questions, debrief from any aspect of the study or to express any concerns.

What will happen to the information that you provide?

- The audio recording will be typed up as a transcript using a pseudonym/number and saved on a password protected document on a password protected computer. You will not be identified. Only the researcher, supervisor and examiners can access the transcripts.
- All recordings, names and contact details will be permanently deleted after the examination of the research. Anonymised transcripts will be permanently deleted three years after the completion of the study.
- The results of this study, including your data may be published in academic journals. No identifiable information will be published.

What if you want to withdraw?

You have the right to withdraw from the study within two weeks following the interview, without any explanation, disadvantage or consequence. However, if you withdraw at a late stage, the researcher would reserve the right to use your anonymised data.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me on xxx@study.email. If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Katy Berg on k.l.berg@uel.ac.uk. School of Psychology, University of East London, Water Lane, London E15 4LZ,

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: xxx@uel.ac.uk)

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Appendix D: Demographic Questionnaire

ABOUT YOU AND YOUR ROLE

Age - Please circle one of the following:
Under 25 26-35 36-45 46-55 56-65 Over 65 Prefer not to answer

Gender
- ☐ Female
- ☐ Male
- ☐ Non-binary / third gender
- ☐ Gender fluid
- ☐ Transgender
- ☐ Prefer to self-describe:
- ☐ Prefer not to answer

Ethnicity - Please indicate one of the following:
- ☐ White / White British
- ☐ Mixed / Multiple Ethnic Groups
- ☐ Asian / Asian British
- ☐ Black / Black British / African / Caribbean
- ☐ Other ethnic group – Please specify:
- ☐ Prefer not to answer

Religion - Please indicate one of the following:
- ☐ Religious – Please specify:
- ☐ Spiritual
- ☐ Atheist
- ☐ Agnostic
- ☐ Other – Please specify:
- ☐ Prefer not to answer

Which term best describes your current role?
- ☐ Cognitive Behavioural Therapist
- ☐ High Intensity Therapist
- ☐ Psychological Wellbeing Practitioner
- ☐ Clinical Psychologist
- ☐ Counselling Psychologist
- ☐ Psychotherapist
- ☐ Family Therapist
- ☐ Counsellor
- ☐ Other – Please specify:

How many hours do your work in IAPT per week? Please circle
Full-time Part-time Other – Please specify:

How long have you been working for IAPT?
- ☐ 1 to 3 years
- ☐ 3 to 6 years
- ☐ 6 to 9 years
- ☐ 10 years or over
- ☐ Prefer not to answer

Working region - Please circle one of the following:
- ☐ South East
- ☐ East Anglia
- ☐ South West
- ☐ West Midlands
- ☐ East Midlands
- ☐ North West
- ☐ North East
- ☐ Yorkshire and Humberside
- ☐ Other:

Appendix E: Interview Schedule – First Version

1. What does the term compassionate care bring to mind?

2. Can you describe times when you have noticed compassionate care in your workplace, and what was it that made it compassionate care for you?
    - Are there any other times that you can think of? Can you tell me more about those times?

3. What would you say are the different aspects in the process when compassionate care emerges?
    - (Different levels: client / clinician / organisational)

4. What might facilitate compassionate care?
    - (Potential factors: environmental / personal / relational / organisational)

5. What might hinder compassionate care?
    - (Potential factors: environmental / personal / relational / organisational)

6. Are there other aspects of compassionate care that I didn't ask about and you would like to share or consider?

7. Is there anything else that came to mind now about what we discussed that you would like to revisit or add?

Appendix F: Revised Interview Schedule

1. Thinking about your role in IAPT, what does compassionate care mean to you in this context?

2. Where these ideas come from?

        - (Personal, training, experience, religion)

3. Can you describe times when you have noticed compassionate care in your workplace?
    - What was it about that experience that made it compassionate care for you?

    (Different levels to consider: clinician, client, others, setting, service, organisation)

4. What might facilitate compassionate care in IAPT?

5. What might hinder compassionate care in IAPT?

    - Potential factors: environmental / personal / relational / organisational)

6. Are there other aspects of compassionate care that I didn't ask about and you would like to share? or that you consider important for me to think about going forwards?

7. Is there anything else that came to mind now about anything we've discussed that you would like to revisit or add?

Appendix G: Transcription Conventions – Adapted from Parker (2005)

(inaudible)	Indicates unclear speech.
-:	Unfinished word.
(interrupted)	Indicates speech interruption.
/:	Indicates overlapping speech.
(5s)	Indicated length of pause.
…	Ellipsis indicates part of the speech (no more than 20 words) has been removed from the extract as it was not deemed relevant to the point being illustrated.
[CC]	Indicates author’s insertion rather than participants direct speech.
(laughs)	Indicates speaker laughed.
V	Researcher speaking.

H: University of East London Ethical Application Form

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

If you need to apply for ethical clearance from HRA (through IRIS) for research involving the NHS you DO NOT need to apply to the School of Psychology for ethical clearance also. Please see details on https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/NHS-Research-Ethics-Committees.aspx

Among other things this site will tell you about UEL sponsorship

PLEASE NOTE that HRA approval for research involving NHS employees is not required when data collection will take place off NHS premises and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

If you are employed by the NHS and plan to recruit participants from the NHS Trust you work for, it please seek permission from an appropriate person at your place of work (and better to collect data off NHS premises).

PLEASE NOTE that the School Research Ethics Committee does not recommend BSc and MSc/MA students designing research that requires HRA approval for research involving the NHS as this can be a demanding and lengthy process.

Before completing this application please familiarise yourself with:

The *Code of Ethics and Conduct (2018)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

And please also see the UEL Code of Practice for Research Ethics (2015-16) https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Documents/Ethics%20forms/UEL-Code-of-Practice-for-Research-Ethics-2015-16.pdf

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.

2. Type your name in the ‘student’s signature’ section (5.1).

3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc**

4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. Your supervisor will then look over your application.

5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' (section 5) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See section 4)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the participant invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants.

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external institution or organisation if you need it (e.g. a charity, school, local authority, workplace etc.). Permissions must be attached to this application. If you require ethical clearance from an external organisation your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation (see Section 5).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. If you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice.

- DBS clearance is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 5 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Tim Lomas (Chair of the School Research Ethics Committee) at t.lomas@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see Section 5 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another for the duration of your studies in order to conduct research with vulnerable populations.

Please read all guidance notes in blue carefully to avoid incorrect or insufficient applications

If yours is an online study using Qualtrics please see the example ethics application in the Ethics folder in the Psychology Noticeboard

SECTION 1. Your details

1. **Your name**: Valéria Lupes de Souza

2. **Your supervisor's name**: Dr Katy Berg

3. **Title of your programme**: Professional Doctorate in Clinical Psychology

4. **Submission date for your BSc/MSc/MA research:** May 2020

5. **Please tick if your application includes a copy of a DBS certificate (see page 3)** **N/A**

6. **Please tick if your research requires DBS clearance but you are a Prof Doc student and have applied for DBS clearance – or had existing clearance verified – when you registered on your programme (see page 3)** **N/A**

7. **Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Tim Lomas for confidentiality reasons (Chair of the School Research Ethics Committee) t.lomas@uel.ac.uk** **N/A**

8. **Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics** (See links on page 1)

☒

SECTION 2. About your research

9. What your proposed research is about:

Title - Compassionate Care in Improving Access to Psychological Therapies Services: A Grounded Theory Approach

The proposed research aims to interview qualified clinicians working therapeutically with service users in Improving Access to Psychological Therapies (IAPT) services in the United Kingdom, about the process of compassionate care in IAPT services.

Research questions:

- What is compassionate care?
- How does compassionate care emerge?
- What might facilitate compassionate care?
- What might hinder compassionate care?

10. Design of the research:

The study will use a qualitative design, adopting a critical realist epistemological framework. Participants will be invited to a semi-structured interview with the researcher to discuss compassionate care within the context of their workplace. These interviews will be transcribed verbatim and analysed using a Grounded Theory approach.

11. Recruitment and participants (Your sample):

Participants will be recruited through the researcher’s own and supervisor’s personal and professional contacts as well as from online forums for Clinical Psychologists and other clinicians such as the UK Clinical Psychology Facebook page. This method will facilitate the recruiting of participants from a wide range of geographical locations.

People will be able to demonstrate an interest in participating by contacting the researcher.

People will be provided with all the details of the study as part of the study information sheet as outlined in Appendix A.

The researcher will aim to conduct interviews with 12 participants, which is suggested to be an adequate amount to conduct research within the framework of Grounded Theory.

The inclusion criteria for participants are as per the following:

- Be a qualified professional working therapeutically for an Adult IAPT service
- Have a minimum of one year experience working in an Adult IAPT service
- Able to have a face to face interview or a Skype interview with the researcher at participants’ preferred date, time and location

On the day of the interview, demographic data will be asked so that the characteristics of the sample can be described, and this can be taken into account when appraising the findings. The following will be asked, and participants can decide whether to indicate an answer.

- Age
- Gender
- Ethnicity
- Religion
- Type of employment (e.g. full-time, part-time or contract)
- Current role / Professional title
- How many years they have been working in IAPT
- Working region

12. Measures, materials or equipment:

An audio-recorder will be used to record the interviews face to face or via Skype. A plan for the semi-structured interview is attached to this document (See Appendix C).

13. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

NO

14. Outline the data collection procedure involved in your research:

A pilot interview will be carried out in order to test and develop the draft interview schedule, identify any pitfalls and to ensure a smooth process and implementation.

The researcher plans to meet participants individually on appropriate venues such as private rooms booked by the researcher including the University of East London and Libraries across London. Appropriate venues may also be organised by each participant according to their preference. The date and time of each interview will be agreed according to participants' availability.

People from all over the UK will be invited, and if participants are unable to attend the interview in person, they can also participate via Skype. It is estimated that interviews will last for up to approximately 60 minutes.

SECTION 3. Ethical considerations

15. Fully informing participants about the research (and parents/guardians if necessary):

The information sheet will provide a detailed overview of the study (See Appendix A). The details of the study will be repeated at the beginning of the interview.
The researcher will make it clear that they are interested in hearing about clinicians' perspective on the topic of compassionate care in IAPT, regardless of what it means for them. Participants will be reassured that the research is not aimed at judging them personally, professionally or their experiences.

16. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

Participants are required to read, sign and return a consent form prior to starting the interview (See Appendix B). Forms can be returned to the researcher electronically or alternatively participants can return the form to the researcher in person on the day of the interview.

17. Engaging in deception, if relevant:

No information will be withheld from participants regarding the study. Deception does not feature in any process of this study. Participants will have the opportunity to debrief and ask questions at the end of the interview, should they wish to.

18. Right of withdrawal:

The study's information sheet will be made available to participants and will contain the following information regarding their right to withdraw:

You have the right to withdraw from the study within two weeks following the interview, without any explanation, disadvantage or consequence. However, if you withdraw at a late stage, the researcher would reserve the right to use your anonymised data.

19. Will the data be gathered anonymously?

NO

20. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

The email address and the telephone number that will be used to contact the researcher is a specific account and a telephone number that will be used solely for research purposes. Only the researcher will know the login details.
Participants will be made aware at the start of the interview that if there are concerns about anyone's safety confidentiality will have to be broken.

Participants will also be made aware at the start of the interview of how their data will be protected. Participants personal and identifiable information such as names will be kept separately from all other data on the researcher's password protected computer and password protected Microsoft Word document.

A recording device will be used for the interviews. Data from the audio recordings will be transcribed verbatim by the researcher and kept safe on a password protected document on a password protected computer. Any personally identifiable information will be removed during transcription and all data will be anonymized using a number to refer to each contributing participant. Only the researcher, supervisors and examiners will be able to access the data.

All recordings, names and contact details will be permanently deleted after the examination of the research. Anonymized transcripts will be permanently deleted three years after the completion of the study.

21. Will participants be paid or reimbursed?

NO

If YES, why is payment/reimbursement necessary and how much will the vouchers be worth?

SECTION 4. Other permissions and ethical clearances

22. Research involving the NHS in England

Is HRA approval for research involving the NHS required? NO
Please see Page 1 of this application for important information and link

Will the research involve NHS employees who will not be directly recruited through the NHS and where data from NHS employees will not be collected on NHS premises?

YES

If you work for an NHS Trust and plan to recruit colleagues from the Trust will permission from an appropriate member of staff at the Trust be sought and is a copy of this permission (can be an email from the Trust) attached to this application?

N/A

23. Permission(s) from an external institution/organisation (e.g. a school, charity, workplace, local authority, care home etc.)?
Is permission from an external institution/organisation/workplace required? NO
If YES please give the name and address of the institution/organisation/workplace:

COPIES OF PERMISSIONS (LETTER OR EMAIL) MUST BE ATTACHED TO THIS APPLICATION

In some cases you may be required to have formal ethical clearance from the external institution or organisation or workplace too.

24. Is ethical clearance required from any other ethics committee?

NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? YES / NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation confirming its ethical clearance is acceptable.

Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

SECTION 5. Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible.

If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

25. Protection of participants:

The researcher will reiterate the nature of the study prior to the start of the interview. Although the researcher does not foresee the topic of this research evoking distress to participants, the researcher does not want to minimise how participants' might feel about compassionate care in relation to their current work or workplace. Therefore, at the start of the interview participants will be informed that time has been allocated at the end of the interview for participants to ask questions, debrief from any misunderstood aspect of the study or to express any concerns.

26. Protection of the researcher:

It is expected that interviews will take place in appropriate venues including the University of East London, participants preferred venues or via Skype. The Director of Studies will be made aware of the location, dates and starting and finishing time of the interviews. The Director of Studies will follow a safety protocol of contacting the researcher if the researcher has not confirmed their safety at the end of an interview.

27. Debriefing participants:

The true nature of the study will be explained to participants in the information sheet and then reiterated prior to the start of the interviews (See Appendix A). Deliberate deception does not feature in this study and therefore a debrief sheet for this purpose is not deemed necessary. Participants will be informed that time has been allocated at the end of the interview to debrief in case they have questions or concerns.

28. Other: N/A

29. Will your research involve working with children or vulnerable adults?*

NO

If YES have you obtained and attached a DBS certificate?

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see:

https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/Research-involving-children.aspx

30. Will you be collecting data overseas? NO

If YES in what country or countries (and province if appropriate) will you be collecting data?

Please click on this link https://www.gov.uk/foreign-travel-advice and note in the space below what the UK Government is recommending about travel to that country/province (Please note that you MUST NOT travel to a country/province/area that is deemed to be high risk or where essential travel only is recommended by the UK Government. If you are unsure it is essential that you speak to your supervisor or the UEL Travel Office – travelúel.ac.uk / (0)20 8223 6801).

SECTION 6. Declarations

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Valéria Lupes de Souza

Student's number: Date: 06/03/2019

Supervisor's declaration of support is given upon their electronic submission of the application

YOU MUST ATTACH THESE ATTACHMENTS:

1. PARTICIPANT INVITATION LETTER(S)

See pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This can be adapted for your own use and must be adapted for use with parents/guardians and children if they are to be involved in your study.

Care should be taken when drafting a participant invitation letter. It is important that your participant invitation letter fully informs potential participants about what you are asking them to do and what participation in your study will involve – what data will be collected, how, where? What will happen to the data after the study is over? Will anonymised data be used in the write-up of the study, or at conferences or in possible publications etc.? Tell participants about how you will protect their anonymity and confidentiality and about their withdrawal rights.

Make sure that what you tell potential participants in this invitation letter matches up with what you have said in the application.

2. CONSENT FORM(S)

Use the pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This should be adapted for use with parents/guardians and children.

3. PARTICIPANT DEBRIEF SHEET

This can be one or two paragraphs thanking participants, reminding them what will happen to their data and, if relevant, should include the contact details of a relevant agency or organisation that participants can contact for support if necessary. Should include the true nature of the study if your research involved deception.

OTHER ATTACHMENTS YOU MAY NEED TO INCLUDE:

See notes on Page 2 about what other attachments you may need to include – Example interview questions? Copies of questionnaires? Visual stimuli? Ethical clearance or permission from another institution or organisation? Current DBS clearance certificate?)

SCANNED COPY OF CURRENT DBS CERTIFICATE

(If one is required. See notes on Page 3)

Appendix I: University of East London Ethical Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Florentia Hadjiefthyvoulou

SUPERVISOR: **Katy Berg**

STUDENT: Valéria de Souza

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Compassionate Care in Improving Access to Psychological Therapies Services: A Grounded Theory Approach

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

approve

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*
Has an adequate risk assessment been offered in the application form?
YES / NO

Please request resubmission with an adequate risk assessment
If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Florentia Hadjiefthyvoulou
Date: 18/3/19

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix J: Participant Consent Form

Compassionate Care in Improving Access to Psychological Therapies Services: A Grounded Theory Approach

By signing this form, you are agreeing with the following (please tick):

☐ I have read the information sheet about the study and have received a copy.
☐ The nature and purposes of the research have been explained to me.
☐ I have had the opportunity to discuss the study and ask questions.
☐ The procedures in which I will be involved have been fully explained to me.
☐ I hereby freely and fully consent to participate in the study.
☐ Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw after two weeks of the interview the researcher reserves the right to use my anonymous data.

Confidentiality

☐ I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

Participant's Name (BLOCK CAPITALS)…………………………………………….

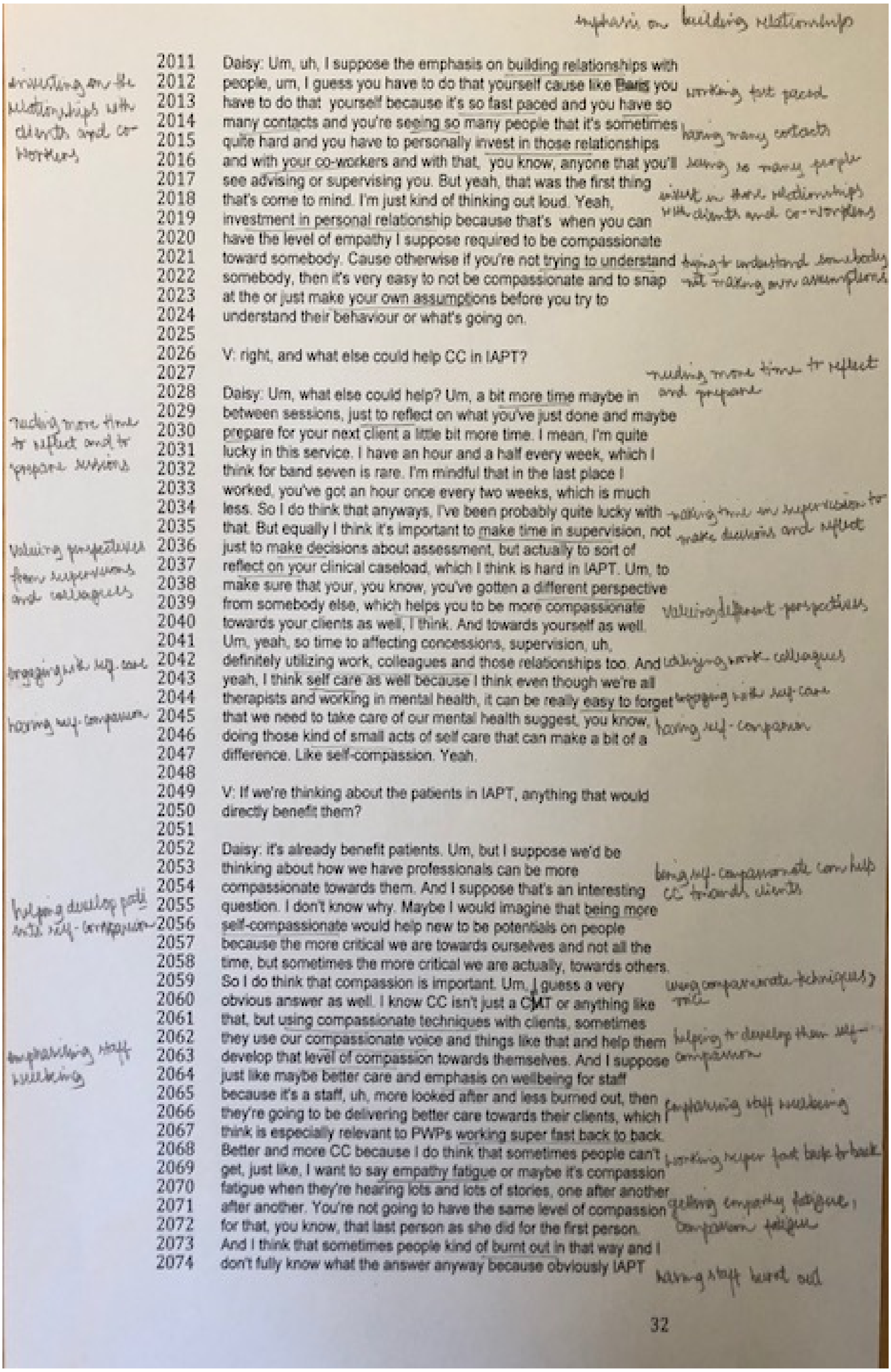
Participant's Signature…………………………………………………………….

Researcher's Name (BLOCK CAPITALS)…………………………………………….

Researcher's Signature……………………………………………………………

Date…………………..……………………………………………………………

Appendix K: Analysed Text – Extract Example



emphasis on building relationships

Daisy: Um, uh, I suppose the emphasis on building relationships with people, um, I guess you have to do that yourself cause like Paris you have to do that yourself because it's so fast paced and you have so many contacts and you're seeing so many people that it's sometimes quite hard and you have to personally invest in those relationships and with your co-workers and with that, you know, anyone that you'll see advising or supervising you. But yeah, that was the first thing that's come to mind. I'm just kind of thinking out loud. Yeah, investment in personal relationship because that's when you can have the level of empathy I suppose required to be compassionate toward somebody. Cause otherwise if you're not trying to understand somebody, then it's very easy to not be compassionate and to snap at the or just make your own assumptions before you try to understand their behaviour or what's going on.

investing on the relationships with clients and co-workers

working fast paced

having many contacts

seeing so many people

invest in those relationships with clients and co-workers

trying to understand somebody

not making own assumptions

V: right, and what else could help CC in IAPT?

needing more time to reflect and prepare

Daisy: Um, what else could help? Um, a bit more time maybe in between sessions, just to reflect on what you've just done and maybe prepare for your next client a little bit more time. I mean, I'm quite lucky in this service. I have an hour and a half every week, which I think for band seven is rare. I'm mindful that in the last place I worked, you've got an hour once every two weeks, which is much less. So I do think that anyways, I've been probably quite lucky with that. But equally I think it's important to make time in supervision, not just to make decisions about assessment, but actually to sort of reflect on your clinical caseload, which I think is hard in IAPT. Um, to make sure that your, you know, you've gotten a different perspective from somebody else, which helps you to be more compassionate towards your clients as well, I think. And towards yourself as well. Um, yeah, so time to affecting concessions, supervision, uh, definitely utilizing work, colleagues and those relationships too. And yeah, I think self care as well because I think even though we're all therapists and working in mental health, it can be really easy to forget that we need to take care of our mental health suggest, you know, doing those kind of small acts of self care that can make a bit of a difference. Like self-compassion. Yeah.

needing more time to reflect and to prepare sessions

making time in supervision to make decisions and reflect

valuing perspectives from supervisors and colleagues

valuing different perspectives

utilizing work colleagues

engaging with self-care

engaging with self-care

having self-compassion

having self-compassion

V: If we're thinking about the patients in IAPT, anything that would directly benefit them?

Daisy: it's already benefit patients. Um, but I suppose we'd be thinking about how we have professionals can be more compassionate towards them. And I suppose that's an interesting question. I don't know why. Maybe I would imagine that being more self-compassionate would help new to be potentials on people because the more critical we are towards ourselves and not all the time, but sometimes the more critical we are actually, towards others. So I do think that compassion is important. Um, I guess a very obvious answer as well. I know CC isn't just a CMT or anything like that, but using compassionate techniques with clients, sometimes they use our compassionate voice and things like that and help them develop that level of compassion towards themselves. And I suppose just like maybe better care and emphasis on wellbeing for staff because it's a staff, uh, more looked after and less burned out, then they're going to be delivering better care towards their clients, which I think is especially relevant to PWPs working super fast back to back. Better and more CC because I do think that sometimes people can't get, just like, I want to say empathy fatigue or maybe it's compassion fatigue when they're hearing lots and lots of stories, one after another after another. You're not going to have the same level of compassion for that, you know, that last person as she did for the first person. And I think that sometimes people kind of burnt out in that way and I don't fully know what the answer anyway because obviously IAPT

being self-compassionate can help CC towards clients

helping develop pati with self-compassion

using compassionate techniques, voice

helping to develop their self-compassion

emphasising staff wellbeing

emphasising staff wellbeing

working super fast back to back

getting empathy fatigue, compassion fatigue

having staff burnt out

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Appendix L: Memo – Extract Example

Interview 1 – Alisha

As part of various answers to different questions the participant mentioned considering patients as a whole and offering a holistic approach to care as an indication of compassionate care in IAPT. This seemed to be linked to how this participant hoped/wished that care could be delivered in IAPT, and how the IAPT set up, and daily demands may interfere with this. She wishes to do more and is dependent on service flexibility, which is at times achieved with the support of others such as her supervisor. This participant states that compassionate care comes with the clinician, can be enhanced with training but a clinician is vulnerable to losing it due to the day-to-day stresses of the job. She thinks that as a service there should be a way of reminding clinicians of compassionate care, and supporting them to deliver it, through for example bringing awareness of clinicians distress and of compassionate care in supervision, meetings and within and towards the workforce. Awareness was actually mentioned many times. I wondered whether there was something to do with not feeling able to fully engage with all clients, due to time pressures mentioned and needing a reminder. High levels of suffering seemed to have evoked more attention, compassion and action. This is something that I want to investigate in further interviews if appropriate. This participant was inclusive of patients, and mentioned the importance of them having a say, sharing control and power with them. As another study is being conducted investigating service users views on compassionate care, I did not probe much, but I wonder how much of this should be considered in future interviews. Also, this participant has had different roles in IAPT and was able to provide perspectives and comparisons based on both roles, e.g. dynamics, support received, privileges, resources and different focus. This elucidated differences that might facilitate or hinder compassionate care. I think it will be essential to interview people in different clinical roles within IAPT.