APPLYING SELF-COMPASSION: THE EXPERIENCE OF STUDENT NURSES

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A thesis in partial fulfilment of the
requirements of Anglia Ruskin University
for the degree of Doctor of Philosophy.

Submitted: 8th November 2020

ACKNOWLEDGEMENTS

ABSTRACT

ANGLIA RUSKIN UNIVERSITY

FACULTY OF HEALTH, EDUCATION, MEDICINE AND SOCIAL CARE

DOCTOR OF PHILOSOPHY

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The centrality of compassion is emphasised throughout nursing literature. Despite professional and social expectations that nurses are compassionate, the meaning of compassion remains ambiguous. The literature review undertaken in this study enabled the development of my initial model of interconnections between compassion and self-compassion, and associated links to nursing and education. Gaps identified in knowledge relate to the experience of learning and applying self-compassion in nursing. This research investigates student nurses' understanding and development of compassion, the experience of applying self-compassion, and the potential to enhance compassionate practice.

Multiple case study methodology was used with seven cases recruited from first year student nurses. Semi-structured in-depth interviews were carried out at the beginning of the research to explore understanding of compassion and its development, and following a series of self-compassion workshops to explore the experience of applying self-compassion. Leiblich et al's pluralistic approach to data analysis was used to interrogate the data, prioritising the participant voices, with researcher reflexivity identified using Peshkin's I's.

Key findings pertinent to nursing and nurse education emerged from this research. The application of self-compassion enhanced psychological wellbeing, supported effective coping, and enhanced intrinsic motivation for learning. Particularly relevant to nursing, self-compassion enhanced compassion towards others through increased noticing and being less judgemental. The findings extend my model of interconnections to propose learning and teaching strategies for self-compassion development that are practically achievable within current curricula provision e.g. a metaphor for compassion, use of story and reflection, developing noticing skills, role modelling and socialisation, permission, and self-compassion exercises. Areas for future research are identified to further extend knowledge and understanding of these strategies. This new knowledge will be of value in nursing and nurse education, but is also likely to be of interest in all professions/agencies where compassion comprises a fundamental aspect of their professional role.

Key words: compassion, self-compassion, nursing, nurse education, multiple case study, metaphor, self-compassion tools

TABLE OF CONTENTS

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CHAPTER 1: INTRODUCTION

It is my ontological perspective that compassion is a desirable virtue, central to nursing practice; an understanding with widespread global agreement in nursing and healthcare (American Nurses Association, 2015, Austin, 2011, Cutliffe, 2000, Darzi, 2008, Department of Health, 2015, Dewar, Pullin and Tocheris, 2011, Gilbert, 2010, McCaffrey and McConnell, 2015, McLean, 2011, Tehranineshat et al., 2019, Von-Dietze and Orb, 2000, Weiss et al., 2002). The introductory chapter will challenge and provide rationale for this perspective, contextualising the foundations on which it is based. The inspiration for the research will be presented, the concept of self-compassion will be introduced, and the research questions and methodological approach identified.

1.1 Compassion in nursing

The concept of compassion was first recorded in early philosophical and religious texts, particularly from Christian-philosophical and Buddhist traditions (van der Cingel, 2009), often with an emphasis on self-sacrifice (van der Cingel, 2014). However, it is a fundamental tenet of many religions (Alharbi and Al Hadid, 2019, Neuberger, 2011). Compassion was not specifically associated with nursing until Florence Nightingale's reforms in the 19th Century embedded it as a necessary quality virtue for nurses. In response to her perception of nurses exhibiting immoral behaviours (including drunkenness and slovenliness), Nightingale wrote in her letters (1873-1897) that nursing was a "noble art", and as such required "morality, up-righteousness, and kindness" (Howard Gotlieb Archival Research Center, nd). Nightingale's belief resulted in her clear assertion of the need for moral education in nursing, encouraging virtues such as compassion and honesty (Sellman, 1997). The idea of character virtues, whether inherent or learned, continued to be central to the professional

identity of the nurse. A review of Florence Lees' Handbook for Hospital Sisters (1874) noted that "devotion" was more important than "great faculties of mind", placing greater emphasis on character virtues such as being patient, cheerful and kindly than having knowledge and understanding.

Compassion as an essential virtue in nursing was also reflected in the early international context. Lillian Wald, Lavinia Dock, and Annie Goodrich, three American nurse leaders in the late 19th and early 20th century, understood compassion as a guiding principle of nursing; not one that stemmed from religious motivation, but a principle that was motivated by a desire for social responsibility and social justice, and promoted a connectedness with humankind (Hamilton, 1994). The conceptual shift from compassion motivated by religiosity to compassion motivated by social justice, resulted in the combining of the character of a nurse, with the procedures and actions undertaken which, contrary to Nightingale's resistance to professionalisation (Baer, 2012), underpinned the idea of nursing as a professional practice. Hamilton (1994) summarised this early understanding as:

> *"Compassion was not a sentiment, but making justice and doing works of mercy. Compassion was not a favour to the poor, but something to which patients had a right, and for the nurse, an opportunity. Compassion was not pity, but celebration of the kinship of the human spirit. Compassion was not private, but public service. Compassion was not simply knowing about the suffering of others, but entering into it, sharing it, and understanding it. Compassion was not anti-intellectual, but sought to know and understand the interconnections of all things. Compassion was not a commandment, but a spirituality that treated all creation with respect. Compassion was not an organised religion, but it was, for the nurse inventors, a way of life."* (p20)

Often in response to changes in social contexts and technological advances, the continued development of scientific knowledge, professionalism, pedagogy, research and theory in

nursing over the past century has further extended and embedded the concept of nursing as a professional practice (Baer, 2012). However, the centrality of compassion to nursing has remained constant, embedded in professional policy and standards (Department of Health, 2015, Nursing and Midwifery Council, 2018a), desired by Registered Nurses in a national consultation on nursing values (Cummings and Bennett, 2012), seen as essential for good care by patients (Soto-Rubio and Sinclair, 2018), and despite negative media attention, nurses are described as compassionate (Bond et al., 2018). Although more unusual, there are arguments against the emphasis of compassion in nursing. Smajdor (2013) questioned the centrality of compassion and suggested that it was not a necessary component of healthcare, as essential nursing procedures and tasks can be carried out with or without it.

The centrality of compassion has not, however, prevented the unearthing of a catalogue of poor care experiences in the UK where nurses have failed to demonstrate compassion, for example the Mid Staffordshire Inquiry (Francis, 2013), the Ombudsman's report into the care of older people (Abraham, 2011), the serious case review of events at Winterbourne View (Flynn, 2012), and current Care Quality Commission reports (Care Quality Commission, 2020). Prior to, and supported by the publication of these reports, the need for re-emphasis on compassion led to the recommendation that it should be measured (Department of Health, 2008a, b). The measurement of compassion reflected the political and organisational emphasis on objective and measurable patient outcomes at a time when nurse training was transferred into higher education. The move to higher education supported the increased focus on the development of evidence and research for practice, placing a greater emphasis on professional knowledge than moral and emotional virtues. However, this appeared to separate the production of research and evidence from implementation in practice (Rolfe, 2015), leading to accusations of graduate nurses being 'too posh to wash' or 'too clever to care' (Scott, 2004).

A tense dichotomy was then produced between a healthcare system locked into a 'scientistic ideology' (Smajdor, 2013), that is, reliant on evidence and measurable outcomes, and the need for compassion, an intrinsic quality virtue that is difficult to measure (Bradshaw, 2009, Sinclair et al., 2016b). In response to the increasing emphasis on observable and measurable practice, a range of tools have been developed to measure compassion, for example the Compassionate Love Scale (Sprecher and Fehr, 2005), Santa Clara Brief Compassion Scale (Hwang, Plante and Lackey, 2008), Martins et al's (2013) compassion scale, the Compassionate Care Assessment Tool (Burnell and Agan, 2013), the Compassion Competence Scale (Lee and Seomun, 2016), and the Sussex-Oxford Compassion Scale (Gu et al., 2019). However, the compassion measurement tools to date lack acceptable levels of reliability and validity (Strauss et al., 2016), and need further testing.

The difficulties of objectively measuring or proving compassion have led to the inclusion of compassion as a value in codes of practice (American Nurses Association, 2015, Nursing and Midwifery Council, 2018a), professional standards (Nursing and Midwifery Council, 2018b), and the UK NHS Constitution (Department of Health, 2015), but have prevented it being mandated (Paterson, 2011). It has been suggested that if compassion became a measured concept linked to performance monitoring and targets, nurses could perform the behaviours required to meet the target without feeling compassion (Bradshaw, 2009, Sturgeon, 2010). An imposed or enforced compassion to meet a financially incentivised target was a sham, not true compassion. Smajdor's (2013) questioning of compassion as a necessary component suggested that whether compassion was authentic or imposed was irrelevant, it was the competence of the nurse that mattered. The tensions between outcome focused care, and compassion as an intrinsic quality virtue remain in professional debate, and will no doubt continue for many years to come. However, whether compassion is deemed to be authentic or not, compassion and compassionate behaviours are believed to be essential for good nursing care.

The increasing amount of emergent research and theory over the past decade has generated discursive and innovative approaches to the development and implementation of a culture of compassion, but there remains a level of ambiguity about what compassion really is, and is not, in relation to nursing (McCaffrey and McConnell, 2015, Sinclair et al., 2016b). Psychologists define compassion as an awareness of suffering, and a desire to ease that suffering (Gilbert, 2005, Irons, 2013); the Chief Nursing Officer for England defined it as the way in which care is given, intelligent kindness forming relationships based on empathy, respect and dignity (Cummings and Bennett, 2012).

1.2 Background and inspiration

Increased public, political and professional emphasis on the importance of compassion in nursing, alongside the publication of reports highlighting non-compassionate practice, led to extensive personal reflection. My own experience of working as a Registered Nurse for over twenty years had supported my understanding that nurses were compassionate, so the cognitive and emotional dissonance this produced resulted in a desire to explore the potential reasons for non-compassion, and ways in which it could be prevented.

Zimbardo (2007) highlighted the relevance of situational influences on behaviour, and identified these influences as anonymity, dehumanisation, and permission/authorisation. It appeared from reports of non-compassionate care that the situational influences of anonymity, dehumanisation, and permission were also seen in nursing and healthcare organisations. The potential for anonymity was seen in the large number of different healthcare roles, associated uniforms, and high levels of transient agency staff, making it difficult to differentiate between people providing care (Castledine, 2011, Jones-Berry, 2020), particularly for individuals with altered mental capacity. Dehumanisation has been previously raised as a concern in healthcare, particularly for hospitalised patients, due to the

everyday processes, procedures and routines of the ward environment (Armstrong, 2006, Boddington and Featherstone, 2018, Haque and Waytz, 2012). Although no evidence of explicit permission was found in the reports of non-compassionate care (Abraham, 2011, Flynn, 2012, Francis, 2013), there was evidence of implied permission from ineffective organisational responses to whistleblowing. Despite concerns being raised (Nursing and Midwifery Council, 2013), non-compassionate practice was permitted to continue.

Zimbardo (2007) claimed that not only did "*situations matter*" (p211), but it was the systems that impact on situations, and in turn those situational forces influenced individual and team behaviours. As identified in Chapter 1.1, healthcare systems are currently dominated by the measurement of targets, cost-effectiveness and efficiencies. An example of this was seen when market forces led to nurse-patient interaction times having strict limits imposed on them to meet the required targets (Georges, 2011), causing a potential incongruence with national campaigns such as 'Releasing Time to Care' (Abendroth and Flannery, 2006, Hooper et al., 2010, Maytum, Bielski Heiman and Garwick, 2004, NHS Institute for Innovation and Improvement, 2007, Yoder, 2010).

A further contributory factor for people to behave without compassion was believed to be the fear of exclusion, rejection, embarrassment, shame, or the need for approval (Gilbert, 2005). Whether this led to nursing staff feeling obliged to behave in ways they were not comfortable with in order to meet the organisation's targets could be called into question. However, socialisation and the desire to belong were recognised as strong motivators for behaviour (Barsade, 2002, Maslow, 1954).

Despite the situational influences identified, Zimbardo (2007) found that some people, referred to as everyday heroes, were able to resist or remain unaffected by them. He also believed that this heroism could be learned and taught (Zimbardo, 2011). The potential benefits of developing everyday heroes in nursing, nurses who could resist situational

forces, and advocate for and enhance compassionate care, provided an interesting area for further exploration. As a nurse educator, I was interested to explore ways in which this development could be supported. One area with an interesting potential to add to this discourse was the newly emerging field of self-compassion.

Neff (2003a) had been exploring self-compassion as an alternative to self-esteem in the development of a healthy attitude towards oneself, and had identified three main components of self-compassion that mutually interact and engender each other: self-kindness, common humanity, and mindfulness. Although limited empirical investigation had been undertaken in self-compassion at that time, the theoretical perspective it presented resonated with my reflections on developing everyday heroes. Neff (2003a) found increased levels of self-compassion resulted in reduced stress and anxiety, an increased ability to cope, increased connectivity with others, intrinsic motivation, and pro-active behaviours to promote or maintain wellbeing. She also noted that "*people who approach their own experiences with compassion are more likely to have compassion for others*" (p92). Neff's (Neff, 2003a, 2011a, 2003b) proposed outcomes of self-compassion appeared to offer a strategy that may mitigate against the effects of situational forces in healthcare that had caused non-compassionate behaviour.

1.3 Identifying the knowledge gap

Firestein (2012) referred to gaps in knowledge as areas of ignorance, which once found, can inspire and stimulate exploration and knowledge development. Not to be confused with the common use of the term ignorance with its negative connotations, but ignorance defined as "*the absence of fact, understanding, insight, or clarity about something. It is not an individual lack of information but a communal gap in knowledge*" (p6). Based on initial reading and reflection, and experience as a nurse and nurse educator, I believed self-compassion was an interesting potential strategy to support the development of everyday

heroes, and was inspired to explore the connection in greater detail. A further literature search at the time found minimal evidence of self-compassion being applied to or developed in nursing, suggesting this was a communal area of ignorance (Firestein, 2012) waiting to be explored. Empirical evidence related to self-compassion at the start of the research was scarce, and tended to be quantitative, for example, the development and validation of a self-compassion scale (Neff, 2003b), or the identification of correlations between self-compassion and other factors (Akin, 2008, Barnard and Curry, 2011, Iskender, 2009, Neff, Hsieh and Dejitterat, 2005). The lack of qualitative research supported the uniqueness of my study, to explore the experience of applying self-compassion, within the wider corpus of knowledge. A personal conversation with Neff at the 'Empathy and Compassion in Society' conference (2013) also confirmed the application of self-compassion in nursing, and the teaching of self-compassion as a gap in knowledge.

The potential connections between compassion in nursing, the situational forces influencing behaviour, the role of everyday heroes, and the teaching of self-compassion to support the development of everyday heroes, inspired and stimulated my research. The experience of learning and applying self-compassion in nursing aims to add to the current dialogue about self-compassion, and offer an original contribution to knowledge, extending Neff's (Neff, 2003a, 2011a, 2003b) classic work to the nursing profession and nurse education, and meeting the requirements of a Doctoral level thesis.

1.4 Research aims and research questions

The aim of the study was to explore student nurses' experience of learning and applying self-compassion.

The research questions developed to address the study aim were:

1. How do student nurses understand compassion at the beginning of their 3-year nursing degree? [RQ1]

2. How is the understanding of the concept of compassion developed? [RQ2]

3. Can student nurses incorporate exercises to enhance self-compassion into their everyday practice? [RQ3]

4. What is a student nurses' experience of applying self-compassion? [RQ4]

5. Do student nurses perceive behaviour change, professional or personal, following the application of self-compassion? [RQ5]

1.5 Methodology overview

A qualitative research paradigm, from a constructivist perspective (Silverman, 2014) was utilised to address the research questions as it was congruent with my ontological understanding of multiple realities based on context and experience (Lincoln, Lynham and Guba, 2011). It was also deemed to be more effective in understanding people's experience through their correspondence with the world (Ingold, 2017). Case study methodology supported the exploration of phenomenon, namely the experience of learning and applying self-compassion, over a period of time (Yin, 2014), making it congruent with the research aim and questions. Multiple case studies were used, with a total of seven cases. A literal replication design (Yin, 2014) meant that each case could be studied for its own merits, capturing the individual experiences of the participants. Multiple case studies also provided the opportunity to explore and identify findings replicated across cases that would not otherwise be evident in single case study (Blackstone, 2009), thereby enhancing the research credibility.

Semi-structured, in-depth interviews (Johnson and Rowlands, 2012) were carried out at the beginning of the research to explore the participants' understanding of compassion and their development of that understanding. Participants then attended a series of workshops to

learn and develop the practice of self-compassion. A second semi-structured, in-depth interview was then carried out to explore the participants' experiences of using the exercises and applying self-compassion. Interviews were transcribed verbatim and in edited form, cross checked against the audio recording (Polit and Beck, 2012), and sent for participant checking. Data were analysed using Lieblich et al's (1998) four-point narrative analysis model, a pluralistic approach using holistic and categorical perspectives. Peshkin's I's (Peshkin, 1988) were used as a reflexive lens to identify the influence of researcher subjectivity in the data collection and data analysis. Finding were identified and discussed (Chapters 5 and 6 respectively) in relation to the research questions.

1.6 Thesis structure

Chapter two explores and interrogates the literature to inform gaps in the knowledge. The conceptualisation of compassion and the factors that influence the development of compassion and compassion behaviour are reviewed, followed by the development and application of self-compassion. The chapter concludes by presenting a model of interconnections between compassion and self-compassion, and proposing potential links between these and nursing and nurse education. Chapter three explores the case study methodology and the steps taken to strengthen research rigour. Implementation of ethical principles is considered, with the identification of potential risk areas, and strategies planned to mitigate these risks. The multiple case study research methods are discussed in Chapter four. The identification of the case and case boundaries are discussed, with a description of the sample selection process. The use of data collection utilising in-depth interviews, and the pluralistic approach to data analysis are explored. Chapter five presents the findings of the research, using verbatim quotes and stories to illustrate key themes and reflect a constructivist position. Study findings are then discussed in Chapter six with reference to the wider corpus of knowledge to identify the original contribution to knowledge required of a Doctoral thesis. The final chapter of this thesis summarises the theoretical contribution of

my research, extending the model of interconnections to suggest learning and teaching tools that support the safe education of compassion and self-compassion in nurse education. A critical review of the study is made to acknowledge the strengths and limitations of the original study design, and demonstrate my personal learning from engaging in doctoral level research. Engagement in this PhD has led to the inclusion of self-compassion in the nursing curriculum, and the use of a metaphor for compassion as a learning and teaching tool within nurse education. Recommendations for future practice and research are presented.

While it is for the reader to judge, I hope this study will be of particular interest to nurse educators who are responsible for the development and implementation of nursing curricula, and to nurse leaders wanting to develop and support a compassionate culture within the workplace. It aims to contribute to a better, empirically-supported understanding of the use of self-compassion in nursing, and to provide nurse educators with a range of tools that can be utilised to safely support the facilitation of compassion and self-compassion education.

CHAPTER 2: LITERATURE REVIEW

A literature review was carried out using an integrative approach, to allow the cumulative review of a depth and breadth of research and literature that led to a richer data set (Aveyard, 2019, Kirkevold, 1997, Whittemore, 2005). Systematic reviews, meta-analyses and meta-syntheses literature reviews were not chosen due to their reliance on evidence from similar methodologies or research approaches (Whittemore and Knafl, 2005), which would exclude theoretical discussion and grey literature. An initial literature search on compassion and self-compassion in 2012, revealed a significant amount of theoretical discussion that, although not empirical research, was no less valuable in contributing to the debate. Therefore, an integrative review was deemed most appropriate. Reflective of the contemporary interest in compassion and self-compassion, a significant increase in related literature and evidence has been published during the course of the research. An iterative approach to reviewing literature enabled ongoing engagement with the growing corpus of knowledge. In addition to nursing literature, knowledge was drawn from the fields of philosophy, psychology, reflective practice, policy, and education. Drawing on these wider disciplines encouraged innovative thought and connections to be made between theoretical perspectives, informing and extending knowledge-building to develop a corpus of work on which to base conceptual understanding (Finfgeld-Connett and Johnson, 2013, Trafford and Leshem, 2008). During the review, care was taken with the quality and interpretation of data. Whittemore and Knafl (2005) acknowledged the potential for inaccuracy and bias when combining mixed theoretical and empirical reports and proposed a strategy to enhance the rigour of the analysis, synthesis and conclusion-drawing process. The literature review has been guided by this strategy.

2.1 The search strategy

The aim of the literature search process was to identify from current and established literature, an understanding of:

- The concept of compassion in nursing;

- The factors that influence compassionate and non-compassionate behaviours;

- The concept of self-compassion; and

- The effects of self-compassion on student nurses.

Several search techniques were used including computerised database searching, ancestry searching, and journal hand searching (Aveyard, 2019). The literature included research studies, books, conference papers, articles, policy documents and guidelines from an international arena. Three electronic databases were chosen for their breadth of relevant literature in the field of healthcare and nursing: Cumulative Index to Nursing and Allied Health Literature (CINAHL Plus), a comprehensive database providing access to over 750 full-text journals in medicine, nursing and allied health; MEDLINE provides access to over 25 million journal articles from global biomedical and health journals; and PsychINFO, the world's largest resource for peer-reviewed literature in behavioural science and mental health.

The search terms 'compassion' and 'self-compassion' (with and without the hyphen) were used with Boolean operators AND meaning, AND defin*, AND factors (Hart, 2001). Truncation of words were used and the search terms were adapted as necessary for the databases used. Due to the significantly increased focus on compassion and self-compassion since the turn of the century, and the desire to develop and maintain a contemporary understanding of the body of knowledge, the databases were searched for literature published between 2000-2019. Following the searches, the results were refined by

scrutinising titles, reading abstracts, and applying inclusion and exclusion criteria. Results of the database searches can be seen in Appendix 1.

The inclusion criteria related to accessibility and focus, that is, available in full text, written in English, and related to compassion or self-compassion. Exclusion criteria also related to accessibility and focus. Literature was excluded if it was not accessible, or was in a language other than English.   Compassion focused therapies have been used in relation to many mental health conditions. However, this research was not intended to add to the knowledge of mental health therapies, but aimed to focus on compassion within the wider 'healthy' nursing population. Therefore, literature with a focus on mental health therapies were excluded from the literature review. Although an associated term, empathy differs from compassion so literature solely focused on empathy was excluded. Mindfulness is considered to be one of the elements of self-compassion (Neff, 2003a), however, it has been extensively studied as a subject in its own right. In order to manage the quantity of literature, mindfulness was only included if it were part of self-compassion, not if it were the sole focus of the literature.

Literature was also sourced from Neff's website: 'Self-compassion – a healthier way of relating to yourself', due to the strong influence of her work in the field of self-compassion. Snowball referencing (Greenhalgh and Peacock, 2005) was then used, searching through the reference lists to identify frequently cited work. Literature that met the criteria was saved in a referencing database, EndNote. The search methods finally produced approximately 680 hits, although this final number has changed over time due to the relatively rapid increase in publications relating to self-compassion over the past twenty years (see Figure 1), and the iterative searching process during the compilation of the thesis. Literature relevant to compassion has not had the same exponential growth.
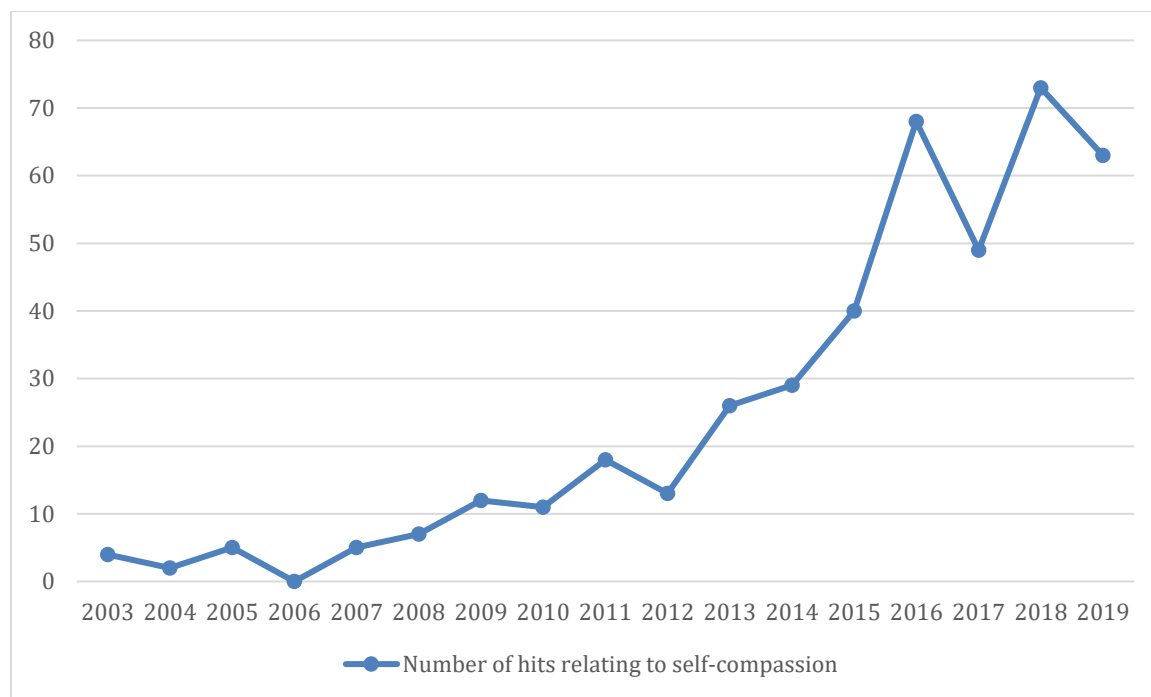
Figure 1: Illustration of the increase in self-compassion literature

Conn et al (2003) recognised a diverse range of search strategies were required in order to give a fuller picture, and to avoid publication bias. Research was more likely to be published if it had positive findings of significance, therefore a literature search for exclusively published material may not have included work that showed little significance or negative findings, potentially jeopardising the validity of the review (Soeken and Sripusanapan, 2003). Although I have attempted to take a critical view of the literature in this review, the potential for publication bias is a limitation.

The literature review then exploited the sources identified to ensure the background and context of the subject, along with a sound theoretical knowledge, was presented (Trafford and Leshem, 2008), and to identify a gap in the knowledge and literature that justified the uniqueness and relevance of this research.

2.2 Data synthesis and general findings

A generic overview of the identified literature noted clear differences between compassion and self-compassion literature. Literature relating to compassion was primarily from the UK and USA, with a smaller amount from Canada and Australia, and very little from other countries. Literature relating to self-compassion was primarily from the USA and Canada, with increasing amounts from Australia and the UK, and smaller amounts from many other countries including Turkey, China, the Netherlands, Germany, and Iran. The dominance of the USA as the source of research was unsurprising as Neff, author of the self-compassion scale, was an Associate Professor at the University of Texas, USA. However, self-compassion literature had a wider global authorship than compassion, and included a range of global collaborations.

Differences were also seen in the type of literature. There was a relatively equal number of research studies and discussion papers relating to compassion, with the research studies being approximately 60% qualitative and 40% quantitative. The self-compassion literature was primarily research, with far fewer discussion papers or literature reviews. Of those research studies, approximately 94% were quantitative, with only 6% qualitative. Potential reasons for these differences may relate to the age of the concepts, or the professional fields from which they were primarily developed. Compassion has been widely discussed in nursing since the 19th century (see Chapter 1.1), implying a level of familiarity about the concept within the nursing profession. The literature therefore tends to include more discussion papers about the application of compassion in different care settings. Reflective of the wider nursing and social science disciplines, researchers tended to use a qualitative approach to explore the experiences and perspectives of compassion and compassionate care (Armstrong, Parsons and Barker, 2000, Bramley and Matiti, 2014, Dewar, 2011, Hudacek, 2008, van der Cingel, 2011). In comparison, self-compassion, although evident in early Buddhist texts, became established in the literature from 2003 through Neff's (2003a,

2003b) work. The relative newness of self-compassion as a formal concept could support the predominantly quantitative approach to research, measuring self-compassion, validating the self-compassion scale in a variety of countries, finding associated correlations, or measuring the impact of interventions to improve self-compassion (Allen, Goldwasser and Leary, 2012, Boellinghaus, Jones and Hutton, 2013, Neff, Hsieh and Dejitterat, 2005). Also, self-compassion research predominantly stemmed from psychology, a discipline with a stronger focus on empirical research. The limited amount of interpretive research conducive to the use of self-compassion in student nurse education was an evident gap in knowledge, and supported the value of this study to explore the experiences of student nurses.

The literature related to compassion was predominantly drawn from nursing and healthcare. Rationale for this decision was based on three key factors. Firstly, as a nurse and nurse educator, I was undertaking the research in a nurse education setting with the intention of primarily considering any findings and recommendations within a nursing context. Secondly, there was significant emphasis placed on compassion within nursing and healthcare supporting the relevance of the research within this field. And thirdly, saturation of information within the literature was reached, with no new themes being identified.

Themes from the literature were analysed using the system recommended by Miles and Huberman (2002) of data reduction, data displaying, and conclusion drawing/verification. These themes are identified in Table 1.

Table 1: Themes from the integrated literature review

Theme	Sub-theme
Meaning of compassion	- Compassion as distinct from other concepts - Affective domain: compassion as an emotion - Cognitive domain: knowledge and understanding - Compassion and suffering - Noticing and acknowledging suffering - Easing the suffering - Connectivity
Factors that influence compassion	- Compassion experience - Familiarity - Deservedness - Organisational influences - Cultural influences - Reciprocity of compassion
Self-compassion	- Model of self-compassion - Factors affecting self-compassion - Measurement of self-compassion
The application of self-compassion	- Enhanced psychological wellbeing - Increased compassion towards others - Motivation for personal growth and change - Reduced stress and enhanced coping

The collection of references used in this research had similarities with other work in the field

of compassion and self-compassion, and drew on the work of key authors and researchers

in the field. However, the connections made and parallels drawn between compassion as a requirement for nursing, the factors that influenced compassion and compassionate nursing care, and Neff's (2003a) theory of self-compassion as a potential strategy to support and enhance compassion, differentiated it from other work in the field. These unique connections supported the development of the model of interconnections illustrated in Chapter 2.7, and identified a potential gap in knowledge. The research aim and research questions of this thesis aim to extend the knowledge of compassion and self-compassion to address this knowledge gap.

The literature review begins with an exploration of the meaning of compassion, and the factors that affect compassion in nursing. It then goes on to explore the concept of self-compassion, and the potential outcomes from the application of self-compassion.

2.3 Meaning of compassion

Compassion in healthcare was acknowledged to be a phenomenologically complex concept (Armstrong, Parsons and Barker, 2000, Sinclair et al., 2016b, van der Cingel, 2009), the subjective nature of which made it difficult to articulate. It was, however, considered an active state (Dewar, Pullin and Tocheris, 2011, Gilbert, 2005, McCaffrey and McConnell, 2015), a process with both cognitive and affective dimensions (van der Cingel, 2009). Compassion in nursing and healthcare has been described in the literature using a range of different terms. It is defined as an awareness of suffering, and a motivation or desire to ease that suffering (Chochinov, 2007, Dunn and Rivas, 2014, Gilbert, 2005, Goleman, 1996, Irons, 2013, McCaffrey and McConnell, 2015, Schulz et al., 2007), a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action (Sinclair et al., 2016a), giving care from the heart, valuing people, respect, trust and loving concern (Lundberg and Boonprasabhai, 2001), intelligent kindness forming relationships based on empathy, respect and dignity (Cummings and Bennett, 2012), and

the action of giving care (Dewar and Nolan, 2013). Van der Cingel (2014) attempted to collate understandings of this diverse concept by identifying seven dimensions required for the construct of compassion. Of these dimensions, four relate to the noticing of suffering (attentiveness, active listening, naming of suffering, and involvement), two to the act of relieving the suffering (helping, and being present), and one to developing knowledge and understanding of the suffering (understanding). Sinclair et al (2016a) developed an empirically based model of compassion. Based on the perspectives of palliative care patients, the model defined compassion as the healthcare provider's virtuous response to patient suffering, that involved seeking to understand, relational communicating, and attending to needs, within a relational space, to achieve positive patient reported outcomes.

However, despite a significant increase in compassion literature over the past decade, and illustrated by the breadth of language used to describe it, it is widely acknowledged across nursing and healthcare and the corpus of literature that compassion remains difficult to define (Bengtsson, Söderström and Terjestam, 2016). A level of ambiguity remains (Durkin, Usher and Jackson, 2019), and discussions to define compassion continue.

The following sections critically discuss the themes identified in Table 1 relating to the meaning of compassion.

2.3.1 Compassion as distinct from other concepts

Compassion was often discussed with associated, but not synonymous, terminology (Constantinides, 2019) such as empathy and sympathy (Armstrong, Parsons and Barker, 2000, Galetz, 2019), care (Gilbert, 2005, Wang, 2005), pity (van der Cingel, 2014), and kindness (Bierhoff, 2005, Snow, 1991, van der Cingel, 2009), terms which are often used interchangeably (Dunn and Rivas, 2014). However, despite the closely related links

between compassion and these other concepts, interchangeability of the terms is an erroneous assumption (Schantz, 2007) that should be avoided. There are distinct differences.

2.3.1.1 Care

Care can be described as the nurturing of someone or something to achieve a goal that is of benefit to them. Although potentially the closest in definition to compassion, care can lack either the cognitive or affective aspects of compassion. 'Caring about' someone (Boleyn-Fitzgerald, 2003) was defined as a broad emotional response to a person or situation without necessarily acknowledging or needing to understand the cause or experience of the suffering. Barker (2009) suggested this 'ordinary caring' could be carried out by anyone. It was a non-complex skill, different to that required of healthcare professionals. 'Caring for' someone (Boleyn-Fitzgerald, 2003) involved cognitive ability, knowledge and understanding of the care goals and strategies to achieve them (Butcher, 2002), but did not require warmth (Gilbert, 2005) or affective response. A combination of 'caring about' and 'caring for' (Boleyn-Fitzgerald, 2003) someone would be required to reflect compassion.

A grammatical difference also emphasised the conceptual difference, with compassion used as the adjective to describe care, 'compassionate care', in nursing literature (Babaei and Taleghani, 2019, Blomberg et al., 2016, Burnell, 2009, 2013, Christiansen et al., 2015, Dewar, 2013, Dewar et al., 2014b, Dewar and Mackay, 2010, Msiska et al., 2014, Su et al., 2019, Von-Dietze and Orb, 2000). The use of compassion as an adjective suggested that care could be delivered without compassion, evident in task based care, and seen as a potential barrier to person-centred care (Sharp, McAllister and Broadbent, 2018). Task based care, 'caring for' (Boleyn-Fitzgerald, 2003), in response to an increase in organisational demands and healthcare targets (discussed in Chapter 2.4.4) has been

shown to result in a lack of compassion (Francis, 2013, Sharp, McAllister and Broadbent, 2018).

2.3.1.2 Empathy

In nursing, empathy was thought to be a positive affective dimension, supporting awareness, sensitivity, shared respect, mutual goals, and an understanding of individuals within a social and historical context (Alligood and May, 2000). However, empathy differed from compassion in three key ways. Firstly empathy was considered an emotional response that did not require the action of compassion (Galetz, 2019, Lim and DeSteno, 2016). Secondly, empathy was perceived to be other-facing rather than the self-facing potential of compassion (Neff, 2015a), and thirdly, empathy was a concept with moral neutrality (Bein, 2013) as opposed to compassion that aimed to easing suffering.

Eisenberg (2002) described empathy as an emotional response to a situation that stemmed from our understanding of another's emotional state or condition, and reflected what the other person was feeling or would be expected to feel. A way of recognising the vulnerability of others in ourselves (Dunn and Rivas, 2014, van der Cingel, 2014). Preckel et al (2018) described it as a process of shared feelings. Galetz's (2019) comparison concept analysis of empathy and compassion identified empathy as an active process, an emotional link to a person.

As an emotional contagion, empathy may have been motivated by evolutionary origins for survival (Gilbert, 2005), for example a distressed baby stimulated a sense of distress in the mother to urge her to take action. However, it was acknowledged that empathy ended with the emotional connection, without prosocial motivation, action, or a commitment to act (Butcher, 2002, Von-Dietze and Orb, 2000). Empathic concern was seen as a short lived

emotion compared with compassion which was thought of as an attitude (Leiberg, Klimecki and Singer, 2011). Compassion was an active process to relieve suffering (Galetz, 2019, Sinclair et al., 2016a) that required empathy and prosociality (Knafo et al., 2008). Following the noticing of suffering or need, an emotional empathic response was required in order for action to take place. Although ending at emotional connection, empathy was seen as a condition for compassion (Galetz, 2019, van der Cingel, 2014), that compassion included empathic concern (Boyatzis, Smith and Beveridge, 2012).

The empathic resonance (Decety and Chaminade, 2003) of emotional connection was supported by Goleman and Boyatzis' work (2008) on mirror neurones, which identified the benefits of empathic resonance to enhance interactions. The nurse could simulate the feelings of others through empathic resonance, which gave them better knowledge and understanding of the patients' needs and enhanced effective care giving. Extending the identification of empathy as an emotional response (Eisenberg, 2002, van der Cingel, 2014, Von-Dietze and Orb, 2000), the increased level of knowledge and understanding gained through empathic resonance (Goleman and Boyatzis, 2008), and empathy training (Ancel, 2006) suggested that empathy also had a cognitive dimension. However, the cognitive dimension was only to attempt understanding of another person's perspective or situation, and did not result in the implementation of any action.

A more controversial difference for the nursing profession, was that empathy did not necessarily act for the wellbeing of others (Gilbert, 2005). It had a moral neutrality that reflected Scheler's concept of fellow-feeling (*Mitgefühl)* (Bein, 2013, Scheler, 2017). The ability to stimulate empathic resonance allowed film-makers to frighten or distress audiences, and an empathic terrorist may threaten the child or loved one of a person rather than the person themselves. For nurses, learning to use mirror neurones could enable the manipulation of emotional contagion and empathic resonance to enhance the relationship with the patient (Goleman and Boyatzis, 2008). Mirror neurones cause us to reproduce

emotions detected in others. A nurse could approach an anxious patient in calm way, using positive emotional signals such as nods and smiles. By consciously remaining calm and using these emotional signals, the patient can unconsciously detect the emotion and reproduce the calmness, relieving their anxiety. Goleman and Boyatzis (2008) suggested that even if the message to be delivered was anxiety-provoking, the manipulation of mirror neurones through the use of positive emotional signals could reduce the perceived negative impact. However, despite these potential benefits, the cognitive abilities of empathy and empathic resonance could be used for positive, neutral or even malevolent interference (Gelhaus, 2012b).

2.3.1.3 Sympathy

Like empathy, Eisenberg (2002, Eisenberg, VanSchyndel and Hofer, 2015) described sympathy as an emotional response consisting of feelings of sorrow or concern for a distressed other. It was the ability to share feelings with the other without the cognitive dimension required for compassion (Dunn and Rivas, 2014, Gelhaus, 2012b). However, unlike empathy, it was not the same emotion as the other (Eisenberg, VanSchyndel and Hofer, 2015). Sympathy did not need knowledge or understanding of a situation. A person in distress was enough to trigger a sympathetic response, even before having any knowledge of why they were distressed. Sympathy also differed from compassion by being a passive response (Boyatzis, Smith and Beveridge, 2012), that did not necessarily result in action (Eisenberg, VanSchyndel and Hofer, 2015), unlike compassion which was active.

Although similar to empathy, sympathy was seen as a different concept. Sympathy did not reflect the same strength of emotion or experience the distressed other was demonstrating (Faust, 2009). It was perceived as an appropriate response to more trivial situations (Snow, 1991) that may not be judged to be deserving of compassion. Sympathy was also focused

on the positive wellbeing of the other (Gelhaus, 2012b, Gilbert, 2005), unlike empathy which could be used for positive, neutral or negative response (Gelhaus, 2012a).

2.3.1.4 Pity

Nussbaum (1996) used the terms pity and compassion interchangeably, noting that pity was an archaic word for the same emotion. However, through historical semantic changes, pity now had negative connotations (Dunn and Rivas, 2014, van der Cingel, 2014) such as condescension or gloating (Faust, 2009), which were viewed as distasteful social and psychological burdens (Boleyn-Fitzgerald, 2003) that could lead to paternalistic care (Von-Dietze and Orb, 2000). Boleyn-Fitzgerald (2003) identified two different types of pity: aloof pity and fearful pity. Aloof pity was referred to as a response that was different to, or emotionally distant from that of the person experiencing suffering. The person who felt aloof pity did not feel connected to the suffering, or believe that it could happen to them, a lack of connectivity that clearly separated aloof pity from compassion (Gelhaus, 2012b). This was further emphasised by Snow (1991) who contrasted the immediacy or urgency in a compassionate response with the lack of this in pity. Fearful pity was defined as a fear of experiencing the same suffering as the other person (Boleyn-Fitzgerald, 2003). The suffering was noticed and acknowledged, but unlike compassion, the motivation to ease the suffering to the best of one's ability was not necessarily part of this fear-based concept. Continued experience of fearful pity had the potential to result in emotional exhaustion and burnout.

2.3.1.5 Kindness

Kindness has been described as an emotional concept that dictates the feelings and actions of a person towards the wellbeing of others (Ballatt and Campling, 2011, Faust, 2009). It

was identified as an other-regarding virtue (Armstrong, 2006) focused on behaviours to support and enhance the wellbeing of others, and therefore viewed as an important character trait when working with vulnerable people . As with compassion, the concept of kindness shared the need for connectivity (Bickford et al., 2019, Dunn and Rivas, 2014, Schulz et al., 2007). It was the relationships and recognition of common humanity (Ballatt and Campling, 2011) that encouraged and motivated acts of generosity toward each other. However, unlike compassion which required knowledge and understanding (Constantinides, 2019, van der Cingel, 2009), kindness was perceived as an altruistic virtue that did not require professional knowledge and understanding of strategies to ease suffering. Holding the hand of a friend in pain would be an act of kindness, but without knowledge and understanding of the cause of the pain and potential pain management strategies, the suffering may not be eased.

For nursing, kindness without supporting knowledge and understanding was deemed to be insufficient for quality healthcare (Ballatt and Campling, 2011). Therefore, nursing required kindness with intelligence. The concept of intelligent kindness reflected the original Florence Nightingale idea of compassion toward the other, but lacked focus or connection with compassion toward the self.

2.3.2 The affective domain: compassion as an emotion

The definition of compassion identified by van der Cingel (2009) highlighted the inclusion of an affective domain, the concept of compassion as an emotion. Reflecting Aristotle's thoughts on 'eleos' (pity) as a reactive and emotional response to others (Bein, 2013), compassion was considered to be a care-taking emotion (Oveis, Horberg and Keltner, 2010). Compassion included an emotional response or emotional resonance (Cameron et al., 2013, Chochinov, 2007, Gelhaus, 2012b, Leget and Olthuis, 2007) that had an object of focus (van der Cingel, 2009) and a degree of spontaneity and authenticity (Dunn and Rivas,

2014). Cameron et al's (2013) study of physician-patient interviews in an oncology setting noted the importance of emotional resonance for compassion. The emotional response caused by noticing suffering enhanced the sense of connectivity, which facilitated further emotional resonance and motivation for action. However, they also highlighted the risks of emotional resonance, and supported the need for psychological preparation to prevent compassion fatigue or burnout from high levels of emotional stress (Baverstock and Finlay, 2016, Coetzee and Klopper, 2010).

Nussbaum (1996) referred to compassion as a basic social emotion. However, emotions were perceived as transient and often short-lived responses to a specific stimulus (Barsade, 2002, Fredrickson et al., 2008, Gilbert and Choden, 2013, Leiberg, Klimecki and Singer, 2011). Emotions were sometimes unreliable as they were based on irrational (Nussbaum, 1996) or unrealistic thoughts (van der Cingel, 2009). Therefore, debate ensued about whether compassion was an emotion, a motivation, or had both emotional and motivational components (Gilbert and Choden, 2013, Leiberg, Klimecki and Singer, 2011, Schulz et al., 2007). Reflecting my stance in this debate, Von-Dietze and Orb (2000) and Armstrong, Parsons and Barker (2000) supported the perception of compassion as more than an emotion, believing it to be a moral virtue, a motivation for our behaviour and ethical reasoning to ease suffering. Gilbert and Choden (2013) agreed, noting that contrary to the short-lived emotional response, compassion was a motivation, a longer lasting desire to behave in a certain way.

Despite the recognition of compassion as having an affective domain, it was acknowledged that the emotion was based on, or steered by, thought, without which one only had physical feelings (Nussbaum, 1996, Preckel, Kanske and Singer, 2018, van der Cingel, 2009). Compassion comprised affective, cognitive and behavioural components (Knafo et al., 2008).

2.3.3 The cognitive domain: knowledge and imagination

The need for rational thought about the wellbeing of others led to the understanding that cognitive processing was a condition of compassion (Durkin, Usher and Jackson, 2019, Nussbaum, 1996, Schulz et al., 2007, Taylor et al., 2017, Von-Dietze and Orb, 2000). Compassion was coordinated by cognitive operations (Bengtsson, Söderström and Terjestam, 2016). The knowledge and understanding required for compassion related to three areas: the experience of suffering (Constantinides, 2019, van der Cingel, 2014), the causes of suffering (Bickford et al., 2019, Lundberg and Boonprasabhai, 2001), and strategies that exacerbated or alleviated suffering (Gilbert, 2005). Gelhaus (2012a) argued that the understanding did not always have to be correct. A compassionate response could be misplaced due to a lack of understanding, but remain compassionate. Given the subjective nature of suffering (Gilbert, 2005, Wall, Higgins and Hunter, 2016), one could argue that it was not possible to fully understand another's situation or experience (van der Cingel, 2009), thereby supporting Gelhaus' (2012a) argument that the understanding does not have to be completely correct to be compassionate. However, knowledge and understanding could be developed, and were seen to develop with age, particularly social perspective taking skills, which were believed to play a key role in the generation and integration of compassion (Bengtsson, Söderström and Terjestam, 2016).

Van der Cingel (2014) highlighted the importance of having knowledge about the experience of suffering, without which suffering could not be recognised. Constantinides (2019) extended this to acknowledge common humanity (Neff, 2003a) and the commonality of suffering and traumatic experience (Wall, Higgins and Hunter, 2016). All nurses understood suffering because all people, including nurses, experienced suffering. Philosophers of embodied learning and knowledge, however, argued that having the experience alone was not sufficient to develop understanding, and that true understanding required both experiential and conceptual knowledge (Gendlin, 1962, Lakoff and Johnson, 1999).

Conceptual knowledge and the cognitive processing to understand the causes of suffering were deemed to be important if one were going to exacerbate or alleviate suffering (Bickford et al., 2019, Gilbert, 2005, Lundberg and Boonprasabhai, 2001). However, like compassion, suffering was deemed to be a complex construct, developed within the context of one's personal trauma history (Wall, Higgins and Hunter, 2016, Wilson, Hutchinson and Hurley, 2017), thereby having subjective causes that were open to interpretation. In order to better understand a situation and the causes of someone's suffering, it was identified that nurses must spend time with that person, demonstrating attentiveness and engagement to develop knowledge (Armstrong, 2006, Bickford et al., 2019, Lundberg and Boonprasabhai, 2001, van der Cingel, 2009). Despite this recognition, and models of nursing that have emphasised the importance of holism, communication and interpersonal relationships (Orem, 1995, Peplau, 1991, Roper, Logan and Tierney, 1980), exploration of the cause of suffering through effective communication with patients in the form of trauma-informed care has only recently been introduced to healthcare and nursing (Hall et al., 2016, Wall, Higgins and Hunter, 2016, Wilson, Hutchinson and Hurley, 2017).   The introduction of this trauma-informed approach, that asked 'what happened' rather than 'what's wrong', was one approach to recognising the contextual subjectivity of suffering, and the need for nurses to enhance their understanding of and attitudes towards those who were suffering (Hall et al., 2016).

The ability to reflect on and judge one's own thoughts and feelings, referred to by Gilbert (2005) as metacognition, enabled the flexible updating of knowledge and understanding. Dewey (1910) believed that knowledge and understanding was developed through curiosity, inference or suggestion, and testing of ideas or experimentation. Curiosity supported the need for effective communication and interpersonal skills discussed above, to explore peoples' experience of suffering. However, the development of knowledge and understanding through inference suggested something more speculative, and required imagination. Imagination enabled one to gain an insight into and understand another's

emotion (van der Cingel, 2009), to actively imagine the sufferer's condition (Cameron et al., 2013). Tulving (2002) described chronesthesia as the human ability to be aware in the present, of our past and possible futures. Imagination allowed the collation of these past, present, and future experiences to be able to explore and learn from myriad simulated possibilities (Gilbert, 2005). The development of knowledge through the exploration of imagination provided what Dewey (1910) described as "clear insight into the remote, the absent, the obscure" (p224). Cognitive development utilising imagination used both an inductive and deductive approach to reflection (Dewey, 1910), that was further developed and championed by Schön (1987). The use of reflection is a well-established teaching and learning strategy in nurse education (Johns and Freshwater, 2005, Sanders, 2009), a strategy that has the potential to be enhanced by the use of imagination (Armstrong, 2006).

2.3.4 Compassion and suffering

Recognised as an unavoidable part of the human condition (Lim and DeSteno, 2016), the concept of adversity and suffering was perceived as a core variable, central to most definitions of compassion (Armstrong, Parsons and Barker, 2000, Constantinides, 2019, Gilbert, 2005, Goleman, 2013, Irons, 2013, Schantz, 2007, Sinclair et al., 2016a, van der Cingel, 2009, Von-Dietze and Orb, 2000). Van der Cingel (2009) noted that the definition of suffering remained recognisable from Aristotle's description of "*painful and destructive evils such as death, physical injuries and disorders, old age, diseases, food deficiency, repeated disasters and also having no friends"* (p126). Although reflective of its time, the concepts Aristotle proposed still resonate with many modern day causes of suffering. However, this definition fails to explicitly encapsulate psychological or existential suffering. Schulz et al (2007) acknowledged this gap and proposed suffering had three components – "physical, emotional, and existential or spiritual" (p5). Bueno-Gómez (2017) further extended the definition, describing suffering as an unpleasant or even anguishing experience which severely affected a person at a psychophysical and an existential level.

Compassion included the need to notice suffering, the motivation to respond to suffering (Dunn and Rivas, 2014, van der Cingel, 2014) and the desire to ease suffering to the best of one's ability. Boyatzis et al (2012), however, challenged the use of the term suffering, and suggested that a "disquietude" or "unsatisfactoriness" (p157) may demonstrate a desire for personal development to achieve wellbeing, but was not necessarily suffering. Whilst not disregarding the concept of suffering in compassion, Boyatzis et al (2012) proposed an extension to compassion definitions, that a person's need (rather than suffering) was noticed, and actions taken to enhance wellbeing in response to that need. My understanding of the concept of suffering reflects that of Schultz et al (2007), that it includes physical, psychological and spiritual aspects. However, within each of these aspects, perception of the extent of suffering can be wide-ranging, from the recognition of need to severe distress. All could be considered within the context of suffering.

2.3.5 Noticing and acknowledging suffering

In order to be compassionate, a person first needed to be open to and notice the suffering, vulnerabilities, or needs of others and the self in a non-judgemental, non-defensive way (Bein, 2013, Boyatzis, Smith and Beveridge, 2012, Cameron et al., 2013, Dewar et al., 2014a, Gelhaus, 2012b, Gilbert, 2005), paying attention to the 'everyday ordinary' (Perry, 2009). The noticing and acknowledging of suffering resonated with definitions of empathy discussed in Chapter 2.3.1.2, but was deemed to be the first part of a larger compassion process (Ancel, 2006). Van der Cingel (2014) referred to this as "attentiveness" (p1255), a conscious action, providing space, intentional presence, and time (Beck, 2001, Dunn and Rivas, 2014) to show interest in the issues important to another person. Communication and interpersonal skills, particularly active listening and naming the suffering were perceived as essential in order for healthcare professionals to notice suffering (Cameron et al., 2013, van der Cingel, 2014). The engagement demonstrated through active listening encouraged

the person to talk about their experience (Shipley, 2010), which enabled the healthcare professional to be aware of and increase their understanding of the person's priorities, and their perception of the seriousness of their experience.

Noticing the need for compassion, however, was seen as potentially difficult with so many demands on our time and attention (Bickford et al., 2019, Christiansen et al., 2015, Georges, 2014, Georges, 2011).   Darley and Batson (1973) explored helping behaviour in their research using theology students studying the parable of the Good Samaritan. They found that despite the intentional focus of the mind on helping behaviour, it was not the religiosity of the person that affected their helping behaviour, but the pressure of time that acted as a barrier to noticing suffering. It could be argued that the distraction from what is happening 'in the moment', and the need for time (Perry, 2009), remained the case in an increasingly busy modern society, health service, and nurse education setting (Beck, 2001).

In addition to noticing the suffering, it was also important to explicitly demonstrate that suffering had been noticed (Perry, 2009). A lack of acknowledgement suggested the suffering or loss causing it had no value (van der Cingel, 2009), further exacerbating the suffering. In naming the suffering, the healthcare professional not only offered acknowledgement, but was also able to assess the emotional significance of the suffering to the person (van der Cingel, 2014). These communication skills were found to enhance the development of trusting relationships by demonstrating active involvement with the patient (Dewar and Nolan, 2013, Sinclair et al., 2016a), leading van der Cingel (2009) to conclude that compassion facilitated communication in good quality care. It could however, be argued that rather than a one-directional approach, the facilitation is bidirectional, that is, that good communication skills facilitate the implementation of compassionate care. Good communication skills and active involvement with a patient may encourage more opportunities to notice suffering, and therefore act compassionately to ease it.

2.3.6 Easing the suffering

Once suffering is noticed, and emotional resonance experienced (Cameron et al., 2013), one needs to be motivated to take action to ease the suffering (Bickford et al., 2019). The desire to help relieve suffering, and the action of being present in order to provide this emotional and physical relief, were identified as the fifth and sixth dimensions of compassion (van der Cingel, 2014). However, the action did not have to succeed in order for it to be compassion. Action, even if ineffective, was still seen as sufficient to be classed as an instance of compassion (Boyatzis, Smith and Beveridge, 2012).

Sinclair et al (2016a) identified virtues as the internal motivator for compassion. However, the historical image of compassion as an altruistic moral virtue (Armstrong, Parsons and Barker, 2000, Begley, 2008, McGaghie et al., 2002, Von-Dietze and Orb, 2000) with altruistic motivation had been closely scrutinised and called into question, leading to some debate about whether compassion was an altruistic or egoistic behaviour (Straughair, 2012a, van der Cingel, 2009). McGaghie et al (2002) believed that compassion was the foundation of altruism, part of our innate caregiving system (Mikulincer et al., 2005). Schulz et al (2007) associated altruism with high levels of compassion, and egoism with low levels. In the building of the concept 'compassionate knowing', Constantinides (2019) highlighted an altruistic motivation for choices made by nurses, "guided by an ethic of selflessness to relieve suffering" (p220).

The altruistic desire to give compassion, or a prosocial tendency, was perceived as evolutionary, to maintain and protect the species (Gilbert, 2005, Knafo-Noam et al., 2015), and part of human nature (Hoffman, 1981). By helping family (kin-altruism) the shared gene pool was passed on, and by helping non-family (reciprocal altruism) a co-operative exchange of help and support was encouraged, which increased the chance of survival (Gelhaus, 2012b, Gilbert, 2005, Mikulincer et al., 2005). The history of compassion in

nursing discussed in Chapter 1.1, also focused on altruistic motivations, an approach that urged one to 'do unto others as you would have done unto yourself', or 'do not treat others as you would not like them to treat you' (Neuberger, 2011). Reflecting the need for imagination discussed in Chapter 2.3.3, one could only imagine exactly how another person would wish to be treated (Dewar et al., 2014a, van der Cingel, 2014) based on one's own judgement. A nurse could utilise experience and knowledge to enhance their imagination in any particular context, but could not assume specific compassionate behaviours that would suit the nurse would meet patient needs, for example, hand holding or silent space. As Dewey (1910) proposed, a suspension of judgement was required in order for critical thinking to take place, and decisions made about the strategies to ease suffering.

Miers et al (2007) noted the altruistic motivation driving career choices in healthcare, although from their survey content analysis, they found this was less evident in nursing compared with other non-medical professionals. Their survey formed part of an increasing body of work that suggested a reduction in the levels of altruism in nursing, both at the point of recruitment and selection and as nurses became socialised into the profession, in favour of a more pragmatic approach to nursing (Johnson, Haigh and Yates-Bolton, 2007, Straughair, 2012b).

Contrary to the thoughts about altruistic motivation was the suggestion of egoistic motivations for compassion. It was suggested that compassion was a way of looking for relief from one's own pain or distress, to nurture vanity and look good in a society that valued compassion (Mongrain, Chin and Shapira, 2011), and protect personally valuable relationships (Clark and Leiter, 1998, Mikulincer et al., 2005). An increasing number of studies have demonstrated the association between the giving of compassion and psychological wellbeing (Klimecki et al., 2014, MacDonald, 1992, Mongrain, Chin and Shapira, 2011), with Mongrain, Chin and Shapira (2011) noting that the giving of compassion had more psychological benefits than receiving it. MacDonald (1992) when

theorising about warmth, proposed that the human affectional system was a positive social reward system, providing the motivation required for caring for others. Giving compassion felt good, which then motivated further giving of compassion, a finding supported by Zhou et al (2002). In a study of brain plasticity, Klimecki et al (2014) found that compassion resulted in increased positive affect associated with affiliation and reward, even after exposure to suffering. The generation of positive emotion may have acted as an emotion regulation strategy, which counteracted the potential emotional distress caused by experiencing others' suffering (Preckel, Kanske and Singer, 2018). Nussbaum (1996) commented on the egoistic behaviour of '*improving the lot of the worst off'* (p37) in case one had to become a member of that group. Egoistic motivation also enabled learning from others' experiences in a way that could protect or enhance one's own life (van der Cingel, 2009).

The complexities of compassion, and the recognition that egoistic and altruistic motivations were based on interpretations of behaviour, the development of which lacked empirical evidence (Hoffman, 1981), meant that a choice between altruism and egoism was not necessary. Reflecting my perspective in this debate, within the helping relationship between nurse and patient (Armstrong, 2006), one could have both altruistic and egoistic motives simultaneously (van der Cingel, 2009), aiming for the wellbeing of the self as well as the person suffering. As the patients' advocate, the nurse was in a position to provide a voice for the suffering or need (van der Cingel, 2009) whatever the motivation, acting as conduit to the multi-disciplinary team to access strategies to ease suffering where possible. Having looked at potential motives for compassion, my stance supports the argument that the motivation for compassion is less relevant than the patient perception of receiving compassionate care. Nurses are likely to adopt a stance that balances the professional requirement for compassion with a more pragmatic approach to care, that takes into account the dynamic factors influencing compassion on a daily basis.

2.3.7 Connectivity in compassion

Humans have a deep seated need to feel connected (Hutcherson, Seppala and Gross, 2008). When considering definitions of compassion, it was clear that it involved the 'other', for example an interconnectedness to others (Dunn and Rivas, 2014), a sensitivity to the suffering of others (Irons, 2013), open to the suffering of others (Gilbert, 2005), feeling kindness towards people who are suffering (Neff, 2011a), a central bridge between an individual and the community (Nussbaum, 1996), other-oriented (Singer and Klimecki, 2014), an other-regarding virtue (Armstrong, 2006), or a connection towards the sufferer (Bickford et al., 2019, Schulz et al., 2007). The recognition of the other in these definitions suggested compassion occurred in an interdependent relationship, and that compassionate care was "*a collaborative (ad)venture*" (Gilbert, 2005) that related to interactions rather than specific actions (Gustin and Wagner, 2012). Von-Dietze and Orb (2000) and Dewar et al (2014a) described compassion as not what was done *for* other people, but together *with* others. Even semantically, the prefix 'com' referred to togetherness and collaboration. Connectivity in compassion was not exclusively related to individual relationships. Collective compassion occurred when people gathered together to form a group that offered compassionate support to a particular cause or range of causes (Blackstone, 2009), such as political lobbying to prevent food poverty.

A relational dimension of compassion was identified (Dewar, Pullin and Tocheris, 2011, Neff, 2011a, Sinclair et al., 2016a, Sinclair et al., 2016b) that highlighted the importance of being able to relate to others, being able to connect with them (Constantinides, 2019). Referred to as affiliative relating (Heard and Lake, 2012), the sharing of positive affect that indicated liking and affection was central to care giving, the skills for which began in infancy. Neff (2011a) highlighted the importance of being able to relate to a range of perspectives in order to increase awareness of common humanity. The ability to relate to a range of perspectives was thought to come from a 'theory of mind' type of thinking (Gilbert, 2005), the human

ability to understand other people, what they may be thinking or feeling, and what motivated their behaviour, creating a sense of connectedness. Not a static understanding, but a dynamic and flexible cognitive ability that was moulded by experience and education, and enabled us to be able to identify with another's experience, a key condition of being able to give compassion (Bickford et al., 2019, van der Cingel, 2009). Without this connectivity, Dunn and Rivas (2014) argued that care became just a series of technical tasks.

However, the starting premise for 'theory of mind' was that other people shared one's values and beliefs, without which relationship building was impossible (Gilbert, 2005). For nursing, the concept of shared values created a dichotomy, as nurses were expected to make professional caring relationships with all patients, whether or not they shared values and beliefs (Department of Health, 2015, Nursing and Midwifery Council, 2018a). Nussbaum (1996) recognised that the further apart one's values were, the more difficult it was to be able to understand another's perspective and therefore give compassion. However, to be compassionate nurses needed to be open to differing opinions, and harness the flexibility of cognitive ability to learn from and continually update their understanding of other people in a non-judgemental way (Wang, 2005).   The individualized emotional connection with all patients was a powerful element of compassion (Dewar and Nolan, 2013). Contrary to this, Van der Cingel (2009) argued that compassion required a temporary setting aside of one's own values in order to give compassion. She suggested that having a close connection could lead to a blurring of boundaries between the self and the other, therefore keeping a distance was a necessary condition for compassion. There needed to be a separateness to distinguish between the self and the other in order to give compassion (Nussbaum, 1996), which supported the professional expectation of objectivity and clear professional boundaries in nursing (Nursing and Midwifery Council, 2018a). My position in this argument supports that of Wang (2005) and Dewar and Nolan (2013). The belief that one can put aside one's own values in order to give compassion appears naïve, and is not congruent with my understanding that realities, understandings, and behaviours are based on context

and experience, and one's interactions with others in the world. For nursing, a more dynamic approach to holistic knowledge development is required in order to support non-judgemental compassionate care.

2.3.8 Summary of the meaning of compassion

The extensive use of the term compassion throughout nursing and healthcare literature, policy and professional guidelines highlighted the importance of the concept for healthcare professionals. However, despite agreement of some of the key features of compassion, a shared understanding of the concept was not clearly evident.   The operational definition I have collated for this research, based on a review of the definitions and conceptualisations of compassion, and an exploration of the themes identified in Table 1, is:

> Compassion is a subjective, complex construct with both an affective and cognitive domain, in which the suffering of the person (self or other) is noticed and acknowledged, and there is motivation to ease that suffering to the best of one's ability.

For suffering to be noted, acknowledged and eased, there needed to be some knowledge and understanding of the experience of suffering, the event causing it, and appropriate strategies to ease it. Cognition was flexible and dynamic, developed in response to learning from actual experiences, and from imagination and simulated experiences. For healthcare professionals, in addition to personal experience, cognitive ability was developed through formal higher education, continuing professional development, and life-long reflective practice. The affective domain, also seen in other constructs such as sympathy and empathy, was more challenging for healthcare professionals and could lead to inner conflict between personal and professional values and standards. Emotions could be short-lived, irrational, and judgemental, none of the qualities that would be valued in the healthcare

professional, supporting Gilbert and Choden's (2013) view that compassion was a motivation, a longer lasting desire to behave in a certain way.

Although it was possible to suggest a shared meaning of compassion based on the literature review, it was not clear how closely this reflected student nurses' understanding of compassion, and therefore the teaching and learning required for a shared understanding. It was clear, however, that development of the understanding of compassion, and the implementation of compassionate care was influenced by a range of personal and external factors. The following sections explore these factors in greater detail.

2.4 Factors that influence compassion

Discussed in the following sections, the factors that influenced compassion were identified as compassion experience, familiarity, deservedness, organisational factors, cultural factors, and reciprocity of compassion.

2.4.1 Compassion experience

There was some evidence to support the genetic effect of prosociability, empathy and compassion, that one could have an empathic, prosocial personality (Josefsson et al., 2013, Knafo et al., 2008, Knafo-Noam et al., 2015). However, life experiences were believed to play a significant role in the development of compassion (Bengtsson, Söderström and Terjestam, 2016). Much of the learning about compassion was thought to be done within families (Nussbaum, 1996), in early childhood experiences (Koestner, Franz and Weinberger, 1990) and moderated by environmental influence and situational context (Knafo et al., 2008, Knafo-Noam et al., 2015). Maternal sensitivity, and use of language that enabled children to reflect on, recognise and understand emotion, was found to increase compassionate and helping behaviours, and supported the development of compassion

through early socialisation and role modelling (Brownell et al., 2013, Eisenberg, VanSchyndel and Hofer, 2015, Newton, Thompson and Goodman, 2016). Although focused on childhood development of prosocial behaviour, the findings of Brownell et al's (2013) study could be considered a useful strategy in nurse education to support the facilitation of reflection on the emotions of others. The opportunity for facilitated conscious reflection in a safe environment may enable nursing students, supported by a nurse educator, to recognise and explore emotions and emotional responses in themselves and others. Neural plasticity was identified in relation to compassion development, which suggested compassion could be influenced and increased by compassion training (Singer and Klimecki, 2014). The concept of neural plasticity further supported the potential for the development of compassion and compassionate behaviours through nurse education.

Compassion was linked to positive affect (Gilbert, 2005), but there were different types of positive affect that were influenced by early relationships and experiences. Gilbert (2005) maintained that if a child was loved, soothed and comforted, the soothing dimension of the affect-regulating system would be more developed, and therefore an adult could draw on these feelings during times of threat (Gilbert, 2005). If a child's sense of safeness was regularly threatened, it would be the threat focused dimension that would be strongly developed, leading to a deficiency in resources to sooth and comfort in times of stress or difficulty. Lim and DeSteno (2016) offer the tangential view that adversity and suffering was not found to prevent compassionate behaviour, but could foster and enhance compassion. The idea that adversity fostered and enhanced compassion meant that past experience of adversity and suffering would not hinder development within the profession, and indeed could enhance the compassion nurses were able to provide. Eisenberg, VanSchyndel and Hofer (2015) noted that there was an optimal degree of emotional regulation required for compassion, as people who were emotionally over-aroused were more likely to focus on their own needs than the needs of others. Izard (2002) suggested that an early secure

relationship enabled people to become emotionally competent, meaning they could understand and tolerate a wider range of emotions.

Josefsson et al (2013) found that compassionate character traits in adulthood were strongly predicted by parental behaviour and childhood environment. Parental warmth in early life experiences was believed to be a critical component for secure attachment (Hintsanen et al., 2019, Zhou et al., 2002). In a longitudinal study that spanned 3 decades, Hintsanen et al (2019) found that higher levels of parental warmth predicted higher levels of compassion in adulthood, supporting Koestner et al's (1990) earlier findings. Limited in its generalisability and validity due to the sample being predominantly Caucasian females with good socio-economic status, the benefits of warmth and connectedness in the development of compassion supported the research findings discussed below.

Parental warmth was associated with attachment security (Hintsanen et al., 2019) which, linked to Bowlby's (1978) work on attachment theory, was found to facilitate helping behaviours, and foster empathic, compassionate and altruistic responses to perceived suffering (Mikulincer et al., 2005, Zhou et al., 2002). Gilbert (2005) argued that the construct of attachment should be analysed as two separate social mentalities: care-eliciting and care-giving. Care-eliciting involved forming relationships with others who could offer protection and investment for survival and emotional regulation. Care-giving involved forming relationships with others to provide them with time, energy, and resources that reduced suffering and increased the chances of their survival and growth (Gilbert, 2005, Mikulincer et al., 2005). It was seen to be activated by the presence of someone suffering (Mikulincer et al., 2005), and was believed to be an important source of early compassion experiences (Bengtsson, Söderström and Terjestam, 2016).

Attachment insecurity was not believed to prevent compassionate behaviour. The temporary activation of a sense of attachment security using a subliminal priming technique

(a 20ms exposure to the names of people their participants had previously identified as security enhancing attachment figures) was found to enable even chronically insecure people to respond in the same compassionate way as those who were secure (Mikulincer et al., 2005). It was suggested that some people used their experiences of suffering as a motivator to avoid repeating the same behaviours (Gilbert, 2005).   The potential to develop attachment security, and activate the care-giving system through exposure to compassion experiences and socialisation into a compassionate culture, indicated an interesting, and to date unexplored, area for further research in nurse education.

2.4.2 Familiarity

Familiarity was deemed to be a fundamental component of species preservation and a critical component of compassion (Gilbert, 2005, Von-Dietze and Orb, 2000), with people likely to help kin before anyone else (Burnstein, Crandall and Kitayama, 1994). It was believed that people were moulded and linked by similar life experiences (Bengtsson, Söderström and Terjestam, 2016). Compassion required shared experience (Von-Dietze and Orb, 2000), recognition of shared vulnerabilities and/or similarities (Snow, 1991), and was associated with an enhanced sense of similarity to others, particularly to those in need (Oveis, Horberg and Keltner, 2010).   Singer and Klimecki (2014) noted an increased neurological activation of compassion towards those with whom one was more familiar. Hoffman (1981) suggested a potential association between similarity and the evolutionary process of kinship through inclusive fitness; that people behaved in a more altruistic way to those they perceived as similar. Shared experience provided individuals with a greater understanding of the ways in which a sufferer may be affected, and a greater perception of the sufferer as distressed (Stellar et al., 2012). In a study of class and compassion (Stellar et al., 2012) familiarity of situational context was thought to have influenced compassion when lower class individuals responded to suffering with greater compassion than upper

class individuals. In a study of perceived self-other similarity, Oveis et al (2010) found that the greater the perceived similarity, the more likely that altruistic behaviour was facilitated, and compassion responses were amplified. Inversely, Preston and de Waal (2002) found that the more unfamiliar one was with a situation, or the more dissimilar it was to oneself, the harder it was to feel empathy, and therefore give compassion.

The contagion of emotion also suggested familiarity in terms of proximity, and close relationships, which led people to be more attuned to each other's moods and emotions, and more likely to notice suffering and invest in a compassionate response (Schulz et al., 2007). In a study of empathy and prosocial behaviour in twins, Knafo et al (2008) found that although similar levels of empathic concern were expressed, children performed more prosocial acts to their mother than to an unfamiliar adult, supporting the influence of proximity and close relationships.

When applied to nursing, the need for similarity or shared experience has the potential to pose significant challenge. Nursing individuals across the lifespan, from a wide range of backgrounds, such as different socio-economic, cultural, and educational backgrounds, suggests the need for an associated wide range of similarity and shared experience. Despite this range not necessarily being reflected in the nursing workforce, there remains a professional requirement to provide compassionate care to all (Nursing and Midwifery Council, 2018a). If nurses were not able to draw on shared experience or similarity, it could be suggested that the requirement to provide an equal level of compassionate care to all was unrealistic. Nurse education therefore had a key role in widening the knowledge and understanding about the context of other's lives, and the skills for nurses to continue the development of their knowledge and understanding throughout their nursing careers.

Batson et al (2005), however, called into doubt the importance of similarity in producing the empathy and compassion response felt for strangers, suggesting similarity appeared an

insufficient explanation. Whilst not dismissing similarity, their experiments found no evidence to support perceived similarity as an explanation. Instead, they proposed similarity was a moderator of perception of need, that it enhanced the imagination of the self in a similar situation, but judgements about compassion may be the result of generalised nurturant tendencies (Batson et al., 2005). The development and use of imagination, discussed in Chapter 2.3.3, has not specifically been explored in relation to nursing and nurse education, but may provide interesting data for the future development of education strategies that support compassion and compassionate care.

Familiarity with our own thoughts and feelings was also perceived to be critical for diffusing negativity, particularly when listening to our inner critic, as criticism directed towards the self resulted in the dichotomous position of being both the attacker and the attacked (Neff, 2011a).

2.4.3 Deservedness

A controversial condition of compassion was the suggestion that it may or may not be deserved. The decision to respond compassionately to suffering was believed to be influenced by the following:

- the perceived severity of the suffering, the greater the severity the more compassion was deserved (Gelhaus, 2012b, van der Cingel, 2009),

- that the suffering was an undeserved fate, not caused by the person's own actions (Faust, 2009, Nussbaum, 1996, Schulz et al., 2007, van der Cingel, 2014),

- the personal cost versus benefits involved in acting to relieve suffering, with higher costs associated with less compassionate action (Burnstein, Crandall and Kitayama, 1994, Leiberg, Klimecki and Singer, 2011, Newton, Thompson and Goodman, 2016),

- the perceived capacity for the other to contribute (Burnstein, Crandall and Kitayama, 1994),

- and the agreeableness or politesse of the person (Burnstein, Crandall and Kitayama, 1994, Crocker and Canevello, 2008).

Deservedness related to the cause of the suffering, that is, as a result of one's own actions, had formed some contentious ethical debate around rationing of healthcare (Bringedal and Feiring, 2011, Underwood and Bailey, 1993) with the concept of personal responsibility for health coming into conflict with the NHS Constitution's principle of providing a comprehensive and non-discriminatory service to all (Department of Health, 2015).

The behaviour of others also influenced one's sense of deservedness, with compassion reduced in situations where one is exposed to violence, aggression or frustration (Bickford et al., 2019). Singer and Klimecki (2014) noted in a football team that a greater level of compassion was activated for those who were perceived as playing fairly. Although thought to be underreported, an increase in aggressive behaviour and violence against nurses in the workplace has been recorded internationally (Sato et al., 2013), estimated to be between 8% and 38% who suffer physical violence, with many more exposed to threats or verbal aggression (World Health Organization, n.d.). When applied to the findings of psychology research on helping and prosocial behaviours (Burnstein, Crandall and Kitayama, 1994, Leiberg, Klimecki and Singer, 2011, Newton, Thompson and Goodman, 2016), the physical and psychological costs to the nurse from violence and aggression in the workplace was likely to result in a reduced perception of deservedness and associated compassionate care. It was suggested that underreporting of aggressive and violent behaviour may have related to the perceived intentionality of it, or the socialisation of aggression as an occupational norm (Sato et al., 2013). However, further research would be required to explore the impact of this on the delivery of compassionate care.

There were few measures to capture the extent of suffering (Schulz et al., 2007). Van der Cingel (2009) suggested it related to the level and permanence of any loss, the more minor and temporary the loss, the less suffering, and the less compassion deserved. Decisions about compassion and helping were made differently in life and death situations compared to everyday needs for help. Burnstein, Crandall and Kitayama (1994) found that judgements in life and death situations were strongly influenced by the age of the person, with the youngest likely to be prioritised. Based on neo-Darwinism, they proposed that older people were less likely to produce genetic offspring, so may be perceived as having less value. In everyday helping needs, a more curvilinear picture was found, with the very young and very old perceived as more deserving as they were less able to help themselves. Age was also seen as a factor that influenced judgements about deservedness by Gelhaus (2012a) and Batson (2005).

Under everyday conditions, worthiness of character or obligation was found to be the default value for deciding who to help (Burnstein, Crandall and Kitayama, 1994, Gelhaus, 2012a). Made on assumptions, often compared with cultural expectations and norms, these judgements were thought to be reflected in our attitudes towards others (Chochinov, 2007, Sharp, McAllister and Broadbent, 2018), often without conscious knowledge. Decisions about deservedness were based on personal judgment that often reflected one's own values and ideas about human flourishing (Nussbaum, 1996). For nurses, this resulted in an uncomfortable dichotomy between the witnessing of suffering as an everyday condition, as a cultural norm, and the professional requirement to deliver non-judgemental compassionate care to all. Van der Cingel (2009) argued that justice (linked to deservedness) and compassion were separate entities, and nurses must withhold their judgements when delivering care. However, the suggestion that nurses could guarantee an unlimited flow of compassion for each patient was perceived by Smajdor (2013) as dangerous. An alternative approach muted by Gelhaus (2012b) was for nurses to consider compassion as a

professional attitude without necessarily feeling a spontaneous warm emotional response to all patients, thereby reducing the emotional cost.

2.4.4 Organisational influences on compassion

Organisational influences on compassion were seen at political, professional, and individual organisation levels. In England, compassion formed a key theme within the NHS Constitution (Department of Health, 2015) both in the principles that guided the NHS, and as one of the NHS values. The need to reiterate the values of nursing in 'Compassion in Practice' (Cummings and Bennett, 2012) reflected a perceived loss of these values over a period of time (Dewar and Christley, 2013). Reflecting Roach's (2002) model of caring, the identification of the 6Cs (compassion, caring, communication, competence, courage, commitment) in Cummings and Bennett's (2012) work have remained a key element of NHS England's framework for nursing, midwifery and care staff (NHS England, 2016). Similar core values were also reflected in NHS Scotland, Wales, and Northern Ireland (Baillie, 2017). Whilst it was recognised that nursing and healthcare were not exclusive to the NHS, the guiding principle of compassion was understood to apply wherever healthcare professional practices were undertaken. In New Zealand, consideration was given to the mandating of compassion (Paterson, 2011). The complexity and subjectivity of compassion prevented the development of a legal mandate, however, the debate placed compassion high on the political agenda. The political expectation for values based, compassionate care, also reflected the dominant societal ideas about the role of the nurse (Mahan and McPherson, 2014).

Professional bodies of nursing in many countries have emphasised compassion as a professional requirement. In the UK and Australia the professional codes of conduct (Nursing and Midwifery Board of Australia, 2018, Nursing and Midwifery Council, 2018a) require registrants to treat people with respect and compassion, a requirement that was

reflected in the Canadian (Canadian Nurses Association, 2017) and American (American Nurses Association, 2015) Codes of Ethics. Failure to comply with these professional requirements resulted in the questioning of nurses' fitness to practice, and risked sanctions or removal from the professional register. Compassion was not universally included in nursing codes of ethics, for example in South Africa (South African Nursing Council, 2013), however, associated concepts such as altruism and caring indicated a similar requirement for compassionate care.

The health service as a business became a key agenda in the UK and healthcare systems across many developed countries (Austin, 2011, Burtson and Stichler, 2010, Milton-Wildey and O'Brien, 2010, Shannon and French, 2005, Weiss et al., 2002), with growing tensions identified between the art and science of nursing, and the business of health. Sir David Nicholson (2011) highlighted in his letter to Trusts that in order to meet "*the scale and nature of the QIPP* (Quality, Innovation, Productivity, and Prevention) *challenge"* the NHS needs to make "*up to £20 billion of efficiency savings by 2014/15",* and he launched the Innovation, Health and Wealth report that set out how this target was to be delivered. The productivity and efficiency strategies were measured by pre-defined outcomes with clear targets. In product-focused industry this was an effective way to optimise the cost-effectiveness and efficiency of the organisation, which had gathered global momentum. Rizter's work on Macdonaldization (1996) discussed the four principles of the fast-food restaurant (efficiency, calculability, predictability, and control), and how these were impacting on the wider society. Bryman (2004) developed this work further, discussing the fact that Disneyization (the adoption of the business principles and customer service of the Disney corporation) was influencing the economy, culture and society on a global scale. Examples of the global impact were demonstrated by some healthcare regions in Canada contracting Disney to deliver seminars on 'how to be' with patients (Austin, 2011), and the book "If Disney ran your hospital: 9½ things you would do differently" was awarded the 2005 book of the year from the American College of Healthcare Executives (Lee, 2004). The UK health services

approach to measuring and rationalising healthcare appeared to demonstrate the adoption of similar industrial and business models (Richman and Mercer, 2004), evident in the Health and Social Care Act (2012), which laid out approaches to commissioning of care, taking into account the use of competition to increase efficiency. However, an efficiency approach was not always positive, with the focus on a culture of target-driven management seen as a causative factor in failings of care in mid-Staffordshire (Francis, 2013).

Nurses reported feeling constrained by health policy that mandated efficiency (Mahan and McPherson, 2014, Milton-Wildey and O'Brien, 2010, Sharp, McAllister and Broadbent, 2018). A business model comparing patients with products risked an exacerbation of dehumanisation (Goodman, 2014), and dehumanisation was seen to be a factor in non-compassionate or abusive behaviours (Zimbardo, 2007). People, not products were at the centre of healthcare. There was a recognised need for care to be taken to address the cognitive dissonance caused by tensions in organisational systems, between the product-focused processes and the NHS Constitution's aim to put patients first, treating them with respect, dignity, and compassion (Department of Health, 2015, Goodman, 2014). The business of health reduced expressive care (Murphy et al., 2009), and accentuated a blame culture that focused more on protection of personal accountability and prevention of litigation than on delivering compassionate care (Goodman, 2014). Organisational pressures on nurses provided competing motivators (Sinclair et al., 2016a), which impacted negatively on the ability to spend time with patients (Dempsey, 2009, Sharp, McAllister and Broadbent, 2018), to be intentionally present (Constantinides, 2019), and to deliver compassionate care (Curtis, Horton and Smith, 2012). The impact of time pressures was shown to reduce the cognitive processing of any decision making, and resulted in more intuitive and instinctive reactions to situations, reduced empathy, and a higher incidence of emotionally driven decisions (Liu et al., 2019). As finding time to spend with patients was seen as key to compassionate practice (Curtis, Horton and Smith, 2012), a perceived lack of time was said to be a hindrance to compassion (Sharp, McAllister and Broadbent, 2018).

Perceived stress, threats, worries and anxieties were reported to supress caregiving and compassionate responses to suffering (Mikulincer et al., 2005). The clinical speciality in which staff worked was also identified as a risk factor in the development of compassion fatigue and burnout. Those areas that experienced higher levels of patient acuity (Dempsey, 2009, Sharp, McAllister and Broadbent, 2018), and higher numbers of patient deaths, such as palliative care settings, intensive care units, and emergency departments, were at greater risk.

Concerns were raised about nursing workload, particularly in relation to poor levels of staff numbers and skill mix, and the detrimental effect this had on basic caring, compassionate nursing care and mortality (Milton-Wildey and O'Brien, 2010, Royal College of Nursing, 2012, Sharp, McAllister and Broadbent, 2018). The suggestion was that the skills workforce was being replaced by lower paid non-registered staff in order to meet the financial demands of health organisations, and that one of the resulting costs of these cuts was the overlooking of compassionate care (Flynn, 2012, Royal College of Nursing, 2012). Following examples of non-compassionate practice, a review of staffing levels, skill mix, roles and responsibilities was carried out. From this review, the Chief Nursing Officer for England published clear guidelines for staffing capacity and capability (Cummings, 2013), and increased recruitment and clarity of role descriptions. The Shape of Caring Review (Willis, 2015) also emphasised gaps in the nursing workforce skill mix. A range of recommendations were made to address the gaps, including the development and professional registration of the Nursing Associate role in England. It was anticipated that the Nursing Associate would bridge the gap between the registered and unregistered workforce to enhance patient care. Still in its professional infancy, and only implemented in England, the impact of the role is currently being examined.

Goodman (2014) challenged the use of a managerialist approach, in which efficiency was the defining goal regardless of the activity itself, and noted that bureaucratic load needed to be removed, tiers of centralised inspection reduced, adequate resources supplied, and staff supported in order allow professionalism and a compassionate culture to flourish. While the need for fiscal responsibility and accountability in healthcare organisations was not called into question, a balance needed to be found between efficiency, and the desire of nurses to deliver person-centred, compassionate care.

2.4.5 Cultural influences on compassion

Sociocultural factors were recognised as key to shaping the context of compassion and compassionate responses (Mikulincer et al., 2005). Compassion was seen to be influenced by cultures within an organisation (Barsade, 2002, Gilbert, 2005, Mikulincer et al., 2005, Sharp, McAllister and Broadbent, 2018, Zimbardo, 2007).

Gilbert (2005) suggested that cultures were developed and grown through the sharing of experiences and language, and the passing of these from one person or generation to another. When sharing was focused on the needs of others, it became in itself a source of compassionate care. A compassionate culture was cultivated through a sharing community (Gilbert, 2005), re-emphasising the relevance of connectivity in compassion discussed in Chapter 2.3.7. For nursing, it was the socialisation into a shared, connected community and professional culture that influenced the shaping of professional values, including compassion (Boyatzis, Smith and Beveridge, 2012, Curtis, Horton and Smith, 2012, Murphy et al., 2009). Suggested as a powerful influencer (Dempsey, 2009), compassionate organisations influenced the development of compassionate individuals (Nussbaum, 1996). Nurses were said to learn to nurse through a process of occupational socialisation into the culture of the clinical and educational setting (Goodman, 2014). Dempsey's (2009) research on falls prevention surprisingly did not support the hypothesis that psychological and social factors

influenced nurses work behaviour, although she suggested the power of socialisation as a potential reason for the findings.

Cultures were influenced by social and emotional contagion, as these caused ripple effects across teams and organisations (Barsade, 2002). Individuals were mostly unaware that emotional contagion was happening, but it significantly influenced a group's mood, judgements and behaviour. Some behaviours and attitudes became established in nursing's social and occupational structures even when the original purpose for the behaviour could not be recalled (Goodman, 2014, Milton-Wildey and O'Brien, 2010). There was some suggestion that negative emotions spread more quickly than positive emotions, however this was not found in Barsade's (2002) study where there was no significant difference seen. Non-verbal communication was key to understanding emotions, therefore there needed to be direct interpersonal contact for the transmission of emotions and emotional contagion. As nurses were exposed to patients who may be more likely to express negative emotions, the contagion of these negative emotions risked having a negative impact on the nurses, further emphasising the importance of a culture of compassion amongst the healthcare team to support the contagion of positive emotions.

Through a single cross section survey, Murphy et al (2009) found a decrease in the caring behaviours of student nurses, which was primarily caused by occupational socialisation. Younger students with less previous care experience were particularly vulnerable to this. Similar concerns about professional socialisation were expressed in Curtis et al's (2012) grounded theory research where socialisation of students into a professional nursing environment had resulted in vulnerability. Students expressed the desire to 'fit in' to the healthcare team, but found themselves balancing the dilemma between upholding ideals and challenging constraints of compassionate practice, or adapting their ideals and accepting the constraints (Curtis, Horton and Smith, 2012).

The desire to belong was not exclusive to student nurses. Sharp et al 's (2018) ethnographic study of the tension between person-centred and task-focused care found people were strongly influenced by the culture they operated in, and perpetuated that culture in order to belong. Poor congruence between espoused values and behaviours (Dempsey, 2009) demonstrated a tension between nursing staff wanting to develop and achieve their ideal self, the ideal vision of a compassionate and competent nurse, and the reality of needing to comply with organisational pressures (Boyatzis, Smith and Beveridge, 2012).

Behaviours depended on cultures to make them possible (Gilbert, 2005). The workplace culture and organisational philosophies could either impede or facilitate compassionate care (Sharp, McAllister and Broadbent, 2018).   Perceptions of compassion varied depending on the context of the people involved and the situations they were in, and humans flexibly adapted their behaviour to their environment or culture (Gilbert, 2005). Zimbardo (2007) believed it was the cultures that authorised behaviours, either through explicit or implicit permission. The hierarchy of power for authorisation was not always reflective of the organisational hierarchy. Sharp et al (2018) found the authorisation that governed the limits of acceptable behaviour in an acute surgical setting was often found to be exercised by informal leaders. It was the collective team that had a subversive impact on individuals to ensure they complied with the culture. Examples of organisational culture that impeded compassionate care were seen at Mid-Staffordshire NHS Trust (Francis, 2013) and Winterbourne View (Flynn, 2012) where attempts to raise concerns or whistle-blow was ignored or made so difficult that it prevented honesty and transparency. The inaction in response to raised concerns could have been interpreted as implicit permission (Zimbardo, 2007) for the behaviours to continue. Feelings of powerlessness were believed to reduce quality of care and cause nurses to practice in ways that contradicted their values and the ways in which they wanted to provide care (Sharp, McAllister and Broadbent, 2018).

2.4.6 Reciprocity of compassion

Human beings have been identified as social beings who have a fundamental need to belong (Baumeister and Leary, 1995, Crocker and Canevello, 2008). Chapter 2.4.1 and 2.4.2 identified the influence of parental behaviour on children's empathy and social functioning. However, this influence was believed to be bidirectional, with parents also affected by children's behaviour (Eisenberg, VanSchyndel and Hofer, 2015, Zhou et al., 2002). The bidirectional approach supported the perceived norms of reciprocity that encouraged the giving of compassion in response to the receiving of it (Crocker and Canevello, 2008). One was more likely to give compassion if one had received it, even if there were a cost to helping (Leiberg, Klimecki and Singer, 2011).

In order to prevent or minimise the challenges associated with giving compassionate care, the receipt of compassion care within the healthcare team was deemed to be essential (Barron and Sloan, 2015). The reciprocity of compassion amongst the team nurtured a culture of compassionate care, preventing issues such as compassion fatigue and burnout. Emotional and social contagions strongly influenced a culture, so if compassion was demonstrated by members of the team to patients and each other, a compassionate culture was nurtured, amplified if compassion was demonstrated by someone in a leadership position (Boyatzis, Smith and Beveridge, 2012). The contagion supported reciprocity and had the potential to become self-perpetuating. The reciprocity of connectivity was also seen to support the development of caring and compassionate behaviours within the pre-registration nurse education setting, a reciprocity between staff and students (Beck, 2001).

In building and navigating our social worlds, Gilbert (2005) suggested that 'role-matching' occurred. That is, one tried to create a social network that reinforced one's own beliefs, values, and character traits. Stellar et al (2012) found that lower class individuals, living in more threatening environments, were more empathically attuned to the emotions of others,

more interdependent, and more likely to respond to the suffering of others with compassion. The desire to nurture a reciprocally compassionate network was suggested as a potential motivating factor in these findings. A sense of connectivity tended to nurture reciprocity (Hutcherson, Seppala and Gross, 2008). Motivation for reciprocity was found to be relevant for the development of reciprocal support and compassion, with those who were motivated to act by compassion goals more likely to develop and maintain compassionate support networks than those who acted to enhance self-image (Crocker and Canevello, 2008). Compassion fostered prosocial behaviour, which became a mechanism to enhance social support networks (Lim and DeSteno, 2016). For nurses with compassionate orientations, this means networks need to be created with other compassionate people. Working within a multi-disciplinary team of compassionate healthcare professionals should naturally produce levels of reciprocal compassion amongst the team. However, as Leiberg et al (2011) pointed out, it was not always possible to know whether reciprocity was from a sense of obligation rather than compassion, and further research needed to be done to explore this.

Lakoff and Johnson (1999) proposed a morality metaphor that "wellbeing is wealth". The use of the term wealth suggested a level of "moral accounting", that doing good (acting compassionately) put you in moral credit, whereas causing harm, or not doing good put you in moral debt. Based on the desire for balanced moral accounting to achieve optimal social functioning, an overt reciprocity was noted: that of a "moral imperative to pay one's moral debts". There is a potential limitation to this approach to reciprocity for nurses, in that the nurse:patient relationship does not always facilitate or support a direct reciprocal payment. The nurse could develop high levels of moral credit, which cause a significant imbalance when the patient was not able to pay their 'moral debt'.

The imbalance was seen by Lakoff and Johnson (1999) as a lack of justice and a hindrance to social functioning. In this situation, it would be useful to consider whether the moral balance needed to be achieved through a two-way transaction, or whether others' good

actions could repay a debt made by someone else. It could be argued that patients' moral

debts were re-payed at times by relatives, carers, or colleagues within the healthcare team.

Also, given the short timeframes of some nurse:patient relationships, a wider 'pass it

forward' social approach to moral accountancy would support opportunities to achieve moral

balance. What is not currently considered in models of compassion, or moral accounting, is

the possibility that one can pay a moral debt to oneself. Could an act of self-compassion

repay a harm caused by the self or others? The wider social approach to the giving and

receiving of compassion supported my stance in this argument, that the nurse gave and

received compassion to and from patients, families, and colleagues. The balance was

maintained by the amount of compassion given and received, not the specific details of the

person giving or receiving it. Based on the model of interconnections developed in Chapter

2.7, I would therefore suggest that in those teams where less compassion was given to each

other, moral debt could be re-payed in part through self-compassion.

The following sections explore the literature relating to self-compassion, and consider its

potential relevance for nursing, including Neff's (2003a) self-compassion model, the

development and validation of a tool for self-compassion measurement, and the effects of

applying self-compassion.

2.5 Self-compassion

Research on self-compassion was based on a theoretical model proposed by Neff (2003a).

The meaning of self-compassion closely reflected the meaning of compassion, but was self-

directed, that is, to notice when oneself was suffering, and to feel motivated to ease that

suffering to the best of one's ability. Related to the meaning of compassion, Neff (2003a)

defined self-compassion as:

> "*Being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness. Self-compassion also involves offering non-judgemental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience.*" (p87)

Compassion for the self, where the self and other were recognised as interdependent, was seen as a long-established and central feature in Buddhist practice and philosophy (Neff, 2004, 2011a). However, the exploration of self-compassion as a construct within Western psychology has only occurred in the past eighteen years. Initially identified as a theoretical construct (Neff, 2003a, Neff, 2003b), limitations of the research were recognised as it tended to be based on self-reported data, and although correlations were identified, causality was not. Research since Neff's (2003a, 2003b) proposal has focused on exploring and testing correlations, and the creation of empirical evidence to support the theoretical proposals.

Self-compassion was developed as a potential alternative construct to self-esteem (Neff, 2003a, Neff, 2003b). It used a self-reflective process (Neff, Hsieh and Dejitterat, 2005) to support psychological wellbeing and take a positive emotional stance towards oneself when faced with failure or suffering. Self-esteem referred to one's sense of worth, perceived value, or self-liking, and was based on social comparison and a need to feel above average (Neff, 2004). The pursuit of self-esteem therefore involved inflating one's own self-worth, and putting others down (Neff, 2011b). The benefits of good self-esteem were widely recognised (Baumeister et al., 2003, Donald et al., 2018, Edwards et al., 2010, Öhlén and Segesten, 1998), however, negative aspects were noted in relation to the attainment of self-esteem, and the effects of poor self-esteem (Neff, 2004). Social comparison created interpersonal distance and separation that undermined connectedness (Neff, 2009).

Significant overlap was found between self-compassion and self-esteem (Neff and Vonk, 2009), with high levels of self-compassion correlated with high levels of self-esteem (Barry, Loflin and Doucette, 2015, Neff, 2003b, 2011b). However, although self-compassion was believed to have many of the psychological benefits of self-esteem such as positive self-affect and a sense of self-acceptance (Neff, Kirkpatrick and Rude, 2007), it had fewer of the negative aspects (Neff, 2003a, 2003b) such as social comparison (Neff, 2011a) and narcissism. If anything, self-compassion was thought to step in at exactly the point when self-esteem failed (Neff, 2011b). Self-compassion was believed to provide protection against the negative aspects of self-esteem (Neff and Vonk, 2009) because it was not based on evaluation of one's performance or worth against others or ideal standards (Neff, 2003b).

The negative correlation between self-compassion and narcissism was believed to be of particular importance (Neff and Vonk, 2009), as narcissism was one of the most commonly criticised outcomes of the pursuit of self-esteem (Neff, Kirkpatrick and Rude, 2007), suggested to be responsible for the creation of 'generation me', the rise of narcissism levels in American culture since the 1960s (Twenge, 2006). It was also noted that whilst self-esteem fluctuated in response to one's most recent positive or negative self-evaluations (Neff, 2011b), self-compassion predicted greater stability in feelings of self-worth, potentially because individuals were seen as part of humanity and, like all other people, worthy of compassion, rather than being contingent on performance outcomes (Neff, 2004, Neff and Germer, 2013, Neff and Vonk, 2009). Self-compassion was thought to be similar to self-forgiveness, in the ability to forgive failures and respect oneself as fully human, with both strengths and imperfections (Neff, 2003a).

Self-compassion was therefore proposed as a useful alternative conceptualisation of a healthy attitude and relationship with oneself (Neff, 2003a, Neff, 2003b, 2011b). It improved self-awareness and provided emotional safety to identify and rectify inadequacies (Neff, 2003a). The aim of self-compassion was positive health and wellbeing (Neff, 2003a), which encouraged change to rectify any harmful or unproductive behaviour (Neff, 2003b).

Interestingly for nurse educators, while self-esteem was noted to be highly resistant to change (Neff, 2011b), self-compassion was identified as a teachable skill that enhanced overall quality of life, and could be increased with practice (Neff and Germer, 2013, Neff et al., 2018).

2.5.1 Model of self-compassion

As seen in Figure 2, there were three basic areas of self-compassion, based on six different factors, that interacted to mutually enhance each other: self-kindness rather than self-criticism or harsh self-judgement, recognition of one's experience as part of common humanity rather than a sense of isolation, and mindfulness rather than over-identification with or avoidance of suffering (Neff, 2003a, 2003b). If one approached suffering in a mindful way, with calm curiosity, the balanced perspective-taking involved countered the sense of isolation and enhanced common humanity. A space was then created by this calm and balanced approach for self-kindness and reduced self-criticism. In a corresponding way, self-kindness also supported mindfulness, as when one reduced self-criticism, it became easier to gain a balanced perspective, and allowed for more feelings of interconnectedness. Recognition of common humanity, the understanding that all humans had suffering and failures, reduced the degree of self-blame and self-judgement, which enhanced the generation of self-kindness and understanding (Neff, 2003a). Self-compassion represented the balance of these compassionate and uncompassionate responses to oneself in times of suffering (Neff et al., 2018).
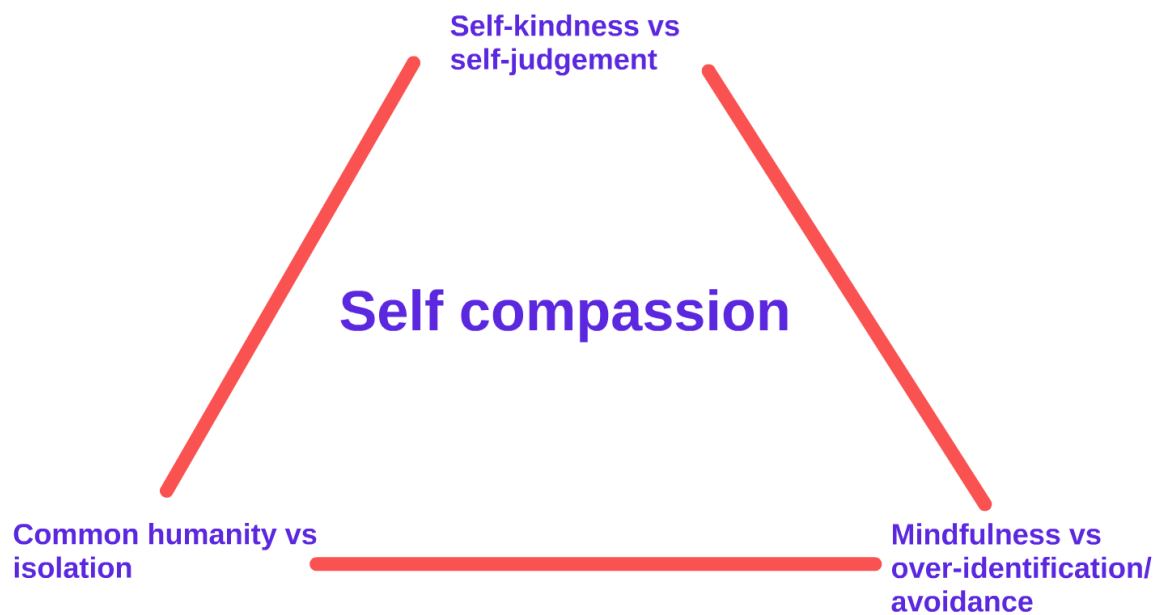
Figure 2: Neff's model of self-compassion

The following sections consider each of the elements within Neff's (2003a) model of self-compassion.

2.5.1.1 Self-kindness versus self-judgement

Self-kindness involved extending warmth, love, forgiveness, and sensitivity to all aspects of one's self, the strengths and qualities, and the inadequacies and limitations, particularly during times of stress, distress, or suffering (Barnard and Curry, 2011, Neff, 2003a). In contrast to this, self-judgement involved harsh self-criticism and hostility, evaluating oneself and one's thoughts, feelings and behaviours as less worthy. Neff suggested that people were often harder on themselves than others (Neff, 2003a), without necessarily being aware of their self-judgements (Barnard and Curry, 2011). However, if the self was judged harshly, it was suggested that the ego may prevent inadequacies from being noticed in order to protect and not threaten self-esteem (Neff, 2003a), which meant inadequacies were not acknowledged or addressed. Self-compassion circumvented the self-evaluation process

(Neff, Hsieh and Dejitterat, 2005). Reduced self-judgement led to reduced judgement of others, as without the emphasis on social comparison, there was less need to evaluate others (Neff, 2003a). Although self-compassion was non-judgemental, unlike the narrow, rigid interpretation of judgements as right or wrong, self-compassion still included discriminating wisdom (Neff, 2003b), which allowed a situation to be seen in context with an understanding and open attitude rather than a rigid, severe and judgemental approach (Neff, 2004).

Neff, Kirkpatrick and Rude (2007) used the 'Gestalt two chair' exercise, a popular tool used in psychotherapy (Pugh, 2018), in their research to support the development of self-compassion. The exercise aimed to increase self-kindness by guiding the participant through a conversation with the self, where the participant took on two roles, the harsh, critical voice of the criticiser and the voice of the criticised, until an understanding or resolution was reached. The exercise was found to be effective, and participant self-compassion was increased. Although this may be effective in a therapeutic setting, applied to a nurse education context, the facilitation of a 'Gestalt two chair' exercise would not be practicable, and an alternative approach to exploring the voices of the criticiser and criticised would need to be considered. A possible alternative strategy for use within nurse education could be that used in Germer and Neff's (2013b) Mindful Self-Compassion Programme where participants were encouraged to find their compassionate voice. Participants consciously try to distinguish the inner critic from the compassionate self, and to actively converse with that compassionate self. Facilitation of this exercise may be more appropriate in group settings such as nurse education, and would be more practicable in a higher education setting.

Loving kindness meditation was also used to support the development of self-kindness. Identified as a strategy that actively cultivated positive emotions (Fredrickson et al., 2008), and feelings of kindness, compassion and care towards oneself and others, its use was

suggested as a coping strategy that built resilience (Klimecki et al., 2013) and enhanced

clinician's self-care (Boellinghaus, Jones and Hutton, 2013). Fredrickson et al (2008)

suggested this increase in positive emotions and compassion was done through the building

of personal resources, including mindful attention, self-acceptance, positive relations with

others, and good physical health, which led to a decrease in depressive symptoms.

2.5.1.2 Common humanity versus isolation

The Dalai Lama preached that all human beings belonged to a single family, and therefore

deserved the same levels of compassion (Dalai Lama, 2011). One of the reasons why

compassion offered comfort was that in acknowledging suffering it was made visible, and

this visibility made it clear to the sufferer that they were not alone (van der Cingel, 2009),

that their vulnerabilities were similar to others (Nussbaum, 1996). In a similar way, self-

compassion entailed seeing one's own experience as part of common human experience,

that all humans experienced suffering, failures, inadequacies, and all humans, including the

self, were worthy of compassion (Neff, 2003a, 2003b). Self-compassion, therefore,

highlighted the importance of social connectedness as an essential aspect of wellbeing

(Neff, Hsieh and Dejitterat, 2005).   The connectivity of self-compassion was also seen

linguistically, where those higher in self-compassion were found to use language including

first person plural pronouns (e.g. we, us) and social references (e.g. friend, family), rather

than first person singular pronouns (e.g. I, me) (Neff, Kirkpatrick and Rude, 2007). The

different language used illustrated the greater level of interconnectedness associated with

self-compassion, with a reduced sense of isolation or separation from others.

In recognising common humanity, that everyone had strengths and weaknesses,

compassionate individuals reported greater similarity to perceived weaker groups (Oveis,

Horberg and Keltner, 2010). Recognition of the experiences of the self and others through

the application of self-compassion decreased egocentric feelings of separation and increased a sense of interconnectedness (Neff, 2003b). The loving kindness meditation identified in Chapter 2.5.1.1 to develop self-kindness, also enhanced the sense of common humanity. It was found to increase positivity towards others and the self, so one became more accepting (Hutcherson, Seppala and Gross, 2008).

2.5.1.3 Mindfulness versus over-identification or avoidance

Self-compassion incorporated, but differed from, mindfulness (Neff, 2004). Mindfulness was described by Kabat-Zinn (2015) as "*moment-to-moment, non-judgemental awareness, cultivated by paying attention in a specific way, that is, in the present moment, and as non-reactively, as non-judgementally, and as openheartedly as possible*" (p1481). The ability to review an experience with greater objectivity, to see and accept an experience as it arose, without avoiding or over-identifying with it, then allowed space for compassion and action (Neff, 2003a). One of the differences between mindfulness and self-compassion was that in mindfulness, the experience being considered could be positive, negative or neutral, whereas self-compassion was a balanced awareness of the negative thoughts and feelings involved in personal suffering (Neff and Germer, 2013). However, self-compassion was not seen as exclusive to suffering, but was also identified as relevant in less aversive circumstances, trying to prevent suffering in the first place (Neff, 2003a). In addition to the focus on suffering, mindfulness and self-compassion also differed becuase mindfulness focused on the experience (sensations, emotions, thoughts), and self-compassion focused on the experiencer (Neff and Germer, 2013). As self-compassion focused on the self, the 'experiencer' of sensations, thoughts and emotions, rather than the experience itself (Neff and Germer, 2013), it enabled individuals to put the experience into greater perspective, so the extent of suffering was seen with greater clarity (Neff, 2003b). Referred to in Bengtsson et al's (2016) research as 'self-focused perspective-taking skills', they proposed mindfulness was a key structure of self-compassion, that although focusing on the self was

difficult, particularly for adolescents, self-focused perspective-taking skills helped to reframe experiences which supported a more balanced perception of the self.

Over-identification was the term coined by Neff (2003b) to describe the behaviour when an individual was carried away with their feelings, and tended to exaggerate the extent of their suffering. Although over-identification was seen as negatively associated with mindfulness, so too was avoidance, where individuals were unable to gain a balanced perspective because they avoided paying attention to the suffering experienced. Mindfulness in self-compassion aimed to help individuals notice what was going on in the moment, to notice suffering and hear the inner critical voice (Neff, 2011a). Mindfulness allowed for a non-judgemental, receptive mind state in which thoughts and feelings were observed for what they were, without trying to change or avoid them, not how they impacted on self-concept (Neff, 2003a, 2003b).

Mindfulness training, such as the Mindfulness Based Stress Reduction programme (MBSR), has been seen to increase self-compassion (Neff, 2011b, Neff and Germer, 2013). It helped to prevent depression by encouraging individuals to accept and tolerate painful thoughts and emotions rather than trying to change them, while simultaneously putting them into greater perspective as part of a larger context (Neff, 2003a). The benefits of compassion training were found to be toward the self through increased positive affect even when faced with the suffering of others, and towards others through the fostering of prosocial behaviour (Klimecki et al., 2013).

2.5.2 Factors affecting self-compassion

The factors identified in the literature that affected self-compassion closely reflected those factors discussed in Chapter 2.4 that affected compassion. Although there was a range of empirical evidence about the development of compassion (see Chapter 2.4.1), Bengtsson,

Söderström and Terjestam (2016) noted that little was yet known about the sources and development of self-compassion. The research suggested that like compassion, early experience of sensitive care-giving may foster positive views of the self, and that the development of self-compassion was influenced by parental warmth and supportive relationships in childhood experience (Bengtsson, Söderström and Terjestam, 2016, Neff, 2003a, Neff and McGehee, 2010). Self-compassion was found to be related to maternal support, maternal criticism, attachment schemas, family functioning, and the messages given to young people by their families (Neff and McGehee, 2010, Neff and Vonk, 2009).

Experiences of accepting or critical interactions during formative years became internalised, and were expressed as self-criticism or self-acceptance (Neff, Kirkpatrick and Rude, 2007), particularly if the interactions and experiences were with attachment figures such as parents in childhood, or romantic partners in adulthood (Neff and Beretvas, 2013). Similar findings were also seen across different cultures, where the cultural emphasis on compassion or criticism translated to levels of self-compassion (Neff, Pisitsungkagarn and Hsieh, 2008), across the lifespan (Neff and Beretvas, 2013). Interestingly, the strength of relationship found between self-compassion and family factors in Neff and McGehee's (2010) research indicated the involvement of maternal support, family functioning, and attachment in one's ability to be self-compassionate, but did not determine the level of self-compassion one had. Alongside Mikulincer and Shaver's (2003) assertion that attachment schemas could become more secure by the receipt of love, care and support, the potential to increase self-compassion through training was strengthened.

A level of ambiguity was found in relation to the influence of age, gender, or cultural norms on self-compassion. It was recognised that self-compassion was lowest in adolescence (Neff, 2003a, 2004) and tended to increase with age (Neff and Vonk, 2009). Reduced self-compassion in adolescence was unsurprising as it was a known time of introspection,

egocentrism (Neff and McGehee, 2010), self-conscious behaviours, and the belief that the challenges adolescents experienced were unique to them (Bluth et al., 2016).

With regards to gender, testing using the self-compassion scale found that women, particularly American women (Neff, Pisitsungkagarn and Hsieh, 2008), including young female adults (Neff and McGehee, 2010) and some adolescent girls (Bluth et al., 2016), had lower self-compassion scores than men (Neff and Beretvas, 2013, Neff and Vonk, 2009). Of the six components of self-compassion, women had particularly higher levels of self-judgement, isolation, and over-identification, and lower levels of mindfulness (Neff, 2003b). However, women were not less likely than men to be self-kind or to view their experiences as part of common humanity (Neff, Hsieh and Dejitterat, 2005, Neff, 2003b). A gender difference in self-compassion levels was not consistently found though, with other research finding no gender difference in their participant groups (Neff, Kirkpatrick and Rude, 2007, Neff and Pommier, 2013, Neff, Rude and Kirkpatrick, 2007). Nor was a gender difference found in a cohort of Buddhists who regularly practiced self-compassion (Neff, 2003b), in college students in Thailand or Taiwan (Neff, Pisitsungkagarn and Hsieh, 2008), or in some adolescents (Neff and McGehee, 2010).

In a cross-cultural exploration of self-compassion in America, Thailand and Taiwan, Neff, Pisitsungkagarn and Hsieh (2008) found differences in the levels of self-compassion in each population group, with Thais having the highest levels of self-compassion, and Taiwanese having the least, despite both being from collectivist cultures that emphasised interdependence and connectedness. Similar findings were also reported in a comparison between American and Japanese adults (Arimitsu et al., 2019). However, the findings indicated that although there were cultural differences, with a stronger association between self-compassion and positive affect in American adults (Arimitsu et al., 2019), self-compassion appeared to transcend the individualistic or collectivist cultural orientations. The

limited influence of cultural orientation highlighted the potential for self-compassion to be universally beneficial for psychological wellbeing (Neff, Pisitsungkagarn and Hsieh, 2008).

Based on the influence of family, and the inconsistency found in gender and cultural difference, Neff and McGehee's (2010) suggestion that it may be easier for some people to learn self-compassion than to improve complex family dynamics was an important consideration for nurse educators. Nursing students, although primarily female (89.3% in the UK (Royal College of Nursing, 2019)), come from a range of cultural, social and family backgrounds. The potential for them to learn self-compassion may enhance their psychological wellbeing, and develop their emotional resilience as they progress through a challenging course and profession.

2.5.3 Perceived misconceptions of self-compassion

There was some suggestion that self-compassion, in particular self-kindness, was self-centred, and self-indulgent (Neff, 2004), but this was not found to be the case (Neff, 2003a). Self-compassion was not egocentric (Neff and McGehee, 2010), but related to compassion and concern for others (Neff, 2003b). A focus on overall pleasure may have resulted in self-indulgence, but self-compassion aimed for health and wellbeing, the attainment of which may not always be pleasurable (Neff, Rude and Kirkpatrick, 2007), for example sacrificing personal time to achieve study goals, or changing one's diet and exercise regime to achieve better health.

Some participants in Neff's (2003b) research believed self-criticism was required to provide motivation for improvement, a belief reflected in Taiwanese cultural tradition (Neff, Pisitsungkagarn and Hsieh, 2008). However, harsh self-criticism was found to be an ineffective motivating force (Neff, 2004). There was some debate about the usefulness of self-criticism as a motivator, with Kurman et al (2003) suggesting that constructive self-

criticism given in a kind manner was less likely to be detrimental to wellbeing than harsh self-judgement, and could support behaviours such as persistence. Motivation generated from self-compassion did not stem from the need to escape self-criticism, but from a desire to create health and wellbeing (Neff, 2004). Individuals were still able to discern the quality of their own performance, but did not use this as a measure of their self-worth (Neff, Hsieh and Dejitterat, 2005).

There were fears identified by participants in Neff's (2003b) pilot study, that self-compassion would lead to passivity or inaction, as a pretext for being complacent, or as an excuse not to take responsibility for one's actions (Neff, 2003b), particularly when self-awareness was lacking (Neff, Kirkpatrick and Rude, 2007). However, when self-compassion was complete and genuine, this was not the case. Self-compassion still enabled one to notice and acknowledge failures or inadequacies, but not judge oneself harshly for them. Self-compassion, contrary to being inactive or lazy, supported action for change (Neff, Kirkpatrick and Rude, 2007). A self-compassionate individual did not adopt lower standards (Neff, 2003b), but instead, actions for personal improvement were gently encouraged (Neff, 2003a).

There was some suggestion that self-compassion was self-pitying, or that self-pity could masquerade as self-compassion if there was no recognition of common humanity (Neff, Kirkpatrick and Rude, 2007). However, self-pity was seen as an egocentric and solipsistic process (Neff, Hsieh and Dejitterat, 2005), where an individual became immersed in their own problems, forgetting that others experienced similar problems (Neff, 2004). The self-absorption involved in self-pity resulted in isolation and a sense of disconnection from others (Neff, 2003b), or over-identification where someone ruminated on and tended to over-exaggerate the problem. Self-compassion involved taking the stance of an 'other' towards oneself (Neff, Hsieh and Dejitterat, 2005) recognising common humanity, which allowed the experience to be seen as related to other's experiences. A space to view experience with

greater objectivity and perspective (Neff, 2004), without distortion or disconnection (Neff, 2003a), was then provided, following which self-kindness could be given.

2.5.4 The self-compassion scale

Following the identification of self-compassion as an alternative strategy to support psychological wellbeing, Neff (2003b) undertook a series of three initial studies to develop and validate a tool to measure self-compassion, the self-compassion scale (SCS). The proposed self-compassion scale included 26 items in six subscales, each scored on a 5 point scale from 'almost never' to 'almost always'. The scale included a 5 item self-kindness subscale (e.g. "I try to be loving towards myself when I'm feeling emotional pain"), a 5 item self-judgement subscale (e.g. "I am disapproving about my own flaws and inadequacies"), a 4 item common humanity subscale (e.g. "When things are going badly for me, I see the difficulties as part of life that everyone goes through"), a 4 item isolation subscale (e.g. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world"), a 4 item mindfulness subscale (e.g. "When something painful happens I try to take a balanced view of the situation"), and a 4 item over-identification subscale (e.g. "When I'm feeling down I tend to obsess and fixate on everything that's wrong") (Neff, 2003b). Through these studies, Neff (2004) demonstrated that the six factor scale "*exhibited good psychometric properties in terms of its factor structure, reliability, and convergent and discriminant validity*" (p33). The measure addressed each of the components within the self-compassion model, with negatively worded outcomes reverse coded, and the mean of each subscale added to produce a total overall self-compassion score (Neff, 2003b).

Multiple usage of the self-compassion scale demonstrated excellent test-retest reliability (Neff, 2003b, Neff, Kirkpatrick and Rude, 2007, Neff, Pisitsungkagarn and Hsieh, 2008), including being reliable for use with adolescents (Neff and McGehee, 2010). Limitations of the self-compassion scale were, however, noted due to its self-reporting nature (Neff,

2003b). To address this limitation, Neff, Kirkpatrick and Rude (2007) compared therapist ratings of self-compassion with participant self-reported ratings, and found an association between them that supported the construct validity of the self-compassion scale. The use of romantic partners' assessment of self-compassion also corroborated the self-reporting in Neff and Beretvas' (2013) research, further validating the self-compassion scale as an accurate measure of self-compassion.

Evidence for cross-cultural validity was seen through the validation of the self-compassion scale in different countries and languages (Azizi et al., 2013, Deniz, Kesici and Sümer, 2008, Garcia-Campayo et al., 2014, Karakasidou et al., 2017, Mantzios, Wilson and Giannou, 2013, Neff, Pisitsungkagarn and Hsieh, 2008, Neff et al., 2019, Raes et al., 2011, Tsai, 2015) most of which replicated the six-factor structure of Neff's (2003b) self-compassion scale. There was some criticism that although the self-compassion scale measured the six separate components effectively, the higher order model to measure overall self-compassion was less effective (Williams et al., 2014). Responding to this criticism, Neff (2015b) agreed with the limitation, and with colleagues (Neff, Whittaker and Karl, 2017), tested and updated their understanding, recommending a bifactor model as a better representation of the relationships between the factors within the self-compassion construct. However, an overall self-compassion score was still deemed to be justified and useful, and provided flexibility for future researchers to either view self-compassion as a single experience, or to examine the components separately, depending on the interests of the researcher. Muris, Otgaar and Petrocchi (2016) argued strongly that the evidence did not support the use of an overall self-compassion score, and urged future researchers to analyse the subscales separately. However, Neff (2016) maintained that as the six factors mutually influenced each other, without examining both the overall score and the subscales, key findings to support psychological wellbeing may be missed. The debate about the use of an overall self-compassion score continues and further research is currently being undertaken by psychologists to provide empirical evidence for the arguments.

Criticism was also made about the inclusion of negative factors in a scale to measure self-compassion (Muris, 2016) as the negative factors were believed to over-inflate the associations between self-compassion and psychological wellbeing (Muris, Otgaar and Petrocchi, 2016). It was suggested that the negative items linked to psychopathology (Muris, 2016) and neuroticism (Pfattheicher et al., 2017), and therefore were either not relevant, or duplicated existing measurement scales. Neff (2015b) acknowledged the criticism, but noted that self-compassion was a balance between the compassionate and uncompassionate items of the scale. The inter-correlations found between the different components of self-compassion (Neff et al., 2018) supported the inclusion of compassionate and uncompassionate items working together as a holistic system, and reflected Neff's (2003a) original theoretical definition of self-compassion. Neff, Tóth-Király and Colosimo (2018) found that while there were overlaps between the negative items of self-compassion and neuroticism, they were different constructs. Exclusion of the uncompassionate items from the scale would not have reflected Neff's theoretical definition (Neff, 2016), and would have underrepresented the impact of self-compassion on reducing psychopathology (Neff et al., 2018).

There was also some suggestion that the self-compassion scale should be a two-factor, rather than six-factor scale (Costa et al., 2016, López et al., 2015) that reflected Gilbert's (2005) model of social mentalities: self-compassion to reflect the soothing and safeness system, and self-criticism to reflect the threat-defence system. However, a two factor approach was not found to be supported in Neff et al's (2018) later research, and a combined approach meant the potential to examine the nuances within each of the six different items was lost (Neff, 2015b), which may have limited future research and application. The discussion about the self-compassion scale is clearly set to continue as the amount of research increases, and although clearly relevant to researchers measuring self-

compassion, is less relevant for the research aim of this work to examine the qualitative experiences of student nurses applying self-compassion.

2.6 The application of self-compassion

It was suggested that in terms of the body's emotional regulation system, self-compassion deactivated the body's threat system and activated the self-soothing system (Gilbert, 2005), which helped to counter destructive self-critical tendencies, acknowledge interconnection with others, and deal with emotions with clarity and equanimity (Neff, 2003a). The benefits of self-compassion were similar to those of self-esteem, but as discussed in Chapter 2.5, unlike self-esteem were not based on comparisons, and therefore did not have the pitfalls of self-esteem (Bengtsson, Söderström and Terjestam, 2016). The benefits were identified as increased social connectedness, sense of community, happiness, optimism, wisdom, curiosity and exploration, personal initiative, emotional intelligence, ability to cope with stress, improved relationship functioning, and reduced self-criticism, lower anxiety and depression, less rumination, less neurotic perfectionism, reduced fear of failure, a greater willingness to acknowledge negative emotions, and reduced thought suppression (Akin and Akin, 2015, Neff, Hsieh and Dejitterat, 2005, Neff and Germer, 2013, Neff, Kirkpatrick and Rude, 2007, Neff and McGehee, 2010, Neff, Rude and Kirkpatrick, 2007, Neff and Vonk, 2009).

Despite much of the research data being reliant on self-reporting, Neff and Germer (2013), found similar associations in a randomised control trial of their mindful self-compassion programme, which strengthened the evidence supporting the development of self-compassion. Longitudinal research found that following self-compassion training, the changes experienced were maintained at both six month and one year retesting (Neff and Pommier, 2013), which indicated that the skills of self-compassion can be learned and maintained over time (Neff and Costigan, 2014).

The findings of research and literature related to the application of self-compassion have been themed into four key outcomes: enhanced psychological wellbeing, decreased stress and enhanced coping, increased compassion towards others, and motivation for personal growth and change. The following sections consider each of these four themes.

2.6.1 Enhanced psychological wellbeing

Self-compassion was positively correlated with connectedness, subjective wellbeing, and life satisfaction (Neff, Hsieh and Dejitterat, 2005) in multiple cultures (Arimitsu, 2016, Neff, Pisitsungkagarn and Hsieh, 2008, Neff and Vonk, 2009) and age groups (Allen, Goldwasser and Leary, 2012, Allen and Leary, 2013, Neff and McGehee, 2010), and predicted enhanced psychological health over time (Neff, Kirkpatrick and Rude, 2007). Self-compassionate individuals were found to experience significantly more positive moods than negative moods (Neff, Rude and Kirkpatrick, 2007). However, this did not mean self-compassionate individuals experienced all and only positive thinking. Self-compassion enabled individuals to acknowledge difficult negative emotions in non-judgemental awareness, without avoiding or denying their existence. Self-compassion was also negatively correlated with depression, anxiety, rumination, thought suppression (Neff, 2003a, 2003b), neuroticism (Neff, Rude and Kirkpatrick, 2007), social comparison, and public self-consciousness (Neff and Vonk, 2009), and was therefore deemed a potential strategy to prevent these states, and promote mental wellbeing and greater life satisfaction.

Neff, Kirkpatrick and Rude's (2007) study to explore the relationship between self-compassion and adaptive psychological functioning found that even in a situation where participants were asked to consider their greatest weakness, self-compassion acted as a buffer against self-evaluative anxiety. Giving oneself kindness, and recognising the imperfect nature of the human condition, appeared to reduce the pressure to constantly

need positive evaluations, which linked to adaptive psychological functioning. Self-compassionate individuals were more accepting, and therefore experienced less distress when they failed to meet their personal standards. Similar findings were reported in relation to events associated with ageing (Allen and Leary, 2013). It was not about the likelihood of experiencing negative events, or older people's evaluation of those events, but it was the way older people thought about the events that influenced the perception of wellbeing.

Self-compassion was not just seen as supporting the absence of psychopathology, but was found to be linked to positive psychology, associated with happiness, optimism, and agreeableness (Neff, Rude and Kirkpatrick, 2007, Neff and Vonk, 2009). The feelings of warmth generated by self-kindness, alongside the connectivity with common humanity, and the ability to view situations in a mindful and balanced way may have generated the feelings of happiness and optimism, and made it easier to get on with other people. However, it was not possible to identify causality. It was noted that both self-esteem and self-compassion were predictors of these positive states, but for different underpinning reasons. People with high self-esteem may have felt happy and optimistic because they evaluated themselves positively which increased their sense of self-worth, whereas people with high self-compassion may have experienced positive feelings because they accepted themselves as they were and felt more socially connected (Neff and McGehee, 2010, Neff and Vonk, 2009).

Self-compassion was viewed as a useful emotional regulation strategy (Neff, 2004), where negative emotional patterns were neutralised (Neff, Hsieh and Dejitterat, 2005). Painful feelings were not avoided, but positive feelings of kindness and understanding were generated, from which actions to change were facilitated. The impact of this on healthcare workers was demonstrated by Babenko et al (2019) where an association was found between self-compassion and better professional wellbeing, which led to greater work engagement and less work related exhaustion, highlighting the professional as well as personal benefits of self-compassion.

2.6.2 Decreased stress and enhanced coping

Self-compassion was related to better coping with stressful situations (Arslan, 2016), through emotional-approach rather than emotional avoidance, thereby making it a useful coping strategy (Neff, 2003a) that enhanced emotional resilience (Neff, 2011b). Reduced thought suppression and fear of failure meant there was a reduced need to avoid painful thoughts and emotions (Neff, Kirkpatrick and Rude, 2007). Neff (2003b) suggested the positive correlation between self-compassion and emotional processing may have been a factor in enhanced coping. Even in the face of perceived failure, self-compassion's ability to support balanced perspective-taking, and enhance non-judgemental, kind, acceptance of a situation, made it an effective coping strategy (Neff, Hsieh and Dejitterat, 2005).

Demonstrated in Allen and Leary's (2013) research with older people, those with higher levels of self-compassion were better able to cope with the negative events associated with ageing. Individuals with increased levels of self-compassion were better able to self-soothe in the face of stress or threat (Arch et al., 2014), indicated by the physiological changes of increased heart rate variability, reduced levels of cortisol (Rockliff et al., 2008), reduced sympathetic nervous system reactivity, and reduced subjective anxiety (Arch et al., 2014).

The role of self-compassion in sport has seen an increase in research interest over the past few years, particularly in relation to coping with performance appraisal and motivation. Self-compassion was identified as strongly associated with task-oriented coping in swimmers (Barczak and Eklund, 2018), where efforts were made to problem solve or manage a stressor to facilitate achievement of a task. However, overlaps between the strategies for task-oriented coping and the compassionate elements of self-compassion were noted as a potential explanation for the association.

Student nurses needed to develop personal resilience to support and advocate for compassionate practice (Curtis, Horton and Smith, 2012) and to thrive in challenging environments. Self-compassion was one of the ways in which resilience could be developed and nurtured. Babenko et al (2018) examined this in relation to medical students in Canada, where the pressure of workload and the use of inadequate coping strategies resulted in exhaustion and academic burnout for some students. They found that students who were more self-compassionate reported greater engagement with their studies rather than exhaustion. It could be suggested that nursing students experience similar pressures and risk of exhaustion, therefore the development of self-compassion may be an equally effective coping strategy.

2.6.3 Increased compassion towards others

Reflective of the relationship between self-compassion and the sense of belonging and connectedness (Akin and Akin, 2015), increased self-compassion was believed to enhance feelings of compassion and concern for others (Neff, 2003a). Self-compassion and compassion for others was said to go hand in hand (Neff and Germer, 2013), and was seen physiologically through similar neural activity in functional MRI testing (Longe et al., 2010). In a study to examine the relationship between self-compassion and compassion towards others (in meditators, adults in the community, and college students), Neff and Pommier (2013) found the two were clearly associated, although the strength of that association depended on the person's age, meditation experience, and gender.

Age significantly predicted higher levels of self-compassion and compassion for others, possibly as a result of greater emotional maturity, and increased experience that led to a greater understanding of situations and the common human condition of imperfection (Neff and Pommier, 2013). As nursing students are generally adult, and often mature students, one might therefore anticipate they enter nurse education with a higher level of self-

compassion and compassion for others. My experience supports this supposition, although to the best of my knowledge it has not yet been tested, and it may be difficult to differentiate between age as a factor and alternative influences.

Meditators reported higher levels of self-compassion, compassion for humanity, empathic concern, perspective taking, altruism, and forgiveness, than adults and younger people, and lower levels of personal distress when faced with the suffering of another (Neff and Pommier, 2013). A stronger link between self-compassion and compassion for others in meditators and adults emphasised the value of self-compassion practice, that an increased amount of formal and informal self-compassion practice resulted in increased self-compassion, compassion for others, and perspective taking.

A gender difference was seen as women reported higher levels of compassion towards others than men, particularly if the women lacked self-compassion (Neff and Pommier, 2013). Self-compassion was not found to predict empathy (Neff et al., 2018), which provided some explanation for why those with low self-compassion could still have empathy towards others. Women with higher levels of self-compassion reported the same levels of compassion for others (Neff and Pommier, 2013). Interestingly, a similar difference was found in older people, who were more likely to encourage self-compassion in others, even when their own self-compassion levels were low (Allen and Leary, 2013). Although the cause of this difference in compassion towards the self and others in women was uncertain, the role of gender socialisation in Western culture that identified women as caring, nurturing and self-sacrificing was muted as a potential influencer (Neff and Pommier, 2013). In nursing, the ratio of female to male nurses has remained high, with 89.3% of all NMC registrants being female (Royal College of Nursing, 2019). While the increased compassion towards others found in women may be attractive to the nursing profession, it did not protect those women from personal distress in the face of suffering. The development of self-

compassion in nurses may therefore act as an effective strategy to increase emotional resilience and prevent burnout, whilst still supporting compassion towards others.

Crocker and Canevello (2008) found that people with increased self-compassion were uniquely motivated by compassionate goals, and a belief in interconnectedness with others, which indicated a positive association between self-compassion and compassion towards others. Correlations were identified between compassion for others, self-compassion, and compassion for the environment (Bengtsson, Söderström and Terjestam, 2016), with a statistically significant link found between self-compassion and compassion for others. The link was also supported by the negative association found between self-compassion and anger towards others, and a closed mind that did not tolerate alternative viewpoints (Neff and Vonk, 2009).

Neff and Beretvas (2013) considered the role of self-compassion in romantic relationships and found self-compassion was significantly related to relationship satisfaction and quality due to its positive link with care, relatedness, acceptance and autonomy, and its negative link with control, dominance, detachment and verbal aggression. Self-compassion was also associated with greater motivation to correct interpersonal mistakes (Baker and McNulty, 2011). Self-compassion appeared to support a level of reciprocity, discussed in Chapter 2.4.6, where the self-compassionate attitude of one person may have caused the other to behave in a similar way when conflict or problems arose (Neff and Beretvas, 2013). Although related to romantic relationships, when considered alongside the significant relationship between self-compassion and a sense of community (Akin and Akin, 2015), the findings could be applied to the influence of self-compassion on healthcare team relationships. If self-compassionate people were more likely to be able to balance the needs for autonomy and connectedness in their relationships (Neff and Beretvas, 2013) and forgive transgressions (Allen, Barton and Stevenson, 2015), it could be suggested that healthy and productive interactions between members of the healthcare team, where care and

acceptance was reciprocally nurtured, could be enhanced by the development of self-compassion.

Drawing on Buddhist philosophy, Neff (2004) noted that an individual must have compassion for the self in order to have the emotional resources available to give compassion to others. For nurse educators, the link between self-compassion training and increased compassion for others (Neff and Germer, 2013) indicated the potential value of self-compassion training within nursing curricula. As discussed in Chapter 2.4.4, the political and professional requirement for compassion and compassionate care remains central to nursing. Therefore, I would suggest that increasing self-compassion in nursing students within the curriculum may impact positively on compassionate patient care as well as the life satisfaction of the nurse.

2.6.4 Motivation for personal growth and change

Self-compassion was believed to be a powerful motivator for personal growth and change (Neff, 2003a). It was positively correlated with self-determination, autonomy, intrinsic motivation (Neff, Hsieh and Dejitterat, 2005), curiosity and exploration, and conscientiousness (Neff, Rude and Kirkpatrick, 2007), rather than a response to an external motivator (Neff, 2003a). Self-compassion helped to motivate productive, proactive behaviour aimed at promoting or maintaining wellbeing (Neff, 2003a), which could prevent suffering occurring in the first place (Neff, 2003b).

For student nurses and other health care professional students, undertaking a degree course was stressful. Students were regularly exposed to new knowledge, skills, and behaviours, but unlike other University courses, this exposure occurred whilst trying to integrate into different clinical teams, meet practice competency standards, and work to achieve the academic requirements of a degree. In my experience, the demands of the

course were such that it was not uncommon for the students to experience actual or perceived failure. However, self-compassion was suggested to have academic benefits (Neff, Rude and Kirkpatrick, 2007).

Neff, Hsieh and Dejitterat (2005) undertook research to examine the relationship between self-compassion, achievement goals, and coping with academic failure, and found that self-compassionate people were kinder to themselves when they fail, or were disappointed with their performance. Self-compassionate individuals had less fear of failure, so were more able to see failure as a learning opportunity rather than worrying about the perception of negative performance on their self-worth. A positive association was found with mastery goals (Babenko et al., 2018), intrinsic motivation, and perceived competence, and a negative association with performance goals, particularly performance-avoidance goals (Neff, Hsieh and Dejitterat, 2005). People motivated by performance goals were motivated in two ways: performance-approach, which was the desire to achieve success to demonstrate superiority over others, to be the best; or performance-avoidance, where the fear of failure and being perceived as stupid or incompetent prevented engagement with learning. People motivated by mastery goals were intrinsically motivated by curiosity, the desire to develop knowledge and skills, and to master new tasks. They tended to be more academically adaptive, persistent, make greater effort to learn, and were willing to ask for help. They enjoyed learning for learning's sake (Neff, 2004).

Self-compassionate individuals were more likely to forgive their own transgressions (Allen, Barton and Stevenson, 2015), were better able to solve problems in an effective and constructive way (Arslan, 2016), be motivated to achieve goals through a desire to learn and develop, rather than a desire to improve their self-image (Neff, Hsieh and Dejitterat, 2005), and were more adaptive in their strive for academic achievement (Neff, 2004). Significantly related to personal initiative, self-compassionate people showed greater self-determined motivation (Barczak and Eklund, 2018), and were more actively involved in making changes

to achieve fulfilment and optimum health and wellbeing (Neff, Rude and Kirkpatrick, 2007). Applied to a nurse education context, these findings indicated the potential value of developing students' self-compassion through the nursing curriculum. Development of self-compassion had the potential to enhance intrinsic motivation for personal growth and development through a professional career of life-long learning, increase confidence in students' ability to learn, and increase resilience in a challenging profession (Neff, Hsieh and Dejitterat, 2005).

Self-compassion was also found to be strongly related to reflective wisdom (Neff, Rude and Kirkpatrick, 2007), defined by Ardelt (2003) as wisdom and depth of understanding gained through "*looking at phenomena and events from many different perspectives to develop self-awareness and self-insight*" (p278). Nursing practice has a strong and established history of reflection and reflective practice, therefore developing self-compassion during nurse education may enhance nurses' ability to reflect in a self-kind, non-judgemental, balanced way. Self-compassion was associated with greater self-clarity and knowledge about one's limitations (Neff, 2003b), and therefore more effective self-regulation (Neff, 2003a, 2004). Neff, Rude and Kirkpatrick (2007) also found self-compassion was moderately related to affective wisdom, the ability to assess the presence of positive emotions and behaviour, and the absence of indifferent or negative emotions and behaviour towards others (Ardelt, 2003). It was suggested that this provided students with emotional resilience in the face of failure (Neff, 2004).

Beyond academic growth and development, self-compassion was also found to enhance personal growth and development in other populations. Allen, Goldwasser and Leary (2012) examined the influence of self-compassion on ageing and found that self-compassionate individuals were less concerned by the need to use assistance or aids to maintain an independent high quality lifestyle, although the effect on asking for help was more

inconsistent. While not examined, it could be suggested that these findings may provide a reduced need for health care interventions or hospital admissions.

To summarise, similarities were seen between the factors that influenced the development and practice of compassion and self-compassion. Self-compassion had been found to have positive outcomes with potential relevance to nursing and nurse education. The following section draws these themes together into a model of interconnections (Figure 3), that considers potential links between compassion, self-compassion, nursing, and nurse education, from which gaps in knowledge are identified.

2.7 Theoretical interconnections that informed the research

Drawing on the theoretical perspectives and conceptualisations discussed in the literature review, and my experience as a nurse and nurse educator, interconnections (highlighted with blue arrows in Figure 3) were found between compassion, self-compassion, nursing and nurse education. Alongside these interconnections (highlighted with pink arrows in Figure 3), gaps in current knowledge were identified that could add value to nursing and nurse education. The following discussion summarises these interconnections, and places this research within the wider theoretical context.
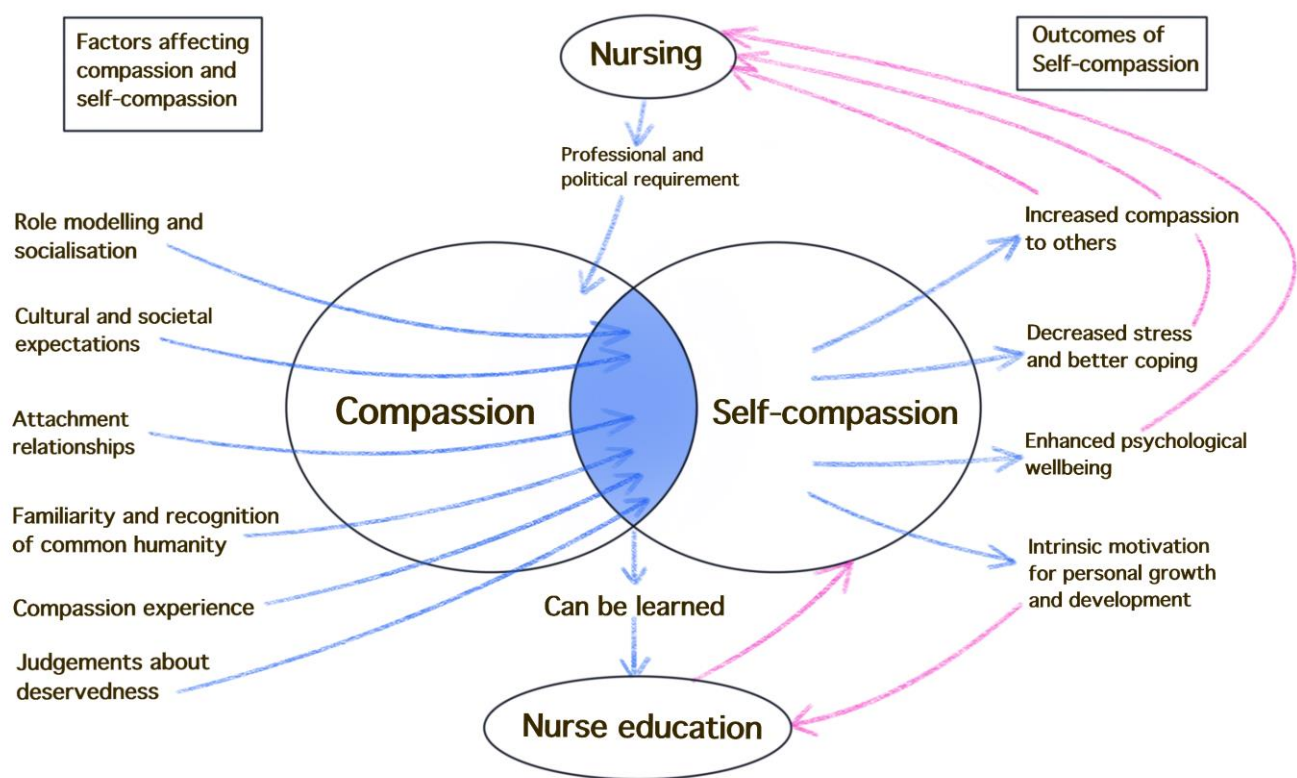
Figure 3: Model of interconnections between compassion, self-compassion, nursing and nurse education

The connection between nursing and compassion was well established, and remains central

to contemporary nursing through political emphasis (Department of Health, 2015) and

professional requirements (Nursing and Midwifery Council, 2018a, b).   Following a reduced

focus on compassion that saw examples of non-compassion in health care over the past

decade (Flynn, 2012, Francis, 2013), a re-emphasis on the development and maintenance

of compassion has occurred throughout nursing and healthcare. An emphasis that is

continued in the recommendations of the latest King's Fund report, 'The Courage of

Compassion: Supporting nurses and midwives to deliver high-quality care' (West, Bailey and

Williams, 2020). Reflecting its centrality in nursing, compassion also interconnected to

nurse education, seen throughout nursing curricula, from values based recruitment and

selection, to lectures on the concept of compassion and related concepts, the delivery of compassionate clinical skills, and the assessment of compassionate care within the practice setting.

The factors that affected compassion and self-compassion illustrated a range of interconnections, including experience of giving, receiving and witnessing compassion, familiarity, deservedness, and cultural influences. Secure attachment relationships, parental warmth and sensitivity were believed to be influential in the development of compassion and self-compassion through role modelling and socialisation (Brownell et al., 2013, Eisenberg, VanSchyndel and Hofer, 2015, Hintsanen et al., 2019, Koestner, Franz and Weinberger, 1990). The influence of these relationships also illustrated an interconnection between perceived judgements of deservedness that affect compassion, and the self-judgement aspect of self-compassion, where an individual's inner voice could reflect that of a critical or kind parent (Neff, Kirkpatrick and Rude, 2007, Neff and McGehee, 2010, Neff and Vonk, 2009).

Familiarity, the sense of shared experience (Oveis, Horberg and Keltner, 2010, Von-Dietze and Orb, 2000), that was seen to influence compassion to others, connected with the common humanity component of self-compassion (Neff, 2003a). The recognition that imperfections were part of the human condition, and that all people experienced suffering, supported the sense of familiarity that enhanced compassion, and the mindful perspective-taking that supported self-compassion.

Similar interconnections were seen in relation to social and cultural influences on compassion and self-compassion. From global organisational influences (Bryman, 2004), social and cultural expectations within countries or large communities (Neff, Pisitsungkagarn and Hsieh, 2008), and smaller, more local communities and organisations (Barsade, 2002, Mikulincer et al., 2005, Zimbardo, 2007), the culture in which an individual was socialised

and immersed significantly influenced compassion towards themselves and others. If one was socialised into a shared, connected community, a compassionate culture was enhanced (Boyatzis, Smith and Beveridge, 2012, Curtis, Horton and Smith, 2012). Likewise, individuals who experienced higher levels of social and cultural connectedness were more likely to have higher levels of self-compassion (Neff and Pommier, 2013).

A key interconnection for nurse education was found through the evidence of neural plasticity, that compassion and self-compassion could be learned.   It was seen throughout the literature that compassion could be developed through training (Gilbert, 2005, Singer and Klimecki, 2014), and that self-compassion was a teachable skill that improved with practice (Neff and Germer, 2013, Neff et al., 2018, Neff and Pommier, 2013). Gilbert (2005) when discussing the influence of culture on learning values, noted that caring and compassion were "*highly open to activation and modification via learning in partnerships with others*" (p15). Van der Cingel (2009) also believed that compassion could be practised in order to develop expertise in the same way as other clinical judgement skill (Benner, 1984). Mindful self-compassion programmes had been successfully designed to provide participants with tools to develop their self-compassion (Neff and Germer, 2013). The potential for the teaching and learning of compassion and self-compassion was of particular significance for nurse educators, and consideration should be given to the educational strategies to support it.   The influence of compassion experience, and existing compassion and self-compassion workshops (Neff, 2013, Neff and Germer, 2013), indicated the potential for reflection to support learning. Learning through reflection was a well-established educational strategy in nursing and nurse education (Freshwater, 2002, Schon, 2016), which placed nurse educators in a good position to facilitate compassion and self-compassion development.

Potential interconnections between self-compassion, compassion, nursing and nurse education were seen in the literature through the impact of applying self-compassion. For

nurse education, outcomes relating to the increased sense of psychological wellbeing (Allen and Leary, 2013, Arimitsu, 2016, Neff, Kirkpatrick and Rude, 2007), decreased stress and increased coping (Arslan, 2016, Neff, Hsieh and Dejitterat, 2005), increased compassion towards others (Bengtsson, Söderström and Terjestam, 2016, Neff and Germer, 2013), and improved motivation for personal growth and learning (Neff, 2003a, Neff, Rude and Kirkpatrick, 2007) were of particular interest. The connections between these outcomes, nursing, and nurse education remain relatively unexplored, and offer interesting areas for further research. Based on the potential interconnections, and associated gaps in knowledge, I would suggest that research to consider the experience of applying self-compassion may be of considerable value to nurse educators and the wider nursing profession. From a nurse educator perspective, it would be valuable to consider whether inclusion and development of self-compassion in nursing curricula would influence students' ability to be compassionate to others, their motivation to engage in learning, and their psychological wellbeing within a challenging and stressful profession.

Interconnections formed the theoretical underpinnings of this research, and placed the focus of it within a wider theoretical framework. Interconnections also identified potential gaps in the knowledge, particularly in relation to the impact of increased self-compassion in a nursing context, and informed the aim and research questions for this study (seen in Chapter 3.1.1 and 3.1.2).

2.8 Chapter conclusion

The cognitive domain of compassion was particularly pertinent to healthcare professionals, and nurse educators. Compassion involved knowledge and understanding of the suffering experience, the cause of the suffering, and strategies to ease the suffering to the best of one's abilities (Armstrong, 2006, Gilbert, 2005, van der Cingel, 2009), and could be taught (Singer and Klimecki, 2014). Self-compassion was identified as a complex concept that held

the same meaning as compassion, but with a directional flow towards the self rather than the other (Neff, 2011a), and was also a concept that could be taught (Neff and Germer, 2013).

Given the limited control a healthcare professional had over the range of personal and professional issues that influenced compassion, the development of self-compassion through education could be of significant benefit. The literature identified quantitative correlations between increased self-compassion and, amongst other things, enhanced psychological wellbeing (Neff, Kirkpatrick and Rude, 2007), reduced stress and anxiety (Germer and Neff, 2013b), increased compassion towards others (Bengtsson, Söderström and Terjestam, 2016), increased intrinsic motivation, and personal growth (Barnard and Curry, 2011). However, there was limited research involving healthcare professions, and minimal qualitative research to explore the experience of using self-compassion, that is, in what way did it make a difference to care givers.

For nurse educators, like myself, there were some interesting questions to be investigated in relation to the impact of self-compassion education on healthcare professionals, and their experience of applying self-compassion in the delivery of care. The limited evidence and understanding seen in the literature relating to self-compassion in the healthcare professions, or the qualitative experiences of applying self-compassion, identified a clear knowledge gap. Firestein (2012) identified these gaps in knowledge as areas of 'ignorance', which once found, inspired and stimulated exploration and knowledge development. Not to be confused with the common use of the term ignorance with its negative connotations, but ignorance defined as "*the absence of fact, understanding, insight, or clarity about something. It is not an individual lack of information but a communal gap in knowledge*" (p6). The potential benefits of self-compassion for healthcare professionals, seen through the interconnections in the literature review (see Chapter 2.7), provided personal inspiration to investigate this further. The research intended to provide an original contribution to

knowledge that would in part address the knowledge gap, and consider the incorporation of

self-compassion teaching into nursing curricula.

The literature review identified a gap in knowledge related to self-compassion in the healthcare professions, and the experiences of healthcare professionals in applying self-compassion. Chapter 3 begins by examining the aim of the study and associated research questions designed to explore this identified area of 'ignorance' (Firestein, 2012). Being cognisant of the study aim and research questions, the chapter then goes on to provide rationale for selecting a qualitative paradigm using case study methodology, the research rigour necessary to produce credible and trustworthy findings, and ethical considerations. Throughout the chapter I have attempted to provide explicit detail and rationale for decisions made about the research design, and to demonstrate reflexivity in relation to challenges faced during the research process.

3.1 Study aim and research questions

3.1.1 Aim

The aim of the study was to explore student nurses' experience of applying self-compassion, and approaches to learning and teaching compassion and self-compassion in nurse education.

3.1.2 Research questions

The research questions developed to explore the area of ignorance (Firestein, 2012) identified in the literature review were:

1. How do student nurses understand compassion at the beginning of their 3-year nursing degree? [RQ1]

2. How is the understanding of the concept of compassion developed? [RQ2]

3. Can student nurses incorporate exercises to enhance self-compassion into their everyday practice? [RQ3]

4. What is a student nurses' experience of applying self-compassion? [RQ4]

5. What is the perception of behavioural change, professional or personal, following the application of self-compassion? [RQ5]

3.2 Study paradigm and methodology

The meaning of compassion, and the way it is developed through an individual's cognitive and affective experience, reflected my ontological understanding of multiple realities, based on context and experience (Lincoln, Lynham and Guba, 2011); an ontology congruent with my concept of epistemological development of knowledge and understanding through human correspondence with the world (Ingold, 2013, 2017). Human correspondence with the world was interpreted as an individual's interactions with others and things, making a unique network or mesh of social experience (Ingold, 2017).   My ontological belief, along with the research aim to explore experiences, ruled out the appropriateness of positivist, post-positivist or quantitative methodological approaches (Lincoln, Lynham and Guba, 2011). The objective belief in one reality supported by these approaches conflicted with my ontological understanding of multiple realities and the subjective nature of participant experience. A qualitative research paradigm, from a constructionist perspective (Silverman, 2014) was therefore more congruent with the research aim and research questions, and deemed more effective in understanding human correspondence with the world (Ingold, 2017). The following section presents the rationale for the choice of case study methodology in favour of other qualitative research approaches.

3.2.1 Case study methodology

The choice of case study methodology was primarily influenced by the research aim and research questions, with secondary consideration given to the methodological expertise of the researcher. RQ3-RQ5 required contemporary data about participants' experiences, ruling out the use of historical or archival analysis approaches (Yin, 2014). Narrative inquiry (Chase, 2011), phenomenology (Polit and Beck, 2012), and anthropological approaches (Ingold, 2013) were considered due to their association with contemporary data and lived experience.

Narrative inquiry explores the narrative of people's everyday experiences to find meaning in these everyday events (Chase, 2011), meeting the aim of the research to explore experience. However, in providing narratives, participants are encouraged to take the narrative wherever they choose, with limited guidance or questioning. The research questions for this study were focused on experiences specifically related to compassion and self-compassion, and the interviews needed structure to focus and capture data that could answer those questions. The freedom to allow narrative to naturally evolve in any direction would not have ensured the collection of data that could answer the research questions, and thus narrative inquiry was not deemed suitable.

Phenomenology met the requirement to explore and understand the lived experience of a particular phenomenon (Polit and Beck, 2012), in this case compassion and self-compassion. However, phenomenology is commonly used to capture and study a snapshot of a phenomenon, a direct and immediate experience (Crotty, 1998) rather than the journey of application and perceived change over time. Whilst a phenomenological research design could capture data about participants' understanding and development of the concept of compassion, it would not capture the experience of applying self-compassion over a period of time. The methodology chosen needed to utilise prolonged and persistent engagement

with the participants to capture experience over time, enhancing the credibility of the research (Schwandt, Lincoln and Guba, 2007) and providing a much richer data. Therefore, phenomenology was not deemed to be the most effective approach.

Historically an anthropological approach to research involved immersion in the participants' environment and observation of behaviours within that environment (Erickson, 2011), which was not practicable for a research sample of student nurses working in different care settings.

Case study as a research paradigm supports the exploration of contemporary data about a specific phenomenon over a period of time (Yin, 2014), and was therefore chosen as an appropriate methodology to answer the research questions. Gomm, Hammersley and Foster (2000) defined case study as a research paradigm with assumptions about how the social world should be studied. These assumptions recognise that tacit knowledge is developed (Stake, 2000) based on meaning and interpretation, and aim to capture a greater understanding of the uniqueness of cases. Case study methodology begins with the relativist ontological presupposition that the nature of reality is relative to the person observing or experiencing it (Lincoln and Guba, 2013, Schwandt, Lincoln and Guba, 2007). If the person or the context is changed, then there will be a different experience of reality.

Case study has different meanings for different disciplines, some professional such as law, medicine or social work, and some specifically relating to research. In relation to research, MacDonald and Walker (1975) defined case study as the "*examination of an instance in action",* a concise definition that has continued to develop with increased use of case study methodology. Stake (1995) defined case study as "*the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances"* (p xi); Gerring (2004) as *"an in-depth study of a single unit where the scholar's aim is to elucidate features of a larger class of similar phenomena"* (p341). These

earlier definitions capture the complexity and individuality of the cases in my study, but place less emphasis on the exploration of multiple cases or the contextual influences on the participants' experiences. Considered more explicitly in later definitions, Simons (2009) defined case study as "*an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a 'real-life' context.*" (p21), and Yin (2014) as "*an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-world context*" (p16), both of which definitions are congruent with my ontological approach and research aim.

Stake (2000) noted that whilst case study methodology could be highly statistical and used to test hypotheses, this was not generally true of case study in social science research. Case study in social science tended to be more complex and holistic, utilised more narrative data, and was often used in an exploratory way to develop theory. This exploration expanded areas of investigation rather than narrowing, adding to "*existing experience and humanistic understanding*" (Stake, 2000).

There has been much debate about case study research over the last century: how it can be defined, and its value as a research methodology. Historically developed from human studies (Erickson, 2011), case study was criticised for its ambiguity, and compared poorly both to the more established scientific and empirical experimental approaches, and to larger scale social surveys (Gomm, Hammersley and Foster, 2000). Paradoxically, despite being perceived as hierarchically lower than other methodologies, case study was extensively used across a wide range of disciplines (Flyvbjerg, 2011). While there was no confirmed cause of this paradox, it could be suggested that the learning from case study methodology is single-loop (Argyris, 2003). New behaviours and skills are learned, but the underlying values and beliefs of researchers in relation to methodological hierarchies remain the same, thereby reducing the likelihood of any change being sustained.

The next section considers the key characteristics that set case study aside from other research methodologies, such as, the number of cases investigated, the depth of information gained, the level of control the researcher has over any research variables, and the context of the participant and the researcher.

3.2.1.1 Number of cases investigated

The number of cases investigated is a key characteristic of case study, differentiating this methodology from others (Simons, 2009). In the design of case study methodology, consideration needed to be given to the concept of a single case study or multiple case study method. Many authors defend the classic use of a single case (Gerring, 2004, Stake, 1995, Thomas, 2011, Yin, 2014) in order to focus on a particular theoretical proposition that could build, confirm, challenge or extend the theory (Yin, 2014). A single case study provides a good insight into the phenomenon being studied (Yin, 2014) and answers research questions that are particular (Stake, 2006) to that case. However, it has led to criticism about the dependability (reliability) of the study, the transferability (external validity), and scope for analytic generalizability (Schwandt, Lincoln and Guba, 2007, Yin, 2014). Single "unit" studies (Gerring, 2004), in which multiple cases are embedded in a single case study, allow for comparability as the cases and phenomenon are similar. However, the representativeness of any relationships found can be questioned. There is a "*trade-off between comparability and representativeness*" (Gerring, 2004)(p348). Multiple case studies enable both particular and general research questions (Stake, 2006), identified through a review of the theoretical perspective to be answered, whilst having significant analytic benefits (Yin, 2014).

A literal replication design with multiple case studies (Yin, 2014), means that each case can be studied for its own merits and any findings replicated between cases can then be explored. This provides opportunities to triangulate findings (Schwandt, Lincoln and Guba,

2007) and identify patterns that would not otherwise be evident in a single case study (Blackstone, 2009), thereby enhancing the credibility of the research. As my main interest is student nurses' beliefs about compassion, self-compassion, and whether these could be learned, the research was designed to initially interview participants to gain an insight into their understanding of compassion and the ways in which that understanding had been developed. A series of five self-compassion workshops were then set up to train students in using self-compassion, with the expectation that they would practice the skills in their everyday lives. A final interview would explore their experiences of applying self-compassion. The semi-structured set of interview questions planned for this study, and the fact that the participants attended the same self-compassion workshops, supported a literal replication design, and ensured there was some equivalence for each participant. Replication logic is intentionally different to the sampling logic used in other methodological approaches, because it identifies whether any of the same findings were seen in each case, despite the variations in context, whereas sampling logic is looking for findings that can represent a much wider population (Yin, 2014).

The number of cases deemed necessary for multiple case study research is based on the discretionary judgement of the researcher (Yin, 2014), but is suggested as between 2 and 10 (Stake, 2006, Yin, 2014). Seven case were used in my study. The choice of multiple case studies was to ensure as far as practicable that the study was able to answer the research questions. A single unit, embedded approach to the research design (Gerring, 2004, Yin, 2014) where multiple participants were embedded within a single case, would have offered some opportunity for comparison, but the context of each case varied in this research depending on the students' life experience and clinical learning environment. Therefore, to support credibility and external validity when analytic conclusions were drawn, a multiple case study utilising Yin's (2014) literal replication design was chosen, allowing an holistic approach to the study of each case before cross case patterns were identified. Thd design included case definition and design; preparation, collection and analysis of case data;

cross-case analysis and conclusion-making; and case reporting (demonstrated in Figure 4).

This systematic approach aided the reduction of potential research errors and bias, and

enhanced the rigour of the study (Yin, 2014).
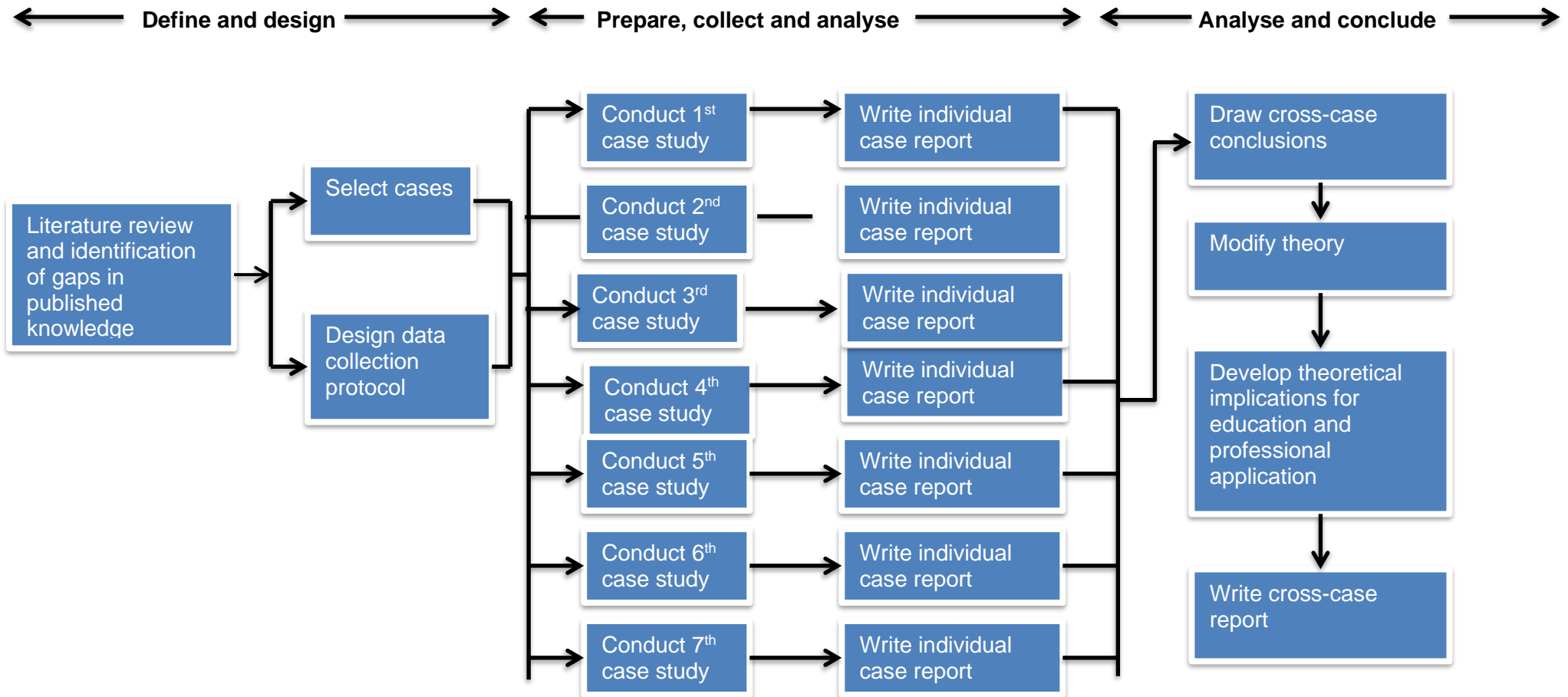
Figure 4: Multiple case study procedure (Adapted from Yin, 2014)

3.2.1.2 Depth of information gained

There is widespread agreement that a case study methodological approach is characterised by the in-depth nature of its investigation into a current phenomenon (Flyvbjerg, 2011, Gerring, 2004, Keddie, 2006, Stake, 2006, Yin, 2014). Indeed, the ability to explore and analyse a phenomenon to this depth is seen as a significant strength of case study methodology (Flyvbjerg, 2011). The researcher can engage with the participants in a more active way to gain a truer insight into their understanding and experiences. It is this subjectivity and depth that allows for the potential generation of multiple theories and further research questions (Flyvbjerg, 2011, Willig, 2013) in a more effective way than gaining a "*thin set of data"* from a larger sample (Flyvbjerg, 2011). That is not to dismiss "*thin sets of data*", as they may be the most appropriate way to answer research questions in other methodological designs. However, the research questions in my study exploring participants' understanding and experience of compassion and self-compassion, would not be effectively answered without gathering in-depth data, giving case study methodology with a narrative approach a natural advantage over other methodologies such as social surveys and experiments (Gomm, Hammersley and Foster, 2000, Lieblich, Tuval-Mashiach and Zilber, 1998).

3.2.1.3 Level of control over research variables

In empirical experiments the researcher is able to isolate and control the level of independent variables before measuring the level of dependent (non-controllable) variables, that is, there can be a level of control and randomisation (Webster and Sell, 2007). As the participants in this study were applying the techniques and strategies of self-compassion in both their personal lives and during their clinical placement, there was no way in which these behavioural events could be controlled. A prevailing characteristic of case study is its ability to manage a range of contemporary evidence and data when the variables are beyond the control of the researcher

(Yin, 2014). Although this characteristic applies to other qualitative approaches to research, the inability to control the variables *combined* with the focus on participants' understanding of compassion and experience of applying self-compassion over a period of time, (Yin, 2014), made case study the most appropriate methodology for this study.

3.2.1.4 Context of the participants and researcher

A notable omission from the earlier definitions of case study (Gerring, 2004, MacDonald and Walker, 1975), is the context in which the phenomenon takes place. However, it is the practising in context that enables meaningful learning to take place (Flyvbjerg, 2011, Schwandt, Lincoln and Guba, 2007) and facilitates the development of expert knowledge (Benner, 1984). Without this correspondence with the real world (Ingold, 2013, 2017) and the continuous active feedback it provides, the research can lead to theoretical, rule based knowledge where the effect and usefulness of the knowledge is unclear (Flyvbjerg, 2011). In later discussion of case study, the context and it's interaction with the phenomenon being investigated, has been identified as one of the defining features (Willig, 2013). The ability of the researcher to understand the context, and to consider the case within that context is a key strength of case study methodology (Flyvbjerg, 2011, Willig, 2013).

Parallel to understanding the context of the phenomenon, the researcher must also be actively aware of the perspective of their personal contextual knowledge. Anthropologist Tim Ingold (2011) discusses the informal knowledge gained through the long experience of living within one's environment, concluding that *"simply to exist as sentient beings, people must already be situated in a certain environment and committed to the relationship this entails. These relationships, and the sensibilities built up in the course of their unfolding, underwrite our capacities of judgement and skills of discrimination." (p25)*

It is this contextual knowledge that, over time, forms one's intuition and expertise (Benner, 1984, Ingold, 2011). A reflexive approach to the subjective, embodied and contextual knowledge of the researcher, is therefore a source of knowledge in its own right, and closely linked to interpretation and construction of new knowledge (Mauthner and Doucet, 2008). I have over thirty years of nursing experience, including twenty years as a nurse educator, and have carried out in-depth theoretical study of the concepts of compassion and self-compassion. Therefore, any interpretation and construction of new knowledge must be considered from the perspective brought about through this contextual expertise.

3.2.2 Types and purpose of case study

A variety of approaches to case study methodology were available, the choice of which was influenced by the purpose of the study. Differentiation between the approaches was an important element of the research design as the methods used differ according to the type of case study chosen (Simons, 2009). Thomas (2011) suggested that the purpose and approach to case study are linked, but not the same, emphasising that it is the purpose that leads to the approach. He categorised the purpose of case study as intrinsic, instrumental, evaluative, explanatory, and exploratory; and the approaches to case study as testing a theory, building a theory, drawing a picture, illustrative, descriptive, interpretive, and experimental. However, there were overlaps and similarities in many of the case study types identified. Table 2 summarises the different types of case study (named within the grid) identified by different authors in relation to their purpose, highlighting the approach chosen to reflect the purpose of this research, that is, to explore student nurses' understanding of the concept of compassion and their experience of applying self-compassion.

Table 2: Types and purpose of case study

		(Yin, 2014)	(Bassey, 1999)	(Simons, 2009)	(Stake, 1995)	(Garbett, 1970)	(Mitchell, 2000)	Merriam (1988)
The purpose of the case study	To explain how or why a phenomenon did or did not occur	Explanatory						Interpretive
	To develop propositions, generalisations and theories based on a typical case		Theory-seeking and theory-testing	Theory generating				
	To explore a phenomenon with a view to identifying future research questions or procedures, sometimes from a particular theoretical perspective	Exploratory		Theory-led or evidence-led				
	To describe an event or phenomenon in real-world context	Descriptive	Story-telling and picture-drawing				Illustrative	Descriptive
	To answer a specific research question, with the aim of getting an understanding of other cases through the study of one.				Instrumental			
	To determine the worthwhileness or value of a programme, project or event.		Evaluative	Evaluative				Evaluative
	To analyse a collection of connected events over a restricted timespan					Social analytical		
	To explore a pre-selected case because one has an intrinsic interest in that particular case, not specifically to find transferable learning.				Intrinsic			
	To understand a case in its socio-cultural context and with concepts of culture in mind.			Ethnographic				

Yin (2014) defined exploratory case study as one "*whose purpose is to identify the research questions or procedures to be used in a subsequent research study*" (p238), the implication being that exploratory case study was only useful for generating hypotheses in the first stage of a larger research project (Flyvbjerg, 2011). However, this view of exploratory study seemed limited and did not take into account the potential for concept formation and theory building that was central to other exploratory methods, for example, experiments in psychology (Feest and Steinle, 2012). A cautionary note in relation to Yin's (2014) definition was also supported by Cohen, Manian and Morrison (2011) who emphasised the value of case study in its own right rather than as a pilot or preliminary study. Simons' (2009) defined case study as '*research-based'* and '*evidence-led'* (p21), enabling the researcher to observe and analyse evidence as it is enacted in practice (Simons, 2009), which could lead to the extension of an original theoretical framework, or the generation of new or interconnected theories. The research aim of exploring student nurses' understanding of compassion, and the experience of applying self-compassion was congruent with an exploratory purpose, and an evidence-led approach with the potential for generating theory, and was therefore deemed to be most appropriate for my study.

Case study methodology, using both single and multiple cases, is not without its critics (Flyvbjerg, 2011, Simons, 2009, Yin, 2014). It has been suggested that this 'aexperimental' (non-experimental) (Guba, 1967) approach may lack rigour and reliability in the way the research process is carried out (Yin, 2014), and that it must be subject to the same rigorous and systematic approach as other experimentation (Flyvbjerg, 2011, Guba, 1967, Schwandt, Lincoln and Guba, 2007). The following section discusses research rigour, and how quality was ensured through case study methodology in this research.

3.3 Research rigour

The tensions between rigour and creativity (Whittemore, Chase and Mandle, 2001), and the challenges of applying rigour that is appropriate to experimental research, to qualitative non-experimental research, are widely debated (Flyvbjerg, 2011, Gomm, Hammersley and Foster, 2000, Schwandt, Lincoln and Guba, 2007, Simons, 2009, Yin, 2014). Trustworthiness is seen as a key element analogous with rigour in this paradigm. The gold standard, and most commonly used, criteria to assess the rigour of qualitative research (Houghton et al., 2013, Whittemore, Chase and Mandle, 2001) are credibility, dependability, confirmability, and transferability (Guba, 1981). Schwandt et al's (2007) review of these criteria acknowledge their origins in, and parallels to, the positive paradigm. Credibility was identified as parallel to internal validity, dependability to reliability, confirmability to objectivity, and transferability to external validity. Although appropriate to non-experimental research, the addition of authenticity was also recommended as a quality criteria. Authenticity includes fairness, and ontological, educative and catalytic authentication (Schwandt, Lincoln and Guba, 2007).

The demonstration of research rigour includes a comprehensive level of detail about the theoretical framework, methodological choices, interpretive decision-making, influence of researcher bias, and conclusion drawing, with an audit trail of research activities (Robson, 2002). Often referred to as "thick data" (Flyvbjerg, 2011, Schwandt, Lincoln and Guba, 2007), having sufficient information allows the reader to judge the credibility and dependability of the work, that is, to establish confidence in the truth of the data and its interpretation (Polit and Beck, 2012), and to make judgements about the transferability of the findings in other contexts (Schwandt, Lincoln and Guba, 2007). A detailed description of the methodology, methods, and decision making processes within this study provide the "thick data" required for the reader to be able to judge the rigour of the research, or to replicate the research design. Conclusions are drawn and recommendations proposed in

Chapter 7. Although suggestions are made about the value of the findings within nursing and nurse education, and the potential for transferability to different professions, it is for the reader to judge the transferability to their own context. A definition of how 'thick' the information needs to be remains to be found, but Gerring (2004) recommended 'over-reporting' to avoid reporting only those elements that are transferable to other cases, and address potential concerns about credibility and dependability.

Schwandt et al (2007) proposed an external audit of the research process to confirm dependability where possible, although it was acknowledged that this is not always practicable. Although a full external audit of my research process was not carried out, my research supervisory team provided some aspects of quality review. Reflective discussions, in which my semi-structured interview schedule was reviewed and critiqued, identified a potential gap in the data captured relating to the participants' views of the patient's understanding of compassionate behaviour. From this external review, I was able to update the interview schedule, supporting the collection of a richer data set. The risk of confirmability was managed by the audio-recording and verbatim transcribing of all interviews (Parahoo, 2006), ensuring field notes were written up immediately after each self-compassion workshop, and the keeping of a research journal to record decision-making during data analysis and interpretation. The transcripts were sent to each participant for member checking and validation to ensure, as far as possible, the correct interpretation of the participants' voice was made (Grinyer and Thomas, 2012, Parahoo, 2006, Polit and Beck, 2012, Robson, 2002, Schwandt, Lincoln and Guba, 2007). Data analysis was reviewed by an independent nurse academic and researcher. With regard to transferability, it is worth reiterating that the study was not aimed at generalising to the population as a whole (Yin, 2014), or proving a generalizable hypothesis (Whittemore, Chase and Mandle, 2001). It aimed to expand the theory to gain a new understanding of 'how' and 'why' self-compassion has made a difference in this participant group of student nurses. This

important distinction from other scientific research approaches has been recognised throughout the history of qualitative inquiry (Erickson, 2011).

An in-depth understanding of experience gained through the study of a particular case is a strength of case study methodology, giving a level of insight not gained from other comparable methodologies. However, it must be recognised that the specific focus on a particular case results in a weak understanding of the occurrence of any phenomenon in the wider population and therefore is not generalisable (Flyvbjerg, 2011). A criticism often voiced about case study (Yin, 2014), this should not lessen the value of case studies. The learning gained from in-depth exploration makes an important contribution to knowledge in the subject field, and although may not be formally generalisable, is often considered to be 'transferable' to other similar cases (Flyvbjerg, 2011).

3.4 Reflexivity

A reflexive approach to the research supported the credibility, dependability, confirmability, and authenticity of the work. Bradbury-Jones (2007) defined reflexivity as "*the process of reflecting critically on oneself as a researcher*" (p292), which, if incorporated into the design of the research, can add a contextual richness and depth to the findings (Gough and Madill, 2012). There is a risk that the subjectivity of the researcher could influence the way in which data is interpreted. Indeed Schwandt et al (2007) suggested that the researcher-participant relationship *"is one of mutual and simultaneous influence"* (p 17), and that objectivity could not be achieved. Simons (2009) elaborated on this, emphasising that it is one's actions, values, beliefs, preferences and biases that need to be reviewed in relation to the research.

I utilised a reflection-in-action approach (Schon, 1995) to identifying subjectivity by keeping a research journal (Gough and Madill, 2012, Simons, 2009), which was reviewed regularly to identify my own contextual knowledge, subjective I's (Peshkin, 1988), and how they

influenced the research process. When used alongside analysis of the data through a

reflexive lens, these strategies were noted as effective elements of pluralistic narrative

analysis (Frost, 2009, Gough and Madill, 2012) thereby supporting credibility, dependability

and confirmability. The use of reflexivity in data analysis and interpretation also supported

ontological authentication, where there is appreciation of the changes that have taken place

as a result of the research, whether those changes are positive or negative (Schwandt,

Lincoln and Guba, 2007). However, a reflection-on-action (Schon, 1995) approach, even

with some distance between the research and the reflection, is useful and can produce an

on-going level of analysis and debate to generate new learning.

Reflexivity also addressed the oft cited criticism of case study research, that human nature

tends to be biased towards positive verification of one's opinions (Flyvbjerg, 2011, Gerring,

2004, Parahoo, 2006). Supporting the concept of fairness, reflexivity aimed to present a

balanced view, considering different value systems and experiences of reality (Polit and

Beck, 2012, Schwandt, Lincoln and Guba, 2007) Researchers have a personal context

based on values, experience, knowledge, and circumstances, which inform their pre-

conceived ideas and judgements. The subjective nature of case study risks these biases

influencing which values are diminished or enhanced in the presentation of the research.   In

particular, based on my expertise and values, there was a risk of bias from the perspective

of the 'I as a nurse', 'I as a teacher', and 'I as an evangelist for self-compassion'. Defined by

Peshkin (1988) as "situational subjectivity" (p18), this dynamic, context-driven process

needed to be actively recognised in the research process to avoid falling into the trap of only

verifying what one already knew (Simons, 2009) and being blind to falsification (Gerring,

2004), new or conflicting concepts. Reflexivity using Peshkin's I's (Peshkin, 1988) was

undertaken as part of the data analysis in this study to overtly acknowledge and manage

any potential bias (further details of Peshkin's I's are found in Appendix 2). An inability to

recognise and manage this bias could lead to erroneous and unsubstantiated interpretations

of the data (Whittemore, Chase and Mandle, 2001), where researchers only hear and

observe what their personal intellectual and ethical development prepared them to hear (Johnson and Rowlands, 2012). Although identified as a risk to research rigour, Flyvbjerg (2011) argued against Gerring's (2004) suggestion that case study is a 'bane to falsification', purporting that it is falsification, not verification, that characterised case study. As a result of the close feedback gained from in-depth study, where the participant can confirm, deny, or offer an alternative viewpoint on the subject during the research process, Flyvbjerg (2011) argued that researchers undertaking case study more regularly experienced 'falsification', finding things that were surprising or contrary to their pre-conceived subjective expectations. Falsification was experienced in this study through analysis of data that challenged my pre-conceived belief that all nurses are, or want to be compassionate. A reflexive approach to all stages of the research process was deemed to be the most effective way to manage the risks of bias in case study, and to support the demonstration of credibility, dependability, confirmability and authenticity (Lincoln and Guba, 1985, Peshkin, 1988, Schwandt, Lincoln and Guba, 2007, Simons, 2009, Yin, 2014).

3.5 Implementation of ethical principles

Research ethics are guided by the World Medical Association's Declaration of Helsinki (World Medical Association, 2013), guidelines developed in response to human rights violations (Polit and Beck, 2012) to ensure the protection of research participants and guide the decision making of most ethical research committees. It was my intention to engage with and be cognisant of 'ethical literacy' (Wiles, 2012), not just at the point of research ethics application, but throughout the research process, particularly considering respect for autonomy, beneficence, and non-maleficence. The following sections discuss these ethical considerations and actions taken to support them within this research.

3.5.1 Respect for autonomy

Respect for autonomy was initially considered in the selection of participants, to ensure that no student felt coerced into participating. Coercion was a potential risk as the invited participants were students embarking on a nursing degree, and I was a Principal Lecturer on that degree programme within the Faculty. To minimise the risk, and enhance voluntariness (Wiles, 2012), participants were invited either from cohorts based on a different University campus, or cohorts on the same campus, but with whom I had minimal direct contact. The small number of respondents in relation to the cohort size (12 out of 150 invited), suggested that invitees did not feel coerced.

Respect for autonomy was also demonstrated through informed consent, a basic doctrine of ethical behaviour (Bulmer 2008). All participants were given a Participation Information Sheet (Appendix 3) outlining the aim of the research and the participation requirements. There was some debate about the amount of information required in order to give informed consent (Antoniou et al., 2011), but the Participant Information Sheet clearly identified the scope and purpose of the study, the process and level of engagement required. It identified the potential risks and how these would be managed, and how anonymity and confidentiality would be maintained (Appendix 3). The information provided was beyond the minimum requirements expected in order to give informed consent (Richards and Schwartz, 2002, Streubert and Rinaldi Carpenter, 2011). Participants had an opportunity to ask questions about the information provided to inform their decision making, and all signed consent forms (Appendix 4). Written consent was gained prior to data collection (Parahoo, 2006), and checked verbally at each point of contact to ensure participants had a good understanding of the study, and agreed to continue (Rooney, 2015). Nunkoosing (2005) questioned whether fully informed consent could be gained prior to an in-depth interview as participants did not know what the content of the interview would be, a question relevant to the initial interview in this study where participants only had a brief overview of the interview focus.

However, the advantage of the multiple contact methodology used in this study was that participants could better predict the likely disclosures in subsequent interviews and therefore the informed nature of the consent was enhanced (Nunkoosing, 2005). The right of participants to withdraw from the research (Royal College of Nursing, 2011) without penalty or any recourse to their nursing degree was also made clear in the participant information sheet. Participants demonstrated their confidence in this right, as attrition was experienced from the sample.

Confidentiality and anonymity were also considered in order to demonstrate respect for autonomy (Wiles, 2012). In-depth interviews can elicit highly personal information (Johnson and Rowlands, 2012), so in order to protect the participants, confidentiality and anonymity must be assured. The content of each interview was confidential to the participant and researcher, and the same researcher undertook all the interviews to further reduce the risk of confidentiality breaches. Audio recordings of the interviews were kept on a password-protected computer in a locked environment (Polit and Beck, 2012). Transcripts were sent to each participant for checking, (Grinyer and Thomas, 2012, Parahoo, 2006, Polit and Beck, 2012, Robson, 2002, Schwandt, Lincoln and Guba, 2007) and the participants were advised that they could keep or destroy their own copy as they wish. During the workshops, it was not possible to maintain confidentiality as there were multiple people in the group. Participants were therefore asked to respect others' confidentiality – what was done in the room stays in the room. It was explained that participants could talk about the workshops and their experiences of them, but to avoid using fellow participant names or any other details that may identify them.

In the reporting of the data, particularly as it was a small group of people, care was taken to prevent the identification of any participant as a result of their cultural background or gender, referring to individuals using research numbers (P1-P7). Utilising research numbers to anonymise each participant in the data analysis stage ensured I was still able to

appropriately connect data from multiple contacts with each participants (Polit and Beck, 2012).

3.5.2 Beneficence and non-maleficence

The principle of beneficence relates to the researcher's duty to do good (Wiles, 2012), and is often considered alongside the principle of non-maleficence, the responsibility to avoid, prevent or minimise harm (Polit and Beck, 2012). The greatest risk to participants during the in-depth interviews and self-compassion workshops was the potential for distress (Johnson and Rowlands, 2012), a concern that can be more extreme for people in therapy (Neff 2013). It was made clear to the participant that these workshops were not intended to be therapy, and the students were not pre-selected based on any evidence of therapeutic needs. However, when approaching a general populous, it is likely that some may have therapeutic needs, may experience increased distress, and would need advice or referral to appropriate services. Described by Neff (2011a) as 'backdraft', the surfacing of difficult emotions was a predicted risk of undertaking a self-compassion programme. To minimise the risk of harm associated with this predicted risk, I included the concept of 'backdraft' in the second workshop so participants were prepared for the possibility and did not become overly concerned about their potential reactions to the exercises.

For each of these interviews and workshops, I ensured an additional member of academic staff was available to care for the participant if they experienced any distress. I also contacted the participant later the same day to ensure as far as possible that they had not been harmed by the experience.

3.5.3 University research ethics application

To ensure the ethical principles within the Declaration are upheld, the World Medical Association state that "*the research protocol must be submitted for consideration, comment, guidance and approval to the concerned research ethics committee before the study begins*" (World Medical Association, 2013). The University Research Ethics Policy, implemented by the Faculty Research Ethics Panel, ensured these ethical principles were adhered to. A mandatory requirement for any research undertaken within the University, to ensure the researcher has considered ethical principles prior to the planning, undertaking and disseminating of research, a research ethics application was submitted to the Faculty Research Ethics Panel, and was approved (Appendix 5).

3.6 Chapter conclusion

Clear gaps in the knowledge and understanding of compassion and self-compassion in nursing and healthcare emerged from the literature, and were made explicit through the development of a model of interconnections (Chapter 2.7). The research aim and questions were proposed to address these gaps, exploring student nurses' understanding of compassion, their experiences of applying self-compassion, and the extent to which this led to their perception of behavioural changes. In harmony with a relativist ontology (Lincoln, Lynham and Guba, 2011), the research questions supported the participants to tell their stories, taking into account their individual experiences. The congruence of relativist ontology with case study methodology (Lincoln and Guba, 2013, Schwandt, Lincoln and Guba, 2007), and the ability of case study design to explore the 'how and why' of an experience in context (Yin, 2009) made this an appropriate methodology. The selection of an exploratory case study design allowed the research questions to be addressed, and led to the complementarity of case study and other research (Yin, 2014) to expand the theoretical and applied knowledge of self-compassion as a concept.

Having established and discussed the rationale for case study methodology, Chapter four will go on to explore the methods used within this research design. A detailed description will be provided of the approach taken and decisions made to support replication of the study and enable the reader to make judgements about research rigour (Flyvbjerg, 2011, Schwandt, Lincoln and Guba, 2007).

The purpose of this chapter is to discuss the research methods used. Beginning with the identification and selection of cases, the chapter then takes the reader through the different phases of data collection, including the initial interview, the self-compassion workshops, and the post-workshop interview. The approach to data analysis is then explored, providing rationale for the use of a data analysis model with a multi-layered approach, to ensure a full and detailed exploration of the narrative data.

4.1 Sampling plan

Sampling procedures are often divided into two broad categories, probability and purposive (Parahoo, 2006, Polit and Beck, 2012), although Teddlie and Tashakkori (2009) extended these categories to include convenience and mixed methods sampling. Probability sampling, a randomised selection process to identify a sample representative of the entire population being studied, was seen as a strength in larger scale quantitative research where it formed a basis for statistical inferences (Affleck, 2012, Polit and Beck, 2012, Teddlie and Tashakkori, 2009). However, in qualitative research probability sampling could not assure provision of the richness of data required to answer the research questions (Curtis et al., 2000, Miles and Huberman, 1994), and therefore was ruled out for this research.

Convenience sampling would ensure that all the participants are easily accessible and willing to participate (Polit and Beck, 2012), but as with probability sampling, would not provide assurance that participants have the knowledge or experience to answer the research questions. Also, RQ1 required a specific target group, student nurses at the beginning of their degree, to capture '*believable descriptions*' (Miles and Huberman, 1994)

(p34) before the participants were influenced by the course content. Convenience sampling would not achieve this and therefore was also ruled out as an appropriate choice.

Deviant or extreme cases can often hold a wealth of information that would not be reflected in a more representative case (Flyvbjerg, 2011), but could not be identified at the point of sample selection as the experiences of each student was unknown prior to the interviews. It was only following the data collection and analysis that an extreme case was identified within the participant group.

A purposive sampling plan was therefore deemed to be most appropriate, and met the recommended requirements for qualitative sampling proposed by Miles and Huberman (1994), and adapted by Curtis et al (2000) (see Table 3).

Table 3: Sampling plan

Sampling criteria	Sampling plan to recruit participants from a group of first year student nurses
Is the sampling relevant to the research questions?	Yes. The aim of the research was to look at the experience of student nurses, with RQ1 particularly focusing on students' understanding of compassion at the beginning of a 3-year degree course.
Does the sample have the potential to generate rich information? Will the phenomena being studied appear?	Yes. Especially the experience of applying self-compassion as they all took part in self compassion workshops and had the potential to articulate their experiences.
Does the sampling plan enhance transferability/analytic generalisability?	Yes. The use of multiple cases with diverse individual experiences enabled cross case analysis to identify

	potential commonalities and transferable knowledge (Flyvbjerg, 2011).
Can believable descriptions and explanations be produced?	Yes. Although the concept of 'believable' is open to interpretation (Curtis et al., 2000), the regular contact with the participants through multiple linked interviews and workshops supported triangulation and narrative consistency.
Is the sampling plan feasible?	Yes. Access to the first-year student nurse cohorts was possible through my job role, and the travel to other campuses to meet the participants was integrated into my work travel, making it cost and time effective.
Is the sampling plan ethical?	Yes. All participants gave informed consent, which was rechecked at each point of contact throughout the data collection process. Plan was approved by the Faculty Research Ethics Panel.

4.1.1 Identification of cases

Yin (2014) noted the importance of defining the 'case' and its boundaries in order to answer the research questions. The cases for this study were defined as student nurses from an identified local University who met the criteria identified in Table 4.

Table 4: Inclusion and exclusion criteria to meet the requirements of a 'case'

	Inclusion criteria	Exclusion criteria
1.	Students were in the first year of a pre-registration BSc (Hons) Nursing course at the commencement of the study.	Students from the second or third year of the three-year nursing degree.
2.	Students were able to attend the series of self-compassion workshops, and agreed to participate in two in-depth interviews.	Students were not able or willing to attend the series of workshops or participate in two in-depth interviews.
3.	Students were able to provide or withhold informed consent.	Personal students of the researcher, who may have felt obliged to participate.
4.	Students were fluent in English (NMC entry requirement for the course).	Students not fluent in English.

The criteria were chosen to ensure those participating would be best placed to provide information-rich data to address the research questions (Johnson and Rowlands, 2012, Polit and Beck, 2012, Stake, 2006). In order to be on the nursing degree course, students must have relevant academic qualifications, demonstrating an appropriate level of cognitive ability (Nursing and Midwifery Council, 2011, Polit and Beck, 2012) to be able to provide or withhold informed consent. The BSc (Hons) Nursing course was underpinned in both theory and practice by NHS values, one of which is compassion (Department of Health, 2015). There was therefore a risk that participants would recite a learned definition of compassion that did not necessarily reflect their own views, that is, say what they think the researcher wants them to say (Johnson and Rowlands, 2012). By capturing their knowledge and understanding at an early stage in the course, it was anticipated that the challenge of getting

beyond this professionally taught knowledge to gain information about their own views would be reduced (Morse, 2012).

4.1.2 Boundaries of the case

Once the case was identified, it was important to consider how it was bound (Stake, 2006, Verschuren, 2003, Yin, 2014). The concept of having a clear boundary was evident in some definitions of a case, for example, Gerring (2004) defines a case as a "*spacially bounded phenomenon … observed at a single point in time or over some delimited period of time*" (p342). The case boundaries may then be clear and fixed for the period of the research (Creswell, 2014). In contrast to this opinion, Yin (2014) suggested that the boundaries may not be so clearly evident as they are interlinked with the context of the phenomenon. The boundaries may need to be flexible in order to respond to unanticipated findings during the data collection or analysis (Simons, 2009, Yin, 2014).   As the cases in this research were individual people, boundaries such as group membership or geography (Yin, 2014) were not relevant. The focus of the research was on the students' experience, which takes time to develop. Therefore it was appropriate and desirable (Yin, 2014) for a specific timeframe to form the boundary of the case. The case boundaries were defined as starting at the point of the initial interview, and ending at the final interview, a period of approximately eight months. There was data provided from outside of these boundaries, for example the students' previous experiences of compassion, but it is acknowledged that this added contextual knowledge rather than being the main focus of the study (Stake, 2006).

4.1.3 Selection of cases

Invitations were sent out by email to pre-registration nursing cohorts on two separate University campuses. The email contained a brief summary of the subject area, and an

overview of the requirements of each participant, that is, interviews and attendance at workshops. The participant information sheet was also attached, so students interested by the brief summary could access further details before deciding whether or not to accept the invitation to participate and provide informed consent, a prerequisite for research involving human participants (Streubert and Rinaldi Carpenter, 2011).

The response rate from the invitations to the first two cohorts (Table 5) was disappointing, and I believed a potential risk to the study in terms of sufficient data to draw conclusions and propose transferability. Discussion with an independent panel at Confirmation of Candidature supported my concerns, and recommended a third cohort was recruited. In total, from the invitations to participate, twelve responses were received from three different student cohorts. All met the case inclusion and exclusion criteria and were therefore chosen to answer the research questions (Yin, 2014), and provide an insight into the phenomena of applying self-compassion.

Eleven of the twelve students were female, and one male. The potential gender bias in the data, and therefore the possible effect on generalizability (Polit and Beck, 2013) was acknowledged. However, this reflected the demographic of student nurse cohorts, and contrary to Polit and Beck's (2013) findings, all males within the invited cohorts were given an equal opportunity to participate in the research. The choice not to participate was theirs. The age range of the participants was nineteen to forty-nine.

All twelve participants completed the initial interview. The challenge of sample attrition in longitudinal research (Grinyer and Thomas, 2012) was experienced with one participant in the first cohort leaving the University prior to the workshops. Although in the process of withdrawing, the participant explicitly agreed to the inclusion of her interview data in the research, this data was excluded on the grounds that it would only address RQ1 and RQ2, and would not capture the application of self-compassion. Four further participants withdrew

from the research with no explanation, and did not attend workshops or respond to contact following the initial interview. The attrition experienced resulted in a total of seven cases, those participants who undertook both interviews and the series of self-compassion workshops. The recruitment and attrition within each cohort can be seen in Table 5.

As each of the student's stories and experiences were different, it was deemed more appropriate to keep them as individual cases rather than embedding them into a larger cohort or single unit focused case. The in-depth nature of the interviews, the fact that the researcher was the facilitator of the five self-compassion workshops, and that each participant would be interviewed for a second time, ensured sufficient, rich-quality data for a multi-case study. Therefore, it was deemed that seven cases would be an appropriate number (Morse, 2000, Polit and Beck, 2012, Stake, 2006).

Table 5: Participant recruitment and attrition

	Cohort 1 Campus 1	Cohort 2 Campus 2	Cohort 3 Campus 2	Total
Potential participants invited	74	48	28	150
Participants recruited	4	3	5	12
Withdrawn following initial interview	1	2	2	5
Total participants completing research	3	1	3	7

4.2 Data collection

Data collection commenced with individual in-depth, semi-structured interviews. Although case study methodology can result in a trade-off between extensiveness of cases and intensiveness of study (Gerring, 2004), the depth of analysis available puts this approach at a considerable advantage for exploratory research. In consideration of the multi-process approach to the study, and for ease of understanding, a diagrammatical representation of the research phases is presented in Figure 5.

Research phase	Timeline
Initial interview	Signals the start of the data collection
Self-compassion workshop 1	Completed approximately 1 month post initial interview (Month 1)
Self-compassion workshop 2	Completed 1 month after workshop 1 (Month 2)
Self-compassion workshop 3	Completed 1 month after workshop 2 (Month 3)
Self-compassion workshop 4	Completed 1 month after workshop 3 (Month 4)
Self-compassion workshop 5	Completed 1 month after workshop 4 (Month 5)
Final interview	Completed 1 month after workshop 5 (Month 6)

Figure 5: Diagrammatic representation of the planned research phases

4.2.1 Rationale for in-depth interviews

In-depth interviews are one of the most commonly used data collection strategies in qualitative research (Nunkoosing, 2005, Sandelowski, 2002).   Congruent with

constructionism (Silverman, 2014), in-depth interviews were chosen for data collection. They were deemed best suited to the exploratory research questions as they reflected the individuality of case study methodology, exploring the construction of experience and knowledge in context (Johnson and Rowlands, 2012). Alternative ways of collecting the data, such as surveys or questionnaires were not considered appropriate (Polit and Beck, 2012), due to the criticism that they resulted in a "thin set of data" (Gerring, 2004) (p348) that the researcher was unable to clarify or probe (Polit and Beck, 2012). Although the generalizability of findings is limited with in-depth interviews (Johnson and Rowlands, 2012), it was the intention of this study to look for and interpret the uniqueness of participants' experience, and to explore "*inter-textual relations rather than causality*" (Rosenau, 1992), thereby making active interviews an appropriate data collection method (Gubrium and Holstein, 2003).

Active interviewing takes place when the participant and researcher have a more equal partnership. It was believed to empower participants to have ownership of their voice (Mishler, 1986), and together with an in-depth approach to interviewing, allowed the participants to actively piece together their experiences and construct knowledge before, during and after the interviews (Gubrium and Holstein, 2003). There was some scepticism about the romanticised view of active interviewing as an equal partnership (Gubrium and Holstein, 2003) when in fact it remains somewhat asymmetrical (Johnson and Rowlands, 2012). The researcher set the focus of the questions, as seen in the interview schedule (Appendix 6), and the participants provided responses. The use of a more minimalistic, semi-structured interview schedule, ensured a protocol of questions that guided the interviews whilst providing flexibility. Flexibility allowed the participant to partially direct the narrative, and the researcher to respond to the narrative of the participant if that was required (Johnson and Rowlands, 2012), supporting participant empowerment (Mishler, 1984).

4.2.2 Initial interviews

For the first phase of data collection, each participant was individually interviewed. The planned focus of the initial interview related to research questions one and two:

1. How do student nurses understand compassion at the beginning of their three-year nursing degree?
2. How is the understanding of the concept of compassion developed?

The initial interviews were semi-structured with seven questions (Appendix 6). The questions were developed to be open-ended in order to encourage the narrative, and to gather data from the perspective of different footings (Holstein and Gubrium, 1995). For example, 'What does compassion mean to you?', and 'What do you think the patients think compassionate behaviour is?'. The questions also asked for specific illustrations within their narrative, for example, 'Can you tell me about a time when you experienced someone being compassionate towards you?' As discussed in Chapter 3.3, the questions for the semi-structured interview were reviewed by the research supervisory team. Utilising this independent review ensured the questions were relevant and unambiguous (Wilson, 2010), and identified and reduced the risk of unconscious bias (Simons, 2009).

The interviews were conducted in a quiet visitor's office on the University campus, reflecting Seidman's (1991) recommendation that the interview location should be convenient and familiar to the participant, and in a private setting. This quiet, private location enhanced the participants' feelings of being in a safe and trusted environment, and supported the researcher's communication skills for developing an optimum rapport (Goudy and Potter, 1975). It also ensured the quality of the audio recording could be optimised. The interviews were audio-recorded with permission of all participants to ensure a verbatim record (Johnson and Rowlands, 2012), and later transcribed for analysis.

To maintain a reflexive approach to the research process (as discussed in Chapter 3.4), notes were made following the interviews of any non-verbal or other behaviours not necessarily captured on an audio-recording, and any personal reflections on the interview. As an inexperienced research interviewer, the level of personal disclosure made by the participants with regard to significant traumas they had experienced in their past was unexpected. This level of disclosure was viewed as positive, and suggested to be the result of a skilled interviewer developing an optimum level of rapport (Goudy and Potter, 1975), reducing the risk of interview bias and having a positive impact on validity (Grinyer and Thomas, 2012). The development and level of rapport, however, was difficult to measure, and may have an unexpected negative impact on data collection. There was believed to be a risk that the higher the rapport, the greater the bias in the interview, resulting in less data to answer the research questions (Goudy and Potter, 1975). As a Registered Nurse with extensive experience in emergency nursing and teaching, interviewing different people to gain information in urgent and time-limited situations was a regular part of my role, meaning I had considerable experience and expertise in this type of communication (Nixon, 2013). The many transferable communication skills gained from this experience were then able to support my more limited experience of research interviewing.

The initial interviews were between 41 and 77 minutes (average 61 minutes) in length, reflecting the typical interview length of 20 minutes to 2 hours (Parahoo, 2006, Wilson, 2010). This was appropriate for an in-depth interview as it allowed for greater exploration of topics raised by the participants in response to the set questions.

4.2.3 Self-compassion workshops

Following the initial interviews, each participant was invited to engage in five, monthly two-hour self-compassion workshops that I facilitated. The timeframe was consciously chosen

to enable the participants to apply the learning from each workshop, and to be able to notice and reflect on any changes in their experiences, before the final interview.

The workshops were interactive and experiential, based on Neff's model of self-compassion (Neff, 2003a), with a mixture of information giving, discussion, and self-compassion exercises and meditations. The first workshop gave an overview of self-compassion and the three elements within it: (1) self-kindness versus self-judgement, (2) common humanity versus isolation, and (3) mindfulness versus avoidance or over-identification (Neff, 2003a). Workshops two, three, and four then focused on each of these three elements. Finally, workshop five focused on qualities and strengths, and how self-compassion can be used to acknowledge and nurture these. The exercises and meditations were adapted from personal experience and expertise in self-compassion, meditation, and nursing, Neff's (2015a) guided meditation and self-compassion exercises, and Chris Irons' (2013) exercise reflecting on ones' emotional regulation system. An overview of the workshops with the associated exercises and meditations can be seen in Table 6.

Functional neuroimaging and lesion studies have demonstrated the ability of music to evoke emotion and affect mood (Diaz, 2011, Koelsch, 2010), therefore meditative music was played at the beginning of each workshop to support the creation of a relaxed environment. As part of the welcome and introduction to each workshop, students were reminded that they could wholly dedicate this next 2 hours to themselves; that they had made arrangements to be there, so there was nothing urgent that they could not come back to after the workshop had finished. The giving of permission, although not necessary, helped the students to relax and move towards a state of 'stable attention' (Goodman, 2013), giving over the time in the workshops for their own development and growth.

Table 6: Self-compassion workshops

Workshop	Focus of session	Exercises
1	An overview of the self-compassion model; physiology relating to emotional regulation; evidence-based benefits; and common criticisms.	The 'pause' button. Experiencing self-compassion.
2	A focus on self-kindness; recognising the effect of backdraft; links to attachment and motivation.	Experiencing loving kindness. Motivating ourselves through kindness.
3	A focus on mindfulness; the default mode network; exploration of own emotional regulation system; avoiding over-identification; and stages of self-compassion.	Basic mindfulness meditation. Exploration of own emotional regulation system. Giving ourselves loving kindness.
4	A focus on common humanity; self-esteem and how it differs from self-compassion; links to the caring professions; and the difference between empathy and compassion.	Expanding the circle of loving kindness. Seeing yourself as you are. Equanimity and compassion practice for caregivers.
5	Relating self-compassion to our strengths, qualities and successes; cultivating positive emotions.	The compassionate friend. Self-appreciation. Silver linings.

As discussed in Chapter 3.5.2, it was important to note that these self-compassion training workshops were not designed to be therapy sessions. Compassion-focused therapy has been used within mental health services for the past 20 years, developing self-compassion

particularly for people who suffer from severe shame and self-judgement (Gilbert, 2010, Gilbert, 2014). The intention of these workshops was quite different, not to be used as therapy, but to enhance the levels of self-compassion in student nurses in order to support their professional skills and capacity to implement values based nursing care.

Two of the seven cases did not complete all of the self-compassion workshops. P2 missed a workshop due to being on placement, and P3 missed two workshops due to emotional backdraft and uncertainty about coping with the subsequent workshops. In cohort three, P5, P6, and P7 requested that workshops four and five be combined in order to facilitate ease of access when they were in placement. Reflecting the participants' request, reflection-in-action (Schon, 1995) captured through my research journal had questioned the need for the self-compassion content to be spread over five workshops, and whether fewer workshops may have enhanced greater recruitment and retention. Combining the workshops successfully supported the participants to access the learning and practice the self-compassion exercises. It did not appear to be detrimental to their learning. Therefore, it could be suggested that the content could be delivered in four workshops rather than five. Table 7 illustrates the case journey that each participant took through the data collection. The variances identified still enabled the collection of rich data for analysis.

As discussed in Chapter 4.1, on analysis of the interview data, P3's emotional response to the workshops and the application of self-compassion highlighted this as a deviant or extreme case (Flyvbjerg, 2011), although could not have been identified prior to the data collection.

Addressing the issues of reflexivity and rigour discussed in Chapter 3.3, reflections were written immediately following each workshop, noting any participants' verbal reports of applying self-compassion, any comments made during the workshop that had clear links to the theoretical perspective, and as far as possible, any personal reflection on the

experience. While these notes acted as an aide-memoire for the post-workshop interviews and data analysis, the practice of reflexivity was primarily carried out to enhance the credibility and rigour of the research (Luttrell, 2010, Parahoo, 2006).

Table 7: Case journeys through data collection

Case	Initial interview	Workshop 1	Workshop 2	Workshop 3	Workshop 4	Workshop 5	Post workshop interview
P1	✓	✓	✓	✓	✓	✓	✓
P2	✓	✓	x	✓	✓	✓	✓
P3	✓	✓	✓	x	x	✓	✓
P4	✓	✓	✓	✓	✓	✓	✓
P5	✓	✓	✓	✓	✓ workshops 4 and 5 combined		✓
P6	✓	✓	✓	✓	✓ workshops 4 and 5 combined		✓
P7	✓	✓	✓	✓	✓ workshops 4 and 5 combined		✓

4.2.4 Post-workshop interviews

The final phase of data collection consisted of a second individual in-depth interview with each participant (Nunkoosing, 2005, Sandelowski, 2002). The focus of these interviews was to empower the participants to tell their stories of applying self-compassion, thereby addressing research questions 3-5:

3. Can student nurses incorporate exercises to enhance self-compassion into their everyday practice?

4. What is a student nurses' experience of applying self-compassion?

5. What is the perception of behavioural change, professional or personal, following the self-compassion workshops?

The location of the second interviews was negotiated between the participant and researcher, with some carried out on the University campus and some in the participant's clinical placement. They were still undertaken in a setting that was convenient, private, and familiar to the participant (Seidman, 1991), but this negotiation demonstrated the 'democratization' of the interview process and therefore a move towards more active interviewing (Herzog, 2012, Mishler, 1986).

One of the limitations of in-depth interviews was that participants will report what they think the researcher wants to hear, rather than a 'true' account of their experiences (Johnson and Rowlands, 2012), potentially bringing into question the authenticity of the narrative (Nunkoosing, 2005). It was also believed that the constraints placed on interview question development in order for research to go through 'human subject committees', may limit the ability to probe and clarify the participant's 'truths' (Warren, 2012). While this can be mitigated to some degree by the reflexivity of the researcher on their own perspective, beliefs and values, the use of multiple interviews increased the trust and rapport leading to a fuller and more honest account (Grinyer and Thomas, 2012). The use of multiple interviews appeared to be an effective strategy in striving for veracity in this research, with participants willingly volunteering information that was surprising in its sensitivity (Renzetti and Lee, 1993).

For the research question focusing on the participants' perception of change (RQ5), multiple-occasion interviewing enabled the participants to reflect on their experiences between interviews. The time between interviews allowed the first phase of data analysis to be undertaken, which then influenced the development of more precise questions for the second interview (Earthy and Cronin, 2008, Grinyer and Thomas, 2012). Semi-structured

interviews were carried out (see Appendix 7) that utilised an overview of each workshop as an aide-memoire for the participants to discuss their experiences. The post-workshop reflections recorded in my research journal also enabled the participants to be prompted about experiences disclosed during each workshop, supporting them to clarify and explore these in more detail (Johnson and Rowlands, 2012).

All seven participants were interviewed for a second time. The interviews were between 35 minutes and 63 minutes (average 48 minutes). The initial and post-workshop interviews were transcribed verbatim by the researcher. Although time consuming, this reduced the risk of error from deliberate or accidental alterations of the data by external transcribers (Poland, 1995), and provided the opportunity for immersion in the data to become completely familiar with each interview. To enhance the trustworthiness of the transcribed data, each transcript was cross checked against the audio recording prior to analysis (Polit and Beck, 2012). Transcripts of the interviews were also sent to the participants for checking. The data collection process spanned two and a half years, and resulted in 679 pages of verbatim transcripts.

4.3 Data analysis

The general analytic strategy (Yin, 2014) selected for this research was influenced by the research aim and questions designed to explore experiences of applying self-compassion, (Lieblich, Tuval-Mashiach and Zilber, 1998), the ontological perspective of multiple realities based on context and experience (Lincoln, Lynham and Guba, 2011), and the understanding of epistemological development through correspondence with the world (Ingold, 2013, 2017). The use of a positivist approach to data analysis to search for an objective reality that was independent to the researcher and research participants (Silverman, 2014), was in conflict with my ontological and epistemological perspective and so was ruled out.

The research questions were designed in part to explore participants' understanding of the meaning of compassion and their experience applying self-compassion, questions that could have been answered using a naturalistic theoretical approach. However, the concept of naturalism emphasised the 'what', that is the meaning or experience itself, but not 'how' that understanding or experience was constructed (Silverman, 2014). A constructionist approach was therefore required to remain congruent with the underpinning ontology and epistemology based on context, experience and correspondence with the world.

4.3.1 Analytic approach

Approaches to data analysis procedures differed between researchers (Miles and Huberman, 1994, Polit and Beck, 2012, Yin, 2014). However, there was a shared aim to identify themes within data, and look for patterns within and across those themes to find areas of potential transferability (Schwandt, Lincoln and Guba, 2007) or analytic generalisability (Yin, 2014). It was anticipated, and demonstrated during the data collection, that the participants told stories about their experiences. Analytic approaches using thematic analysis alone were considered (Miles and Huberman, 2002, Miles and Huberman, 1994), but it was thought that the coding process of organising the data would lead to a fragmentation of the context of the narrative, which may then change the interpretation (Mishler, 1986) to the extent that the original function of the narrative was lost (Labov and Waletzky, 1997).

In harmony with the ontological presupposition that the nature of reality was relative to, and constructed by, the person experiencing it (Lincoln and Guba, 2013, Schwandt, Lincoln and Guba, 2007), it was by narratives and stories that researchers could "*explore and understand the inner world of individuals*" (Lieblich, Tuval-Mashiach and Zilber, 1998). A

narrative analysis approach, underpinned by the concept of constructionism (Silverman, 2014) was therefore selected for this research.

4.3.2 Narrative analysis

Narratives were often seen as a form of story-telling, an art with such social and cultural familiarity that it was strongly embedded in the way people portrayed their lives and experiences to make sense of the world (Murray, 2000). Narratives played a key part in the transfer of knowledge, skills, and history (Polkinghorne, 2015). Most stories contained characters and events weaved into a story plot (Grbich, 2013), some simple and unbroken with a clear beginning, middle and end, some more complex stories that overlapped, were unfinished, contained digressions and subplots, and some that lacked in detail. The different type of story narrated did not mean that some narratives were better than others, but did prompt the analyst to question why the story-teller had chosen the information to share or withhold (Wong and Breheny, 2018).

4.3.3 Preparing for narrative analysis through research design

Narrative was a term widely used in literature and media, and increasingly, in social, psychological, education, and historical theory or research, to mean a story or account (Earthy and Cronin, 2008, Lieblich, Tuval-Mashiach and Zilber, 1998). In-depth interviews were an effective data collection tool for narratives as they gave the participants the opportunity and time to tell their stories (Bold, 2012). The design of the interview questions in this research supported the narrative approach by consciously inviting the participants to tell their stories, for example, 'can you give me any examples from your own life where you have experienced or seen compassion?'. The utilisation of multiple interviews in the research also provided several advantages in supporting the collection of narrative data. It

enhanced the trust and rapport between myself and the participants, and provided time between each interview for reflection on our own interpretation of the experience, all of which increased the likelihood of gathering rich narrative data (Earthy and Cronin, 2008).

Software tools were seen as useful adjuncts for the researcher in data analysis (Miles and Huberman, 1994). Atlas ti and Nvivo were considered to support the data analysis, with Atlas ti being chosen due to its ease of use, functionality in terms of reporting and developing networks, and the quality of tutorial support available. Using Atlas ti was an effective and efficient way to identify, categorise, and manage the data. However, it must be noted that it was only a tool to assist analysis, it did not do the data analysis. I was able to use this tool to organise the data into families that addressed the research questions, and to identify data that was frequently highlighted in the narratives, but was outwith the research questions. Once organised, I was then able to analyse the data to look for meaningful patterns.

4.3.4 Approach to narrative analysis

There was no definitive approach to narrative analysis identified in the methodology literature. However, there was recognition that narratives should be examined through different lenses, perspectives, or levels (Murray, 2000) to enhance research rigour. The analysis of narratives through different lenses, including reflexive awareness, enabled the researcher to develop layering in the analysis, and provided within-method triangulation that added texture and understanding to the participants' stories (Frost, 2009).

An awareness of rival explanations, including investigator bias and commingled explanations, was considered in the general analytic strategy (Yin, 2014). Actively searching for and overtly coding potential researcher bias using Peshkin's I's (Peshkin, 1988) helped to mitigate against any rival explanations resulting from investigator bias. A

reflective journal was kept throughout my research, which although did not formally identify any subjective I's (Peshkin, 1988) during the data collection phase, did enable a recognition and engagement with any explicit feelings of support or conflict with the data. These journal notes were made as soon as possible after each participant contact to reduce the risk of errors in interpretation or recall. Analysis of the data from a reflexive standpoint was then used to identify subjective I's, noted as an effective element of pluralistic narrative analysis in which the impact of the researcher on the interviews and interpretation could be explored (Frost, 2009, Gough and Madill, 2012). It was important for research rigour to be aware of preliminary interpretations identified in the reflexive journal and memos, as they shaped the lens through which the rest of the data was seen, posing a risk for unconscious bias if not monitored through researcher reflexivity. The use of memos and reflective journal also supported an iterative approach to the data analysis, going back to each case to look for further potential patterns.

The potential for commingled rival explanations (Yin, 2014) was also considered. As the data collection took place over a period of two and a half years, while the participants were undertaking a nursing degree with exposure to a range of placement experiences, there was potential for any perceived change in behaviour (RQ5) to be influenced by these experiences rather than the self-compassion workshops. Commingled rival explanations were specifically looked for in the data, and coded so they were clearly identified. The results of the data analysis reflected these potential sources of rival explanations.

4.3.5 Lieblich et al's four-point narrative analysis model

Lieblich et al (1998) developed a four-point narrative analysis model that provided multiple lenses through which to read, analyse, and interpret narrative data, along two continua: holistic-categorical, and content-form (Figure 6). From each of the model's four points, Lieblich et al (1998) identified three 'voices' which must be heard when listening to the data:

(1) *"the voice of the narrator",* (2) "*the theoretical framework",* and (3) "*a reflexive monitoring of the act of reading and interpretation".* (p10).   The model was chosen for this study as it provided structure to ensure a full and detailed exploration of the narratives, with flexibility to analyse the data from any point on the model, and with any 'voice', as the two continua were so integrated. The holistic aspect of the holistic-categorical continuum examined the narrative as a whole, often seen in the analysis of life stories.   The categorical aspect of this continuum extracted particular parts of the narrative. Within the content-form continuum, one aspect examined the content of the narrative, the themes that were embedded in it. The other aspect focused not on the content, but on the form of the narrative, the structure and shape of the story, mitigating against the criticism of constructionism that it could have a narrow focus on the content and pay little attention to form (Silverman, 2014).

Holistic

Uses complete narrative and focuses on the content. Looks at sections of the narrative in the context of the whole.	Looks at plots or structure of the narrative e.g. comedy or tragedy. Searching for a turning point that sheds light on the whole.

Content ——————————————————————————— **Form**

Also known as 'content analysis'. Categories and themes in the text are extracted and classified.	Focuses on discreet stylistic or linguistic characteristics e.g. use of metaphors, passive vs. active comments. These are extracted and counted.

Categorical

Figure 6: Lieblich et al's (1998) four-point model of narrative analysis

4.3.5.1 Holistic-content

The first approach addressed the holistic-content section of Lieblich et al's (1998) model, and consisted of a global analysis of key themes threading through and influencing the whole narrative. Abridged transcripts were used for this approach, with any repetition and paralinguistics such as 'yeah', 'right', and 'okay' removed from the script, making it easier to see the narrative and identify overall themes.

The narratives were exposed to continual readings in a similar way to that used by phenomenological interpretivists (Miles and Huberman, 1994) to identify and understand meanings in the text. It was important to be aware of any pre-suppositions during this stage in order for the narratives to be read with an open mind (Lieblich, Tuval-Mashiach and Zilber, 1998), and of the potential for 'falsification' discussed in Chapter 3.4 (Flyvbjerg, 2011). Particular attention was paid to the opening of the narratives as these often identified the beginnings of a theme that was then expanded on and revisited throughout the narrative. To identify themes from the holistic-content perspective, decisions were based on the emphasis of a particular story, that is, the amount of space in the narrative devoted to it, and the frequency with which the theme was revisited. Codes were used to identify the holistic themes, for the purpose of identifying space and frequency. The themes and associated codes were noted separately to the analytical findings from the other perspectives within the analysis model in order to minimise the risk of fragmentation (Labov and Waletzky, 1997, Mishler, 1986) and to support the holistic, global view of the narrative. Examples of the holistic-content coding of two transcripts can be seen in Appendices 7 and 8.

An awareness of the "*theoretical framework*" voice (Lieblich, Tuval-Mashiach and Zilber, 1998) in the analysis meant the narratives were examined for themes that answered the research questions, and how these themes were developed and constructed from

participant experience (Silverman, 2014). Initial global thoughts and impressions were noted, including any contradictions or things left unsaid. Each identified global theme was then taken in turn, and the narratives re-read to follow that theme from beginning to end. The development of the theme was considered in the context of the wider narrative, the influence of the theme on other areas of the narrative, and any contradictions, conscious or unconscious, within the narrative.

As a single lens to data analysis, the subjective interpretation and potential for researcher bias was a limitation to the holistic-content approach. However, as part of a multi-lens approach, it provided valuable interpretations that were triangulated against the findings from the model's (Lieblich, Tuval-Mashiach and Zilber, 1998) other data analysis perspectives to enhance the trustworthiness of the research.

4.3.5.2 Holistic-form

The holistic-form perspective of the model examined the structure of the narrative and the global themes identified within it, including any narrative progression or decline (Lieblich, Tuval-Mashiach and Zilber, 1998) and any overall story plot (Booker, 2004). Narrative structure in data analysis, although less focused on the content, was recognised as a way to explore and present valuable information not captured through other perspectives (Rejno, Berg and Danielson, 2014). The narrative content was used as a basis for demonstrating the direction of each holistic theme over time, allowing for comparison between thematic structures in the narrative. It was worthy of note that these thematic structures were based on my interpretation of the data, a potential limitation of the holistic-form approach if not used as part of the wider multi-lens model (Lieblich, Tuval-Mashiach and Zilber, 1998). The dynamic nature of these structural plots meant that changes within the narratives could be identified, and when multiple structural themes were overlaid, points of convergence were seen that corresponded with key turning points or significant events in the participants' story.

In accordance with Lieblich et al's (1998) recommendation, cross-case comparison was then carried out to identify the potential for the development of a prototypical story structure.

Holistic-form analysis also aimed to identify any overall story plots (Lieblich, Tuval-Mashiach and Zilber, 1998), although there was limited evidence of this being used more widely in research as a strategy for narrative structure analysis. A review of literary theory did not identify a validated tool to measure story plots. Lieblich et al (1998) identified four principle narrative types: the romance, the comedy, the tragedy, and the satire. Drawing on the discipline of literary theory, Booker (2004) identified seven basic story plots that could be applied to all stories, old or modern (Table 8). The plots could on occasion be incomplete, but all involved a central character and ended in death or joy. The paucity of validated tools to identify story plots resulted in a pragmatic decision to choose Booker's (2004) definitions based on the fact that I found the definitions clearer, easier to apply to the narratives, and they incorporated the four narrative types identified by Lieblich et al (1998). The structures of the holistic themes were examined for resonance with any of these seven story plots.

Table 8: Booker's seven basic story plots

Type of plot	Definition
Overcoming the monster	People feel threatened by an all-powerful monster. An ordinary hero gets special weapons and goes on a journey to confront the monster, resulting in a fight with inevitable defeat for the hero until the last minute when the monster is overcome and slain. The hero returns to win a prize.
Rags to riches	The hero is poor, but glimpses richer life. They are called into the wider world with some initial success, followed by a crisis. The crisis acts as a turning point in the story, from which the

	hero becomes more independent and can achieve their goal, reaching a stage of maturity – they have grown up.
The quest	A journey from an unpleasant, oppressive and intolerable place. The hero overcomes obstacles, includes thrilling escapes, and uses the help and support of others on the way, before finally reaching a life renewing and sustainable goal and living happily ever after.
Voyage and return	The central character travels out of their normal, familiar life to an abnormal, unfamiliar life. Although initially exciting and exhilarating, they become threatened and trapped, ending in a thrilling escape back to the safe and familiar world they started in.
Comedy	These plots can vary, but generally include a love interest, a dark force, and a series of increasingly complicated misunderstandings until finally there is recognition, the misunderstandings are cleared up, and everyone ends happy.
Tragedy	This begins with the hero feeling unfulfilled and then finding temptation, which they succumb to. This is initially fine, but starts to go wrong resulting in them committing more wrongs until they are out of control and there is a mounting sense of threat and despair. They want to return back to their innocent stage but can't, so the ending is one of death or destruction.
Rebirth	The hero falls under the shadow of a dark power. All is well until the threat returns and imprisons them in a state of living death for a long time. Finally comes miraculous redemption and they are liberated from their prison into the light.

4.3.5.3 Categorical-content

Categorical-content analysis, also known as content analysis, was undertaken using the system recommended by Miles and Huberman (1994), the process of data reduction, data displaying, and conclusion drawing/verification. Content analysis was a commonly used approach to qualitative data analysis with narrative materials (Lieblich, Tuval-Mashiach and Zilber, 1998), that utilised coding strategies to categorise data and draw conclusions. Although there were slightly different approaches to content analysis, for example, Yin's (2014) pattern matching, explanation building, addressing rival explanations, and using logic models; and Gearing's (2004) reflexive bracketing using abstract formulation, research praxis and reintegration, there were significant similarities across all approaches in the elements of the analysis process. Content analysis was a strategy open to criticism as it risked the fragmentation of the narrative (Labov and Waletzky, 1997) and losing sight of the sequencing of the narrative (Marvasti, 2004), which could result in the loss of the wider context, and potentially change the interpretation (Mishler, 1986). However, utilised as one of multiple analytic lenses in this study, it enabled within-narrative triangulation, and supported the inductive development of themes outwith the research questions.

Categorical-content analysis was undertaken on full, unabridged transcripts. First level coding, that is, the application of broad categories to the data, was carried out using codes based on the research questions (Table 9: definition of codes for first level coding). Peshkin's I's (Peshkin, 1988) were also coded during this phase of the analysis to raise awareness of the reflexive voice in the interview, and identify the potential for areas of conscious or unconscious researcher bias.

Table 9: Definitions of codes for first level coding

Code	Code description	Research question
MEA	Meaning of compassion: how compassion was defined.	Research question 1
DEV	Development of compassion: how the understanding of compassion had been developed	Research question 2
SCEX	Use of self-compassion exercises: experience of using the exercises taught in the self-compassion workshops.	Research question 3
APP	Applying self-compassion: experience of applying self-compassion following the workshops.	Research question 4
CHA	Perception of change: what, if any, changes were experienced through applying self-compassion.	Research question 5
RES-REF	Researcher's reflexivity: behaviours or language demonstrating conscious or unconscious bias.	Reflexivity using Peshkin's I's

During first level coding it was found that further codes were required to capture all the relevant data from developing inductive themes, therefore additional codes were defined (Table 10: additional first level codes).

Miles and Huberman (1994) suggested that this first level coding enables basic organisation and reduction of the data, allowing for further pattern coding.

Table 10: Additional first level codes

Code	Code definition
NUR	Compassion and the nurse: professional requirements and expectations of nurses, and nurse specific behaviours.
CONT-EX	External context: external contextual factors that influenced the development of compassion, and the experience of giving or receiving compassion, including barriers to compassion.
CONT-PER	Personal context: personal contextual factors that influenced one's ability to give or receive compassion, including barriers to compassion.

As the first level coding related to broad categories, the data within each code was then examined in greater detail. Each code was exploded to analyse patterns within it, then reorganised taking into account any overlaps, repetition, or comments made only by one person. Each transcript was then read again in its entirety to ensure the coding that had taken place at the beginning of the process was congruent with the final reorganised codes. Examples of the categorical content of two transcripts can be seen in Appendices 9 and 10. Data analysis software (Atlas ti) frequency reporting was then used to demonstrate 'hotspots', aspects highlighted by all, or the majority of, participants. Patterns emerging from the categorical-content analysis were then triangulated with the analytical findings from the other perspectives within Lieblich et al's (1998) model to achieve a multi-lens approach.

4.3.5.4 Categorical-form

Data analysis from a categorical-form perspective examined the language used in the narratives, for example, the use of metaphors, active or passive language, or the use of the first or third person. Lakoff and Johnson (2003) purported that human thought processes

were largely metaphorical, and therefore the human conceptual system, our making sense of the world, was metaphorically structured, defined, and reflected in our linguistic expressions. In harmony with the concept of constructionism (Silverman, 2014) and my ontological and epistemological position, language development to form our linguistic expressions was believed to come from experience and engagement with the world (Feldman, 2006), and cultural and societal influence, often acquired unconsciously (Lakoff and Johnson, 1999).

A limitation of the categorical-form data analysis was noted as I had less experience and expertise in the area of linguistics and semantics, potentially risking the unconscious omission of themes, particularly in relation to non-verbal aspects, paralinguistics, or pauses. However, by studying the language in the narratives, conceptual understandings that supported or contradicted the themes identified through other perspectives, were explored.

The narratives were examined for structural, orientational, and ontological metaphors (Lakoff and Johnson, 2003) (see Table 11), and the use of passive or active language. Data was then coded using Atlas ti to reflect the use of this language. Examples of this coding can be seen in Appendices 9 and 10.

Table 11: Definition of types of metaphor

Type of metaphor	Definition
Structural	One concept was metaphorically structured in terms of another e.g. argument was war, time was money.
Orientational	A concept was given a spacial orientation e.g. good was up, bad was down, or a non-spacial

	orientation e.g. active was valued (up) and passive was not valued (down).
Ontological	Views events, activities, emotions and ideas as things or entities e.g. the mind was a machine, experience was luggage.

Each case study was examined from all four perspectives on Lieblich et al's (1998) data analysis model, a summary of which can be seen in Appendix 12. Cross-case comparison was then undertaken to examine the potential for commonalities within the findings of each research question, in order to explore the transferability of knowledge, and areas of new knowledge.

4.4 Chapter conclusion

The research aim and questions to explore students' understanding and experience was seen in Chapter three to be congruent with case study methodology (Lincoln and Guba, 2013, Schwandt, Lincoln and Guba, 2007). The purposive approach to the identification and selection of cases (Curtis et al., 2000, Miles and Huberman, 1994) and the use of multiple in-depth interviews (Grinyer and Thomas, 2012) and workshops continued to demonstrate a congruent approach by ensuring the participants chosen were relevant and able to provide rich data with which to answer the research questions. The richness of the data captured through narratives, reflecting the ontological pre-supposition that the nature of reality is relative to the person experiencing it (Lincoln and Guba, 2013, Schwandt, Lincoln and Guba, 2007) resulted in a narrative analysis approach being used to examine the data. In the absence of a definitive approach to narrative analysis, Lieblich et al's (Lieblich, Tuval-Mashiach and Zilber, 1998) four point model was used as it provided a structure to read, analyse and interpret the narratives from multiple lenses, supporting within-method

triangulation to enhance research rigour. The results of the planned research design are

presented in Chapter five.

CHAPTER 5: FINDINGS

Utilising iterative analysis enabled interrogation of the rich data to provide responses to the research questions and highlight areas for further discussion. The following chapter begins with an explanation of the codes, and the decision making for the development, revision, and re-organisation of the codes, from the perspective of the holistic-content, categorical-content, and categorical form analysis (Lieblich, Tuval-Mashiach and Zilber, 1998). Each case was examined and analysed individually, the results of which can be seen in Appendices 11, 12 and 13. Following individual case analysis, a cross-case analysis was undertaken, from which, cross-case themes were identified and explored. Cross-case themes that provided an in-depth insight and responded to the research questions are presented in this chapter. Structured to guide the reader through each research question in turn, Chapter 5.2 considers research question one, the meaning of compassion, and the themes that provide an insight into the participants' understanding of it. Chapter 5.3 considers research question two, the development of the participants' understanding of compassion. Chapter 5.4 presents the findings relating to the context for compassion. Chapter 5.5 considers research question three, the use of self-compassion exercises, exploring the ease with which they could be incorporated into everyday life. Chapter 5.6 considers research question four, the participants' experience of applying self-compassion, and Chapter 5.7 considers research question five, the participants' perception of change following the application of self-compassion. The reporting of the findings in each section is illustrated by excerpts from the participants' narratives. Finally in this chapter, a reflexive approach to the data is considered using Peshkin's I's (Peshkin, 1988). The chapter concludes by identifying themes for critical analysis and discussion in Chapter 6.

Linked research numbers were used to maintain anonymity in study reporting. Of the seven participants, six were female and one male; four were British, two European, and one was African. Reflecting the inconsistency in the literature relating to gender and self-compassion

(discussed in Chapter 2.5.2), the limited literature related to ethnicity as an influencer of compassion and self-compassion, and to prevent identification within the sample, the gender or ethnicity will not be referred to in the results.

5.1 Codes

An inductive approach to analysis expanded the first level codes identified in Tables 9 and 10 (Chapter 4.3.5.3), resulting in the identification of 188 codes in 8 code families for the holistic-content analysis, and 345 codes in 9 code families for the categorical-content and categorical-form analysis. Re-organisation and revision of codes was undertaken based on the following:

- Merging of similar codes

- Deleting of infrequent (no more than twice in a single narrative) or redundant codes

- Linking of codes that support or counter a particular theme.

Linked transcripts from the first and second interviews were reviewed together for the holistic-content analysis, supporting the development of global themes over the period of data collection.

For the categorical-content perspective, each transcript was individually examined and coded on a line-by-line basis to identify themes. Fragmentation of the transcripts using this approach resulted in a larger number of themes being identified. Although fragmentation occurred, this supported the triangulation of data from other analytical approaches, and identified relevant themes not captured elsewhere, such as the use of self-compassion exercises in response to RQ3. The revised and re-organised codes and sub-codes for each analytical approach can be seen in Appendices 14, 15 and 16.

Categorical-form analysis also included the examination and coding of each transcript on a line-by-line basis, the findings of which demonstrated an inconsistency in the use of language when discussing the concept of compassion that reflected the ambiguity highlighted in Chapter 2.3. Each narrative was also examined for the use of metaphors, particularly those that verify or falsify the themes identified through the categorical-form, and categorical and holistic-content analysis. Appendix 17 identifies the revised and reorganised codes and sub-codes for the metaphors found, and where feasible, linked with the appropriate theme.

Holistic-form analysis was not coded, but progression was interpreted through reading and re-reading the narratives to follow global thematic progression and look for an overall story plot.

5.2 Research question one: The meaning of compassion

The following sections (5.2.1 – 5.2.9) present the themes found in the initial interviews that addressed research question one, and explored the participants' understanding of the concept of compassion at the beginning of their 3-year nursing degree. All participants agreed the meaning of compassion was the same in any context, nursing or otherwise (Appendices 12 and 13), and that receiving compassion was a calm and positive experience.

5.2.1 A language for compassion

There was uncertainty about the language used to define or describe compassion. Participants found it *"difficult to describe"* [P5], and used alternative terminology such as *"care"* or *"empathy"* [P1- P4, P5, P7], *"kindness"* [P1, P5, P6], *"respect"* [P1, P4, P5], *"love"*

[P4 - P7], feeling *"sorry"* for someone [P7], *"trust"* [P1, P5], *"valuing"* [P1, P6], *"comfort"* [P4], and *"loyalty"* [P5] to articulate their understanding of it.

The term 'care' was most commonly used to describe the meaning of compassion [P1-P5, P7]. However, there was acknowledgement that "*you can be caring without necessarily being compassionate*" [P3], or "*compassionate, but may not be caring for the person*" [P4], which demonstrated an awareness of difference between the two terms, even if the difference could not be clearly articulated.

The term kindness was used by three of the participants [P1, P5, P6] to describe compassion. Kindness, not just as an action to treat someone with kindness [P1, P5, P6], but as a recipient "*wanting to feel you are being met with kindness"* [P1].   Kindness was also described as a personality trait, that one needed to be "*a kind person to show compassion*" [P5], supporting the theme identified through holistic and categorical-content analysis that compassion was a natural trait (discussed further in Chapter 5.3.1).

Compassion was described as empathy by six of the seven participants [P1-5, P7], meaning putting yourself in another person's position [P5, P2], or walking with them, in their shoes [P2, P4, P7]. Despite the frequent use of the term empathy, participants noted a difference between compassion and empathy. Empathy was seen as an element of compassion [P2, P5], the "*thinking, processing bit*" [P1] that was "*something more passive*" [P3] than compassion. The suggestion that the difference between empathy and compassion related to passivity supported the theme found through holistic and categorical-content analysis, and categorical-form analysis that compassion is an active process, a theme discussed further in Chapters 5.2.2 and 6.1.2.

Categorical-form analysis demonstrated inconsistency of language through the use of metaphor, with compassion referred to as a "*jigsaw*" [P1, P2, P4, P5], a substance [P3-

P6], a human body [P1, P3, P5, P6], a container [P1, P3, P7], an engine [P1-P4], and an "*umbrella*" [P2].

A lack of clarity in terminology, that compassion was *"hard to put into words sometimes"* [P1], and a recognition that people "*need some words and language to it*" [P1], warrants further exploration to facilitate professional definition, discussion and debate around compassionate care. However, despite the linguistic challenges, there were key themes that underpinned participants' understanding of compassion.

A pluralistic approach to the data analysis resulted in the meaning of compassion being described as:

> An active, holistic process, requiring knowledge and understanding, connectivity, and communication. It involves actively noticing suffering, being there, giving time, and acting to ease suffering.

The following sections explore this description in greater detail.

5.2.2 Compassion is an active process

Compassion was described as an active process, a "*thing you have to deploy*" [P1], "*how you go about doing things"* [P7]. Identified in the first minute of P1's interview, "*doing as you would be done by*" reflected a common view of compassion (Neuberger, 2011), that it was epitomised by its active nature, that one was "*actively compassionate*" [P3]. Compassion as an active process underpinned descriptions of participants' experiences of compassionate and non-compassionate behaviours. However, it was worthy of note that exceptions to consciously active compassion were identified, where "*obvious dynamics*" [P1] such as "*a sick child, or you find someone fallen over in the street*" [P1], or a shared

experience such as "*a grandparent … who suffered with cancer*" [P6], or someone's "*situation in life*" [P5] caused the compassion process to occur as a reflex reaction, without active work. The contradiction here implied there were certain people or situations that automatically receive compassion, an idea linked to the concept of deservedness, discussed in Chapter 2.4.3.

P6 described compassion as being "*about the behaviours that you display ... towards people*", illustrated through the description of a wedding that had been organised and facilitated for a terminally ill new mother on an oncology ward. This act was seen as a large, out of the ordinary display of compassion in response to the deteriorating health of a patient. However, narratives more frequently demonstrated examples of active compassion through everyday ordinary experiences. These included, sitting with a child who was feeling unwell, where P1 "*just sat and stroked his hair for a little while*"; checking on vulnerable neighbours "*just to make sure they are alright*" [P5]; or following relocation, another child "*actually came over and said hello … we're gonna be in class together*" [P7], all of which resulted in some ease of suffering.

Compassion as an active process was also supported through the inverse perspective, with participants noting that in non-compassion, "*you'd avoid doing*" [P5] something, and that compassion was "*not being avoidant of the difficult things*" [P1]. A conscious decision to avoid giving compassion was more unusual, but evident when P4 found the behaviour of a patient's anxious wife difficult, noting that as a student "*I could avoid caring for him when the wife is around*". In some cases, avoidance was not overtly intentional, and could be described more accurately as passive non-engagement. For example, anxieties not directly related to a patient's cancer diagnosis "*sort of get brushed under the carpet*" [P2]. Other than P4's conscious decision to avoid giving compassion, all the other examples of non-compassionate behaviours demonstrated a level of passivity, supporting the finding that compassion was active and non-compassion was passive.

An interesting finding related to the active nature of compassion and the passive nature of non-compassion, was the return to active behaviour in episodes of cruelty. Examples of active cruelty were seen in three cases. P1 experienced episodes of cruelty from her father ranging from feeling unsafe as a young child "*because he was drunk a lot*", to acknowledging that "*he couldn't cope with emotions … and so it came across as being cruel*", to active cruelty where "*he pretended not to recognize my brother",* cruelty that was *"really quite devastating to the other person*". P6 also experienced episodes of cruelty from an alcoholic father, with behaviours that "*really hurt me from a very young age … for example he turned round when I was seven … and said that he never wanted to see us again*". The cruelty experienced by P3 was more physical when grandparents *"punished us physically … we couldn't understand why, and they would decide to punish us with – um – wooden spoons in the head, and things like that*". These findings have raised an interesting issue about the potential for active and passive stages in compassion, non-compassion and cruelty, that is further discussed in Chapter 6.1.2.

Compassion as an active process was emphasised through categorical-form analysis of all cases (Appendices 12 and 13), primarily through the use of verbs, supporting the findings of the holistic and categorical-content analyses. There were 222 examples of active language found across the narratives, 163 of which described the meaning of compassion (examples illustrated in Appendix 18), and 59 of which described the application of self-compassion (examples illustrated in Appendix 19). There should be acknowledgement that English is a verb-rich language (Feldman, 2006), but the participants' use of it to specifically describe compassion and compassion experiences demonstrated consistency and congruence between the different analytical approaches, and strengthened the theme of compassion as an active process.

5.2.3 Compassion is holistic

Categorical and holistic-content analysis identified compassion as an holistic process, that "*you're not nursing just the illness … you're nursing the individual*" [P4], and that you "*care about everything about that person, not just that person, what's wrong with them, but … their whole life*" [P2]. Compassion as holistic, including the belief that it was "*a multitude of different things*" [P2] was also found through categorical-form analysis where it was referred to as "*an umbrella*" [P2] covering a wide breadth of bio-psycho-social issues that impacted on a person, and "*a jigsaw*" [P5] that when put together formed "*the bigger picture*" [P2, P5] of issues affecting a person.

P2 compared her experience of holistic compassion with a non-compassionate approach she had witnessed in the care of a terminally ill friend (Box 1). Despite the role differences between healthcare professionals, there was a clear perception that the Macmillan nurse who considered holistic issues was the one providing compassionate care.

Holistic compassion was also seen in the care of a patient who was admitted to hospital "*knowing full well he wasn't going to keep a leg*" [P5]. Although the patient clearly had prioritised medical needs, the compassionate care described considered wider issues. In planning the hospital admission, consideration was given to the fact that "*his wife has multiple sclerosis and he was the only carer … so I tried all ends, everything to try to help the bigger picture*" [P5], demonstrating an understanding of the holistic bio-psycho-social breadth of compassion.

An awareness of context, the "*bigger picture*" [P2, P5] was recognised as relevant to an individual's response to suffering. When caring for a challenging patient, P2 noted that the patient "*might be an aggressive woman who shouts and screams at everyone, but that's not who she is, that's just an aspect of something that caused by something*", acknowledging

understanding of compassion as a bigger picture. Discovering information about the bigger

picture means "*already you've got a bigger understanding of the situation*" [P2]. A greater

understanding to inform holistic compassion led to the next element described in the

meaning of compassion, that it required knowledge and understanding.

Box 1: Story of witnessing holistic compassion

> P2: My friend had cancer, and obviously, she had lots of people going to her. She
> had Macmillan nurses, HALO nurses, all sorts of people. And, she had a Macmillan
> nurse at one point who just got it. She understood. … I'd been sitting with her when
> she'd had visits from various medical professions, and I can say that, you know, a lot
> of them cared, but I don't think a lot of them were compassionate. It felt like they
> didn't really care about the bigger picture. They were treating an illness and a
> person, but they weren't treating the things around it that were affecting her. She
> would be really anxious about her children, and that would sort get brushed under the
> carpet. The Macmillan nurse was amazing. She sort of put things in there even, you
> know, she could almost see what she was thinking. She suggested things for the
> children for the husband, and ways to talk about things, and although some of the
> other ones might have said there's some good websites and some good links, she
> wanted to explain it, and she offered to come and speak to, you know, be there with
> her as she spoke to her family or her husband. So, she could see where the
> stresses were and try and offer some way of supporting those stresses that would
> help in the overall picture.
> I've seen doctors and they're like, it's just a routine … it's like they've got a list of
> things they've gotta ask you and they don't really care, they're just doing what they've
> got to do to care. They're following rules to care.

5.2.4 Compassion requires knowledge and understanding

Holistic and categorical-content analysis in all cases identified the importance of knowledge

and understanding in compassion. Participants tried "*to appreciate and/or understand*

another person's position" [P5] or "*situation*" [P4, P5, P7], because "*to be compassionate …*

is to understand more complex information" [P2] about a person or situation. Inversely, it was noted that people could not "*be compassionate because they don't understand*" [P6].

The impact of knowledge and understanding on compassion was demonstrated in three main areas:

- Knowledge and understanding of the cause and context of suffering.

- Knowledge and understanding of strategies to ease suffering.

- Fear of the unknown, or lack of knowledge, acting as a barrier to compassion.

5.2.4.1 Knowledge and understanding of the cause and context of suffering

An understanding of the cause and context of suffering was believed to be partly obtained through professional education, for example, expecting a counsellor to have had training to "*understand the process*" [P2] of counselling. Box 1 illustrates the professional knowledge held by the Macmillan nurse meant that "*she understood*" [P2] the holistic requirements of the patient and her family. However, professional knowledge also influenced personal judgements made about the need for compassion, reflecting the literature on the concept of deservedness. Examples of these judgements included the belief that people in oncology settings "*need it a bit more*" [P6] compared with patients having elective surgical procedures who "*probably don't need much compassion*" [P6]. Decisions made about compassion based on professional knowledge suggested the knowledge enabled identification of suffering, but influenced judgements about the amount and severity of suffering, and therefore the perceived need for compassion.

Experiential knowledge formed a large part of the participants' understanding of compassion, based on both work and life experience. For example, when working for a long time with a stressed and anxious colleague, compassion included "*understanding a*

colleague's controlling behaviour" [P1]. The fact that P1 understood the context of her colleague's situation meant she did not feel personally attacked or criticised by the colleague, but could be compassionate towards her.

Knowledge and understanding of the context of suffering was also articulated through shared experience or familiarity with a person or situation, that "*if you have experienced that, then you know how they feel*" [P7]. When talking about work experience with a group of young people involved with the youth police and safety partnership, P5 described the high levels of compassion the young people had for each other "*because they didn't see themselves as different*" [P5], they all experienced hardships in life. In describing compassion, P6 explained how a friend was better able to give compassion because "*she was there through all the teenage years of my Dad … what he would do, she saw it … and so she understood*" [P6]. P6 also felt better able to give compassion to her step-son because of similar experiences in her own childhood. Interestingly P4 felt empathy related to "*understanding because you have walked through similar situations*", but it was not necessary for compassion. For compassion, "*you don't have to have walked through or seen something like that, but just wanting to be helpful and understanding*" [P4] was sufficient.

There were contradictory views expressed in relation to giving compassion to a family member. P7's understanding supported familiarity in compassion, that "*if a member of the family came into hospital … and a stranger with the same situation … you obviously feel more compassion towards the somebody who you know, because you know them*" [P7]. However, P1 believed it was easier to be compassionate in a professional context where it was part of your job and if required could be faked, but "*sometimes it's harder with family because you've got more baggage, the context is richer*" [P1].

The experience described in Box 2 demonstrates an interesting dichotomy between the level of knowledge and understanding a person has in order to give compassion, and the recipient's perception of being understood in a positive compassion experience. P1 recognised the nurse was a stranger, with limited understanding of the cause of her distress, but the compassionate gesture gave P1 the perception of being "*really understood*". It was likely that the nurse had some understanding of the father's condition, and the experience of suffering, even if unaware of the wider context. However, any knowledge gap did not appear to impact on the perception of being understood, potentially supporting the equal importance of emotional intelligence and cognitive processing.

Box 2: Story of receiving compassion

P1: Something that I always remember as a moment of being really understood in a really wordless way was in hospital, and my father was very ill. He'd had a stroke and so he wasn't very with it. He was an alcoholic, and … sitting in a room with him and just realising how ill he was. He was kind of sitting in horrible hospital pyjamas that weren't done up properly, and he was dribbling ice cream down his arm and he just looked awful. And as I was trying to talk to him I just started crying, to the point where I couldn't talk anymore and I went and left the room. I was in this strange hospital that I don't know, so I just stood in the corridor and this nurse came up to me … and gave me an absolutely huge, enormous hug and it wasn't quick hug either, it was a really slow like … and it just enabled me to take a big deep breath … and she didn't say anything to me at all apart from this really long hug … and I went back in. But it always stays with me as something that just … she didn't know what was the matter with me, she didn't have any idea – um – I guess she knew I probably wasn't a patient, so actually I'm somebody she doesn't need to spend any time with, I'm not part of her job specifically on that day, but it was just a really lovely kind of wordless gesture.

5.2.4.2 Knowledge and understanding of strategies to ease suffering

As the participants were at the beginning of a three-year nursing degree, their professional knowledge of strategies to ease suffering was limited. However, they were able to articulate the need for knowledge and understanding of the strategies to enhance compassionate care, for example, understanding whether there was "*anything I can do to make them feel better*" [P7]. Participants were able to identify strategies within their own knowledge and understanding that they had or would use to demonstrate compassion to patients, such as "*passing them things, making them comfortable, helping them with their dinner, your basics*" [P6].

Box 1 illustrated the impact of knowledge and understanding of strategies to ease suffering, when the Macmillan nurse was seen to understand the stresses experienced, and offered supportive strategies to ease those stresses. It is worthy of note here that Box 1 identified a perceived lack of compassion from doctors. Doctors had knowledge and understanding of the medical condition and strategies to ease suffering, but this did not appear to be linked to compassion. The anomaly highlighted here raised an interesting question about the type of knowledge and understanding required, and further supported the idea that cognitive knowledge alone was insufficient for compassion. Equal importance needed to be given to emotional intelligence.

5.2.4.3 Fear of the unknown, or lack of knowledge, as a barrier to compassion

The emphasis on shared experience identified in Chapter 5.2.4.1 was supported by the inverse view, that people were unable to give compassion due to lack of understanding. A lack of compassion from a mother because "*she couldn't understand what I was going*

through" [P7], or from a brother "*because he doesn't get it … he can't be compassionate towards me and my feelings*" [P6].

The unknown or lack of knowledge was believed to create fear, which was identified as a barrier to compassion, and a factor in avoidance behaviours. The unknown risk of an unsafe or unpredictable response caused compassion to "*be stifled … by fear and self-protection*" [P5], or an unknown situation resulted in people feeling "*intimidated by some patients and their culture and background*" [P4]. Fear was also caused by a perception of not being able to cope, or know what to do in a situation, for example, "*sometimes you encounter people with such huge problems that … nobody would know where to start with helping them … people are scared of … being able to sit with something without allowing it to totally overtake, but also to understand it*" [P1].

In situations where fear resulted in avoidance behaviours, it became increasingly challenging to gain or develop a sense of connectivity, the next key element described in the meaning of compassion.

5.2.5 Compassion requires connectivity

Participants believed compassion required actively making a connection with another [P1, P2, P4, P5, P7]. Without connectivity, it was deemed much harder to give or receive compassion.

The perceived benefits of connectivity were seen in short term relationships such as caring for an unwell child when "*he looked better just for some contact*" [P1], or checking on the safety and wellbeing of neighbours, acknowledging it was often a hidden act of connecting, that "*it's not so much the cake, it's just popping down*" [P5] to see an elderly neighbour. Benefits were also seen in long term relationships, for example, "*kids I've worked with for a*

long long time, and where you feel the build up in that relationship is sometimes the moments when you think you're going to … lose your temper … but actually you do something else instead … and there's a kind of bonding that goes on in that process" [P1]. P1 noted the "*buzz*" that this connectivity provided and the boost it gave "*when you harness it*", reflecting Dunn's (2009) work on compassion energy.

The active nature of connectivity was acknowledged, that one had to work at "*finding a connection even if your life is completely different to them*" [P2], or "*meet people where they're at rather than where they'd like to be*" [P1]. The amount of work required varied as "*some people you just connect with quite quickly, others need work*" [P1]. Factors that influenced connectivity included shared experience, *"our bond is stronger because of the fact that we have that common ground"* [P2], impairments to communication such as "*the person's either deaf or hasn't got words*" [P2], or one's ability to "*imagine yourself in the other person's situation*" [P7]. Personal judgement also influenced connectivity with recognition that "*it does boil down to that gut feeling you have about somebody, of whether you like them*" [P1]. The impact of personal judgements on connectivity when one did not like the other person was illustrated with an inability to give compassion to a family member because "*we've never connected*" [P4], and following a disagreement with in-laws "*there was a time I just had to … cut them off*" [P4], actively removing the connection.

5.2.6 Communication and compassion

Active communication was identified by all participants as important for compassion (Appendices 12 and 13), and the way connectivity was achieved. Even a "*small interaction makes a big difference to how you feel about that person looking after you*" [P2]. A balance of verbal and non-verbal communication was described, indicating the perceived equal importance of each.

Verbal communication, "*just naturally talking to the patient*" [P5], "*on your level*" [P2] was seen as the way to build a rapport, without which "*you can't have compassion*" [P2]. Conversation did not have to be about the cause of suffering, but "*just generally chatting about your day*" [P6] was an effective way to "*build that rapport*" [P2]. Where the conversation was about the cause and context of suffering, a shared language and avoidance of jargon demonstrated compassion, allowing someone to "*say it in your own words*" [P2]. There was recognition that not everyone wanted to talk, that some "*would like the opportunity to tell someone to bog off*" [P1], but to demonstrate compassion it was important that "*you're still engaging with them*" [P1]. Compassion was shown through reassuring words intended to calm heightened emotions, such as "*it's going to be okay*" [P6, P7]. It was also demonstrated through longer, calming conversations where "*she'd make me a cup of tea and we'd just talk*" [P3].

There was recognition that verbal communication for compassion was not always about free and open dialogue, but was through more direct conversation or instruction, that "*we all have a responsibility to challenge, but as delicately as we can and as sensitively as we can in terms of people's self-esteem*" [P1]. P4 described an experience of compassion when she was unwell at work and a colleague "*just grabbed me and she said 'sit down, you're not doing anything'*" [P4]. This direct instruction acknowledged the suffering and gave P4 permission to stop. Direct compassionate conversation was also experienced through questioning and prompting, where someone "*cared enough to ask the right questions*" [P2] and actively listened to the answers.

The importance of "*talking to people rather than over them*" [P1] was highlighted by P1 in examples of non-compassionate communication with cognitively impaired patients. Experiences where staff talked over patients with dementia, or a man with learning disabilities for whom "*the doctor would never talk to him … he would talk to us and then we*

would just repeat the question directly, and he would answer us and we would go back" [P1], which led to a sense of frustration.

Advocacy was seen by three of the participants as an active way of communicating and "*a massive part of compassion*" [P1]. In the illustration with the GP above, P1 spoke to the man's family and "*in the end moved practice on his behalf*" [P1]. Advocacy was also seen in P1's narrative when she was working with other professionals who could be "*very judgemental … and just reminding people of the context of people's everyday life*" [P1]. The benefits of advocacy and rapport were seen in the narratives as enhancing connectivity and trust, for example, where a young person wanting to escape from regular police drug raids at home caused by her father's illegal activities was able to "*come to us, but if she didn't trust us she wouldn't have done it*" [P5]. It was recognised that advocacy, particularly within a team, was not easy, and that "*it would be easy to take the view everyone else is taking*" [P1], but that it was an important part of communication to demonstrate compassion.

Illustrated in the narratives through non-verbal communication, compassion was clearly seen in the "*lovely wordless gesture*" [P1] in Box 2. Touch was referred to as compassionate by P2, P4 and P6, primarily through "*holding their hand*" [P4, P6], although it was acknowledged that for some people "*this might be too intrusive*" [P4] and should only be done "*if they want it*" [P6]. "*Facial expression*" [P4], particularly if it was relaxed and "*smiling*" [P3, P4, P6, P7] was believed to support compassionate communication, although only if it was genuine, and not nurses "*who kind of just grin at you all the time in a very blank, non-communicative … empty gesture*" [P1]. It was purported that one could judge the compassion of another by "*the body language, the mannerisms, how they come across, their tone of voice*" [P5]. Tone of voice was highlighted as a non-verbal way of demonstrating compassionate communication. Judgements were made about the level of compassion based on the tone of voice [P1, P5, P7], for example, "*sighing*" [P2] at the end

of a sentence, using a brisk abrupt tone [P3], or being "*snappy with them or short with them*" [P1] was not compassionate.

5.2.7 Actively noticing and acknowledging suffering

In the literature, noticing suffering formed the first part of most definitions of compassion. However, when describing the meaning of compassion in the narratives, there was limited reference to noticing and acknowledging suffering, highlighting an interesting omission.

P5 identified the need to notice more than any other participant. Illustrated in Box 3, in a previous role, P5 was trained to check on the wellbeing of people, a custom and practice transferred to nursing. A range of situations were recognised where compassion was better as a result of noticing cues, such as "*seeing someone has so many bags, you have to go and take at least the lightest one*" [P4]. For P1, noticing related more to her own suffering, and generally on reflection rather than noticing at the time. For example "*being able to identify the cruel bits*" [P1] of her father's behaviour, or noticing that "*the hard time she* [her mother] *gave us was only a reflection of how hard she was on herself*" [P1].

Box 3: Story of noticing potential and actual suffering

P5: It's quite strange … it sounds daft but you know the colour of people's front doors … you could go round, with other cars there, why is the car there? … Or anything. It's quite strange how you pick up wrong things … so I mean … the amount of times you, you know like, other people, particularly way out in the rural … we found one guy, he had a heart attack in his greenhouse. The car's not about so I just stuck my head round and he's laying on the floor on the ground … so I call the ambulance … but he died in hospital. But you know when things are wrong. We used to spot no end of things like that. Yeah, the milk's out, well why's the milk out?

The need to acknowledge suffering was recognised in the narratives, illustrated by the verbalisation of noticing suffering. For P4 and P5, the verbalisation was an unconscious acknowledgement. P1 explicitly identified the need to acknowledge suffering as part of compassion, stating that "*people really need to know that other people care*" [P1], and that compassion fatigue was "*where people can't acknowledge it anymore*" [P1].

The disparity between the literature and the extent to which noticing and acknowledging suffering was found in the narratives, is discussed further in Chapter 6.1.3.

5.2.8 Being there and giving time

Six out of seven participants explicitly stated the importance of being there as an essential part of compassion [P1-P2, P4-P7], either with positive statements that compassion was "*being there*" [P2, P6], or inversely with examples of non-compassion through avoidance (as described in Chapter 5.2.2).

"*Really being able to be there for someone*" [P2] was illustrated through stories of compassion towards family, friends, and patients. P4 described the events following her Grandmother's stroke when "*we were there for her twenty-four seven*" [P4]. P5 believed their positive compassionate parental relationship was in part because "*they've always been there for me, and no matter what, they'll always be there for me*" [P5]. There was acknowledgement that people may not want others to be there in person, physically in the same space, but a sense of compassion was still felt from knowing "*they're there if I need them*" [P6]. Inversely, examples of not being there were seen as non-compassionate, such as "*professionals find ways of avoiding dealing with the things they don't like dealing with*" [P1], or "*leaving you sat in a little room for three hours because nobody wants to come and tell you something really horrible's happened*" [P1]. Avoidance was not always intentional,

but the result of being distracted [P2, P6], not being present "*because they're so focused on doing something else*" [P6].

Closely linked to 'being there' was the concept of giving time, for example, providing time for people to "*have the opportunity to talk*" [P1] in a way that they could be "*open with me*" [P5] without feeling pressured. P2, P3, and P6 described the importance of time in both giving and receiving compassion. P2 and P3 described experiences of receiving compassion where the time taken had made a difference to their experience because "*people took the time to talk to me*" [P3], or a counsellor "*waited until I was ready*" [P2] then "*allowed me to speak*" [P2]. P6 described the importance of giving oncology patients, "*the time that they need*" [P6] in order to demonstrate compassion. Concerns were raised, however, about the time pressures experienced by nurses acting as a barrier to compassion when there was "*so much to do and so little time to do it*" [P6], that nurses "*just haven't got time*" [P2, P5]. It was felt that this negatively impacted on their ability to be there for patients, and demonstrate compassion.

5.2.9 Acting to ease suffering

The final element in the participants' description of the meaning of compassion was the action to help or ease suffering to the best of their ability. Related to the knowledge and understanding of strategies to ease suffering presented in Chapter 5.2.4.2, examples of actions to ease suffering of patients included "*making them comfortable in their last days*" [P6], or helping with personal care [P5]. The concept of helping was also evident in compassionate behaviours outside the nursing environment, with participants helping a son "*with his homework*" [P6], "*helping someone pick something up off the floor*" [P4], or "*trying to teach*" [P7] family members English. Important within the nursing profession was the recognition that one may not know how to help, so would need to "*direct the person*" [P4] to help or "*facilitate the caring to come in*" [P4].

5.3 Research question two: Developing an understanding of compassion

The following sections present the cross-case themes that provided an insight into the participants' development of their understanding of compassion, addressing research question two. Development began with the initial belief of six participants [P1-P3, P5-P7] that compassion was a natural trait that one was born with. Consideration was then given to whether and how compassion could be learned. The influence of family was strongly evident in all narratives, through positive and negative compassion relationships, with participants' life and work experience also playing a key role in development.

5.3.1 Compassion is a natural trait

Six participants suggested compassion was a natural trait at the beginning of the research [P1-P3, P5-P7], a belief most strongly held by P5. Holistic and categorical-content analysis consistently demonstrated P5's belief throughout the narratives, referring to it on 45 occasions. P2 also expressed certainty about this view in the initial interview. They believed strongly that "*compassion is something that you have naturally*" [P2], that "*you've got it or you haven't*" [P2], "*it's in-built … something you started life with*" [P5]. A categorical-form analysis of P5's narratives also identified the use of supporting language, for example, "*it brought out his natural compassion*", "*be naturally a compassionate person*"; compassion "*was an automatic response*"; and "*it was subconscious*". For the other participants, compassion as a natural trait was expressed as compassion within their personality, "*the sort of person you are ... it's what you do*" [P6]. P1 was the only participant to contradict this view, stating that "*I don't think it's something that necessarily comes naturally*" [P1] but was something that needed to be worked at.

Interestingly, with regard to development of the understanding of compassion, the self-compassion workshops led to a change of opinion for P2. At the final interview, P2 stated

that "*now I believe that if you've got a caring base … a caring nature … then compassion is something that you can develop*" [P2], suggesting that compassion could be learned, but a natural trait of care was still required.

Categorical-content analysis also identified participants who believed that natural "*compassion is always in the person*" [P5], but that a trigger may be needed for it to be "*switched on*" [P2]. The trigger may be the witnessing or experiencing of suffering, resulting in compassion being "*naturally switched on to go deeper*" [P5], or "*you get a certain amount of knowledge and it switches on*" [P2]. P5 believed compassion could not be switched off, but there was recognition that "*people can lose their ability to be compassionate*" [P2]. The suggestion that compassion could be switched on, or lost, supported the potential for compassion to be learned.

5.3.2 Learning compassion

Uncertainty was expressed about learning or teaching compassion, that "*I don't think you can learn compassion*" [P2], "*I don't know if could be taught*" [P5]. The narratives suggested though, that this related to formal teaching of compassion rather than experiential development of compassion as "*a learning process*" [P4]. There were multiple examples of learning through reflection, and a recognition that "*where you experienced compassion … is where you learnt how to be compassionate*" [P7]. Examples ranged from informal reflection where compassionate people were deemed to be "*reflective of what they've done in the past*" [P5], to positive reinforcement of compassionate behaviours [P4], to formal counselling where "*reflecting on yourself … is crucial to having developed that compassion*" [P2].

Insight provided from reflection was key to the development of understanding. Reflecting on the experience of working with children in therapeutic communities was a turning point in the development of P1's understanding of compassion, when she had "*this horrible moment …*

of insight in my make-up and what makes me tick … that was a real eye-opener for me, and is something I go back to" [P1].

Experiential learning to develop understanding of compassion focused around two key areas: the family, and compassion experience. Progression of the development of understanding, viewed through the holistic-form analysis, was similar for all participants. There were different starting points and trajectories at different stages of their lives, but overall there was a clear positive progression in their understanding, that is, they had learned about the concept of compassion and developed their understanding.

5.3.3 Development of understanding influenced by family

Analysis from holistic-content, holistic-form, and categorical-content perspectives found the family had the strongest influence on the development of participants' understanding of compassion.

Three participants reported positive and supportive compassion relationships with their families [P4, P5, P7], particularly with parents. There was confidence that parents would compassionately 'be there' and 'give time' (described in Chapter 5.2.8), role modelling compassionate behaviours, and providing opportunities to develop skills for themselves by "*putting us in situations where we can show compassion*" [P4]. The "*good role model*" [P5] provided by parents "*supported stability from the compassion side*" [P5], which was later reinforced by a compassionate spouse or partner. Whilst primarily the positive compassion was received from parents, there were examples involving the wider family group, where participants had "*very caring grandparents*" [P7], or a busy household where "*we had to show compassion because we could see them showing compassion to each other*" [P4]

For the other four participants [P1-P3, P6], the experiences of compassion shown by families was mixed, with experience of non-compassionate behaviours or cruelty. As a result of experiences with her father, P1 was able to recognise how her understanding of compassion and compassionate behaviours were "*informed by experiences of him being quite cruel*" [P1]. Although not aware as a young child, the older she got the more she could see this was not "*normal*" [P1] parenting, an experience reflected in P2's narrative about her "*alcoholic*" [P2] mother. Alcoholism had influenced family breakdown for three participants, and resulted in the witnessing of non-compassionate behaviours or cruelty. Two participants expressed compassion towards their alcoholic parent, "*not judging her because she's an alcoholic*" [P2], but being able to understand the reasons behind it [P1]. The third participant no longer spoke to her father, but demonstrated the development of her understanding through comparison, and "*see how amazing my husband is as a Dad compared to ... the experiences I've had with my Dad and his lack of compassion for things*" [P6].

An inter-generational pattern of behaviours within families also influenced the development of understanding compassion, resulting in a desire to break the pattern, for example "*you can see real patterns of behaviour ... between my Mum and my Grandma, and going back to my Great-Grandma, you can see the reactions ... I don't want to be like that, and I'm never beating my daughter*" [P1]. P3 also described her parents as "*an evolution from my grandparents*", because although "*they never showed any compassion towards me*", this was perceived as an improvement from her grandparents who were actively cruel and described as "*even worse, much, much worse*" [P3].

For those participants who had experienced non-compassionate behaviours within their family, being exposed to compassion through meeting their partners or spouses was seen through holistic-form analysis as a turning point. It was "*instrumental*" [P2] in their

development and understanding of compassion (See Box 4), providing a feeling of being "*really settled … like it's my earthing*" [P1].

Box 4: Example story of a turning point in the development of understanding compassion

> Meeting my husband was the biggest trigger. He asked the right questions, you know, whereas other people just go 'oh there's something wrong with her' …he wanted to know … and he didn't, you know, when he did find out he didn't judge, so you know he wanted … he cared enough to ask the right questions and to not judge me when he got the answers … and to still ask more questions … and stay there. … He sort of opened my eyes to, you know, people aren't always judging you … so it kind of contradicted everything I thought I knew … and so I think he was instrumental really.

5.3.4 Development of understanding influenced by experience

After the family, experiential learning from work and life most influenced the development of participants' understanding of compassion. P6 described the compassion she had seen on the oncology ward that had a profound effect on her understanding, recognising "*the amount of compassion there, it's brilliant, and I think I learnt more there … than I could have done anywhere*" [P6]. P1, P2 and P5 gained experience and understanding of compassion through their work with children and young people. Witnessing and experiencing positive outcomes from compassionate care reinforced the development of compassion through reciprocity, that "*as much as you've found something peaceful, I've got something from knowing that I'm trusted*" [P1].

There was a belief expressed that the public expected compassion because "*you're a nurse, it's your job, this is what we pay you for, to be compassionate*" [P7]. Development of understanding occurred through experiences that challenged this naïve belief, for example, a paediatrician examining a new baby who when "*he started crying, she went 'oh stop making a fuss' … and I was like 'you're a children's doctor, my God what's wrong with you?'*"

[P1]. The poor communication described in Chapter 5.2.6, resulted in a change of opinion and recognition that some nurses "*just give the care*" [P4] but "*I don't think a lot of them were compassionate*" [P2]. Development of understanding through challenge was not restricted to healthcare experience. P3's scout group held "*the premise that you must be compassionate towards others, and that really was the first time … I felt challenged*" [P3], a challenge that encouraged reflection on her own judgements and behaviours, and altered her understanding of compassion.

As described in Boxes 1 and 2, experiences of witnessing and receiving compassion in healthcare influenced participants' understanding and recognition of it. Again, development was not restricted to experience in a healthcare setting. Compassion received from a family friend provided respite from "*a really hard childhood*" [P3]. Reflecting the findings presented in Chapter 5.2.2, experience of non-compassionate behaviours and active cruelty also influenced the participants understanding of compassion, and enabled them to identify what compassion was not.   It was these different life experiences that helped understand "*what your values and beliefs are, that shape how compassionate you are*" [P6].

To summarise the findings that provided an insight into research question two, it was apparent that participants had developed their understanding of compassion through reflection on experience. The experiences had been of witnessing and receiving compassionate, non-compassionate, and cruel behaviours, primarily within the family, but also from healthcare professionals, teachers, friends, and other members of the public within their care.

5.4 A context for compassion

Holistic and categorical-content analysis of the narratives found contextual themes that influenced participants' understanding and development of compassion, and the application of self-compassion. Context was most strongly influenced by personal judgements, the judgement of others, and personal, social, and cultural expectations. Categorical-content analysis further identified personal factors, and the environment as contextual issues that affected the participants' ability to be compassionate.

5.4.1 Personal judgements influence the context for compassion

P1, P2, P3 and P5 explicitly emphasised the non-judgemental nature of compassion, with P7 indirectly supporting it by identifying judgements made as "*horrible*", and "*it's really bad*" [P7]. Despite this understanding and the recognition that making judgements was "*quite dangerous*" [P2], judgements were made throughout the narratives. The majority of judgements (110) were made about others, with a smaller number (53) directed towards the self. Judgements about others compared the behaviour of the other with the participant's values, beliefs, stereotypes, and expectations.

5.4.1.1 Judgements about other people

Judgements were made about population sectors, for example, that talking to older ladies about children was a good way to develop communication, connectivity and compassion [P6]. Some sectors were judged to automatically trigger compassion, for example, sick children [P1], or people "*with a terminal illness*" [P2]. Highlighting judgemental subjectivity, contrary judgements were made about similar groups typically not receiving compassion

such as "*older people … with dementia*" [P1], older people trying to learn new things [P7], or "*we don't show an awful lot of compassion to children in society*" [P1].

Judgements were also made about individuals, for example, someone was "*racist*" [P1, P3], someone "*could be a 50-year old junkie from the streets, you know, who just ruined his life because that was his life choice*" [P7], or an anxious wife perceived as an "*obstacle*" [P4]. These individual judgements had a negative impact on compassion, often leading to cruel behaviours [P1, P3] or conscious avoidance of a person [P4]. Individual judgements made when behaviour did not meet expectation, tended to be expressed through frustration or non-compassionate behaviour, particularly for P4 and P7 who had a strong sense of right and wrong. For example, a patient trying to book a GP appointment about which P7 thought "*are you seriously wasting those 10 minutes of doctor's time when somebody else could've been seen with actually genuine problem that needed medication*" [P7].

Judgements influencing compassion were also based on "*that gut feeling you have about somebody, of whether you like them*" [P1], because compassion was easier to give in situations when "*you like them*" [P7]. The inverse of this was demonstrated when it was perceived to be more difficult to feel compassion for people you did not like. For example, it was said of a family member that "*I didn't just like her … I don't know if that is lack of compassion …I didn't even feel anything when she passed away recently*" [P4]. There was an awareness from a nursing perspective that people should be treated equally, but in reality, "*obviously, you have your, probably your favourite patients, or your favourite people*" [P7] and treated them with more compassion.

P2 and P3 were the only participants who noted a specific turning point in their judgemental behaviour when they were exposed to other ways of thinking, for P2 meeting her husband, for P3 joining the scouts. For other participants, holistic-form analysis demonstrated a more gradual progression in their development and challenge of judgements and expectations.

P4 and P7 did not demonstrate progression, but appeared to remain static in their approach to judgements. P7 was the most judgemental, and although able to recognise the judgements were negative and impacted on compassion behaviour, she was unable to demonstrate any change.

Discussed further in Chapter 6.2.3, this raised questions about the role of nurse educators in increasing awareness of, and challenging judgements to develop compassion.

5.4.1.2 Judgements about the self

Although less frequent, self-judgement was also evident. Judgements related to areas of work that participants felt could be improved, for example, when advocating, "*I often feel like I should be able to defend something more than I do*" [P1]. Social comparison also formed the basis for self-judgement, for example, "*I never have more than five friends at any one time which is quite odd*" [P1] compared with others whom she believed had more, or "*I have an academic barrier*" [P2] compared with her perception of other students. There was an acknowledgement that "*preconceived ideas*" [P6] formed inaccurate expectations. However, self-judgements occurred when participants did not meet, or were fearful of not meeting their own expectations. For example, when discussing the desire for success on the degree course P2 emphasised that "*there's all this pressure when it comes to the doing it and passing it … what if I don't … which is when the self-doubt creeps in*" [P2]. Reflecting judgements made of others, P7 also made the most self-judgements, and although aware that "*I am very self-critical*" [P7], continued to make negative self-judgements, such as "*I don't think I'm compassionate enough for them*", "*just ignore me, I think I was just being over-dramatic*", and "*I was acting like a blooming fool*" [P7].

5.4.2 External judgements influence the context for compassion

The perceived judgements of others were based on comparison with social, cultural and individual expectations. Categorical-content analysis identified some recognition of mindfulness, an understanding that "*people aren't always judging you*" [P2]. However, the majority of illustrations related to external judgements reflected the feeling that "*automatically as a human being*" [P2] one felt judged.

Judgements based on national stereotypes were perceived as a barrier to self-compassion, that it was difficult to identify one's strengths and qualities "*'cause we're British*" [P5], and "*that's a bit of an American thing, being kind to yourself*" [P1]. P4 identified national cultures such as "*in West Africa*" and "*some Eastern Europeans too*" [P4], where self-compassion "*is a weakness*" [P4]. Interestingly, although P2 referred to a cultural stereotype that Americans access more therapy to develop self-compassion, this was not seen as derogatory, but that "*Americans have got a point, everyone should*" [P2].

Expectations of a family unit, an imagined ideal, were also perceived as a measurement against which participants were judged. From an early age, P1 was able to recognise her father's behaviour was different to other families, which was "*quite disturbing as a kid … because that doesn't fit with the kind of world view you're taught*" [P1]. P3 experienced dissonance between expectations and reality when her parents "*were unable to show us compassion … because it's just strange you not showing compassion to your kids*" [P3]. Social and cultural expectations within the family created a sense of duty, seen through P4's decision to "*leave my home then and come and live with my Mum*" [P4] to help care for her grandmother. However, the same sense of duty caused anguish for P1 when she made the decision not to allow her father to live with her. The implication in the narrative was that P4 had followed social and cultural expectations and was perceived as compassionate, but P1 was not and felt the need to justify her decision based on her own survival.

Judgements, or fear of judgements made by others, was the final area of external judgement that influenced the participants' perception of receiving compassion, or their ability to be self-compassionate. Perception of judgements was again based on social comparison, but against a perceived perfect image, for example, "*automatically feeling judged before you've even walked into the dentist's surgery*" [P2], or "*my huge fear always has been … for people in the University to find out that I was bipolar … and they will judge me to the end of the earth*" [P3].

5.4.3 Judgements influenced by the behaviour and situation of others

The behaviour of other people was seen through categorical-content analysis to influence the compassion response. P1 and P2 both described experiences (identified in Chapters 5.2.6 and 5.2.3 respectively) where the person had been perceived as difficult, and noted the judgements made by other staff resulted in non-compassionate responses and behaviours. For P3, the link between behaviour and compassion was more explicit, noting hypothetically "*that moment that you snap at me, that you make a rude comment to me … I'm not able to be compassionate towards you*" [P3]. P4 was the only participant who was non-compassionate in response to the behaviour of others, that "*being compassionate towards her was … difficult … because we know she knows what she's doing … I try to avoid every possible way of doing any care when she's around with him*" [P4]. The link between behaviour and judgements was also described from a positive perspective, for example, when a lady receiving palliative care "*was more compassionate to us, and telling us not to worry*" [P4], a greater level of compassion was reciprocated.

Linked to the concept of deservedness, the situation or health of the other person was seen to influence compassion, with increased severity resulting in increased compassion. Described in Chapter 5.2.4.1, the severity of someone's health, such as terminal illness or

loss of limb, triggered a greater level of compassion than those in need of elective or routine procedures. The link between severity and compassion was also illustrated through judgements of personal situations. A sense of despair and acknowledgement of suffering when her family experienced financial hardship and her father's employer "*would give him a crate of mushrooms as payment*" [P7], triggered compassion from the wider family and community to act to ease suffering. P5 expressed a "*deeper compassion*" response for those whose "*situation in life*" was more difficult, noting that "*we used to give them a lot of compassion because of their situation*" [P5], a judgement based on comparison with one's own situation, that "*obviously …, their situation in life, it wasn't going to be the same as somebody like me*" [P5].

5.4.4 Compassion is influenced by personal factors

Categorical-content analysis identified a range of personal factors that influenced the participants' understanding and experience of compassion. These factors included the personality, health and mood of the participant on any given day. Equally subjective, fear was also identified as a personal factor, acting as a barrier to compassion.

5.4.4.1 The influence of personality, health and mood on compassion

All participants expressed an understanding of the type of person they were. For some this was positive and optimistic, for example, "*I generally get on well with people*" [P5], "*I'm a nice kind caring person*" [P5], or being "*more of a glass half full kind of person*" [P1], which enhanced connectivity and the application of self-compassion, and prevented a feeling of being overwhelmed. P6 and P7 described themselves as much more self-critical, being "*quite hard on myself … I never really sit back and think yeah I've done that all right*" [P6], or that "*criticism … it's in my blood*" [P7]. The dissonance between professional expectation to

be compassionate to others, and high levels of self-criticism made the application of self-compassion more challenging for these participants.

Health and mood was an influencing factor on one's ability to be compassionate, that "*on any given day you might not be firing on all cylinders*" [P1]. There were a range of reasons expressed for this, including tiredness, "*I've had days like that with, you know, no sleep*" [P1], or in situations where "*I was really, really embarrassed*" [P7]. Long-term medical conditions such as bipolar, hypertension, visual impairment, and anxiety and depression also impacted on participants' ability to be compassionate, especially self-compassionate. Participants recognised that health and mood could be beyond their control, but in order to prevent non-compassionate behaviours to others and themselves, "*you have to be really aware of it*" [P1].

5.4.4.2 The impact of fear on compassion

Fear was reported as a barrier to compassion and self-compassion. For some this was a fear of the unknown as described in Chapter 5.2.4.3. P5 suggested that a "*natural protection system*" [P5] generated through fear was responsible for the avoidance of compassionate acts to others. Avoidance may have been caused by a fear of intervening due to exposing oneself to attack or false accusation, a fear of challenging someone senior at work, or whistleblowing because "*if you speak out you could lose your job … you could be sidelined … you could be picked on, you could be bullied, you could be pushed out*" [P5].

Fear as a barrier to self-compassion was seen through illustrations of self-criticism, a "*fear factor*" [P2] of not being perceived as good [P1]. Even when practising self-compassion, there was a fear that they might not have been doing it properly [P6], or of feeling "*stupid*" [P7] if someone saw or found out about the participant being self-compassionate.

5.4.5 Compassion is influenced by the environment

Although less emphasis was given to the environment, it did have an impact on compassion. Hospitals and care settings were thought to emphasise or increase suffering because "*when you're in hospital in an alien environment, it's not a natural place*" [P2]. The environment also acted as a prompt for suffering, such as a palliative care speciality [P6], hospice [P2], or through other cues such as "*horrible hospital pyjamas*" [P1]. There was recognition that "*some environments are going to be better than others*" [P2], but this was strongly influenced by "*a good team*" [P6] working effectively together. The influence of a team raised an interesting question about the role of leadership and teamwork to generate a compassionate culture.

5.5 Research question three: Using self-compassion exercises in everyday practice

Self-compassion exercises were categorised during the reorganisation of categorical-content analysis coding as meditation and non-meditation exercises. Responses to the exercises differed between categories, with participants generally finding meditation exercises more challenging and difficult to apply.

5.5.1 Experience of using non-meditation self-compassion exercises

The most frequently used non-meditation exercise was the visualisation of a pause or stop button [P1, P2, P4, P5, P6]. "*Actually having a visualisation*" [P1] and "*being able to push that button and say … stop*" [P2] was an effective way to notice one's own suffering and give oneself time to ease that suffering, to "*take a few deep breaths*" [P5], and "*rearrange things in my mind*" [P5]. The frequency of use indicated the ease with which the exercise was incorporated into everyday practice. It was noted as the exercise "*that I've really used*" [P4], and that "*I think I'll always use*" [P2]. The pause button exercise was incorporated so

effectively within everyday practice that it became embedded, that "*I almost use it without thinking about it now*" [P2]. Interestingly it was embedded to the extent that "*because you've used the stop button, you don't need to use it as much. You start to realise when things are getting overloaded so you're able to manage it better before you need to get to the stop button*" [P5]. Other participants did not speak negatively about the pause button exercise, but noted "*it's not something that I use so frequently*" [P3].

Compassionate touch exercises were reported as useful [P3, P6], but something "*that you would do anyway*" [P6]. P1 and P2 had not previously used or been aware of compassionate self-touch, and had found it a positive experience, one that "*really helps*" [P1]. P2 reported using the exercise "*continuously*" [P2], describing how "*the physical act of doing it makes you … sort of take that moment … consider myself a bit more*" [P2]. For P7, the experience of compassionate touch was more difficult. Learning the exercise in the workshop was described as "*fine because we were in the group*" [P7]. However, outside the workshop it was only attempted a "*couple of times*" because "*I'd feel a bit awkward doing that*" [P7]. P5 was the only participant who described compassionate touch as something "*that doesn't*" [P5] work.

The exercise of 'seeing yourself as you are' aimed to enhance participants' awareness of common humanity. The only participant who explicitly referred to this exercise was P1 who reported that "*I apply that a lot*" [P1].

The final non-meditative self-compassion exercise related to the identification of positives in challenging situations, and identifying one's own strengths and qualities. P1 was the only participant who reported looking for positives, noting that "*I've definitely used that a lot*" [P1]. Identifying strengths and qualities was found to be more difficult because participants could "*certainly list a lot of weaknesses … but strengths – um – probably not so many*" [P7], and that "*it was more easy to say what you were bad at than what you were good at*" [P5].

5.5.2 Experience of using meditation self-compassion exercises

Meditations practiced in the workshops were all guided by the facilitator, with the intention that participants could then practice them independently. With the exception of P5, participants reported guided meditations in the workshops as a positive experience. P5 found meditation difficult because "*I can't sit there for five minutes with my eyes closed … 'cause I'd fall asleep, or get a bit bored and think 'is this working?'*" [P5].

The 'compassionate friend' meditation was enjoyed and used by P1 and P6, described as being "*really nice … I kind of keep that one as part of the tool kit*" [P1]. P6 tried the 'compassionate friend' meditation at home, and whilst it did have a relaxing effect, she "*found it quite hard because I couldn't remember everything … so I didn't feel like I was doing it properly*" [P6]. A guided meditation would have been easier for her to use.

Although meditation was reported as a positive experience, it was seen as more difficult than non-meditation exercises due to the emotional impact (See Box 5). P2 compared her experience of the compassionate friend meditation with "*picking a scab*" [P2], and recommended a caution for future participants, saying "*if they're gonna do … deeper … meditations, if you've got any emotions, make it clear because, you know, that could be quite shocking and – um – upsetting for some people*" [P2].

The self-compassion workshops provided the participants with a range of exercises for their "*tool kit*" [P1] that they were able to practice and apply to their everyday lives, and for some participants, self-compassion became embedded in their practice. The workshops provided the participants with "*some really useful skills*" [P2], "*as long as you remind yourself you've got them*" [P1]. The meditation exercises were more difficult either because the participant

struggled to engage with it, or because the exercises triggered an emotional response.

There was a desire for meditation exercises from some participants, although the caution

expressed by P2, and the preference for guided meditation, may suggest the need to

develop resources that are separate to, or an optional adjunct to, the workshops.

Box 5: Example of the emotional impact of the loving kindness meditation on one of the participants

> I had a really hard childhood … and you feel guilty for the experience you had as a child, although you were just a child, you couldn't really have done anything. So the experience for me now of going back in time, and embracing my inner child, no, my past child, was basically a moment of reconciliation, or saying 'it's alright, it's alright', you know. There was suffering, there was a lot of things, but 'it's okay, it's not your fault' … and there was so powerful, I never felt anything like it, anything like it before. It was so extraordinary, so extraordinary. Well, you saw it, it broke me to tiny million pieces, I just can't even … and that's the power of it … it was fantastic and – um – I've changed completely because of that … and I do it, that's one of the exercises that I do more frequently.

5.6 Research question four: Application of self-compassion

Application of self-compassion was reported to be a positive or helpful experience by all

participants (Appendices 12 and 13), defined as "*useful*" [P1, P2, P6], "*helpful*" [P1, P2, P5],

"*fantastic*" [P3], "*nice*" [P7], and "*makes you feel better*" [P4]. The degree to which

participants found it helpful and positive varied, from minimal impact [P5, P7] to an

"*extraordinary*" [P3] impact that was life changing. No participants reported a negative

impact. However, it was not always an easy experience. P7 found it uncomfortable and

"*difficult to apply into my day to day life*" [P7]. There was some recognition that self-criticism

was habitual [P5], so conscious effort was initially required before exercises became

embedded in everyday practice. The concept of compassion as an active process,

described in Chapter 5.2.2, applied equally to self-compassion. Emotional backdraft was a recognised risk of applying self-compassion, and whilst most participants did not experience this, it proved a challenge for P2 and P3 when undertaking meditation exercises.

5.6.1 Outcomes resulting from application of self-compassion

Participants reported a range of outcomes resulting from the application of self-compassion. P1, P5 and P6 referred to the potential for other variables to have influenced the outcomes as they progressed through a nursing degree, but acknowledged the difference in outlook and behaviours since applying self-compassion. The identified outcomes were:

5.6.1.1 Becoming more accepting

Acceptance was a significant outcome for P3 who had struggled for many years with her bipolar diagnosis. The application of self-compassion enabled her to accept her condition, that "*it's actually quite alright … it's okay being different*" [P3]. Having hidden her diagnosis in fear of judgement, she had now been able to talk about her lived experience in class. P2 and P5 accepted they had weaknesses and limitations, particularly in the earlier stages of their degree, but no longer felt the "*need to explain*" [P2], or be self-critical about them. The acknowledgement that "*everybody gets things wrong*" [P5], enabled them to calmly learn from errors or new experiences.

5.6.1.2 Increased compassion towards others

"*Learning how to be compassionate to yourself is going to improve your compassion towards other people*" [P2]. Participants reported this as a change to their previous practice, that "*I'm a lot more patient that I used to be … I've got more time for people*" [P6]. For P1-

P6, increased compassion to others was illustrated in accounts of their care experience, particularly in stressful or challenging situations.

5.6.1.3 Maturity

P4 and P6 felt a sense of maturity following the application of self-compassion. Although difficult to articulate, they felt "*more grown up … more mature*" [P6], "*matured really in my thinking*" [P4]. Illustrations to support this sense of maturity related to calmer and more carefully considered responses to others, compared with their previous judgemental reactions.

5.6.1.4 Increased retention

Application of self-compassion was key to the retention of P2 on the nursing degree course when she was unhappy and frustrated by her experience in a care home. She felt she "*would just literally have probably just burnt out of the stress and gone off sick*" [P2] without having self-compassion tools. Although only found in one participant, in a stressful profession where students are exposed to new and challenging experiences, the development of self-compassion exercises could have benefits for retention on the course and within the nursing profession, a finding that warrants further investigation in future research.

5.6.1.5 Improved mindfulness

Recognising emotions, and being able to look at situations differently were themes from the holistic and categorical-content analyses that reflected improved mindfulness. Applying self-compassion when caring for a dying patient enabled P2 to identify and separate the different

emotions she was feeling. She was able to "*process each emotion and find the positive, and then move on from it*" [P2] in a timely way, rather than over-identifying or ruminating on one emotion such as "*feeling guilty*" [P2].

P5 and P6 noted that self-compassion resulted in looking "*at things differently*" [P6] to "*get everything into context … in the right perspective*" [P5]. The impact of this altered perspective was positive, that "*I don't find myself writing stories … in my head … overreacting too much*" [P6], or "*elaborating on something that's bad*" [P5]. A more balanced perspective enabled both participants to return to placement feeling calmer, and go on to achieve successful outcomes.

5.6.2 Dissemination of self-compassion skills

Following their experience of applying self-compassion, six participants stated they would recommend it to others, within the nursing course, and in the wider public domain. As identified in Chapter 5.5.2, meditation exercises were more difficult and it was suggested that these were undertaken with caution [P2] or "*an optional workshop*" [P5]. However, they felt that everyone should have "*the stop button*" [P2, P5].

Five participants reported actively teaching or role modelling self-compassion to others. P1 and P4 described occasions when they consciously role modelled self-compassion to their children, with the intention of developing understanding to give them "*some words and some language*" [P1] to be self-compassionate. The enthusiasm with which P3 shared her experience "*ended up having this huge repercussion of … me telling people, people applying it*" [P3]. It was interesting to note the extent of dissemination across participants. Despite the variation in the personal experiences of applying self-compassion, and that some found it difficult to apply, participants believed it should be taught to others.

5.7 Research question five: Perception of behaviour change following self-compassion workshops

Holistic-form, holistic-content, and categorical-content analyses identified perceived changes in behaviour following the application of self-compassion. The changes were categorised and are presented in four themes: the perception of calm, self-kindness, common humanity, and mindfulness.

The extent of change varied between participants, ranging from a perception that "*I don't think much has changed*" [P7] to "*it was fantastic … I've changed completely*" [P3]. Other participants recognised change in some areas, such as in the workplace or home [P1, P2, P4, P5, P6], but less so in other areas, such as the classroom [P2, P4]. The application and development of self-compassion was, however, noted to be a continuing process [P1, P2, P4, P6, P7], a "*work in progress*" [P1, P4].

5.7.1 Perception of calm

Six participants described feeling calmer following the application of self-compassion [P1-P6], which resulted in changed behaviour, an example of which is illustrated in Box 6. Similar perceived changes in behaviour to calm reactions were widely illustrated with participants noting "*this kind of calmer, less stressed person has blossomed*" [P3], and "*it stops the panic … the anxiousness*" [P5].

The sense of calm was seen as relaxing by P3, P5 and P6, and "*because you're more relaxed … it's easier to do things*" [P5], one felt less frustrated [P5, P6], and it was "*self-soothing*" [P3]. The impact of this meant participants were better able to maximise learning opportunities, and develop knowledge and skills more efficiently and effectively. There was

acknowledgement that participants still experienced stresses, "*but I'm better at moving on from them quite quickly*" [P1], and "*the urge to be controlling and a perfectionist seems to have subsided*" [P3].

Box 6: Participant illustration of change to a calmer reaction

P2 described an incident on an aeroplane "with the people behind me … they had a go at my son for slamming his chair back and knocking their champagne … and normally I'd have gone (roar) … and I just thought oh, you know what, they've obviously had it tough … none of their conversation was actually cheery when you listened to the undertone … actually the underlying was, you've been through a really horrible time, and it's kind of shaped you into this person who maybe isn't very kind at the moment.

5.7.2 Perceived changes relating to self-kindness

The most common change related to self-kindness was a reduction in self-criticism [P1, P3, P5, P6], that participants were "*kinder*" [P1, P6] to themselves, and experienced less "*beating myself up*" [P1, P5]. Not all participants experienced this, and P7 remained "*very self-critical*" [P7].

It was suggested that some self-criticism was required for motivation, but "*too much of it is damaging*" [P5]. However, the experiences of applying self-compassion challenged this view. P2, P4, P5 and P6 experienced increased motivation and engagement in learning when they were less self-critical, and were able to respond to feedback to successfully improve performance in theory and practice learning [P2, P5].

An increase in protected time and space for self-compassion was noted by P2, P3 and P4. The use of self-compassion techniques had made them take the time "*even if it means taking myself … to the bathroom, and I will just sit for a minute*" [P2] to process thoughts "*in your own time and your own space*" [P3]. An attitudinal change made it "*more acceptable*" [P4] to take time for self-compassion rather than "*beating myself*" [P4] for not doing something else with that time.

5.7.3 Perceived changes relating to common humanity

Six participants reported an increased recognition of common humanity [P1-P6], that "*it happens to everybody*" [P5], "*it's not just me*" [P6], which generated change through a reduction in social comparison, and an increase in help and support-seeking behaviours. P1 described the benefits of applying common humanity, developing a "*mantra*" [P1] that "*everybody's had their moments; somebody somewhere will have been thought what you've been through right now*" [P1]. Use of this mantra resulted in the dissipation of the discomfort and fear she felt through social comparison, which prior to the workshops had made her "*not want to do things*" [P1].

Recognition of common humanity was reported to reduce stress and anxiety when faced with new learning. For P2 and P5, this was illustrated when they found new learning difficult and were able to reflect on the fact that "*everybody's fallible*" [P5] and "*probably sitting in front of their computers doing exactly the same*" [P2]. Common humanity also gave participants the courage to talk about experiences in a more honest way, resulting in the recognition "*that everybody kind of felt the same*" [P6].

Five participants [P1-P4, P6] agreed they were less judgemental, and less inclined to stereotype based on the judgements of others, for example not pre-judging a new

placement as bad, or a patient as "*difficult*" [P2]. Judgements were also reduced because

participants were better able to consider the perspective of others, that "*I'm more open to*

everybody else's opinions, not just my own" [P6].

5.7.4 Perceived changes relating to mindfulness

There were two significant changes in behaviour related to mindfulness: an increase in the

ability to more objectively consider context, and an increase in noticing.

Often associated with the pause button (see Chapter 5.5.1), time generated by the pause

was enough to say "*hold on a minute, no, that's not actually how it is*" [P5]. Objectively

considering the context changed behaviour, for example, "*being able to … accept that*

people are cross and it's not necessarily because of you" [P2] allowed the participants to

explore alternative ways to ease suffering. An objective consideration of context was also

believed to increase and enhance reflective practice [P4, P6], thinking about "*how would I*

have done that better" [P4].

All participants described an increase in noticing following the application of self-

compassion. For some participants, this was noticing their own suffering when feeling

"*overwhelmed*" [P2, P5], low in mood [P3], angry and frustrated [P4], or "*lonely*" [P1].   For

others [P2, P4], it was listening and "*stop ignoring yourself*" [P2] in order to explore the

suffering, often changing the perspective of suffering, "*not letting it be as much of an*

obstacle as it perhaps would" [P1]. P6 described an increase in noticing "*mind wandering*"

[P6], which meant she re-focused on the task she was doing, and enhanced performance.

Noticing context also supported the development of self-compassion, for example, the time

of day [P1], the environment [P4], or the behaviour of others [P3, P6]. An interesting finding

was that increased noticing also applied to P7, despite her stating that there had been no

change in her behaviour. Although she remained self-critical, she was able to "*notice it more*" [P7]. As noticing was the first part of compassion, this raised questions about the need to notice as a pre-requisite for acting compassionately.

5.8 Reflexivity using Peshkin's I's

The transcripts were examined for Peshkin's I's during the categorical-content analysis. Three Peshkin's I's (Appendix 20) were seen as relevant for researcher reflexivity:

- Researcher as self-compassion evangelist
- Researcher as judge
- Researcher as teacher

5.8.1 Researcher as self-compassion evangelist

The researcher bias towards the use of self-compassion was developed through the study of literature and evidence that supported the benefits of self-compassion, and positive personal experiences of its application. Less frequent during the initial interviews, this unconscious bias was demonstrated through a confidence that self-compassion was "*having very positive impacts on the people experiencing it*" (P1, transcript 1), and an enthusiasm that "*I find this subject so fascinating*" (P2, transcript 1). Following the participants' experiences of applying self-compassion, the researcher as a 'self-compassion evangelist' was seen in the narratives to affirm or reflect positive experiences, expressing pleasure that "*it's brilliant*" (P2 and P3, transcript 2) or "*I'm really pleased*" (P4 and P5, transcript 2). It was reassuring to note that no examples of this Peshkin's I were found in P7's narrative to counter her experience that self-compassion had no impact.

5.8.2 Researcher as judge

Primarily seen in initial interviews, the researcher as 'judge' was an unanticipated Peshkin's I. On reflection, many of the judgemental comments made were attempting to encourage participants to elaborate on their narrative, trying to assure them they were not being judged or compared negatively to others. Assumptions were made that reflected the researcher's expectations without recognition that other's may have a different opinion, for example, "*if you've had a bad day … you need a little bit of support and a hug*" (P6, transcript 1), or that "*deserving compassion is a very contentious phrase*" (P5, transcript 1). It is possible that commonality blindness influenced assumptions. The potential for commonality blindness was supported by the infrequency of researcher as 'judge' in narratives of participants with different lives, experiences, and judgements. This was particularly evident when I found a participant uncomfortably judgemental and made a conscious effort during the data collection to be non-judgemental in order to facilitate the narrative.

5.8.3 Researcher as teacher

Researcher as 'teacher' was the most frequently identified Peshkin's I, evident on 79 occasions, and evenly distributed across initial and final interviews. As an experienced nurse educator, this was an anticipated Peshkin's I. Similarly to the researcher as 'judge', comments were often made in an attempt to encourage continued narrative. The researcher as 'teacher' was seen towards the end of the initial interviews through clarification of the definition of compassion and associated terminology, with reference to supporting literature (P1, P3, P4, P5, transcript 1). Whilst the teaching did not influence participants' earlier descriptions of compassion, on reflection it was not necessary for the research.

Re-iteration of teaching from the self-compassion workshops was evident during the final interviews, particularly of strategies that participants found more challenging. The researcher as teacher also acted to extend learning through encouragement of continued practice, and consideration of future application of self-compassion. As with the initial interviews, the additional teaching did not appear to influence the participants' narrative about their experiences of self-compassion, but was extraneous to the research.

5.9 Summary of key findings

Lieblich et al's (1998) approach to data analysis identified a range of themes that provided an in-depth insight into the research questions. The key findings were:

- The meaning of compassion described as: 'An active, holistic process, requiring knowledge and understanding, connectivity, and communication. It involves actively noticing suffering, being there, giving time, and acting to ease suffering.' (RQ1)

- The need for a language for compassion to support the development of understanding, and professional discussion and debate around compassionate care. (RQ1)

- Compassion and cruelty were active processes, and non-compassionate behaviour was passive. (RQ1)

- A disparity in the extent to which noticing and acknowledging suffering was identified, suggesting the potential for future development of the need to notice. (RQ1)

- Family and experiential learning were key to the development of understanding the concept of compassion. (RQ2)

- Personal judgements and the judgements of others strongly influenced the context for compassion, raising an interesting question about the role of nurse educators in

increasing awareness of, and challenging judgements in order to develop compassion. (RQ2)

- Self-compassion exercises formed an effective toolkit, with non-meditative exercises more frequently adopted and embedded in everyday practice than meditation. (RQ3)

- Application of self-compassion was a positive and helpful experience, although challenging. (RQ4)

- Outcomes from application of self-compassion were: becoming more accepting, increased compassion towards others, maturity, increased retention, improved mindfulness, and dissemination of self-compassion skills. (RQ4)

- A range of perceived changes to behaviour were identified including: a perception of calm, reduction in self-criticism, protected time for self-compassion, increased recognition of common humanity, being less judgemental, improved perspective, and increased noticing. (RQ5)

Chapter six explores these findings in greater detail, locating key areas for discussion within the literature.

CHAPTER 6: DISCUSSION

Through discussion of the key themes, Chapter 6 extends the current body of knowledge, and contributes original knowledge to the field of compassion and self-compassion. Consideration is given to the application of this knowledge to nursing and nurse education, and areas for further research are proposed. Reflecting the structure of the findings chapter, the discussion is structured to guide the reader through the themes relating to each research question in turn.

6.1 Research question one: The meaning of compassion

As identified in Chapter 5.2.1, participants described the meaning of compassion as:

> 'An active, holistic process, requiring knowledge and understanding, connectivity, and communication. It involves actively noticing suffering, being there, giving time, and acting to ease suffering.'

It is useful to acknowledge at this point, the potential inexperience and naivety of the participants' responses, as they were at the beginning of a three-year nursing degree. When compared with the operational definition of compassion developed for this research (seen in Chapter 2.3.8), although the language used could be considered easier to understand and more accessible to students, the notable difference between the two descriptions was the exclusion of an affective domain in the participants' description. However, much of the participants' understanding reflected definitions of compassion found in the literature (Bickford et al., 2019, Durkin, Usher and Jackson, 2019, Sinclair et al., 2016a). Knowledge and understanding, connectivity, communication, and intentional presence were widely agreed to be key components or conditions of compassion

(Constantinides, 2019, van der Cingel, 2011), as were the actions taken to ease suffering (Irons, 2013, Sinclair et al., 2016a). The commonalities between the participants' definition of compassion and definitions in the literature were indicative of some shared understanding. However, a review of the differences between the definitions identified three interesting areas that extended the current body of knowledge, and contributed new knowledge to the field. Discussed in the next sections, these three areas were:

- The development of a metaphorical structure for compassion.
- Active and passive stages of compassion and non-compassion.
- Noticing as a key condition for compassion.

6.1.1 The development of a metaphorical structure for compassion

Difficulties were identified in the use and knowledge of language to define and discuss compassion, highlighting a gap with the potential to hinder the development of understanding, professional discussion and debate around compassionate care. Despite the increase in compassion literature over the past decade, the difficulty with language remains a contemporary issue. Although there are similarities between definitions, there continues to be a lack of coherence (Bond et al., 2018, Feo, Kitson and Conroy, 2018) and a level of ambiguity (Durkin, Usher and Jackson, 2019); an ambiguity reflected in the inconsistent use of language and metaphor highlighted in the categorical-form analysis of the narratives.

A discourse on language development was beyond the remit of this research, however, the use of metaphor when applied to the definition of compassion was worthy of further consideration. The use of metaphors was believed to result in better and more memorable

learning (Petrie and Oshlag, 1993), providing an original approach to defining compassion that could inform nurse education.

Metaphors were believed to influence thought and understanding because they were the vehicle through which ideas were communicated (Vervaeke and Kennedy, 1996). Metaphor was defined as seeing, experiencing, talking (Ritchie, 2013) or thinking (Lakoff and Johnson, 2003) about something in terms of something else, presented in a way that allowed sensible interpretation in context, independent to the customary meaning of the words. Utilised in learning, metaphors introduced new concepts by relating them to familiar concepts (Petrie and Oshlag, 1993). Traditionally metaphors related to figures of speech (Vervaeke and Kennedy, 1996), using words and phrases to substitute or compare one thing with another, using approaches such as categorisation or analogies to develop understanding (Ritchie, 2013).

Underpinned by a philosophical understanding of embodied cognition in language and language development (Lakoff and Johnson, 1999), Lakoff and Johnson (2003) challenged this traditional approach, suggesting connections were made at a deeper conceptual level rather than a surface speech level. The connections were made between abstract concepts and embodied experience. They believed that human thought processes were largely metaphorical, that our making sense of the world was metaphorically structured, defined, and reflected in our linguistic expression, and a shared understanding of metaphors resulted from commonalities of embodied experience (Lakoff and Johnson, 2003). The belief that our conceptual systems were grounded in experience was congruent with my ontological approach that we form the sum of our experiences, a dynamic and interactive being developed through our correspondence with the world (Ingold, 2011).

Lakoff and Johnson (2003) suggested that abstract concepts, which one could argue included compassion, were understood by means of other more clearly delineated concepts

such as spacial orientation or objects. Compassion was seen in the narratives to be a concept that may benefit from metaphorical definition as it was not clearly enough delineated in its own terms to satisfy the purposes of day-to-day functioning. Aiming to address the identified gap in knowledge, and contribute to new knowledge, a proposed metaphorical structure was developed. Identified in Chapter 5.2.1 and Appendices 12, 13 and 16, compassion was metaphorically described by participants as a 'jigsaw', a 'substance', a 'human body', a 'container', an 'engine', and an 'umbrella'. The use of the metaphor 'emotion was contained' was also believed to be of relevance due to the emotional aspect of compassion (Gelhaus, 2012b, Leget and Olthuis, 2007), and was therefore included in the development of a metaphorical structure. The metaphors most frequently used in the narratives related to a substance, a container, or something that was contained.

Attempts were made to consider metaphors for a substance that could be contained, but could also move, reflecting the active nature of compassion (Constantinides, 2019, Durkin, Usher and Jackson, 2019) and the relational dimension of giving and receiving compassion (Sinclair et al., 2016a, Sinclair et al., 2016b). Liquids within different systems, such as engines, containers, or water systems, were ruled out as they suggested closed circuit systems that would not reflect the active flow in the relational dimension of compassion. Ruling out these ideas strengthened the emphasis on compassion as a flowing substance, such as water, that is contained (in a person), but can flow out towards others, and flow in when received from others. As compassion was viewed as a virtuous response (Constantinides, 2019), a metaphor of clean, flowing water was proposed. Also of relevance in the development of a metaphorical structure was the influence of judgements on the flow or amount of compassion given or received. Discussed in Chapter 2.4.3, and reflected in the findings (Chapter 5.4 – 5.4.3), judgements were made about the deservedness of compassion based on a range of contextual factors.

Contributing original knowledge to the field of compassion, the following proposed metaphorical structure for compassion was developed, to enhance understanding and support professional discussion and debate:

- Compassion is clean, flowing water

- Personal judgements are a dam (controlling the flow of compassion)

- People are reservoirs (for compassion)

Although widely influential, Lakoff and Johnson's (2003) conceptual metaphor theory was not without criticism, and a note of caution is required for the generalised nature of a proposed metaphorical structure for a concept that is ambiguous (Durkin, Usher and Jackson, 2019), and ultimately defined within individual groups (Dewar and Nolan, 2013, Singh, King-Shier and Sinclair, 2018). Embodied experience, particularly for people across a global profession, may differ. Papadopoulos et al's (2017, 2016) exploratory study of nurses' views and experiences of compassion across 15 countries found similarities in descriptions of compassionate care, for example, being there and giving time, that was indicative of an internationally shared understanding of the enactment of compassion. However, it also highlighted differences in the way compassion was defined, from 'empathy and kindness' to 'a deep awareness of the suffering of others' with or without 'a wish to alleviate it', supporting the impact of cultural difference and cultural experience on the definition of compassion. The differences in cultural experience may also lead to different interpretations of a metaphor (Ritchie, 2013, Von-Dietze and Orb, 2000).

Changes in culture and experience also resulted in re-interpretation of language, for example the term 'pity' once meant compassion but now has negative connotations (Dunn and Rivas, 2014, Nussbaum, 1996, van der Cingel, 2014). Therefore the metaphor may change or be re-interpreted in response to new cultural experience (Ritchie, 2013).

Further criticism of conceptual metaphor theory (Lakoff and Johnson, 2003) considered the fact that some metaphors cannot be based on experience, for example "she's a dragon", "a cat in hell's chance", but rely on myth (Ritchie, 2013) and imagination, or are based on indirect experience through stories. Imagination was noted to be a condition for compassion to gain an insight into the experience of another (van der Cingel, 2009) and develop reflective practice (Armstrong, 2006). Therefore extending the development of imagination to interpret metaphors related to compassion may be useful within nursing curricula.

Taking into account the critique of conceptual metaphor theory (Lakoff and Johnson, 2003) when applied to a global, multi-cultural profession, the findings of this research, alongside my experience as a nurse educator, suggest that a metaphor for compassion may enhance understanding of compassion within the nursing profession, and could act as a tool to support education. The establishment of a metaphor for compassion may support the provision of a shared language to enhance professional discussion and debate. For nurse educators, a metaphor for compassion could provide a useful tool to support the teaching and learning of compassion. It has the potential to act as a platform from which student nurses can explore the wider factors influencing their compassion, such as personal judgements forming their dam, triggering or preventing the flow of compassion; the ability to recognise when the reservoir is low, and the impact this may have on the self and others; and understanding the sources from which they receive compassion to keep their reservoir filled.

Although not within the scope of this research, future interdisciplinary research with healthcare professionals and linguists is recommended to empirically test the proposed metaphorical structure.

6.1.2 Active and passive stages of compassion and non-compassion

The second theme that provided an insight into the participants' understanding of the meaning of compassion was the active nature of compassion and passive nature of non-compassion. Participant findings supported the wider literature (Burnell, 2009, Sinclair et al., 2016a, van der Cingel, 2009), that compassion was an active process, whether those actions are conscious choices, physical acts, intentional presence (Constantinides, 2019), or taking action through inaction (Durkin, Usher and Jackson, 2019). Participants also described cruelty in similar terms, that cruelty was an active process with intentional physical and verbal acts, neglect and avoidance. Reflective of Gilbert's (2005) assertion that compassion was the antithesis of cruelty, it was unsurprising to see the active nature of each through the intentionality of compassionate knowing (Constantinides, 2019) and cruelty (Gilbert, 2005). It was the intentionality of these behaviours that made both compassion and cruelty active processes.

Between these two extremes, however, differences in compassion and compassionate behaviour were noted when behaviour became more passive, with increased passivity resulting in non-compassionate behaviours. Participants reported a change in the behaviour they had witnessed, from active compassion to passive non-compassion, where healthcare professionals were "following the rules" [P2] to deliver routine and task-focused care (Babaei and Taleghani, 2019), or focusing on technical and biomedical issues rather than addressing emotion (Cameron et al., 2013). The passive nature of indifference (Singh, King-Shier and Sinclair, 2018) impacted negatively on connectivity, the recognition of common humanity, and the inter-relational aspect of compassion. It was worthy of note, however, that passivity was not always attributed to indifference. Reflecting the literature, and discussed further in Chapter 6.1.2.2, there were many contextual factors, including personal judgement, organisational behaviour, and time, that affected the flow of

compassion. Compassion was also reduced, or suffering avoided if the situation was perceived as too difficult or overwhelming (Bickford et al., 2019).

In the majority of cases, whilst a passive approach was described as less compassionate, the care described was perceived as safe and competent [P1-P4], highlighted through examples of nurses who gave care but not compassion. If care was perceived as safe and competent, one could question the need for compassion. However, supporting the centrality of compassion in nursing seen in the literature (Dewar and Nolan, 2013, Sinclair et al., 2016a, van der Cingel, 2009), participants viewed these nurses negatively, suggesting they were not good nurses. Movement beyond passive indifference was also seen in the narratives through conscious avoidance, an active decision to de-humanise someone as an "*obstacle*" [P4] and distance oneself from suffering (Georges, 2004), which could be perceived as non-compassionate or cruel.

6.1.2.1 Risks of passivity in compassion

P3 described compassion as a muscle that needed to be exercised if it was to be maintained, and with P6, commented on the impact of external pressures on the ability to be compassionate. Factors identified in the narratives such as tiredness caused by long shifts, staffing levels, patient acuity, and service demands, meant that maintaining compassion was more difficult, and compassion was forgotten on occasions as nurses focused on tasks. It was important to note that the narratives did not identify abuses or cruelty towards patients. However, the changes in compassion noted by P3 and P6, when considered from the perspective of active and passive stages of compassion and non-compassion, highlighted potential risks of moving from active to passive stages. Parallels were drawn between nursing care and Zimbardo's (2007) work in the penal system, suggesting that movement between active compassion and passive non-compassion, if not noticed and addressed, increased the risk of nurses becoming perpetrators of suffering (Georges, 2013,

McFarland-Icke, 1999) or cruelty. Zimbardo (2007) identified three key factors in the development of actively cruel behaviours or abuses: de-humanisation, anonymity, and permission.

Dehumanisation

Reflecting the literature (Su et al., 2019, Tehranineshat et al., 2019), six of the seven participants [P1, P2, P4-P7] emphasised the importance of connectivity as a key part of active compassion. There was, however, recognition that this was not always easy and the dam controlling the flow of compassion was often influenced by familiarity and personal judgement. The passive nature of task-focused, routine care or indifference highlighted by P1, P3, P4, P5 and P6 was seen to decrease connectivity, resulting in the perception that it was harder to give or receive compassion, and on occasion led to avoidance of suffering. In relation to Zimbardo's (2007) work, the lack of connectivity resulted in distancing oneself. Distancing could be physical, for example not responding to call bells; psychological, for example when P2 was focusing on the next job to be done rather than the patient she was with; or seeing the patient as an illness rather than an holistic individual (as seen in Box 1), which created a culture of 'them and us', de-personalising and de-humanising (Georges, 2011, McFarland-Icke, 1999) rather than recognising common humanity.

Participants clearly identified the passive behaviours caused by a lack of connectivity to be non-compassionate, reflecting the wider socio-political context that de-humanisation resulted in non-compassionate or cruel behaviours (Georges, 2004). In Nazi Germany, nurses were encouraged to reduce connectivity and emotionally distance themselves from patients in order to adapt psychologically to murderous behaviours (McFarland-Icke, 1999). The unique contextual factors within Nazi Germany do need to be recognised, and were clearly not reflected in recent healthcare. However, even with the current political, professional, and media focus on compassion in nursing, biopower (Georges, 2014) and the

external factors identified by participants were seen to limit connectivity and increase passivity. Acknowledged as a barrier to compassion (Babaei and Taleghani, 2019), passivity provided some explanation for examples of healthcare where an absence of compassion was seen in the face of suffering (Abraham, 2011, Francis, 2013).

Knowledge, skills and behaviours to enhance connectivity are taught and practiced within nursing curricula, and are assessed in theory and practice elements of the course. Experience as a nurse educator over the past 20 years has demonstrated the success of this teaching, with numerous accounts provided by students of how their compassion and connectivity made a positive difference to the care and lives of patients and their relatives. The potential risks of a lack of connectivity on passivity, non-compassion, and de-humanisation, emphasised the importance of continuing to provide this curriculum content for student nurses.

Anonymity

Anonymity (Zimbardo, 2007) was not explicitly referred to in the narratives. However, it was implied in illustrations of suffering and non-compassionate behaviour, such as the unwell child who did not know the person collecting him [P1], or the numerous healthcare professionals visiting a terminally ill friend [P2]. Little has been written about the impact of anonymity on compassion or patient care, with the only studies found relating to a lack of anonymity and its impact on nurses and professional boundaries (Lee, 1998, Swan and Hobbs, 2017). Being identifiable and interconnected were found by Swan and Hobbs (2017) to be attributes of a lack of anonymity, with visibility an antecedent, suggesting conversely that anonymity included being unidentifiable, not visible, and having a lack of connectivity. From the perspective of a lack of visibility and connectivity, a level of anonymity was seen in the illustrations of non-compassionate behaviour in the narratives, for example, when P4

was not visible and lacked connectivity as she cut off members of her family; or experiences of patient suffering that were avoided because they were overwhelming [P1].

Although a lack of visibility and a lack of connectivity, resulted in anonymity being demonstrated in the participants' experiences, being identifiable was not highlighted as a barrier to compassion. One can speculate about the potential cause of this omission, that it was due to inexperience and naivety in first year student nurses, or that campaigns to reduce anonymity such as '# hello my name is' (Granger and Pointon, 2020) have embedded introductions into clinical practice to the extent that identifiability was no longer a key cause of anonymity.   Future research would be beneficial to explore the impact of anonymity on patient care and compassion, and to evaluate the outcome of campaigns to enhance identifiability.

Permission

In situations where non-compassionate behaviours were not challenged, a level of implied permission to continue with those behaviours was given (Georges, 2004, Zimbardo, 2007). Permission for non-compassionate behaviour was only seen in one participant through her perception that the role of a student authorised her right to avoid care that would ease suffering [P4].   Utilising her student status to justify avoidance suggested an understanding that she had permission to choose, or refuse, practice based learning opportunities. However, other examples were seen where workload [P6], staffing [P3], the care setting [P2], and normal organisational behaviours [P2, P3] influenced the continuation of passive non-compassionate behaviours. For example, a perception of too much work to be done within the time available, low staffing levels or a high vacancy rate leading to a reliance on transient agency staff.

The care setting was highlighted by participants as an influencing factor. A nursing home was perceived to be more passive, with non-compassionate care seen as normal practice. Conversely an oncology ward was noted to have high levels of active compassion. Although an interesting observation about care settings reflecting the literature (Georges, 2011), there were alternate factors that could account for the difference in compassion experience. The staff:patient ratio was likely to have been different, as was the level of education within the skill mix. An oncology ward was likely to have had more Registered Nurses and advanced practitioners than a nursing home. As knowledge and understanding was seen as a condition of compassion (van der Cingel, 2014), this may have been more influential than the care setting itself.

Judgements about deservedness discussed in Chapter 6.1.2.2, may also have influenced participants' perceptions, with the patients in an oncology ward potentially seen as more deserving than those in a nursing home. However, the factors that influenced passive non-compassion were reflective of the organisational non-compassion seen in Ombudsman reports, and in Mid Staffordshire (Abraham, 2011, Francis, 2013). Georges (2004, 2013) found organisational behaviours, including a commitment to obeying rules, the implementation of policy (McFarland-Icke, 1999), and permission to behave in a certain way, removed personal responsibility, decreased accountability, and increased the risk of non-compassionate behaviours.

In order for nurses and nurse leaders to prevent change from active compassion to passive non-compassion, and therefore reduce the risks identified by Zimbardo (2007), they must have some understanding of the factors that influence change in compassion behaviour. The following section discusses these factors, considering the implications for contemporary nursing, and highlighting areas for further research.

6.1.2.2 Factors influencing change from active to passive behaviours

The contextual factors identified in the narratives that influenced a change from active compassion to passive non-compassion were personal judgements and time. Passive non-compassion was identified in the literature to be a consequence of compassion fatigue, but was not a factor raised by the participants. The omission may be due to limited exposure to compassion fatigue as the participants were in the first year of their nursing degree or, in light of the similarities seen between the factors that influence passive non-compassion and compassion fatigue (Coetzee and Klopper, 2010), that the term 'compassion fatigue' was less familiar. The factors that influenced change from active to passive behaviours differed for each individual, with some being more vulnerable to, and some being more resistant to change. This reflected Zimbardo's (2007) proposition of the 'everyday hero', an individual who despite being exposed to the same factors, did not move from active compassion to passive non-compassion or active cruelty.

Personal judgements

As presented in 5.4.1 – 5.4.3, a key factor that influenced change from active to passive behaviours, and controlled the flow of compassion was personal judgement, judgements that underpinned decisions about deservedness (Gelhaus, 2012b, van der Cingel, 2009). Despite the political and professional emphasis on compassion and the requirement to provide compassionate care to all (Cummings and Bennett, 2012, Department of Health, 2015, Nursing and Midwifery Council, 2018a), the findings reflected Van der Cingel's (2009) proposal that deservedness was a condition for compassion, and that nurses must work to put aside judgements and actively deploy [P1] compassion. Reflecting the literature, participants' decisions about deservedness were often based on severity of suffering, or level and permanence of loss (Gelhaus, 2012b, van der Cingel, 2009). Perceptions of patients experiencing severe suffering resulted in "deeper compassion" [P5], than those

undertaking routine procedures [P6], or perceived as an "obstacle" [P4]. For example the terminally ill lady who wanted to get married [P6], or the man who was likely to need a below knee amputation [P5] were seen as more deserving of compassion than someone having a routine or minor procedure. As compassion was emphasised as an active process, a person or situation perceived as less deserving resulted in a more passive approach being adopted.

For nurses, judgements about the deservedness of compassion may be altered by a shifted sense of severity and routine. When one was surrounded by severely ill or injured patients, someone with a less severe injury, although still life changing for that patient, may be perceived as less deserving. Suffering could become invisible if it happened to the other, and was conceptualised as normal or to be expected in a given situation (Georges, 2004). A sense of altered perception resulting in misreporting and difference between nurse and patient interpretation of suffering has supported evidence based practice for pain assessment since the 1960s (Pasero and McCaffery, 2011). Studies have been undertaken to explore and define patient perception of compassion (Sinclair et al., 2016a), and nurse-patient development of positive compassion practice (Dewar and Nolan, 2013). However, the difference between nurse and patient perceptions of compassion, and strategies to manage any difference, remain in its infancy, and is an area worthy of future research and development.

There was candid and reflective recognition in the narratives that connectivity, a condition for compassion (van der Cingel, 2009), was influenced by whether participants liked the person or not. It was much more challenging to give compassion to someone the participants did not like, or found difficult. In situations where the participants were aware of the feeling of dislike, it took an increased level of active work to demonstrate compassionate behaviour towards them [P1]. These judgements were influenced by the participants' own health and emotions, with positive mood and health enhancing compassion, and a negative state acting as a barrier (Bickford et al., 2019).

Raising self-awareness to notice and address the tension between the professional requirement to be compassionate to all, and the personal judgements affecting connectivity has interesting implications for nurse educators and nurse leaders to notice and challenge these judgements. The raising awareness of, and challenging of judgements in order to develop compassion is discussed in Chapter 6.2.3.

Presence and Time

Being there and giving time were highlighted by the participants as essential elements of compassion. Although being there and giving time were closely linked, when participants identified barriers to compassion, it was the time constraints that they focused on. Participants reported nurse workloads were too high to achieve in the time available, that nurses did not have time to be compassionate [P2, P5, P6], reflecting the findings in the literature that time and workload influenced the ability to show compassion (Bickford et al., 2019, Brown et al., 2014, Curtis, Horton and Smith, 2012). It was implied through the narratives that the intentionality for compassion remained. Nurses still wanted to be compassionate, but were not always able to achieve it because of competing demands on their time (Christiansen et al., 2015), for example multiple call bells ringing at the same time, requests from other members of the healthcare team, or large numbers of medicines to administer.

Even when nurses were physically present with patients, thinking about the next job was deemed to be distracting enough to reduce or remove connectivity, which resulted in a passive approach where the nurse was not intentionally present (Constantinides, 2019). Witnessing the constraints that prevented intentional presence and time influenced the socialisation of student nurses (Curtis, Horton and Smith, 2012), and caused concern amongst the participants about their ability to overcome these constraints once qualified.

Reflective of Darley and Batson's (1973) study on helping behaviours, it could be suggested that it was not the personal values, motivations or intentionality of the nurses that were reflected in their behaviour, but that pressure on time, whether time to notice or time to act, played a significant part in preventing the noticing of suffering required for compassion.

An increase in patient acuity and patient turnover (Wright and McSherry, 2013), patient dependency (Bramley and Matiti, 2014), or a business model of healthcare delivery (Christiansen et al., 2015) may have accounted for the demands on nurse time and therefore made intentional presence more difficult, but this was not the case in all care settings. Participants were able to identify busy clinical areas such as the oncology ward where excellent compassion was consistently witnessed, although as highlighted in Chapter 6.1.2.1, this may also have been influenced by perceived deservedness of the patients and the knowledge and understanding of the staff. The inconsistency in compassion within the different clinical settings, despite similar time demands, indicated that whilst time was required for compassion, it was not necessarily a barrier to compassion.

Evaluations of the NHS Productive Series, including the aim to increase the amount of time providing direct patient care, and improve staff and patient experience (National Health Service Improvement, 2019) supported the suggestion that time may not be a barrier to compassion. The evaluations demonstrated time efficiencies through ward organisation, increased staff morale and staff self-esteem. However, there was little evidence of the way in which the time was reinvested (Wright and McSherry, 2013), with only implied qualitative evidence about personalised care and intentional rounding (Flowers et al., 2016) that suggested increased compassion. Bramley and Matiti's (2014) research into patient experiences of compassion also found that time need not be a barrier to compassion, and that fleeting moments were sufficient to demonstrate compassionate acts through connectivity and communication. It could be suggested that a change from active

compassion to passive non-compassion does not relate to the lack of time available, but to the potential for that limited time to reduce the noticing of suffering and intentional presence.

6.1.3 Noticing as a key condition for compassion

A lack of time (Darley and Batson, 1973) and an inability to pause and notice our experiencing, or the experiencing of others was not a new concept. It was seen by Gendlin (1962) as the "chief malaise in our society" (p15) that was debilitating in terms of human functioning. The lack of noticing continued to be highlighted as a concern in more contemporary nursing literature, with Georges (2014) "struck by both the centrality – and invisibility – of suffering" (p51), an invisibility that highlighted the importance of the need to notice as a condition for compassion. If, as stated by the participants and the literature, noticing suffering formed part of the definition of compassion, then the consequence of not noticing was that compassion was not fully given.

The need to notice formed an essential component of many definitions of compassion, described as noticing another person's vulnerability (Dewar, 2011), suffering (Durkin, Usher and Jackson, 2019) or need (van der Cingel, 2011), a deep (Bramley and Matiti, 2014), open (Christiansen et al., 2015), or conscious awareness (Constantinides, 2019) of suffering, or the recognition of suffering (Cameron et al., 2013) and distress (Dunn and Rivas, 2014). Despite the widespread inclusion of noticing in compassion definitions, there was limited focus on noticing in discussion papers or compassion research, with a much stronger focus on connectivity, intentional presence, and actions to ease suffering.

Linked to the active and passive stages of compassion and non-compassion discussed in Chapter 6.1.2, some of the language used within definitions of compassion was active, such as 'noticing', 'conscious awareness', and 'recognising'. However, the use of active language

was not consistent in the literature, with an equal emphasis on the passive term 'awareness'. Analysis of the narratives reflected this difference. P5 strongly expressed active noticing as key to compassion throughout the narrative, and was conscious of previous training received to effectively notice the situation or health of others. Other participants were able to identify that a compassion response had been triggered, but with limited discussion of the trigger, or how they noticed the suffering.

There was limited discussion about the active or passive nature of noticing in the literature. Inclusion of noticing in the definitions of compassion implied noticing was an element of a wider active process, and therefore was active. Only Galetz (2019) explicitly purported that noticing suffering was passive, and that active compassion commenced when the actions to ease suffering were taken. The omission of noticing as part of the active process of compassion in some of the participants, could imply an understanding that noticing was passive. A passive approach, if applied to noticing in the same way as passivity was applied to easing suffering in Chapter 6.1.2, would suggest there was a level of non-engagement, avoidance, or a lack of connectivity that prevented noticing. However, this was not illustrated in the narratives. The fact that participants reported responses to suffering suggested that noticing was more of an unconscious awareness of suffering.

An understanding of noticing as an unconscious awareness warranted further consideration as it had potential implications for nurse educators, and nurse leaders, in the support of compassion in practice across the profession. The knowledge and skills gained through experience and developed expertise (Benner, 1984) may offer some explanation for awareness to become unconscious and therefore more difficult to articulate (Edwards, 2014), a more intuitive noticing process, based on tacit knowledge. It could be suggested that the more intuitive noticing became, the more invisible it became as part of the compassion process. That is, expert nurses were no longer aware of noticing so did not explicitly demonstrate it, or role model and teach noticing to less experienced nurses and

students. For experienced, expert nurses, unconscious noticing and intuition may be sufficient to identify suffering and trigger a compassion response. However, for less experienced nurses, and student nurses, who have not yet developed intuition based on tacit knowledge, reliance on unconscious awareness risked the noticing component of compassion being omitted in all but the most obvious or severe suffering.

The need to actively notice suffering as a condition for compassion has far reaching implications for future practice across the nursing profession. For nurse educators, teaching and learning strategies need to be developed to place a greater emphasis on active noticing. Pausing during clinical simulation sessions to explicitly identify and discuss what students notice before they act to perform a clinical skill is a realistic and achievable recommendation in all nursing curricula. A review of current digital resources aimed to develop noticing skills would also be beneficial to inform curriculum development. As discussed in Chapter 6.5, application of self-compassion was seen to result in increased noticing, and therefore self-compassion workshops are recommended for inclusion in nursing curricula. For expert nurses, and nurses already in the profession who are supporting learners in practice, an ongoing dialogue needs to take place to overtly demonstrate compassion (Bond et al., 2018), and discuss what is noticed about a person or situation that informed a decision to act or not to act. Practice learning could be enhanced by the Practice Supervisor or Practice Assessor (Nursing and Midwifery Council, 2018c) working collaboratively with the student to develop and reflect on focused learning goals to actively notice.

The need to notice supported the definitions in the wider literature. However, the findings of this research extended the current corpus of knowledge to identify a limited focus on noticing as a component for compassion, inconsistencies in the active or passive approaches to noticing, and a need for greater emphasis to be given to noticing. As the need to notice suffering is an essential condition for compassion, without which compassion

cannot be given, noticing must be given a higher priority in the development of compassion and compassionate nursing practice. The recommendation for increased emphasis on noticing applies to nurse educators in the design and delivery of nursing curricula, to Registered Nurses in the maintenance of dialogue to overtly demonstrate noticing, and to those undertaking future research in the field of compassion or self-compassion.

6.2 Research question two: Developing an understanding of compassion

The holistic and categorical-content analysis of the narratives provided the greatest insight into the ways participants had developed their understanding of compassion. The starting point for development was primarily deemed to be that humans are born with compassion as a natural trait, reflecting the literature that compassion was an altruistic, moral virtue (Constantinides, 2019, Von-Dietze and Orb, 2000). Development of compassion understanding during the participants' lives occurred through reflections on experience, primarily within the family during formative years, and extended to others as more life experience was gained.

There were three areas of interest for further discussion that were believed to influence the development of compassion understanding in nurse education. Discussed in the next sections, the three areas were:

- Compassion as a natural trait.
- Teaching and learning compassion.
- Raising awareness of and challenging judgements.

6.2.1 Compassion as a natural trait

There was widespread agreement in the literature that compassion was altruistic and selfless (Constantinides, 2019), part of one's character (Sinclair et al., 2016a, Sinclair et al., 2016b). Constantinides (2019) believed "*it is the innate, humanistic capacity for compassion … that inspires the caring actions of nurses*" (p224). The suggestion that compassion was an innate humanistic capacity, and the pre-Socratic philosophical idea of a folk theory of essence (Lakoff and Johnson, 1999), reflected the participants' understanding, highlighted in Chapter 5.3.1, that compassion was "*inbuilt*" [P5], something "*you have naturally*" [P2]. The folk-theory of essence purported that every entity had an essence or nature that made it the kind of thing it was, and was the causal source of its natural behaviour (Lakoff and Johnson, 1999). Aristotle developed this philosophical idea further, stating that

"*intellectual excellence in the main owes both its birth and its growth to teaching (for which reason it requires experience and time), while moral excellence comes about as a result of habit. … we have the faculties by nature, but we are not made good or bad by nature*" Nichomachean Ethics, Book II [Aristotle 350BCE, translated by Barnes (1984)].

Applied to compassion, Aristotle's work suggested that people were born with the capacity for compassion, but that it needed to be taught to grow the required knowledge and understanding, and practiced to be developed through habit. The concept of humans having a natural trait, an essence, remained in the narratives even when the understanding of that natural trait changed, i.e. participants changed their opinion about compassion as a natural trait. However, as seen in Box 7, an interesting finding from the data demonstrated a fluidity around the idea of essence, that despite the changed opinion, the concept of a natural trait, a folk theory of essence, remained.   The essence changed from 'compassion' to 'caring', that one must have a naturally caring nature from which compassion could be

learned or nurtured, but the desire for an essence or natural trait to be identified was still evident.

Box 7: Example of change of opinion about natural traits

> I remember when we first met and I said that I felt compassion was something that you had or you didn't have … I think my point of view has changed on that slightly over the course of the workshops. Cause I do think maybe you're a caring person … you haven't explored compassion, so maybe you can develop those skills whereas before I would have said no, I think you've either got it or you've not. So, I'm more convinced now that actually you can teach people to be compassionate… you can be a caring person but not compassionate… now I believe that if you've got a caring base, a caring nature, then compassion is something that you can develop.

Compassion was also seen as an inherent trait in the discourse of the wider general public (Bond et al., 2018). Although limited to internet responses to a politically left-wing non-tabloid newspaper and two peer reviewed nursing journals, Bond et al's (2018) review of media-generated discourse found compassion was described by the public as both inherent and something that could be nurtured or developed. The suggestion in this public discourse was that compassion could be taught or developed, but that firstly, humans were born with compassion, again reflecting the concept of a folk theory of essence (Lakoff and Johnson, 1999). Despite the belief that compassion was a natural trait, there was no evidence in the literature or narratives to suggest this applied to all people, which brought into question the idea that some people may not have compassion as a natural trait. Vick, Dannenfeldt and Shaw (2017) found that students enrolled on nursing, midwifery and social work courses had compassionate attributes. However, it could be suggested that these professional courses were more likely to attract applicants with compassionate traits, and may or may not reflect the wider population. For a profession that identified compassion as one of its key pillars (Cummings and Bennett, 2012, Department of Health, 2015) this had implications for

the recruitment and selection process for student nurses, to ensure the inclusion of activities that assessed the propensity for compassion.

In relation to the folk theory of essence, Plato implied through his philosophy that essences were ideals and that, as ideals are good, only good things, often interpreted as virtues, had essences. Negative things did not have their own essence, but had a deficit of the ideal essence (Lakoff and Johnson, 1999). Applied to the concept of compassion, Plato's philosophy implied compassion was the ideal essence of a person, and that non-compassion or cruelty was not an essence, but was a deficit of compassion. However, Gilbert (2005) presented an argument for our basic natures being more cruel than kind, evolved through thousands of years of human war and atrocities, motivated by a desire for bravery, reward, power, and entertainment. Georges (2004) extended this argument to nurses and their role in the causes of suffering, noting that nurses' participation in the metanarratives of suffering seen in history (McFarland-Icke, 1999), formed "*an integral part of who we are*" (p254).

Contemporary healthcare policies, guidelines, and professional nursing standards (Department of Health, 2015, Nursing and Midwifery Council, 2018a, b) demand a culture of compassion to all, an expectation reflected in many healthcare organisation vision statements. However, despite the overt expectation of a culture of compassion, contemporary reports and investigations have continued to disclose cases of non-compassion and cruelty in nurses' behaviour. Examples of nurses who have demonstrated cruelty and murderous behaviours whilst working in apparently compassionate healthcare organisations include Beverly Allitt who murdered children in her care (Dyer, 1993), and Victorino Chua who murdered 2 adult patients and attempted to murder many more (BBC News, 2015). Examples of non-compassionate behaviours were also found in Winterbourne View (Flynn, 2012), Mid-Staffordshire NHS Trust (Francis, 2013), and continue to be seen in Ombudsman reports (Parliamentary and Health Service Ombudsman, 2020). There were

multiple potential reasons for these behaviours including mental illness (Hunt and Goldring, 1997), an abusive culture (Flynn, 2012), or a total systems failure (Francis, 2013). However, it could be suggested that the choice for individuals to have been involved in these behaviours, within the wider context of a compassionate profession and health service, may have indicated a natural capacity or potential for cruelty as well as for compassion.

All participants were clearly able to articulate patterns of compassionate or cruel behaviours learnt from the family or life experience, not necessarily because the behaviours were a natural trait. A full discourse about the nature or nurture of compassion development was beyond the remit of this research. However, I would suggest from the findings of this research that people may be born with the capacity for both compassion and cruelty, but it was the context in which compassion and cruelty were developed that was likely to influence behaviour.

The data indicated the participants believed compassionate attributes were innate and could be enhanced, a position that finds support in the literature (Vick, Dannenfeldt and Shaw, 2017). Students entered a nursing course with an innate propensity for compassion, and a desire to develop this further to become compassionate nurses. It therefore becomes an imperative for nurse educators to nurture and develop compassion within the nursing curriculum (McLean, 2011), and to challenge behaviours that may be considered non-compassionate or cruel. The next section discusses the ways in which nurse educators can achieve this through the support and facilitation of teaching and learning within the curriculum.

6.2.2 Teaching and learning compassion

There was a strong feeling at the beginning of the narratives that compassion could not be taught, reflective of wider social discourse (Bond et al., 2018) and closely linked to

compassion as a natural trait. Contrary to this, and supporting the literature (Chochinov, 2007, Neff and Germer, 2013), the participants demonstrated that compassion could be learned and developed through illustrations of their own experiences. This dichotomy that presents an interesting challenge for nurse educators and their contribution to embedding a culture of compassion in nursing through the nursing curriculum (Adamson and Dewar, 2015). As suggested by Aristotle, being habituated in an excellence optimises our ability in that excellence i.e. the more we practice compassion, the better able we are to do it [Aristotle 350BCE, translated by Barnes (1984)].

Whilst there is agreement about the importance of developing and embedding compassion in nurse education (Adamson and Dewar, 2015, McLean, 2011), the most appropriate ways to support the teaching and learning of compassion continue to be discussed. Approaches suggested in the literature that reflected the findings in the narratives include:

- The use of story

- Reflection on experience

- Socialisation and role modelling

The following sections consider these approaches in further detail.

6.2.2.1 The use of story in the development of compassion

Humans have connected, articulated experience, and made sense of the world through stories for centuries (Edwards, 2014). The use of interviews as a data collection tool within the case study methodology encouraged a storytelling approach, making it unsurprising that stories were found in the narratives of all participants. However, despite the human familiarity with storytelling, it was apparent in the participants' narratives, and reflected in the literature (McAllister, 2015, Sheilds, 2016), that hearing or telling a story was not necessarily sufficient for learning. P7 told an emotional story of school friends being openly critical of

her, but telling the story did not result in any learning about compassion, and the story was accepted as true without further reflection. Learning about compassion took place when the participants had the time and took the opportunity to explore and reflect on their own stories and experiences.

For P2, the exploration of her story, including her childhood experiences and friend's death, had been guided by a counsellor, resulting in overt learning about compassion and associated changes in behaviour. For other participants, reflection had been more informal, drawing on friends and family to talk about experiences. Johns (2017) referred to professional practice as a source of experiences, each a potential learning opportunity. However, an informal discussion about an experience only tended to focus on the surface issue, and did not explore the experience in depth to develop contextual interpretation or professional artistry (Schon, 1987). Whilst an informal network was useful for participants to make sense of life experiences, the findings supported Johns' (2017) and Schon's (1987) position that it was insufficient to develop a culture of compassion within nursing.

Story was defined by Petty (2017) as "*a real or imagined account, or plot, of events that is constructed from experience and context and is interpreted to generate knowledge*" (p26). The conscious and deliberate use of story in nurse education has been found to be effective in the development of values, including compassion, and the challenging of judgements (Anderson, 2004, Petty, 2017, Sheilds, 2016, Urstad et al., 2018, Waugh and Donaldson, 2016), with stories of those from different cultures, or with different views providing access to learning that could not be gained through personal experience (Anderson, 2004). Stories have been used in nurse education for many years, but were often scenario-based fictional stories, focused on technical or theoretical knowledge and skills. The use of real stories, rather than fiction, were found to be more effective for learning. They captured the human and emotional elements that could often be missing in fictional stories (Edwards, 2014), and supported the exploration of uncomfortable issues. The authenticity of real stories

enhanced students' ability to relate to them, and apply them to their own practice. It promoted critical thinking, discussion, reflection and professional identity, that enhanced learning about person-centred, holistic care and compassion (Urstad et al., 2018, Waugh and Donaldson, 2016).

Participants were asked about their own experiences, therefore, all the stories used to illustrate experience were real. However, the use of real, personal stories was not without risk. Students presenting personal stories in a group learning environment could experience an increased sense of vulnerability and exposure (Urstad et al., 2018), or cognitive dissonance and strong emotional responses (Waugh and Donaldson, 2016). Manifested in P3's narrative, distress was experienced when she started to consider different issues within her story. Although P3's story was self-explored, not as the basis for wider group learning, the distress caused resulted in her being unable to participate in two further self-compassion workshops. A balance is required between the benefits of learning from real stories and the risk of distress from cognitive dissonance and emotional response.

The findings from this research supported Wood's (2014) proposal that stories for learning should be real, but with a level of detachment or personal distance between students and story to allow differences and similarities in experience to be explored, and to support independent and community critical thinking. The recognition that hearing or telling a story alone was not sufficient for deep learning, and the identified risks of cognitive dissonance and emotional response, emphasised the importance of the nurse educator in facilitating learning about compassion through the use of story, in releasing the power in the narrative (McAllister, 2015). Although difficult (as for P3), Christiansen (2011) suggested it was the inevitable discomfort and cognitive dissonance caused by stories that triggered critical reflection. Therefore, stories should not be avoided, but skilled facilitation and management of critical reflection through story was essential to learning and development of compassion.

The implications of these findings for nurse educators using story are:

- Nurse educators should facilitate the co-creation of authentic stories with students, using the student experience to produce a bank of stories that contain a level of objectivity and anonymity, and can be drawn on for multiple student groups.

- Through curriculum design, nurse educators need to explicitly identify the use of different approaches to utilising story as a teaching and learning strategy for the achievement of different learning outcomes. For students who need to reflect on a range of knowledge, skills and behaviours within an episode of care, my experience supported the use of personal stories as an effective way for students to identify and explore the issues. However, taking into account the risk of distress, for the exploration of more subjective or emotionally sensitive issues e.g. compassionate and non-compassionate behaviours, drawing from a bank of co-created, authentic stories would be more appropriate.

- Nurse educators need to be flexible to support the wide range of views and interpretations within the student group through open discussion, and potentially change their own views as new interpretations are found.

- A deconstruction of currently held views and beliefs risked leaving one unsettled and vulnerable (McAllister, 2015), so the nurse educator has a responsibility to compassionately hold a safe space for students as they reconstruct beliefs based on new understandings.

The importance of authenticity, and skilled facilitation that promoted conscious and deliberate critical thinking and reflection through the use of story was also evident in the participants' learning through reflection on experience, discussed in the next section.

6.2.2.2 Reflection on experience

It was highlighted by all participants that compassion was learned through experience, particularly from reflection on experience, supporting the use of reflection as a well-established teaching and learning strategy in nurse education (Johns and Freshwater, 2005, Sanders, 2009). Acknowledgement must be given to the similarities between the use of story discussed in Chapter 6.2.2.1, and reflection-on-action (Schon, 1987). Participants reflected on personal experiences (stories) to develop their understanding of compassion, so the same benefits, risks, and need for skilled facilitation utilised in stories were required to facilitate reflection on real experiences. Nursing curricula have embedded the concept of formal critical reflection to support learning, both in course content and assessment, a practice that continues throughout a nurse's professional career through the NMC revalidation process (Nursing and Midwifery Council, 2019).

For some participants (P2, P4, P5, P6) their experiences of reflection-in-action, the improvisation of actions in response to a live situation, was not conscious. It was only through facilitated reflection-on-action that they were able to move along the reflective ladder (Schon, 1983, 1987) to consider learning from any actions taken. For example, P5 noticed changes such as someone's milk still on the doorstep and took action to check on their wellbeing, but was only able to recognise this as compassionate behaviour with facilitated, conscious reflection during the interview.

For P2 and P6, personal reflection-on-action, partly facilitated through counselling, was the process through which they were able to gain an insight into their own judgements, and explore experiences from different perspectives. The importance of skilled facilitation to support conscious reflection was seen throughout the development of compassion for these participants, and emphasised the need for the nurse educator to undertake this facilitation regularly within the nursing course.

For P1 and P3, reflective insight came at a specific moment in their lives. P1 described a "*realisation*" [P1] that occurred when she suddenly noticed her ineffective behaviour working with young people, swinging between a "*very kind of strict Mum … and then this wishy-washy Dad*" [P1], and needing to pull herself together to "*become a whole parent*" [P1]. P3 described a "*revelation*" [P3] when she noticed her behaviour was the same as her parents, perceived as judgemental and occasionally cruel. These specific moments were indicative of conscious reflection-in-action (Schon, 1987), caused by an uncomfortable emotional response. From these moments the participants made a conscious decision to change their behaviour with immediate effect to become more compassionate, again supporting the importance of conscious reflection in the development of compassion understanding.

Rolfe (2014) argued that Schon's (1983) work had been misinterpreted, and that reflective practice related primarily to reflection-in-action, experimentation on-the-spot to find a solution or a way forward in a complex situation. Although he acknowledged a place for reflection-on-action, it was seen as a retrospective approach that should only play a secondary role in reflective practice. The experiences of the participants described above did not support Rolfe's (2014) interpretation in relation to the development of compassion understanding, but reflected Schon's (1987) updated work that provided more emphasis on the facilitation of active, conscious reflection on action. Whilst two participants had specific moments of reflective insight in action, these were more unusual moments. The majority of learning took place with facilitated reflection after the event. The adjustments made at the time were not noticed, nor identified as conscious compassionate behaviours, and as seen in P5's example, were embedded to the extent they had become tacit knowledge.

The facilitation of reflection-in-action was not discussed in the participants' narratives, and therefore beyond the scope of this research. However, the omission of reflection-in-action as a strategy for learning compassion identified it as an area for future research, in both the

development of reflection-in-action facilitation skills of Practice Supervisors (Nursing and Midwifery Council, 2018c), and the division of practice into real and virtual worlds (Comer, 2016). Within the rapid expansion of digital technologies, reflection-in-action, when one's action takes place in virtual worlds (Harris et al., 2020, Liaw et al., 2020), is an area for future learning that should be watched with interest, particularly its role in supporting or augmenting learning from practice experience.

The outcome for all participants, whether through reflection on or in action, was a behaviour change towards increased compassion, even though the speed and process of the reflection differed.

6.2.2.3 Socialisation and role modelling

In addition to learning through reflection, the culture of an environment and the socialisation of participants into that environment, played a significant role in the development and embedding of a compassionate culture (Bramley and Matiti, 2014). Five participants identified socialisation and role modelling as important in the development of understanding compassion (see examples in Box 8).

The ideologies and behaviours of student nurses were believed to be influenced by the environment and culture within a team, through the effects of emotional contagion, and the transmission of emotions between individuals and groups, on individuals, teams, and whole organisations (Barsade, 2002). It was believed that the contagion of positive emotions and the consistent and repeated role modelling of compassion may encourage similar tendencies in novice practitioners and students through mimicry and feedback (Barsade, 2002, Bond et al., 2018), a positive socialisation into the nursing profession (Adamski, Parsons and Hooper, 2009). Likewise, exposure to negative ideologies and behaviours was

thought to encourage similar attitudes in a student (Bond et al., 2018). Reflecting the literature, the effects of positive socialisation were experienced by P3 and P6 (Box 8).

Box 8: Examples of participant experience of socialization and role modelling

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Examples of socialisation:

P3: On joining the scouts, a group that "*work on the premise that you must be compassionate towards others*", P3's judgements were challenged "*and that really stirred me to the right position in life*" to be less judgemental and discriminatory.

P6: "*I joined the oncology ward and … the amount of compassion there, it's brilliant, and I think I learnt more there … than I could have done anywhere*".

Examples of role modelling:

P2: Referring to the Macmillan nurse in Box 1 – "*she was very inspirational to me, actually part of the reason I ended up on this course*".

P5: Referring to a previous delivery job where they "*used to have duties … in the delivery span, when you, person who trained you, 'oh just go and knock on so-and-so's door, make sure they're alright*'", not a role requirement, but learned compassion from a colleague for whom it was custom and practice.

P5: Learning from a patient – "*she taught me how to feed her, she told me how she wanted the pad changing. It sounds odd, but she taught me a great deal, and she was a very compassionate woman in herself.*"

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However, the findings differed from the literature when related to negative ideologies, with P2 demonstrating the opposite effect when exposed to negative compassion behaviours in a nursing home. In response to the negativity, P2 was compelled to act compassionately, as an 'everyday hero' (Zimbardo, 2007), illustrated through her increased desire and conscious actions to connect with and advocate for patients to ease suffering.

Despite the benefits of positive socialisation and role modelling, Papadopoulos et al (2016) found only a small number (4.3%) of nurses from an international sample received

compassion from managers, yet those who did were significantly more likely to say compassion could be taught. In a busy healthcare system with multiple competing demands (Georges, 2013) the findings suggested the need for a re-emphasis on compassionate leadership in clinical practice to develop and maintain a culture of compassion that supports positive socialisation, reflecting the position held in recent literature (Ali and Terry, 2017, de Zulueta, 2015, Dewar and Cook, 2014). Whilst programmes to develop compassionate leadership have been found to be effective (Dewar and Cook, 2014), these were not focused on the role of self-compassion. Future research to explore the development of self-compassion in nurse leaders, and the impact on the culture of compassion in their care setting would be interesting, and may extend the corpus of knowledge relating to the application of self-compassion.

The dissonance between ideals and reality in the socialisation of student nurses in practice, as experienced by P2, reflected the literature. Students could feel vulnerable as they tried to balance the desire to uphold ideals and challenge constraints to compassion, with adapting ideals and accepting the constraints to compassionate practice (Boyatzis, Smith and Beveridge, 2012, Curtis, Horton and Smith, 2012). There was limited discussion in the narratives about the causes of any imbalance, but P2 identified two potential factors: firstly that "*it was just a battle that was not worth fighting, I wasn't gonna win*", and secondly that her inexperience as a nursing student made her question her knowledge and understanding, that "*I didn't know what I was talking about*" because "*I'm not a fully qualified nurse*". Nurse educators need to be aware of the potential for dissonance, and support students through this vulnerability utilising sensitive and skilled facilitation of reflection.

Nurse educators also need to role model compassionate behaviours, demonstrating professional artistry (Schon, 1987) through skilful questioning and the challenging of judgements, supporting students to develop the skills to professionally and appropriately challenge non-compassionate practice.

6.2.3 Raising awareness of and challenging judgements

The participant findings demonstrated the influence of judgements on the flow of compassion, that judgements acted as a dam, controlling the amount of compassion given. For example, when P5 realised the complexity and severity of the situation for a patient who required an amputation, a judgement was made that they were more deserving, and a "*deeper*" level of compassion was triggered. For P4, a judgement was made that a family member was not deserving of compassion due to a perceived difference of opinion. In many examples, participants were unaware of their judgements, and only through reflection were the judgements noticed. The influence of judgements on compassion highlighted the need for nurse educators to develop learning and teaching strategies that encourage a safe, non-blame, non-judgemental culture in which student nurses can explore and challenge their own judgements.

As discussed in Chapters 6.2.2.1 and 6.2.2.2, facilitation of structured reflection on real stories of students' own experiences and the experiences of others can provide an effective platform from which attitudes, beliefs, values and judgements can be challenged (Adamson and Dewar, 2015), and students' self-awareness can be developed (McLean, 2011). The data collection of the narratives was not an appropriate place for judgements to be challenged. However, there were numerous opportunities within the telling of these stories for a nurse educator to question and facilitate a fuller exploration of judgements made. It could be suggested, therefore, that nurse educators give a greater emphasis in the curriculum design to focusing on raising awareness of and challenging judgements using strategies of story and facilitated reflection.

Chapters 6.2.1 - 6.2.3 have explored the key areas highlighted by participants in relation to the development of their understanding of compassion, providing an insight into research question two. In summary, it was suggested that people had the capacity to develop

compassion and cruelty, but that student nurses entered the profession with a desire to develop compassion. Implications for nurse leaders and nurse educators were identified. Nurse leaders had a key role in the development of a compassionate culture, supporting positive socialisation in clinical practice. A re-emphasis on compassionate leadership in healthcare organisations may be useful to support compassionate cultural development. Nurse educators also have a key role in facilitating the development of compassion in student nurses. Appropriate teaching and learning strategies need to be embedded into nursing curricula to support the development of compassion through the use of story, safe, conscious, facilitated reflection, and raising awareness of and challenging judgements.

6.3 Research question three: Using self-compassion exercises in everyday practice

The holistic and categorical-content analysis of the narratives provided the greatest insight into the ease with which participants were able to incorporate self-compassion exercises into their everyday practice.

A range of self-compassion exercises were used in the workshops (see Table 6 in Chapter 4.2.3), including meditation and non-meditation exercises. However, it was the non-meditation exercises that were consistently seen in the narratives as easier to use and incorporate into everyday practice. Although these findings reflected my pre-conceived subjective expectations, the concept of 'falsification' (Flyvbjerg, 2011) discussed in Chapter 3.4 was experienced in relation to the rationale underpinning the findings. The pre-conceived expectation was that the ease of use would be influenced by the time required to do the exercise, reflecting Darley and Batson's (1973) findings about the influence of time on noticing suffering, and giving compassion. Interestingly though, the data analysis showed the ease of incorporating self-compassion exercises did not relate to the time taken to do the exercise, but was influenced by the extent of self-focus in the exercise. Of the exercises discussed in the narrative, the more self-focused the exercise became, the less

frequent the exercise was done, and the more difficult participants found it. The following sections discuss these findings within non-meditation and meditation categories.

6.3.1 Using non-meditation self-compassion exercises

The pause button, used most frequently by the majority of participants [P1, P2, P4, P5, P6], was the most externally focused exercise. Designed to encourage participants to notice their own suffering in the moment and take action to ease that suffering, it was often undertaken within the context of an external situation, with a greater focus on external stressors than the self. Participants hit an imaginary pause button, giving them time to look at the situation more objectively and gain a more mindful perspective. The majority of participants found this exercise easy to use, effective in helping them gain perspective and feel calmer, and it was the exercise most embedded into everyday practice. The exercise was used by P2 and P5 so effectively that it had become tacit practice, unconscious to them until they were asked to reflect on their practice, suggesting that self-compassion had become part of their professional artistry (Schon, 1987). It was worthy of note that the two participants who did not use the pause button frequently, did not speak negatively about it. It had not been a difficult exercise to do, they just noted infrequent use of it. The fact that it was easy to incorporate into everyday practice leads to the recommendation that nurse educators should introduce this exercise to students early in the curriculum, at induction or within the first module. It is recommended that the exercise should then be revisited at intervals throughout the course as an update for those who had not used it, and to bring it to the forefront of consciousness for those students who had embedded the practice to the extent it had become tacit knowledge.

The compassionate touch exercise had a greater focus on the self, using touch to comfort oneself when suffering. Compassionate touch was used by slightly fewer participants than the pause button [P1, P2, P3, P6], but was reported as a useful effective exercise that had

been easily incorporated into everyday practice. The positive experience of participants reflected the emerging evidence about self-touch causing brain deactivation and reducing stimuli (Boehme et al., 2019, Oveis, Horberg and Keltner, 2010), and the benefits of comforting touch for emotion regulation, and as an effective resource to respond to emotional need in others (Cekaite and Bergnehr, 2018, Maratos et al., 2017, Pedrazza et al., 2015).

The increased focus towards the self in the compassionate touch exercise marked a change in the ability of all participants to incorporate the exercises into everyday practice. For P7, although comfortable undertaking the exercise in the workshop with others, felt "*awkward*" doing it outside the workshops, suggesting a fear of being judged by others. Interestingly, P7 was found to be the most judgemental (of self and others) and self-critical participant (see Chapters 5.4.1.1 and 5.4.1.2), which may have influenced her response, although it could be suggested that she personally found physical touch uncomfortable (Pedrazza et al., 2015). As the majority of participants had found this exercise useful and easy to use, nurse educators should consider introducing it to the students with the pause button exercise early in the curriculum. However, to accommodate those students who may find touch uncomfortable, nurse educators should also extend Pedrazza et al's (2015) suggestion for education, to raise awareness of students' feelings during different types of touch and learn to cope with emotionally involving forms of touch, including self-touch.

Two other non-meditation exercises practiced in the self-compassion workshops were increasingly focused on the self. One asked the participants to identify things they were good at, average at, and less good at; one asked them to identify and acknowledge their own strengths and qualities. Negative bias was a widely recognised phenomenon in which negative situations, experiences, and thoughts, tended to be more influential and perceived as more accurate than positive ones (Hilbig, 2009). Therefore recognising strengths was seen to be difficult (Germer and Neff, 2013a). Reflecting the literature, participants found it

easy to identify weaknesses, but struggled to identify and acknowledge personal strengths and qualities in the self-compassion workshops. This difficulty was extended to their everyday practice, meaning these exercises were less frequently used. For nurse educators, a more consistent approach to the identification of strengths could be considered throughout the course, potentially at times when students may experience increased stress, such as prior to new placements or assessment periods, reflecting Neff and Germer's (2013) proposal that the more self-compassion was practiced, the more it was learned.

6.3.2 Using meditation self-compassion exercises

Mindfulness, a pre-requisite for self-compassion (Neff and Germer, 2013), was commonly practiced through meditation (Boellinghaus, Jones and Hutton, 2013) and therefore meditations were included in the self-compassion workshops. The meditation exercises used continued to be focused on the self, particularly taking time to notice one's own feelings and give oneself loving kindness and compassion. With the exception of P1 and P3, participants found it more difficult to incorporate self-compassion meditation exercises into their everyday practice.

P1 and P3 both reported regular use of the self-compassion meditation exercises in their everyday practice. However, it could be suggested that this was influenced by their personality (Hollis-Walker and Colosimo, 2011), for example, P1 reported naturally being a reflective person, or their previous experience (Boellinghaus, Jones and Hutton, 2013), for example, P3 practiced Buddhist meditation. The familiarity with reflective practice and meditation made it easier to practice meditation independently. P2 and P6 expressed the desire to incorporate self-compassion meditation into their everyday practice, and did attempt to do this on multiple occasions. However, they were not confident in their ability to practice independently, and expressed a preference for a guided meditation. P4, P5 and P7 did not report using self-compassion meditation at all following the workshops. The benefits

of meditation such as reduced levels of stress, anxiety, rumination, and increased self-compassion (Boellinghaus, Jones and Hutton, 2013) suggested it was a useful tool for nurses to learn.

However, reflecting the risks highlighted in the literature (Boellinghaus, Jones and Hutton, 2013), the experience of undertaking guided meditation in the workshops caused emotional backdraft (Neff, 2011a) and distress for some participants; an emotional response that was subjective and unpredictable. The same meditation provoked different responses in different participants, for example P1 found the 'compassionate friend' meditation positive and comforting, and she often practiced it independently, whereas P2 found it emotionally difficult and became tearful. P3 reported a more extreme emotional response to the loving kindness meditation, to the extent she did not feel ready or able to return to the following two workshops. The processing of this emotional response resulted in a positive, life changing outcome for P3, but a positive outcome was unpredictable, and may not be the case for all.

Only when discussing her experience of applying self-compassion following the workshops did P3 disclose a mental health condition, and acknowledge the impact of that meditation on her condition. The implications of this for nurse educators are significant. With approximately one in six adults in England meeting the criteria for a common mental health disorder, and 39% of adults accessing mental health treatment (McManus et al., 2016), nurse educators are likely to have students within the group who are more vulnerable to an emotional response, and at higher risk of distress. Nurse educators need to carefully manage the balance between the benefits of meditation and the risk of distress. As recommended by P2, and Boellinghaus, Jones and Hutton (2013), students should be cautioned about the risk of an emotional response prior to learning self-compassion meditation exercises. Therefore, meditation exercises are not recommended for inclusion in nursing curricula.

To support the benefits of meditation, optional meditation workshops may be a useful value-added element for students to access outside a nursing curriculum. The workshops should be run by someone skilled in the facilitation of meditation, not because loving kindness meditation derives from Buddhist practices and may have the potential for mismatched values or religious beliefs (Boellinghaus, Jones and Hutton, 2013), but to manage the risk of distress.   Nurse educators may not have access to the recommended mental health professional as a facilitator (Germer and Neff, 2013a, Neff and Germer, 2013), but should be able to identify a second facilitator for the workshops to offer support and direct students to relevant services where required. Nurse educators must clearly identify the purpose of learning self-compassion to students, emphasising that it is not part of a therapy process, and could consider providing a list of criteria that may suggest attendance was unhelpful, for example, recent trauma or current high levels of distress or vulnerability (Boellinghaus, Jones and Hutton, 2013). Nurse educators should consider the development of guided meditation resources to support independent practice.

To summarise the insight gained in response to research question three, participants found non-meditation self-compassion exercises easier to incorporate into everyday practice, with exercises becoming increasingly difficult to incorporate as the focus moved from the external to the self. The pause button and compassionate touch exercises should be introduced to nursing students at induction or within the first module of the course, with more self-focused non-meditation exercises introduced and practiced at regular intervals over the first and second year of the course, once students have some experience of mindfulness. Details of these recommended self-compassion exercises can be found in Appendix 21. Teaching and learning of meditation should not be undertaken as part of a nursing curriculum due to the unpredictable potential for an emotional response or distress, but may be made available as optional workshops with skilled facilitators outside the nursing curriculum.

6.4 Research question four: Application of self-compassion

The following sections discuss findings that offer an insight into research question four, the participants' experience of applying self-compassion. Firstly, based on the holistic-form analysis, consideration will be given to participants' overall experience of applying self-compassion, followed by the outcomes identified in the holistic and categorical-content analysis. It is worthy of note that the themes identified were most frequently applied to participants' own lives and overall behaviours, rather than specific to nursing care. Rationale for this focus was not explicit in the narratives, but could include a need for the interview questions to be more specific to nursing care, the freedom of the participants to lead the narrative within semi-structured interview questions (Johnson and Rowlands, 2012, Mishler, 1984), or that the application of self-compassion, whilst taught in one context, affected all aspects of participants' lives and was not specific to nursing (Gustin and Wagner, 2012).

6.4.1 Overall experience of applying self-compassion

When discussing the application of self-compassion, all participants described it as a positive experience, reflecting the literature in which self-compassion has consistently been positively associated with wellbeing and positive affect (Barnard and Curry, 2011). However, demonstrated through the holistic-form analysis (Lieblich, Tuval-Mashiach and Zilber, 1998), there was variability in the extent of impact for each participant. P1, P4, P5 and P6 experienced a gradual positive progression with no clearly identified 'turning points' as they applied self-compassion in their everyday life. P1 and P6 were able to clearly articulate positive changes and increased wellbeing. Similarly, P4 and P5 were able to identify positive changes, but to a lesser degree, and there remained areas of limited change illustrated in their narratives. For P2 the overall experience was positive (as for P1

and P6), but with initial negative progression in response to the compassionate friend meditation exercise. P2 experienced a more fluctuating line of progression.

It was worthy of note that despite the small sample, there still appeared to be extremes of experience. P7 demonstrated a slight overall positive progression, but experienced minimal impact. She experienced increased noticing, but remained highly self-critical. As noticing was found to be a key condition for compassion (discussed in Chapter 6.1.3), an increase in noticing was perceived to demonstrate a small positive progression. At the other extreme, P3 described the overall application of self-compassion as completely life changing, but her line of progression fluctuated. The loving kindness meditation provided a key turning point causing initial distress and a period of negative progression, before changing to a sharp positive progression (Box 5 in Chapter 5.5.2). Lee (2005) discussed the use of a 'perfect nurturer' mental health intervention to elicit feelings of warmth and acceptance, that taught clients how to activate their own nurturing system. It could be suggested that the loving kindness meditation introduced P3 to new skills of self-soothing and self-nurturing, causing an emotional backdraft that took time to process. For the nurse educator, this emphasised the risks of meditation discussed in Chapter 6.3.2. However, despite the distress caused by some of the meditations, and a fluctuation in the line of progression, no participants found it an overall negative experience; an important factor in the nurse educator's ethical duty of care to ensure non-maleficence.

The overall positive experience of applying self-compassion was also demonstrated through the recommendation by all participants that self-compassion should be taught, both within nursing courses, and more widely in the general public. The desire to recommend self-compassion was seen in response to a direct question from the researcher, and consistently illustrated through examples of disseminated practice in the categorical-content analysis.

For five participants, self-compassion was disseminated through role modelling at home and in their placement. P1 and P4, consciously role modelled it to their families with the intention of teaching them self-compassion skills, as they were perceived to be important life skills. Interestingly, P7 also taught her family about self-compassion, despite finding it difficult to apply to herself. This reflected Allen and Leary's (2013) study about self-compassionate responses to aging, where it was found that older people encouraged others to be self-compassionate irrespective of their own propensity for self-compassion. Although only demonstrated by one participant, this could indicate a similarity between younger and older people in the dissemination of self-compassion to others that is worthy of future exploration.

Role modelling was identified in Chapter 6.2.2.3 as a relevant theme in the development of compassion, with role modelling of compassion found to enhance self-compassion in others (Barnard and Curry, 2011). It was unsurprising therefore, that role modelling was similarly involved in the development and dissemination of self-compassion. To develop and nurture self-compassion in student nurses, the implication of these findings is that self-compassion should be role modelled by nurse educators and other health care professionals supporting learning in clinical practice. A wider programme of self-compassion training across faculty staff and healthcare teams is therefore recommended, to enhance the development of students and as an area for future study.

6.4.2 Outcomes of applying self-compassion

In addition to the overall positive experience and desire for dissemination, five other outcomes of applying self-compassion were identified. Two of these, becoming more accepting, and increased compassion towards others, were found in the majority of cases and are discussed in the following sections. There were three other outcomes of interest identified in relation to the application of self-compassion: increased retention, maturity, and

increased mindfulness. The data for these three outcomes was inconclusive as they were only found in one, two and three cases respectively. However, they did indicate areas of interest for future research, with the potential link to student retention a particular interest for nurse education. These outcomes are discussed in Chapter 6.4.2.3.

6.4.2.1 Becoming more accepting

Becoming more accepting was linked to the development of self-kindness and common humanity, and a reduction in self-criticism and isolation, identified in Neff's (2003b) model of self-compassion. Four participants identified increased acceptance as an outcome of applying self-compassion, which reflected the literature that self-compassion played a significant and unique role in people feeling worthy and acceptable (Barnard and Curry, 2011, Lee, 2005). For P3, acceptance related to her bipolar diagnosis, a diagnosis she had previously tried to hide for fear of others' judgements. Although not intended as a mental health intervention, applying self-compassion following the workshops had a similar impact on her acceptance as that reported in mental health therapy literature (Lee, 2005), that people became more accepting of themselves when practising loving kindness meditation (Boellinghaus, Jones and Hutton, 2013). The acceptance was completely life changing for her. Whilst a positive outcome for P3, the risks for nurse educators discussed in Chapter 6.3.2 were re-emphasised, and highlighted the imperative for nurse educators to clearly set out the purpose of self-compassion development in nurse education. In addition to explaining the purpose of self-compassion development, the nurse educator must also set the parameters for what it is not, that is, it is not designed to be a mental health therapy or intervention.

For the other three participants, acceptance was focused on recognising and taking responsibility for regrets, through action or inaction, accepting that like all humans, they

were not perfect, and that "*everybody gets things wrong*" [P5]. The increased ability to accept responsibility for errors and respond self-compassionately reflected Allen et al's (2015) findings that self-compassionate people were less likely to be self-critical following a transgression, and may handle relationship conflict better. The implication of this for practice learning, given the importance of the practice supervisor/student relationship on learning experience and outcomes (Eller, Lev and Feurer, 2014), was the suggestion that developing student self-compassion could help students to optimise the relationship between themselves and their supervisors, and enhance their learning experience in practice. Where participants had previously been self-critical, increased acceptance had supported the motivation to change. Participants no longer felt obliged to justify perceived weaknesses, but instead accepted they existed and were proactive in addressing them, reflecting the recognised correlation between self-compassion and personal improvement (Zhang and Chen, 2016).

6.4.2.2 Increased compassion towards others

Six participants demonstrated increased compassion towards others following the self-compassion workshops, supporting previous research findings (Allen, Barton and Stevenson, 2015, Barnard and Curry, 2011, Gustin and Wagner, 2012).

P2 made the most explicit statement about increased compassion towards others, presenting it as a fait accompli, that increasing self-compassion automatically increased your compassion towards others. For the other participants, the increase in compassion towards others was more implicit, demonstrated through illustrations of compassionate behaviours that were frequently linked to being calmer and less judgemental. Related to the perception of behaviour change discussed in Chapter 6.5, participants reported being more patient with others, giving them time rather than rushing to complete a task [P6], trying to

understand a situation from another's perspective [P1, P2, P3, P4], and responding kindly to others even when unhappy about the behaviour they have demonstrated [P2, P4]. The reported difference in behaviour reflected the participants' description of the meaning of compassion (identified in Chapter 6.1), hence the finding that applying self-compassion increased compassion towards others. Although the participants acknowledged the role of self-compassion in their changed behaviours, there was recognition that other variables may have influenced these findings [P1, P2, P5]. The participants were gaining knowledge and skills through theoretical and practice experiences on their nursing degree, which may also have influenced their compassionate behaviours towards others.

Compassion towards others was seen as key to nursing (Cummings and Bennett, 2012, Department of Health, 2015, Nursing and Midwifery Council, 2018a), resulting in a cultural and societal expectation to put patients first, often at the expense of self-care and self-compassion. There was a scarcity of literature focusing on the relationship between self-compassion and compassion to others, but Andrews et al (2020) developed a conceptual framework from their constructivist grounded theory study that placed the need for permission as central to that relationship in nursing.

The need for permission raised interesting connections between the wider literature and the data from this research in relation to needing permission for action. Permission, whether direct or indirect, was identified by Zimbardo (2007) as a factor in non-compassionate, cruel or abusive actions, and parallels were drawn in this research between nursing care and Zimbardo's (2007) work in relation to the active nature of compassion and cruelty, and passive nature of non-compassion (see Chapter 6.1.2.1). Although compassion (for the self or other) was believed to be the antithesis of cruelty (Gilbert, 2005), both were identified in the data as intentional active processes. Andrews et al's (2020) findings suggested that without permission for active self-care, nurses could develop a passive non-compassionate approach to the self, which ultimately led to poorer care and compassion for others.

If, as suggested by Andrews et al (2020) and supported by the data, increased self-compassion leads to increased compassion towards others, whilst protecting the wellbeing of nurses, there are clear implications for nurse leaders and educators. The implications for nurse leaders are that the development of a compassionate culture must include permission for self-compassion, both through explicit actions and role modelling. For nurse educators, explicit permission to act compassionately to the self and others must be embedded throughout the curriculum, from the introduction of self-compassion and self-compassion exercises at induction, to the integration of self-compassion in the simulation of skills, preparation for assessments, and role modelling from academic staff. The inclusion of explicit permission supports the development of active self-compassion as an established practice early in the students' career, and nurtures compassionate role models of the future.

6.4.2.3 Other outcomes of applying self-compassion

Although found in fewer participants, three other outcomes of applying self-compassion were identified: increased mindfulness, maturity, and increased retention.

A substantial body of research on mindfulness has demonstrated its association with reduced stress (Irving, Dobkin and Park, 2009, Newsome, Waldo and Gruszka, 2012, Ruiz-Fernandez et al., 2020), reduced experiential avoidance (Fulton, 2016), increased coping (Beddoe and Murphy, 2004), increased empathy (Fulton, 2016, van der Riet, Levett-Jones and Aquino-Russell, 2018), increased wellbeing (Hollis-Walker and Colosimo, 2011), and psychological adaptability (Duarte and Pinto-Gouveia, 2017), associations that were also supported by the data. Following the application of self-compassion, three participants expressed increased mindfulness, an ability to view a situation from a more objective and realistic perspective, rather than exaggerating or seeing situations out of context. The change of perspective then enabled the participants to more effectively cope with situations, and consciously adapt their behaviours. Mindfulness was a key aspect of the self-

compassion model and exercises to develop this were included in the workshops, therefore it was unsurprising that the data showed it had increased. Participants had been taught and had practiced strategies for mindfulness. However, the data contributed to the wider findings and recommendation for self-compassion to be included within nursing curricula.

Two participants described a feeling of maturity following the application of self-compassion. Although maturity was not defined within the narratives, it appeared to be related to more effective coping and feeling calmer. The perceived change of behaviour related to calmness is discussed further in Chapter 6.5.2.

Potentially, the most interesting of these three outcomes for nurse leaders and educators was the influence of self-compassion on student retention. P2 was finding her clinical placement in a nursing home difficult to cope with, and was upset and frustrated by the staff culture and perceived non-compassionate behaviours towards the residents. Through the application of self-compassion, she was able to notice and acknowledge her own suffering, gain confidence and trust in her own knowledge, skills and judgements, and was ultimately able to implement change to deliver compassionate care by persuading the multi-disciplinary team to undertake a patient medication review. Without self-compassion, P2 stated she would not have coped with the distress she experienced, and would have left the course.

Although only found in one participant, many nursing students experience clinical placements they find difficult or stressful (Grobecker, 2016). A negative working atmosphere, the inability to deliver the care nurses wanted, or nurses feeling disempowered to implement change (Dempsey, 2009), has been found to strongly influence nurses' decisions to leave the profession (Tummers, Groeneveld and Lankhaar, 2013). If an increase in self-compassion was associated with retention, this could have implications for nurse education and the wider nursing profession, emphasising the need for self-

compassion teaching to be embedded in pre-registration nursing curricula and continuing professional development. Therefore the data, although inconclusive, indicated the need for future research into the relationship between self-compassion and retention, and the impact of that relationship on the nursing workforce.

To summarise the insight gained in response to research question four, the application of self-compassion was a positive experience for all participants that enhanced their wellbeing and inspired them to disseminate their new knowledge and skills to others. Participants became more accepting, both of themselves and of their limitations or mistakes. Through this acceptance they were less self-critical, and more motivated to proactively adapt. Application of self-compassion also increased compassion to others, a key factor in nursing practice.

In addition to the generic outcomes experienced following the application of self-compassion, the participants also identified perceived changes in their behaviour. The changes are discussed below in response to research question five.

6.5 Research question five: Perception of behaviour change following the application of self-compassion

The holistic and categorical-content analysis of the narratives provided the greatest insight into the participants' perception of behaviour change following the application of self-compassion. All participants recognised some change in their behaviour, whether minimal [P7] or complete [P3] change.   In relation to Neff's (2003a) model of compassion, the perceived changes related to all three aspects of the model (self-kindness, common humanity, and mindfulness), and were equally weighted across all aspects of the model. The perceived changes in behaviour and the related aspect of the self-compassion model were identified as:

- Increased noticing (all participants, related to mindfulness)

- Calmer reactions and feelings (6 participants, related to self-kindness)

- Recognition of common humanity (6 participants, related to common humanity)

- Being less judgemental (5 participants, related to common humanity)

- Reduced self-criticism (4 participants, related to self-kindness)

- Increased motivation to learn (4 participants, related to common humanity and self-kindness)

- Objective consideration of context (4 participants, related to mindfulness)

These changes will be discussed in the following sections related to the relevant aspect of the self-compassion model.

6.5.1 Perceived changes related to mindfulness

The most frequently perceived change in behaviour, identified by all participants, was an increase in noticing, whether noticing their own feelings and suffering, or noticing the context and situation they were in. The importance of noticing in self-compassion reflected the discussion in Chapter 6.1.3, in which the need to notice was identified as a key condition for compassion. The definitions of compassion and self-compassion were believed to be synonymous, differentiated by an other-facing or self-facing focus (Neff, 2003a), which therefore indicated that the need to notice was also a key condition for self-compassion. To consider the relevance of the need to notice in self-compassion, it was useful to look at the outcomes of perceived behavioural change.

The outcomes of increased noticing were experienced as positive for the participants. Being able to recognise ones' negative emotions such as frustration, anger, loneliness, or feeling

overwhelmed, meant the participants were then able to recognise the need for compassionate action to ease their suffering. Participants reported that prior to the application of self-compassion, their focus for compassion had been other-facing, reflecting Andrews et al's (2020) findings that nurses tended to comply with social and cultural expectations to put patients first at the expense of self-care. Participants failed to notice their own feelings or were not able to identify their feelings correctly. However, following the application of self-compassion, participants were better able to notice and provide compassion for their feelings. For example, P2 spent a large part of her shift providing end of life care for a patient, who then died while she was on her break. Where previously she would have felt guilty and allowed the negative emotion to dominate her thinking for the next few days, self-compassion enabled her to identify a more specific range of emotions such as feeling sad at the death, happy that the patient had died peacefully with his family present, and angry that she was not there at the point of death. She was then able to process those different emotions more efficiently and move forward without any lingering negative emotion. Without noticing the negative emotions causing suffering, the processing of emotions was likely to have been slower and more distressing, an experience also illustrated by P1.

The change in behaviour was an improvement in the efficiency and effectiveness of processing negative or uncomfortable emotions. In the nursing profession where emotional labour was a recognised cause of suffering (Cheng et al., 2013) and professional attrition (Elliott, 2017), the ability to notice one's own suffering and process the emotions effectively and efficiently using self-compassion has the potential to reduce stress, and improve the wellbeing of nurses. With self-compassion strategies to ease suffering, it may also help to prevent compassion fatigue and burnout.

The increase in noticing was not exclusive to suffering or negative emotions. P6 reported increased noticing of mind wandering. Mind wandering was identified as a normal part of the brain's default mode of operation (Killingsworth and Gilbert, 2010), and was considered

a way for the brain to process memory and enhance creativity by making connections between concepts (Levitin, 2014). However, the ability to notice mind-wandering meant P6 could purposely, but compassionately, bring her focus back to task, which she believed enhanced her performance, particularly in academic work.

Increased noticing also led to a perceived increase in the ability to more objectively consider the context of a situation, illustrating in action the increased mindfulness discussed in Chapter 6.4.2.3. Reflecting the wider literature (Allen, Barton and Stevenson, 2015, Neff, Hsieh and Dejitterat, 2005), a more mindful perspective helped to prevent over-exaggeration of a situation, particularly when the participant felt they had made an error, which supported learning through reflection. A more objective perspective of context also had a direct impact on patient care for P2 when caring for a patient perceived by others as 'difficult'. The application of self-compassion to support mindful contextualisation of a situation enabled P2 to notice the reasons why a patient may be "*cross*" and find ways in partnership with the patient to ease the causes of the suffering. Therefore, it is proposed that increased noticing as a result of the application of self-compassion has positive outcomes for the self and potentially for compassion towards others, emphasising the importance of noticing as a key condition for compassion and self-compassion.

The main non-meditation exercise taught to the participants to improve mindfulness was the 'pause button' visualisation. In light of the ease with which the participants incorporated the pause button exercise into their daily practice (discussed in Chapter 6.3.1), a connection could be made between the teaching and practice of the pause button exercise and an increase in noticing. This further emphasises the recommendation that the 'pause button' visualisation is taught to student nurses at induction, and revisited throughout the course. Also, that exercises are included within the learning and teaching strategies of nursing curricula that prompt students to pause and notice; notice their own feelings within and

about a situation, and a mindful perspective of the context of a situation, helping to embed noticing as an established practice.

6.5.2 Perceived changes related to self-kindness

A significant change in behaviour expressed by six participants was a new sense of calmness. Although there was a scarcity of research about the impact of self-compassion in the student nurse population, self-compassion had been seen throughout the literature to reduce stress and anxiety, and increase coping across a range of different groups of people (Allen and Leary, 2013, Neely et al., 2009, Neff and Germer, 2013, Newsome, Waldo and Gruszka, 2012, Phillips and Ferguson, 2013). The participants did refer to feeling less stressed and anxious, however they also described it as a sense of calm. It was the translation of that calm feeling into action, through calmer reactions to stressful situations or suffering (as seen in Box 6 in Chapter 5.7.1), that demonstrated the perceived change of behaviour. It was relevant to note that the application of self-compassion did not prevent the participants experiencing stress or suffering. However, similarly to the increased noticing discussed in Chapter 6.5.1, participants were able to respond to suffering calmly in a more mindful way, which enabled them to notice and process their emotions more efficiently and effectively, and made it easier for them to take compassionate action to ease suffering.

The relevance of this perceived change in behaviour relate to the known experiences of student stress within nurse education. A wide range of research has identified that student nurses experience stress (Deary, Watson and Hogston, 2003, Edwards et al., 2010, Jimenez, Navia-Osorio and Diaz, 2010, Rudman and Gustavsson, 2012, Sharif and Masoumi, 2005, Watson et al., 2008), although there was some disagreement about when the stress was experienced. Watson et al (2008) found a gradual increase in stress throughout the nursing course that peaked at a post-qualification point, making newly qualified nurses most vulnerable. Other research agreed with increasing stress throughout

the course, but highlighted the second year or beginning of the third year as the peak of self-reported stress and anxiety (Edwards et al., 2010, Jimenez, Navia-Osorio and Diaz, 2010, Sharif and Masoumi, 2005). Although sources of stress could be academic, clinical or external, it was stressors related to clinical practice that were found in the literature to be the major causes of stress, including witnessed pain and suffering, being unable to answer questions, not knowing how to help patients (Jimenez, Navia-Osorio and Diaz, 2010), frequently changing clinical environments to unfamiliar areas (Sharif and Masoumi, 2005, Watson et al., 2008), fear of making mistakes, and having performance evaluated (Sharif and Masoumi, 2005). For the participants, the application of self-compassion eased these stressors in a variety of ways. As discussed in Chapter 6.4.1, becoming more accepting eased the stress caused by the fear of making mistakes or not knowing how to help or answer questions, and enhanced motivation to learn.

The negative impact of stress on confidence and motivation to learn was recognised in the literature (Grobecker, 2016). It was anticipated therefore that a reduction in stress would increase confidence and motivation to learn, findings that were illustrated in the data. The application of self-compassion had been shown to motivate learning and improve performance in college students (Neff, Hsieh and Dejitterat, 2005), but there was minimal exploration in relation to student nurses learning in clinical practice (Moeini, Sarikhani-Khorrami and Ghamarani, 2019). Four participants experienced an increased motivation to learn. For one participant, the motivation related to academic work, enabling her to engage with feedback from a failed theory assessment and significantly improve her performance at the second attempt. For three participants, the motivation to learn related to clinical practice, with perceived changes in the way they pro-actively prepared for future placements, finding out about the speciality prior to the placement to optimise the learning opportunities available, and feeling confident enough to actively seek learn opportunities. All four participants acknowledged these as changed behaviours since applying self-compassion, supporting the benefits of teaching self-compassion in the nursing curricula.

An interesting area for future research would be to explore on a wider scale the relationship between self-compassion and learning in clinical practice.

Also related to the self-kindness aspect of the self-compassion model (Neff, 2003a), four participants found the application of self-compassion resulted in reduced self-criticism. Where previously participants may have berated themselves if they felt they had not performed well, or did not compare well to others, applying self-compassion changed their behaviour so they were kinder to themselves and had a reduced tendency to beat themselves up. As self-criticism was seen as an outcome of negative self-judgement (Germer and Neff, 2013b, Gilbert, 2010), the reduction in self-criticism in the data was deemed to be connected to the participants' reports of being less judgemental (discussed in Chapter 6.5.3).

The reduction in self-criticism was perceived with caution by two participants [P5 and P7] who felt the need for some self-criticism in order to motivate themselves to act. Reflecting concerns in the literature (Boellinghaus, Jones and Hutton, 2013), and discussed in Chapter 2.5.3, being kind rather than self-critical seemed to trigger worries about becoming complacent. However, although the two participants expressed concerns about self-kindness, their concerns were not manifested in descriptions of their experience with academic work or in clinical practice.

6.5.3 Perceived changes related to common humanity

There were two main changes in behaviour found through categorical-content analysis that related to common humanity. The first of these, seen in six participants, was an increased recognition of common humanity, that one does not have to be perfect and, like all humans, one has both strengths and weaknesses. The second change, seen in five participants, was a perception of being less judgemental, both to themselves and towards others.

Prior to the application of self-compassion, participants had a tendency to negatively compare themselves with other nurses or an imagined ideal, which exacerbated the stress recognised in the literature of feeling incompetent and fearful, particularly in a new and unfamiliar clinical placement (Jimenez, Navia-Osorio and Diaz, 2010, Sharif and Masoumi, 2005, Watson et al., 2008). The social comparison experienced by participants in new practice learning environments reflected the literature about self-esteem, that it was based on self-judgements and comparisons, and the perceived evaluations of others (Neff, 2003a, Neff and Vonk, 2009). Edwards et al (2010) proposed nurse educators should find ways to improve students' self-esteem as they believed it was a buffer against stress. However, self-esteem decreased over the period of a nursing course, leading to students experiencing increased levels of stress and anxiety (Jimenez, Navia-Osorio and Diaz, 2010, Sharif and Masoumi, 2005, Watson et al., 2008).

Despite the potential benefits of self-esteem, particularly non-contingent self-esteem (Vonk and Smit, 2012), there were also recognised pitfalls such as the dismissal of negative feedback, trivialisation of failures or the attribution of failures to external causes, which could lead to the development of a false self-evaluation and the hindrance of learning and personal improvement (Neff and Vonk, 2009). Self-compassion, on the other hand, was found to correlate with the positive aspects of high self-esteem, but not with the negative aspects that resulted in maladaptive behaviours (Neff, 2003a).

For the six participants, increased recognition of common humanity, being able to recognise that all people are fallible, appeared to reduce social comparison, and enabled them to accept their limitations as part of the normal human condition. For example, when starting a new placement, rather than feeling incompetent and fearful of making mistakes or not being able to answer questions, participants accepted that they could not know everything about that speciality or the specifics of care in that unfamiliar area, and that they were there to

learn.   As discussed in Chapter 6.4.2.1, the ability to acknowledge and accept limitations in knowledge and competence because everyone has them, or accept responsibility for mistakes because everyone makes them, supported a change of behaviour with reduced stress and intrinsically motivated proactive learning. It is therefore suggested from this data that the focus for nurse educators should be on the development of self-compassion in preference to self-esteem.

Applying self-compassion led to a perceived change in judgements made. The participants became less judgemental towards themselves and others. The reduction in negative self-judgement was illustrated by reduced self-criticism (seen in Chapter 6.5.2) and contributed to reduced stress, and increase motivation to learn. As with compassion (discussed in Chapter 6.1.3), there was a need to notice self-judgement, and where appropriate, acknowledge the suffering caused by it, before implementing strategies to ease the suffering. Although facilitated reflection in nurse education can increase self-awareness, effectively challenge judgements, and provide intrinsic skills and motivation for learning (McLean, 2011), the reliance on external facilitation of reflection remained. The findings reported by participants suggested that self-compassion provided them with a "*tool kit*" [P1] of the skills and knowledge to notice and challenge their own judgements, and actively apply self-compassion to challenge those judgements or to consider them from a more objective perspective. Skills and knowledge that could be utilised and nurtured throughout a nurses' career without the need for external facilitation.

In addition to reduced self-judgements, participants felt they were less judgemental towards others. The recognition of common humanity in others supported a more holistic assessment of a person or situation. Rather than focusing on one aspect or behaviour of a person and making a negative judgement based on that, for example the perception of a 'difficult' patient [P2] or a colleague appearing brusque [P4], the participants holistically considered the situation from the other person's perspective; why they might be behaving in

a particular way. Gaining holistic knowledge and understanding of wider factors that may have caused others' behaviours, without making judgements about that person or situation, meant participants were more tolerant, patient, explored alternative actions to reduce suffering, and were more compassionate to others.

Drawing on the proposed metaphor in this work, and as discussed in Chapter 6.1.2.2, judgements were found to be the dam that controlled or prevented the flow of compassion, particularly judgements about deservedness for compassion. It could be suggested from the data that increasing self-compassion opened the dam and enhanced the flow of compassion, providing increased compassion for patients, families, other members of the healthcare team, and the self. In light of the professional requirement for nurses to be non-judgemental and compassionate (Nursing and Midwifery Council, 2018a), the development of self-compassion through nursing curricula may help to prepare students to meet these professional requirements more effectively.

To summarise the insight gained into the response to research question five, the participants identified a range of perceived changes in behaviour relating to self-kindness, mindfulness, and common humanity following the application of self-compassion. Although discussed as separate aspects within this work, the findings supported Neff's (2003a, 2016) belief that the three aspects interact, and mutually enhance and engender each other. For example, recognition of common humanity and the acceptance of themselves as imperfect (common humanity), meant participants were more likely to view the context of a situation from a more objective perspective (mindfulness), less likely to judge themselves or others harshly (common humanity), and were less likely to be self-critical (self-kindness), all of which supported a sense of calmness, reduced stress, and an intrinsic motivation to take a proactive approach to learning.

CHAPTER 7: CONCLUSION

The aim of this research was to explore student nurses' experiences of applying self-compassion. Utilising multiple case study methodology, seven cases were explored, providing an in-depth rich data with which to address the research questions. In this conclusion, I am going to discuss the main findings of the research, and consider how my research extends the current literature demonstrating an original contribution to knowledge. A methodological review will consider the strengths and limitations of the methodology, and discuss the innovative approaches used, proposing a new model for data analysis in future qualitative research. The potential impact of this new knowledge on nursing, nurse education, and inter-disciplinary education will be considered, and recommendations for future practice and future research made, including a strategy for dissemination.

It is my belief when considering the meaning of compassion and self-compassion, that they are the same concepts with a different directional flow: compassion towards others, whether people, animal or environment, and compassion towards the self. However, in relation to understanding the concept of compassion, the findings reflected the ambiguity seen in the literature. Multiple conceptualisations, whilst highlighting commonalities, had not provided an agreed unambiguous definition of compassion, which made it more difficult for students to develop their understanding of it. One possible reason for this was the abstract nature of such a subjective concept, which resulted in political and professional debate about whether or not compassion could be measured or mandated for. To date there remain limited tools with which to objectively measure compassion.

Another potential reason for ambiguity found in the data was the lack of a shared language for compassion, particularly to support the learning and teaching of compassion. The operational definition of compassion expressed in Chapter 2.3.8 captured the commonalities

of compassion found in the literature, but the language used may be less accessible to students beginning to learn about the concept. The description drawn from the participants' understanding of compassion in Chapter 6.1 may be a more accessible definition for students in the initial stages of learning, but did not include the affective domain. I therefore suggest that the description drawn from my research used to support the learning and teaching of compassion and self-compassion, and act as a platform for exploration of the concepts is:

> Compassion is an active, holistic process, requiring an emotional response, knowledge and understanding, connectivity, and communication. It involves noticing suffering, being there, giving time, and acting to ease suffering.

Although as a nurse educator the description was developed to support the learning and teaching of student nurses, it could also be applicable to support the education of a range of professionals, for example, allied health and medical professionals, social workers, educators, police, and any other profession that has a pastoral dimension.

The model of interconnections seen in Chapter 2.7 identified a range of established interconnections between compassion and self-compassion, and suggested potential new interconnections between the development of self-compassion and nursing. From these potential interconnections, research questions were developed to explore student nurses' understanding of compassion and their experience of applying self-compassion. As seen in Figure 7, my research extends this model of interconnections, demonstrating my contribution to new knowledge.
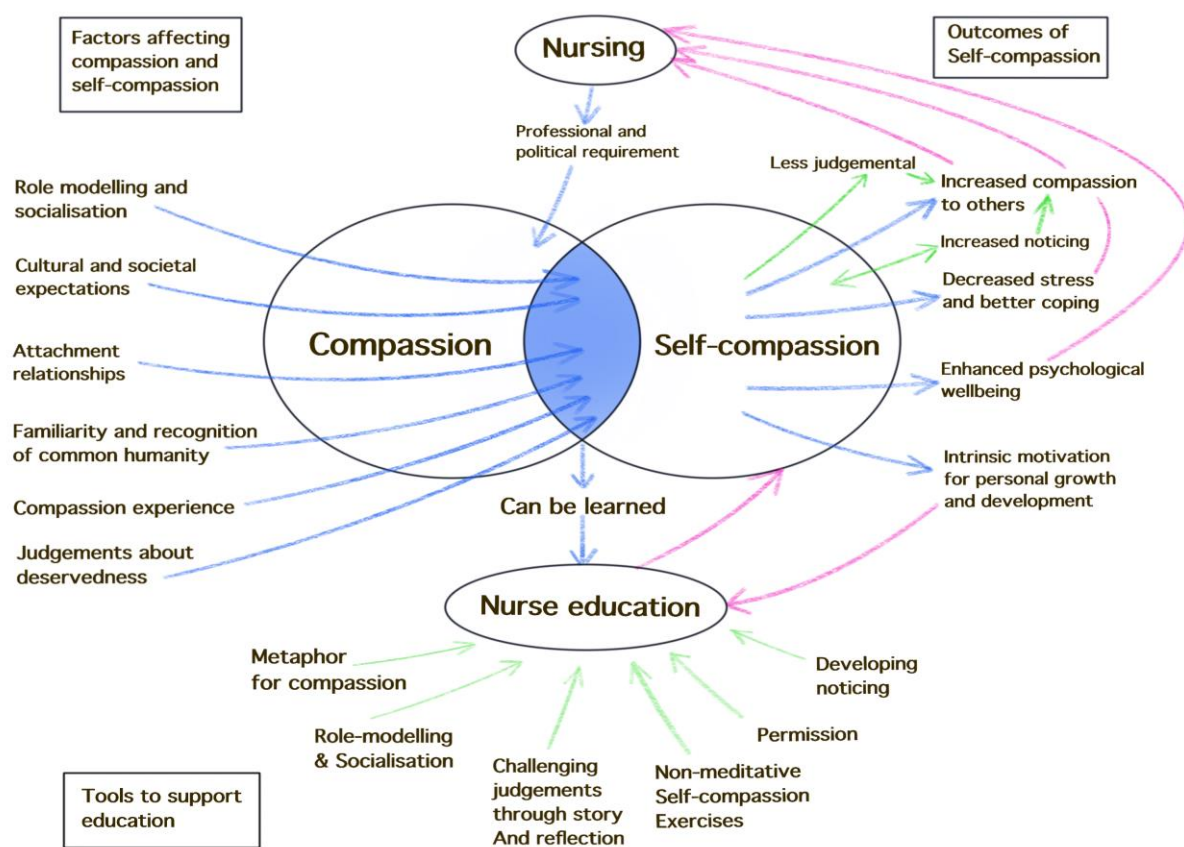
Figure 7: Model of the interconnections between compassion and self-compassion, with proposed tools to safely support education

The data supports the established interconnections (seen in blue in Figure 7), and the proposed interconnections (seen in pink in Figure 7), providing some insight into the factors that address the current gaps in knowledge relating to self-compassion and nursing. Highlighted in green in Figure 7, and discussed below, my findings also identify new outcomes of applying self-compassion that are pertinent to nursing, and propose a range of learning and teaching strategies and tools to safely support nurse educators in the

development of students' knowledge and understanding of compassion and self-compassion.

When considering tools to support the learning and teaching of compassion, the use of metaphor is an interesting area arising from the data. As discussed in Chapter 6.1.1, metaphors were believed to be vehicles through which ideas could be communicated, therefore they had the potential to enhance understanding of new concepts. However, the data showed inconsistency in the language used to describe compassion, including the use of metaphor. I have proposed a metaphor for compassion (Chapter 6.1.1) as a potential tool to support the development of understanding, and enhance professional discussion and debate. The proposed metaphor is:

- Compassion is clean, flowing water.
- Personal judgements are a dam (controlling the flow of compassion)
- People are reservoirs (for compassion)

Dissemination and use of the metaphor has commenced through its inclusion in pre-registration nurse curriculum content. I have developed recorded lectures and online learning resources, which have been utilised to facilitate learning about the concepts of compassion and self-compassion using the metaphor for over 500 students. Early indications from the use of the metaphor as a teaching tool are positive. Students have reported the effectiveness of it in aiding their understanding, and as a framework to consider the different elements of compassion. Further work to explore the value and effectiveness of the metaphor as a teaching tool is ongoing, but goes beyond the scope of this research.

The use of story, conscious facilitated reflection, role modelling and socialisation are also seen as effective learning and teaching strategies to support the development of compassion and self-compassion. Role modelling and socialisation are widely recognised

in the development of compassion and self-compassion (see Chapter 6.2.2.3). Nurse educators therefore have a responsibility to develop and maintain a compassionate culture, supporting students to become socialised into that culture, and role modelling compassionate behaviours. Reflection on personal experience is an established learning strategy in nursing to develop knowledge and understanding of a situation. However, exploring and challenging judgements through reflection on personal experience may increase feelings of student vulnerability and hinder learning. Raising awareness of and challenging judgements is seen to be important in the development of compassion as judgements strongly influenced compassionate or non-compassionate behaviours. I therefore recommend that stories, ideally co-created with students to enhance authenticity, are used to structure facilitated reflection focused on compassion. For the purposes of learning compassion, this study suggests the reflective model or educative strategy used is less relevant; it is the safe facilitation of learning through conscious reflection deliberately focused on compassion that matters.

The need for learning and teaching of self-compassion within nurse education was unanimously agreed in the data, and supported the positive outcomes of self-compassion seen in the literature. However, as with the teaching of compassion, consideration needs to be given to the tools available to support the development of self-compassion in an education setting. The tools utilised in the research reflected those used in established mindful self-compassion programmes, and varied in the extent to which they were self-focused. Unexpectedly, the ease with which self-compassion exercises were incorporated into everyday practice did not relate to the time they took, but to the level of self-focus. In practice this meant that non-meditative exercises such as the 'pause button' visualisation and 'compassionate touch' (Appendix 21) were easy to use and embed in daily practice, and produced positive outcomes. Other non-meditative exercises with a greater self-focus were found to be more challenging, but helped to develop self-compassion skills without causing distress. The exercises focused more on common humanity, the recognition of one's own

strengths and imperfections as a normal part of the human condition. Although these exercises took more practice, and required more facilitation, the outcomes of increased common humanity were felt to be beneficial. With a low risk of distress, and reported positive outcomes, I therefore recommend that these non-meditative exercises are introduced to students early in their course (at induction or within the first module) and revisited at regular intervals throughout the curriculum (see Appendix 21 for details of these exercises).

Meditation exercises had a much greater focus on the self, and the potential for them to cause distress was unpredictable. With expert facilitation, the outcomes of meditation exercises were seen in the literature to be beneficial. However, nurse educators would not necessarily have the expertise required to safely facilitate self-compassion meditation exercises, nor to effectively manage any distress caused. The mental health or vulnerabilities of the student body are also likely to be unknown to the educator. Meditation exercises are therefore not recommended to develop self-compassion in pre-registration nurse education. Self-compassion workshops should only be considered outwith the curriculum if supported and facilitated by people with appropriate expertise.

In addition to the learning and teaching strategies identified to safely develop compassion and self-compassion, new knowledge is found relating to the outcomes of applying self-compassion. The outcomes experienced by participants reflect those seen in the literature, and strengthen the known interconnections. However, the data also extends the detail supporting these interconnections, and highlights other outcomes that could be considered pertinent to nursing (seen in green in Figure 7). A significant new connection is found between self-compassion and increased noticing. The need to notice was identified in the literature and research data as a pre-requisite for compassion and self-compassion, without which neither could be given. Therefore, increasing self-compassion through education and practice may increase noticing, which enhances compassion towards others, but also

provides a positive feedback loop to continued development of self-compassion. In clinical practice, given the potential for experts to perform their artistry at sub-conscious rather than demonstrably visible levels (Schon, 1995), Registered Nurses need to overtly demonstrate noticing. Overt noticing through dialogue, providing explicit rationale for care decisions, has the potential to support the embedding of active compassion as part of their professional artistry (Schon, 1987), and enhance a culture of compassion in the care setting.

Being less judgemental was also found to be an outcome of applying self-compassion, identified as a new connection that results in increased compassion towards others. Recognition of common humanity means it is easier to gain a more balanced perspective, using knowledge and understanding to view suffering in an holistic, non-judgemental way. In nursing, where the delivery of non-judgemental compassionate care is a professional requirement and cultural expectation, the development of self-compassion may help nurses to meet this requirement. As well as increased compassion towards others, being less judgemental is also connected to reduced self-criticism, and an increased sense of acceptance. Being able to see and accept oneself as imperfect, the same as all other humans, appears to make space for a more objective consideration of the context of a situation, which reduces self-criticism and enhances intrinsic motivation for development. As with noticing identified above, the potential for a positive feedback loop can then be seen between enhanced intrinsic motivation for personal growth and development, and engagement and success in nurse education.

The application of self-compassion in nursing is identified as a positive development that should be facilitated and encouraged, as it supports an increase in compassion towards others without compromising one's own self-care and self-compassion. Providing explicit permission for self-compassion, nurse educators and nurse leaders can support the development of a compassionate culture, and nurture compassionate role models of the future.

Although my research findings have extended the current corpus of knowledge, and suggested interesting ways in which nurse educators can safely support the development of compassion and self-compassion, it is appropriate to acknowledge and consider the strengths and limitations of the chosen methodological approach. The following section undertakes this review.

7.1 Methodological review

The methodological approach supported the achievement of the research aim to gain an insight into student nurses' experience of applying self-compassion.

The research questions were designed to gain an insight into two areas: participants' understanding and development of compassion, and participants' experience of applying self-compassion. Although I set out to primarily focus on the experience of applying self-compassion, the data collected focused more on one area, with greater weighting given to the understanding and development of compassion. One can speculate about the rationale for this balance, that participants may feel more comfortable talking about other-facing concepts, and less comfortable talking about the self, (reflecting the challenges discussed in Chapter 6.3 of participants finding it harder to focus on the self), or that they had a greater level of experience with other-facing compassion than self-compassion. Therefore, future research may consider a different approach, separately exploring the two key areas of study: one, using the same case study methodology to explore the understanding and development of compassion; and two, extending the case study methodology to include quantitative data to explore the experience of applying self-compassion. A decision was taken during the research planning phase not to use quantitative measures of self-compassion as previous studies had found training increases self-compassion in different groups, for example college students and older people (Germer and Neff, 2013a, Neff and

Germer, 2013, Neff and Pommier, 2013), and it was felt the data would not add new knowledge to the field. However, a scarcity of literature about the application of self-compassion in nursing suggests the need for future research utilising qualitative and/or quantitative data. Further research could provide insights into the value of self-compassion for students and Registered Nurses, and potential correlates between self-compassion and experience, that would inform curriculum development.

The self-selecting nature of the sample could also be considered a limitation of the research, with those who chose to participate having a specific interest in the development of self-compassion. All participants were mature students who had experienced life trauma or difficulties to some extent, which may have influenced their self-selection decisions. Maximum variance in the sample would have enhanced the analytic generalisation of the findings, particularly in relation to gender and age, but was not possible due to the sample size, and was not the main aim of my study. Using a small sample was useful to explore the research questions in depth. Future research with different sample groups, for example third year students, or qualified nurses could extend the corpus of knowledge.

While self-selection limits the generalisability of findings to a wider population (Flyvbjerg, 2011), the replication and comparison of multiple similar cases in this research, strengthens conclusions and supports case to case transfer and analytic generalisation (Firestone, 1993, Yin, 2014). This is particularly where the data supports the wider research findings, such as enhanced wellbeing (Barnard and Curry, 2011, Neff, 2003a), becoming more accepting (Allen, Barton and Stevenson, 2015, Barnard and Curry, 2011), and becoming intrinsically motivated to engage in learning and personal development (Akin, 2008, Neff, Hsieh and Dejitterat, 2005, Zhang and Chen, 2016). For the reader reviewing the transferability of the findings for their own situation (Firestone, 1993), consideration should be given to the potential for other variables to have contributed to the participants' experiences; a fact acknowledged by P1, P2 and P5 as they continued to engage in

theoretical and practice learning during the research timeframe. It is possible that the development of compassion understanding through theory and practice learning, also increased participants' self-compassion. However, the same situation would apply to all student nurses on a degree programme, enhancing the potential for analytic generalisation.

The advanced communication skills of the researcher, and personal experience and skills in the facilitation of meditation, were seen to enhance the data collection. Use of the same researcher for the interviews and facilitation of the workshops further supported a good rapport that enhanced data collection, demonstrated by participants talking freely with minimal prompts beyond the semi-structured interview questions, and voluntarily disclosing a surprising amount of sensitive personal information about their lives and experiences.

Combining the use of Lieblich et al's (1998) narrative analysis tool, and Peshkin's (1988) subjective I's provided an innovative approach to interrogate the data, contributing new knowledge to the field of case study research methodology. The data analysis tool (Lieblich, Tuval-Mashiach and Zilber, 1998) utilised a pluralistic approach from four different perspectives. Analysis of the data from an holistic and categorical perspective enhanced the analysis through cross-matching of findings, verification and falsification of ideas (Flyvbjerg, 2011), or identification of new themes that would have not have been seen using a single data analysis approach. However, in these case studies the identification of a 'story plot' (Lieblich, Tuval-Mashiach and Zilber, 1998) within the holistic-form analysis was not found to be helpful, or to add to the analysis in a meaningful way.

Lieblich et al's (1998) narrative analysis tool acknowledged the importance of the researcher voice in analysis of data, but lacked a detailed strategy for identifying and accounting for this voice in the data analysis. Peshkin's (1988) approach to identifying researcher subjectivity provided a clear strategy, and was an effective way to reflexively identify the researcher bias within the data (see Chapter 5.8). As a lens through which to view the pluralistic

approaches to data analysis adapted from Lieblich et al's work (1998), the use of Peshkin's I's was an effective tool. Figure 8 illustrates my contribution to new knowledge in case study methodology through the development of a data analysis model that draws on and combines the strengths of Lieblich et al (1998) and Peshkin's (1988) work, whilst excluding the use of 'story plot'.
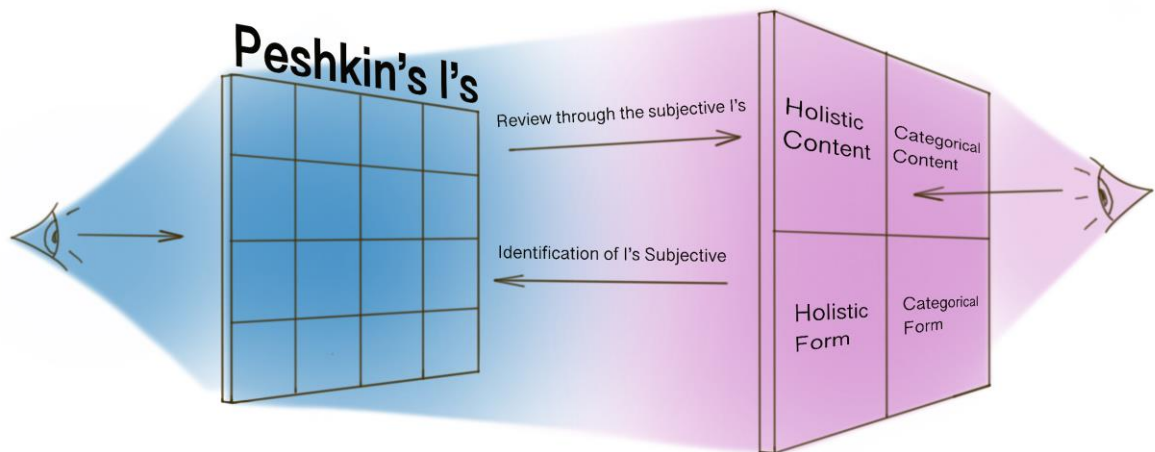
Figure 8: Waller's multidirectional model of narrative analysis utilizing Lieblich et al's (1998) model and Peshkin's I's (1988)

The model has the flexibility to support reflexivity using pre-identified reflexive themes and/or newly identified themes. In the first stage of the data analysis process (on the right of the model in Figure 8), the researcher interrogates the data from four different perspectives:

1. Holistic-content – the researcher uses the complete edited narrative to focus on the content and identify key themes that thread throughout the narrative. The themes are explored in the context of the whole.

2. Holistic-form – the researcher uses the complete edited narrative to identify progression of a theme, whether positive, negative, stable or fluctuating. Turning points that shed light on the whole can also be identified.

3. Categorical-content – the researcher undertakes a content analysis, such as that proposed by Miles and Huberman (1994), on the unedited verbatim narratives to identify and categorise themes.

4. Categorical-form – the researcher uses the unedited verbatim narratives to focus on stylistic or linguistic characteristics, for example, the use of metaphors, active or passive comments. These are extracted and counted.

During this stage of the data analysis the researcher can also look for evidence of subjectivity, which can then be categorised and themed into Peshkin's I's.

In the second stage of the data analysis process (on the left of the model in Figure 8), the researcher reviews the narratives through the lens of each of the subjective I's, whether these are pre-identified or newly identified I's. The transparent identification and acknowledgement of these subjective I's, along with an exploration of their influence on the data collection process and the interpretation of findings from the data analysis, provides the comprehensive level of detail required to demonstrate the research rigour discussed in Chapter 3.4. I recommend this model as an effective approach to data analysis for use within future qualitative methodologies.

Notwithstanding the strengths and limitations discussed, a range of key findings were identified for implementation in nursing, nurse education and inter-disciplinary education which, alongside areas for future research, are summarised in the following section.

7.2 Recommendations for future practice and research

The research findings, when considered in the context of the wider literature identified a range of recommendations for future practice in nursing, nurse education, and inter-disciplinary education, alongside potential areas of interest for future research. The following sections summarise these recommendations.

7.2.1 Teaching and learning tools for the development of compassion and self-compassion

In relation to the understanding and development of compassion and self-compassion, a range of tools and strategies have been recommended, some of which expand on established strategies such as facilitated reflection, and some of which are new proposals. The expansion of established strategies includes the use of co-created authentic stories to raise self-awareness and challenge judgements, as well as facilitated reflection on experiences of compassionate and non-compassionate behaviours. Throughout the use of these strategies, there should be a particular emphasis on noticing as a pre-requisite for compassion. The utilisation of these learning and teaching tools was reported to increase compassion understanding and enhance compassion towards others and the self, which has implications for nursing and other professions in which compassion is a central tenet. Through these recommendations, educators are provided with a range of clearly identified tools and learning strategies that can be easily incorporated into curricula to enhance student understanding and application of compassion and compassionate practice.

Nurse educators should also expand on the established practice of role-modelling and socialisation to develop a culture of compassion within the education setting. Developing and maintaining a compassionate culture needs to involve all staff within the education

setting, noticing, acknowledging and responding to suffering in students, amongst the academic and professional services staff, and visitors. Students are then provided with the opportunity to be immersed in a compassionate culture, where they can see and practice the knowledge, skills and behaviours required for compassionate care. Although out-with this research, I am working with an international inter-disciplinary network to explore and create tools to support the development of a compassionate culture in Higher Education. The findings and recommendations of my research are informing the creation of these tools.

7.2.2 The use of language and metaphor to support compassion understanding

In response to the ambiguity found in the conceptualisations of compassion, and the identified need of a language for compassion, a new definition has been proposed that presents the commonalities of the multiple conceptualisations of compassion in a language that is accessible to students at the beginning of their nurse education.

A metaphor for compassion has also been proposed to support learning and teaching of compassion. This original contribution to knowledge is designed to enhance understanding of a subjective abstract concept using more familiar concepts. As discussed earlier in the chapter, initial use of the metaphor as a tool for learning and teaching has been positively received by students. Despite the initial positive response, it is acknowledged that the use of a metaphor for compassion is an interesting area for future research and would benefit from further testing and development.

The use of a shared language for compassion and self-compassion has implications for the development of compassionate practice in the clinical environment and in educational settings. Shared language has the potential to enhance professional discussion and debate through shared understanding. When applied to the strategies of story-telling and facilitated

reflection, a shared language can support a greater depth of learning in the education setting, and can influence service improvement and care delivery in the practice setting.

7.2.3 The inclusion of self-compassion in curricula

Although there is a significant increase in the research and literature relating to self-compassion, there is limited research relating to self-compassion in nursing or nurse education. In a profession where emotional cost and compassion fatigue are widely acknowledged as reasons for professional attrition, self-compassion has the potential to provide a strategy that develops resilience and minimises the negative impact of these costs. A significant recommendation, therefore, for the future practice of nurse education is the inclusion of self-compassion training within nursing curricula.

The concept of self-compassion should be introduced to students early in the course, with the easiest of the non-meditative self-compassion exercises: the 'pause button' visualisation, and compassionate touch. As these practices become more established, they should be revisited to maintain self-compassion as a conscious practice, and the training expanded to include other non-meditative practices such as recognising the self as part of common humanity, and identifying qualities and strengths. Details of these exercises can be seen in Appendix 21. The findings relating to meditation exercises also have implications for nurse educators. Although students could be directed to additional self-compassion resources, including meditation, these should not be included within nursing curricula due to the risks of exacerbating mental health conditions or causing distress.

The influence of self-compassion on motivation to learn had been previously found in college students (Neff, Hsieh and Dejitterat, 2005), but the findings of this research in relation to learning in clinical practice highlighted an interesting area for future research; to explore on a wider scale the relationship between self-compassion and learning in clinical

practice. The benefits of a more proactive, achievement-oriented motivation to learn, and the changes of behaviour experienced have strong implications for nurse educators, emphasise the value of including self-compassion in nursing curricula.

Although the research was based in nurse education and the recommendations are pertinent to that area, the strategies to support the development of compassion and self-compassion are relevant for wider professional application, such as nursing practice, medicine, allied health, social work, design, philosophy, theology, psychology, and education.

7.2.4 Areas for future research and exploration

The methodological process and interpretation of the findings identified a range of areas for future research and exploration. These include:

- The development of imagination in professional education. Imagination was identified as relevant to inform knowledge and understanding (Chapter 2.3.3), a key component of compassion. Further research should explore different strategies that can be used in education to support the development of imagination, and the impact of this on performance and compassionate practice.

- Exploring the development of self-compassion on retention (relating to Chapter 6.4.2.3), and considering whether increased self-compassion influences student retention and retention within the wider professions.

- Testing and evaluation of the metaphor for compassion (Chapter 6.1.1), and the effectiveness of it as a tool to support education.

- The development and use of co-created stories for facilitated reflection and the challenging of judgements (Chapter 6.2.2.1).

- Although learning through reflection was identified as an effective way to develop understanding of compassion, the omission in the data of learning through reflection-

in-action identified it as an interesting area for future research. It would be interesting to examine the development of reflection-in-action facilitation skills for practice supervisors, and the influence of these skills on student learning, particularly in relation to noticing (Chapter 6.1.3).

- The use of virtual practice and enhanced technology to support reflection in action (Chapter 6.2.2.2).

- Related to the meaning of compassion, was the understanding that compassion was an active process and non-compassion was passive (Chapter 6.1.2). Whilst this understanding reflected the literature (Durkin, Usher and Jackson, 2019, Sinclair et al., 2016a, van der Cingel, 2009), the data also highlighted cruelty as an active process, and identified the risks of passivity in compassion. It was suggested that if movement between active compassion and passive non-compassion was not noticed and addressed, the risk of nurses becoming perpetrators of suffering was increased. Further research to examine active and passive behaviours in compassion would extend our understanding of factors influencing changed behaviours, and potential strategies to enhance active compassion. Areas of potential research include exploration of the impact of anonymity on patient care and compassion, and an evaluation of existing campaigns to enhance identifiability and connectivity such as 'hello my name is' (Granger and Pointon, 2020).

- An exploration of the development of self-compassion in nurse leaders, and the impact of this on the culture of compassion in their care setting. In addition to the qualitative exploration of this, it would also be interesting to consider the impact of self-compassion and compassionate culture on quantitative patient outcomes.

- The role of the nurse educator in developing a culture of compassion in Higher Education (Chapter 6.2.2.3).

- Participants noted that when they applied self-compassion, they were more prepared and better able to learn in the clinical environment. Further research would be useful

to explore the relationship between self-compassion and learning in clinical practice in more detail, and consider strategies to enhance the relationship (Chapter 6.5.2).

- As noticing is identified as a key condition for compassion and self-compassion, research needs to be undertaken to identify and test effective teaching and learning strategies to develop and maintain noticing skills (Chapter 6.1.3).

7.3 Dissemination strategy

Reflective of the significant increase in digital networks and social media, an effective dissemination strategy needs to be a planned process that utilises innovative approaches to reach target audiences, and support a wider engagement in and understanding of research (Ross-Hellauer et al., 2020). Consideration will be given to the purpose of the dissemination for each target audience, from which the framing of the message can be appropriately adapted, and the relevant media or dissemination platform identified.

My dissemination plan includes a range of different target audiences, and therefore different approaches. These include:

- **Students**

  In order for healthcare students to engage in discussion and debate about compassion and compassionate practice, they need to understand the concept. Dissemination of the recommended definition of compassion, and the use of the metaphor, has already begun through an update of our nursing curriculum content. The curriculum has also been updated to include development of the skills of self-compassion. This has now been used to support learning for over 500 students, with positive feedback. To widen the dissemination beyond my own University, I plan to

submit articles to professional journals that are more frequently accessed by students such as the Nursing Standard or Nursing Times.

I also plan to work with the University's communications experts to develop a social media profile to disseminate these findings to other students, and consider recording a short talk for non-experts that could be made available to all through channels such as Vimeo or YouTube.

- **Nurse Educators**

  Nurse educators may find it beneficial to understand the interconnections between compassion and self-compassion, and the links to nursing and nurse education. The recommendation of learning and teaching strategies may also be of use to inform the development of their own nursing curricula. The model of interconnections and recommended learning and teaching strategies will be disseminated through the submission of articles for publication in relevant professional journals such as Nurse Education Today, and through conference presentations. The recommendations will also be shared across a regional network of nurse educators (Midlands, Yorkshire, North East, and East). To enhance access to nurse educators, I would also like to publish the recommended learning and teaching tools for self-compassion in an open-access site, and will liaise with the University's research and communication office to find the most appropriate platform for this.

- **Multi-disciplinary educators**

  The links between compassion, self-compassion, and motivation to learn would indicate the benefits of developing these skills in other discipline areas. Therefore, other educators may be interested to hear about the outcomes of self-compassion related to learning, and strategies to introduce and develop compassion and self-compassion in their student body.

I have joined a multi-disciplinary international network, Compassion in Higher Education, and am collaborating with that network to develop a range of tools to support educators in the development of compassion in Higher Education staff and students. I am also working with members of that network to develop tools to support the development of staff and student self-compassion.

Through social media, research identifiers, and academic and social networks, I will encourage inter-disciplinary collaboration and participation in ongoing research, for example with linguist experts to test and further develop the use of the metaphor.

- **Nurse Leaders and practitioners in clinical practice**

As compassion is a central value in nursing and healthcare, nurse leaders and healthcare practitioners may be interested to learn about the interconnections between compassion and self-compassion, and the outcomes of self-compassion that relate to nursing practice. Dissemination will be through my access to clinical nurse leads across Cambridgeshire and Essex, where I can present the information to nurse leaders, and invite collaboration and participation in future research. I also plan to disseminate this through presentation at nurse leader conference, and in targeted nurse leader journals such as Health Service Journal. Utilising this network will support the alignment of the research outcomes and future research with the requirements and expectations of healthcare practice, and increase the commercial impact of the work.

- **Researchers**

The innovative use of a combined approach to data analysis may be of interest to other researchers using qualitative methodologies with narrative data. I plan to disseminate this approach through the submission of articles in journals focused on research methodology, and by applying to present at research conferences.

In order to access a wider audience, I will also use digital platforms such as ORCID, or ResearchGate.

- **Dissemination for a wider social impact**

    Whilst the research was focused on student nurses and nurse education, the benefits of understanding compassion and developing self-compassion may be relevant to a wider social audience. To disseminate outcomes to this wider audience, I have considered the use of relevant non-expert journals interested in wellbeing and have made an initial approach to a magazine editor. I will also liaise with the University's communication department to develop blogs, visual or video non-specialist summaries, and media coverage.

7.4 Final reflections

In commencing this research, I set out to gain an insight into the experiences of student nurses in applying self-compassion. When preparing to teach the students about self-compassion and provide them with a range of self-compassion exercises to draw on, it became clear that a level of confusion and uncertainty about the meaning of compassion existed. If nurse educators are to prepare students to engage in compassionate practice, an increased focus on clarifying the meaning of compassion needs to be developed in nursing curricula. The development of a metaphorical structure to support the learning and teaching of compassion aims to provide nurse educators with a tool to enhance understanding. The experience of applying self-compassion was positive, and resulted in a range of changes that reduced stress, enhanced wellbeing, increased compassion towards others, and increased motivation to learn. In a stressful profession, with known emotional costs, the benefits of applying self-compassion were evident.

The experience of undertaking the research has had significant personal outcomes. Through professional challenge and debate, I have experienced the process of deconstructing and reconstructing knowledge, understanding and beliefs, at times uncomfortable, but always resulting in personal and professional growth. I developed a level of critical thinking that enabled synthesis of literature and data to form new understandings, from which future practice and research could be proposed. I also clarified my preferences for methodological approach, grounded in the concept of embodied cognition and the development of understanding through our correspondence with the world. As nursing is a practice-based discipline, the knowledge that nursing research produces needs to reflect this methodological approach, going beyond professional practice to the application of new knowledge. The development of self-compassion as an embedded practice is congruent with the concept of embodied cognition, and contributes to the development of a compassionate culture through a compassionate correspondence with the world. To this end I have included self-compassion within the nursing and nursing associate courses at my University, and have also facilitated cross-faculty self-compassion workshops for all staff. I have also become more aware of the potential areas for future research, and feel enthused to pursue those areas of work within the vast field of compassion and self-compassion.

I have encountered compassionate and motivated student nurses who have inspired and strengthened my perspective of nursing as a compassionate profession. Nurse educators can work together with students to achieve and enhance compassionate care, even during difficult and stressful times, to develop role models of the future in a compassionate and self-compassion culture.

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Appendix 1: Electronic database and website literature search results

Database/Website	Key words			
	Compassion AND meaning (2000-2019)	Compassion AND defin* (2000-2019)	Compassion AND factor* (2000-2019)	Self-compassion (2000-2019)
CINAHL Plus with full text	50	361	(full text) 918	(full text) 263
MEDLINE	432	684	232	(full text) 195
PsychARTICLES	40	49	95	61
Self-compassion.org (author Kristin Neff)	n/a	n/a	n/a	786
Total hits (following application of exclusion and inclusion criteria, and with duplicates removed)	136		122	429

Appendix 2: Peshkin's I's

Alan (Buddy) Peshkin (1931-2000) was described as an eminent researcher, methodologist, and Professor of Education, renowned for his studies of American High Schools and their communities, and his scholarship on qualitative inquiry (Henne and Davidson, 2007). Spanning a period of over two decades, Peshkin's work provided an historical portrait of American life in the 20th century (Bredo, 2007), and the ways schools were embedded in and reflected their communities (Feinberg, 2007).

It was during the writing up of his research in two different communities that Peshkin noticed his subjectivity, that he felt more positive about one than the other (Peshkin, 1988). He called these subjectivities I's, for example he identified an 'ethnic-maintenance I' when as a Jew he identified warmly with others in the community trying to maintain their ethnic identity, which influenced his interpretation of that community. However, rather than avoiding it, he made the subjectivity central to his research. He recognized that understanding one's subjective I's had value in preventing them from subconsciously steering the research (Henne, 2007). However, rather than discovering subjectivity during the writing up of research data, Peshkin recommended that researchers were meaningfully attentive to their own subjectivity throughout the research process, developing an enhanced awareness from the formal, systematic monitoring of the self (Peshkin, 1988).

Peshkin (2001) suggested two different approaches to reflexivity using subjective I's. One approach uses pre-planned subjective I's, purposely reviewing the research through a particular lens to explore and enhance research understanding. Although acknowledging the lenses were not mutually exclusive or exhaustive, Peshkin (2001) offered nine potential lenses that could be utilized: patterns, time, emic, postitionality, ideology, themes, metaphor, irony, and silence (details of which can be found in Peshkin's (2001) work).

However, subjective I's are not always pre-planned or consciously known. In exploratory research particularly, noting subjectivity as it occurs has the potential to reveal previously unknown subjective I's (Peshkin, 2001) that can then be used for further exploration. Peshkin (1988) suggested when one's feelings were aroused (either negatively or positively), subjectivity was evoked. Therefore, by making a note of these feelings or sensations during the research process, either in a reflexive journal (Bradbury-Jones, 2007), or on small cards (Peshkin, 1988), one can then consciously examine that aspect of subjectivity in that specific situation, and the actual and imagined impact on the research.

Participant Information Sheet

Section A: The Research Project

Dear student,

Re: Invitation to participate in a research study.

1. Title of study.

Compassion in pre-registration education: how do student nurses describe their experience of applying self-compassion?

2. Purpose and value of study.

Compassion is recognised globally as an essential quality for nursing. It is also emphasised in the first paragraph of the NHS Constitution. However there are a growing number of cases that demonstrate a lack of compassion in nursing care eg. Mid-Staffordshire Inquiry, the Ombudsman's report into the care of older people, Winterbourne abuses etc.

Compassion is a complex concept because it can mean different things to different people. This makes it difficult to measure, and therefore there is a risk that it may be lost as a priority in target-driven healthcare.

The importance of including compassion in the pre-registration nursing curriculum is widely agreed, but there are differing opinions about how this should be done. The literature review I have done recommends the development of self-awareness, and identifies a need to be compassionate to one's self in order to be compassionate to others.

There is growing research around the area of self-compassion and the benefits this can have on one's ability to be compassionate to others. However, the most appropriate and effective way for this education to be undertaken by student nurses is yet to be explored. It is intended that this research will study the impact of self-compassion training on student nurses, exploring your experience of the training and the qualitative changes brought about by it.

3. Invitation to participate.

I would like to invite you to take part in this research study to explore your views on compassion, to undertake some training in self-compassion, then to explore your experiences of applying self-compassion.

4. Who is organising the research?

The research is being undertaken by Vanessa Waller as part of a doctorate. I am also a Principal Lecturer at Anglia Ruskin University.

5. What will happen to the results of the study?

Having done a literature review, there is a significant gap in evidence about student nurses' experiences of applying compassion and self-compassion. It is therefore my intention to publish this work. Anonymised extracts from the data may be used in reports, book chapters, journal articles or conference presentations.

The results will also benefit future nursing students as the outcomes of the study will influence the development of the nursing curriculum.

6. Source of funding for the research.

Anglia Ruskin University are funding the doctoral study, and therefore this research.

7. Contact for further information.

Contact details of researcher: Contact details of research supervisor:

Vanessa Waller   Professor Sharon Andrew
Anglia Ruskin University   Anglia Ruskin University
Guild House   Chelmsford
Oundle Road   CM1 1SQ
Peterborough
PE2 9PW

0845 196 5568   0845 196 4118

Vanessa.waller@anglia.ac.uk   sharon.andrew@anglia.ac.uk

Section B: Your participation in the Research Project

1. Why have you been invited to take part?

As compassion is such a cornerstone of nursing, learning the skills to most effectively develop it should begin at the start of your nursing career. Therefore, in your role as a first year student nurse, you are best placed to begin this process.

2. Whether you can refuse to take part.

Participation in this study is entirely voluntary. You do not have to agree to participate in this research study and may decide to stop being a part of the study without explanation.

3. Whether you can withdraw at any time, and how.

You can decide to withdraw from the study without explanation. Your decision to withdraw will not have any impact on your continuation with the nursing degree programme.

Following the interviews, you will have 2 weeks in which to contact me if you want to withdraw from the study. I will then destroy all information pertaining to you. Following the self-compassion learning sessions and the discussions that occur within them, you will have 2 weeks after each session in which to contact me if you want to withdraw from the study. If you wish to withdraw, any information given by you will not be included in the write up or publication of any findings, although other information obtained during discussions you participated in may be used.

4. What will happen if you agree to take part.

The study will require your participation in the following:
- An interview (approximately 45 mins – 1 hour) with me at a mutually convenient date and venue at the beginning of the study.
- A self-compassion learning programme, comprising 5 x 2 hour sessions over your first year on your base theory site. These sessions will be run by myself.
- An interview (approximately 45 mins – 1 hour) with me at a mutually convenient date and venue at the end of the study.

The first interview will focus on your understanding of compassion, and how this understanding has been developed based on your experiences.

This will be followed by the self-compassion learning programme. This programme will explore the concept of compassion and self-compassion in more detail, and will include a range of exercises and discussions to develop these skills. Some of these will be group exercises and discussions, and some will be individual. You will not be asked to share any personal information that you don't want to. There will be no formal assessment of this learning, although informal discussions about how you have applied the learning will take place. The learning programme will be held on your base theory site, and will be scheduled on dates when you are already in the University for other theory sessions. You must be able to attend at least 4 of the 5 sessions.

The second interview will focus on your experience of the learning programme, and your experience of applying self-compassion.

Following the study you will be invited to a meeting to hear about the findings and conclusions from the research, and to provide feedback about your experience of being a research participant.

5. Whether there are any risks involved and if so what will be done to ensure your wellbeing/safety.

Self-compassion consists of 3 key areas: self-kindness, common humanity, and mindfulness. It is possible that whilst undertaking exercises to personally explore and develop these areas, you may experience some emotional distress. If you do become upset and wish to leave the room, a named academic member of staff (not directly involved with the research study) will be available to support you. Details of additional support services within the University will also be made available to you. If you do choose to leave the session, I will contact you following the session to offer individual support.

6. Agreement to participate in this research should not compromise your legal rights should something go wrong.

If at any point you are unhappy with the way in which the research is being undertaken, or with me as the researcher, you are able to make a complaint. In the first instance, this may be done informally in discussion with myself, or my supervisor Professor Andrew (sharon.andrew@anglia.ac.uk).
Complaints can also be made formally using the University procedures that can be found in the *Rules, Regulations & Procedures for Students*.

7. Whether there are any special precautions you must take before, during or after taking part in the study.

No precautions will be necessary before, during or after taking part in the study.

8. What will happen to any information that is collected from you?

The interviews will be audio-recorded and I will transcribe them. You will then be sent a copy of the transcript to check the data has been accurately interpreted before it is analysed. I will ask you to read the transcript and inform me of any inaccuracies or further comments you wish to make.
The original data collected will not contain any personal information about you. It will only be heard and read by you and I. I will store the data in a secure area, however, your copy of the interviews will be your responsibility and you may keep or destroy them as you wish. Beyond the researcher and participant, the data will be anonymised in order to maintain confidentiality.

9. Whether there are any benefits from taking part.

Participation in this study would benefit you by enhancing your understanding of compassion, and increasing your skills in the application of self-compassion. Increased self-compassion has been shown to result in decreased stress levels, and a greater ability to be compassionate to others.

10. How your participation in the project will be kept confidential.

All transcripts will be anonymised using a code, and only anonymised information will be used during analysis, or publication of the research. I will be the only person with access to the coding. Audio recordings will be stored on a password-protected computer in a restricted access office at Anglia Ruskin University, and will be kept separate from the transcripts. Data will only be used for the purposes of this study and will be deleted after 5 years.

Information provided during the interviews will remain confidential unless a current safeguarding concern is highlighted. If the information provided highlights on-going care that puts any vulnerable person/people at risk, I will be obliged as a Registered Nurse to refer that element of the information to the appropriate professionals that manage safeguarding.

It is anticipated that the members of the self-compassion learning programme will maintain sensitivity and confidentiality within the group, although if you wish to discuss issues raised in the group I ask that you try to keep people's names out of the conversation.

For further information about this research study I will be glad to answer your questions at any time. You should contact me at the address above, or by email at:
Vanessa.waller@anglia.ac.uk

Many thanks for considering this invitation.
Vanessa

INFORMED CONSENT FORM

Title of study:

Case study to explore student nurses' concepts of compassion and the factors influencing this.

This study will explore your understanding of the concept of compassion, and how it is applied to nursing care. It also aims to consider how the pre-registration nursing curriculum can be developed to include effective teaching of compassion.

Participation in this study is voluntary. You do not have to agree to participate in this research study and may decide to stop being a part of the research study without explanation. Following the interview, you will have 2 weeks in which to contact me if you want to withdraw from the study. I will then destroy all information pertaining to you. Following the focus group, you will have 2 weeks in which to contact me if you want to withdraw from the study. If you wish to withdraw, any information given by you will not be included in the write up or publication of any findings, although other information obtained from the focus group you participated in may be used.

Information provided during the interview will remain confidential unless a current safeguarding concern is highlighted. If information provided highlights on-going care that puts any vulnerable person/people at risk, I will be obliged as a Registered Nurse to refer that element of the information to the appropriate professionals that manage safeguarding. The original data collected will not contain any personal information about you. It will only be heard and read by you and the researcher. It will be stored in a secure area, however, your copy of the interview and focus group transcripts will be your responsibility and you may keep or destroy them as you wish. Beyond the researcher and participant, the data will be anonymised in order to maintain confidentiality.

It is anticipated that the members of the focus group will maintain confidentiality within the group, although if you wish to discuss issues raised in the focus group it is asked that you try to keep people's names out of the conversation.

By signing below you are agreeing that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

_____   _____

Participant signature   Date

_____   _____

Printed name of person gaining consent   Signature of person gaining consent

Appendix 5: Letter of ethical approval

Anglia Ruskin University

Cambridge Chelmsford Peterborough

Ref: PL/pmx/VW-13/017
Enquiries: Pamela Maxwell
Direct Line: 01245 684820
Date: 16 October 2013

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Vanessa Waller
Faculty of Health, Social Care & Education
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William Harvey Building
Bishop Hall Lane
Chelmsford
CM1 1SQ

Dear Vanessa,

Re: Application for Ethical Approval

Project Number: 13/017
Project Title: Compassion in pre-registration education: how do student nurses describe their experience of applying self-compassion

Principal Investigator: Vanessa Waller

Thank you for your application for ethical approval which was considered by the Faculty (of Health, Social Care & Education) Research Ethics Panel (FREP), by Fast Track Ethical Review, week commencing 07 October 2013 and are very happy to approve the application, under the terms of Anglia Ruskin University's *Policy and Code of Practice for the Conduct of Research with Human Participants*. Approval is for a period of three years from 07 October 2013.

We think the application addresses an important area related to the education of pre-registration student nurses.

As a point of advice, we would recommend that you consider strengthening your rationale for the study, in terms of how this will add to the overall body of knowledge, and how it might benefit future nurses. This would be especially helpful in terms of rationalising it to potential participants.

We also felt the recruitment / selection processes were a little vague in terms of how you would select 8 participants from a pool of 150 potential participants.

Please note however the above points are for your consideration only and do not require a response to FREP.

It is your responsibility to ensure that you comply with Anglia Ruskin University's Policy and Code of Practice for Research with Human Participants and specifically:

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these changes until you have received approval from FREP for them.

Initial Interview Schedule

The interviews will be semi-structured, so the following questions will act as a skeleton guide of subject areas and will be supplemented by other questions in response to the answers given. These supplementary questions may vary slightly between participants. After question 1, the order of the questions may also vary slightly depending on the answers given.

The interview will begin with a reminder of the aims of the research, an overview of what is going to happen in the interview, an explanation of the process for withdrawing from the study, and verbal consent to continue with the interview.

Q1.
Compassion is a complex concept that can mean different things to different people. What does it mean to you?
If the participants use alternate terminology e.g. empathy, sympathy, caring etc. Do you think there is a difference between these terms? If so what is it?

Q2.
Can you give me any examples from your own life where you have experienced or seen compassion?
If the participants only provide external examples. Can you give me any examples where you have given compassion to yourself?

Q3.
Some theorists suggest there is a link between offering and receiving kindness, happiness, and someone's social network. Could we spend some time listing the people you know and drawing that as a network? (During this process I will ask which of those people know each other? What is the geographical distance between them? Is it a positive or negative relationship? What experience of compassionate behaviour have you experienced with each of them?)

Q4.
If we specifically think about the nursing context now, is your definition of compassion the same in this context or would you amend it? Why?

Q5.
What do you think the patients think compassionate behaviour is? Give some examples.

Q6.
It is widely recognised that delivering care with compassion is an essential nursing quality. What things do you think may make it difficult to be compassionate?

Q7.
From our discussion, you clearly have some understanding of compassion and compassionate behaviour. Where did you learn about this?

The interview will be concluded with a reminder of:
- What happens next
- The process for transcribing and checking the accuracy of the transcript
- The process for withdrawing from the study

And thanks for participating.

Final Interview Schedule

The interviews will be semi-structured, so the following questions will act as a skeleton guide of subject areas and will be supplemented by other questions in response to the answers given. These supplementary questions may vary slightly between participants. After question 1, the order of the questions may vary slightly depending on the answers given.

The interview will begin with a reminder of the aims of the research, an overview of what is going to happen in the interview, an explanation of the process for withdrawing from the study, and verbal consent to continue with the interview. The workshop presentations will be used as an aide memoire.

Q1.

What has been your overall experience of self-compassion?

Whether positive, neutral or negative: Why do you think this is? In what ways has it been helpful/good/difficult?

Subsequent questions followed the pattern of the self-compassion workshops, and asked in relation to each workshop:

Q2.

What was your experience of applying (self-kindness/mindfulness/common humanity/recognising qualities and strengths)?

Can you give me any examples of this experience?

Q3.

Did you experience any emotional backdraft through the application of self-compassion, or when undertaking the exercises?

Q4.

What was your experience of using the exercises in each workshop? (This question will be asked of each exercise included through the workshops)

If the exercises were difficult to use, what made them difficult? What were the barriers to practising the exercise? If the exercises were easy to use, can you give me any examples of when and how you have used these exercises?

Q5.

What was the effect of using self-compassion exercises? Was that behaviour (highlighted in the examples given) different to the way you might have responded to a similar situation before learning about self-compassion?

Q6.

Would you recommend self-compassion training to others?

The interview will be concluded with a reminder of:

- What happens next
- The process for transcribing and checking the accuracy of the transcript
- The process for withdrawing from the study

And thanks for participating.

Appendix 8: Example 1 - excerpt from holistic-content coded transcript

Int So first of all I want to start … we're getting to think about compassion. It's something that's really really complex, and it's a word that's bandied round quite easily, but what does it actually mean? If I were to ask you for a definition of what you think it means …How would you describe it?

P1 I tend to always go back to the kind of statement you get taught as a child about doing as you would be done by … So, how would you like to be treated in that situation… What treatment would you like to receive from another person, and that I think is a good grounding way to go back to it.

> 16:1 I te… | DEV-FAM

Int OK… So, if you were to break that down a little bit further in terms of how would you like to be treated, what would it be?... 'Cause that might be quite different for different people.

P1 When we thought about it, basic care, in one of our sessions … the things people said were important were quite personal and individual … and I think probably some of the main things I would think about that coming into contact with the health care professional particularly would be things about feeling judged. …And, wanting to feel you are being met with kindness … And that you were being listened to … Rather than treated as a … just another patient, or just another statistic, or just another person with this thing. … So, individuality and an equal level of respect I think are probably the really important bits.

Int OK. And, would you say that's applicable outside of healthcare settings as well, if you were thinking about being compassionate to your family or to your friends or …

P1 Yes

Int Is it the same thing?

P1 I think sometimes, yes, and especially … I suppose the times when you have to work at compassion are the times when people perhaps are being difficult, when they're not at their best. … And I suppose then that becomes the more complex thing about being able to think about their behaviour and their actions in context. … And … I guess then, being able to … often understanding when people are scared I guess is one of the biggest things. … And what people need from another human being when they're scared. … I think sometimes actually that's at the heart of … a neediness around nursing isn't it, and the emotional need is sometimes about fear that needs managing and containing.

> 16:83 F… | MEA-ACT

Int But first of all you have to recognize that it's there.

P1 Yeah. Which is … I think the compassion bit …. like charities use that horrible phrase of compassion fatigue isn't it…. It's where people can't acknowledge it any more (laughter). … It's where people have become overwhelmed by it and they can't cope with one more needy thing from one more needy person.

Int OK, so it's about spotting the need for it in the first place … the way you communicate … with people. Not judging them … and being respectful

P1 Yeah. They are good definitions I think for me, for my personal definitions. … And I do think it's an active process. I don't think it's … something that necessarily comes naturally. … I think there are obvious dynamics sometimes of kind of a sick child or you find someone fallen over in the street where that process comes into being, but actually you're … lots of the time it's an active process you have to work at. … And some people probably have more than others but I think it's processing of emotion.

> 16:84 Co… | MEA-ACT

Int So which bits … if you were in a scenario where you had to … you thought I've really got to work at this. Which bits of it are you working at, do you think?

P1 It's definitely a processing and it's definitely about understanding context and about where people are coming from. … And that's not just about reacting. You see this is what's so interesting about it. People think it's like a reflex, but I don't think that it always is. I think if you respond to your reflex sometimes your reflex is a bit judgemental, is a bit dismissive, or is a bit 'come on pull yourself together'. … Whereas actually the compassionate bit is that is thinking 'well this might be really frightening', or 'you're in a really strange situation'. … Or you know 'you've done something really brave in coming and doing this'. … And actually now you've kind of let your guard down a bit, you know, some of the cracks are starting to show. … And you need me to be kind about your cracks. … so it's definitely a thinking … it overlaps a lot with empathy I guess doesn't it. … 'Cause a lot of those things I just said you associate more traditionally with empathy but I think empathy's probably the cognitive process, whereas the compassion is what comes out at the end of that.

	MEA-ACT-PRO
16:3 People think it's lik…	DEV-REF

16:86 Compassion is a process as op…	MEA-ACT-PRO

Int OK, so the empathy is the thinking processing bit … And the compassion is the

P1 the doing

Int the acting … the behaviour that's associated with it.

P1 Yeah

Int OK, that's really interesting thank you. 'Cause there's lots of words bandied round where you talk about … compassion and … empathy's one, kindness, sympathy … there's loads … of words that people use interchangeable when they're talking about compassion or care and compassion they associate with together. … And it's interesting for me to kind of break those down a little bit to see what you think the difference is… between empathy and compassion and

P1 Care is always the doing isn't it, and the compassion is how the doing is done… So are you rough with somebody or are you snappy with them or short with them … Which you don't want to answer any more questions. … It's the tone of your voice, it's how that process is delivered.

1.	MEA-ACT
16…	MEA-ACT-PRO

Int Right. That's more about your interpersonal skills perhaps? … and communication skills.

P1 Yeah

Int Can you give me some examples from your own life where you've either experienced compassion or you've seen compassion.

P1 Actually it's a little bit random, but something that I always remember as a moment of … being really understood in a really wordless way … was in hospital and my father was very ill and … he'd had a stroke and so he wasn't very with it. He was an alcoholic and he was, and he … and sitting in a room with him and just realizing how ill he was … and he was kind of sitting in horrible hospital pyjamas that weren't done up properly and he was dribbling ice cream down his arm and he just … looked awful. And as I was trying to talk to him I just started crying … To the point where I couldn't talk any more and I went and left the room. … And I was on this strange hospital that I don't know, so I just stood in the corridor and this nurse came up to me and … the ward he was on was staffed almost entirely by Philipino nurses … And he was a bit racist, and that was something he was quite unpleasant about. … And I kind of felt embarrassed and this … I didn't know where to put myself … and she just came up to me and gave me an absolutely huge, enormous hug. … And it wasn't a quick hug either, it was a really slow like (laughter). … And it just enabled

16:4 Experience of unknown nurse	DEV-REC
16:8	MEA-ACT

unpleasant about. … And I kind of felt embarrassed and this … I didn't know where to put myself … and she just came up to me and gave me an absolutely huge, enormous hug. … And it wasn't a quick hug either, it was a really slow like (laughter). … And it just enabled me to take a big deep breath and kind of go (inhale) … and she didn't say anything … She didn't say anything to me at all apart from this really long hug, and I kind of went …. And I came out and I … I went back in. .. But it always stays with me as something that just … she didn't know what was the matter with me. … All the things I just said, she didn't have any idea … I guess she knew I probably wasn't a patient. … So actually I'm somebody she doesn't need to spend any time with. … I'm not part of her job specifically on that day but it was just a really lovely kind of wordless … gesture. … I'm kind of someone sobbing in a corridor, and I think sometimes people are really standoffish about touching people as well aren't they … and she just wasn't. And it was lovely. … And it was that proper kind of kindness of strangers (laughter)

Int Yeah, and there is a lot of research to support that. You know, the stranger on the train, in terms of counselling

P1 Yeah… But it was wordless. It was just … and I did, I just needed kind of gathering up … to go back in and deal with him and get me head grounded, but yeah, that was really lovely. And I'm trying to think of … Yeah, that's the time when I've really experienced it. I think times where I've given that professionally, I think of from the other way round of times where … actually, I can think of a similar but … when I was doing a shift in a nursery … I hated doing this nursery work. … With really needy little children, and it was agency work and they don't send you to very nice places and you don't get to know the kids. … And there was a little boy who was poorly and he'd kind of just been dumped in a corner on a beanbag waiting for his nanny to come and get him. And … and they said, oh just go and see if he's alright, he's wingeing, go and see … and as I went over to him he went 'are you my lady' … and (laughter) he thought I was the nanny, which gave me a real heads up that I thought 'oh my god this kid doesn't even know who's coming to get him today'. … And I said no, but I have come to read you a story and sit with you. And he just immediately curled up … kind of in my armpit on my lap. … And I kind of just sat and stroked his hair for a little while and then we read a story, and he said 'do you know when my lady's coming?' and I didn't and he didn't … and when she walked in she didn't recognize him either. But it was just this … that moment where you kind of just click with somebody again of kind of … you could see he looked really green and really poorly. … He looked better just for some contact. But really …worrying in a 3 year old that they do that with anybody (laughter) … Without knowing who they are … necessarily as well. … So that's more random, but then I think of kids I've worked with for a long long time, and where you feel the build up in that relationship is sometimes the moments when you think you're going to … lose your temper (laughter) … but actually you do something else instead … And you find that kind of inner resolve … and something quite lovely comes out of that. … Actually, that they know they haven't kind of overcome you with their bad temper or their angriness or their … (laughter) … And there's a kind of bonding that goes on in that process

Int Yeah. So it's about that connection.

P1 Definitely. It's definitely about connectedness I think… and trust sometimes. … I think trust probably features in all of those … that I just thought about. And I think back, when I'm thinking about that and thinking about a kid I used to work with who I used to have a very difficult relationship with to start with, and by the end when she used to fall asleep … with … kind of on my lap. … And a big teenage girl … Who'd experienced a lot of sexual abuse and a lot of people coming in and out of her bedroom at night and a lot of …. And it just felt like such a trusting … 'Cause she couldn't sleep at all when she first came to the … it's a children's therapy so community - she couldn't settle at all, it was just this constant checking of … And I thought, the first time she did that … I thought blimey something's really changed … between us, that you… you trust me enough to fall asleep while I'm in

Appendix 9: Example 2 - excerpt from holistic-content coded transcript

Int OK, what I want to start with is thinking about what compassion means to you. So if I were to say to you, tell me what compassion is …

P2 Interestingly I know what the books say but … I think compassion is something that you have naturally. … I think you can be caring … and not compassionate … Which kind of contradicts some of the stuff that we've been learning… Or I've read. … I think compassion is more than caring. It's about being able to put yourself in someone else's position, a little bit like empathy but … That care about everything about that person, not just that person, what's wrong with them. But how that's gonna impact on other people and …Their whole life basically … And I think some people just can do that. Naturally… And I think it's a very hard thing to measure.

| 17:1… | MEA-NAT TRAIT |

| 17:2 Tha… | MEA-HOLISTIC |
| 17:3… | MEA-NAT TRAIT |

Int Yes it is

P2 I think … my husband's a caring person … But I wouldn't say he's very compassionate … I wouldn't say he could put himself naturally in someone else's shoes and maybe see the bigger picture … And so I sort of, in that, if that makes sense I think compassion is like a bigger picture than caring is

| 17:4 my hus… | MEA-NAT TRAIT |
| 17:42 I woul… | MEA-HOLISTIC |

Int So caring is a narrower part of it

P2 It's a narrower part of it. I think everyone can care for someone or something … Everyone's got that capability … But compassion, I just think you've got it or you haven't. … And to learn it … I don't know if you can … I honestly personally don't think … I don't know if you can learn compassion.

| 17:5… | MEA-NAT TRAIT |
| 17:1… | DEV-NOT LEARNED |

Int That's an interested perspective of it.

P2 I think you can learn empathy from your own personal experiences … But I don't think you can learn compassion.

| 17:6… | DEV-NOT LEARNED |

318

Int So, just picking on the terminology a little bit, what would you see ... I mean obviously you said care is a narrower part of compassion ... Where does empathy sit?

P2 Empathy ... not everyone wants empathy. Empathy is one of those things where you can sort of understand how that person's feeling. ... Without feeling sympathy for them ... You know, you can put yourself in their shoes ... And you can empathise with their situation ... whereas sympathizing with somebody is like feeling sorry for them. ... So that's empathy. I think that's sort of you have to be ...

Int So you put yourself in their shoes without feeling sorry for them

P2 Absolutely, so that's empathy ... But I think that is part of, again it's still part of compassion. ... I think compassion is like an umbrella ... And you have to have a multitude of different things to be able to be compassionate. ... Again, I think you can probably empathise with somebody without being compassionate. ... I think you can empathise without caring ... Do you know what I mean, you don't need to be caring for somebody ... to go 'oh yeah I know how that feels, that's horrible'. ... Because you've been there ... You can empathise with their situation ... And sympathy, you know, I might not have been there but I can just go 'oh that's horrible'. ... I can know it's not very nice ... Just 'cause of the right and wrong existence of things

17:43 l t...	MEA-HOLISTIC
17:5...	CONT-PER-JUDG

Int Yes. And they might not be ... you're absolutely right you don't have to be caring to be empathetic and there's some ... there's a lovely piece of, I can't remember who wrote it now because I've been reading so much over the last few weeks, but people talk about the fact you can be an empathetic terrorist. ... So if I was an empathetic terrorist, I wouldn't harm you, I would harm your husband or your child because that would be the way to get to you ... It's just you know the way to get to ...To put yourself in their shoes, which I thought was a very interesting take ... On that as a difference

P2 Absolutely, so that's empathy … But I think that is part of, again it's still part of compassion. … I think compassion is like an umbrella … And you have to have a multitude of different things to be able to be compassionate. … Again, I think you can probably empathise with somebody without being compassionate. … I think you can empathise without caring … Do you know what I mean, you don't need to be caring for somebody … to go 'oh yeah I know how that feels, that's horrible'. … Because you've been there … You can empathise with their situation … And sympathy, you know, I might not have been there but I can just go 'oh that's horrible'. … I can know it's not very nice … Just 'cause of the right and wrong existence of things

<div style="text-align:right">17:43 l t… MEA-HOLISTIC</div>

<div style="text-align:right">17:5… CONT-PER-JUDG</div>

Int Yes. And they might not be … you're absolutely right you don't have to be caring to be empathetic and there's some … there's a lovely piece of, I can't remember who wrote it now because I've been reading so much over the last few weeks, but people talk about the fact you can be an empathetic terrorist. … So if I was an empathetic terrorist, I wouldn't harm you, I would harm your husband or your child because that would be the way to get to you … It's just you know the way to get to …To put yourself in their shoes, which I thought was a very interesting take … On that as a difference

P2 Yeah, so I think you have to be caring, empathetic, you have to be able to see the bigger picture … Of a person … You know, not just their physical attributes or pain or …the whole thing, you know … How it's … everything's impacting their whole life, not just … A aspect … For example if somebody's got a terminal illness … Obviously if you had somebody with a terminal illness you can empathise … And you can feel sympathy … If you've not had somebody in that situation you can feel 'oh that's horrible'. I know that's horrible because it's just horrible. … And you can care for that person, but to be compassionate to that person is to understand more complex information about that person. … So, you know, has that person got children and how are they feeling? How's the way they're feeling affecting the person with cancer … Are the husband's feelings affecting them, how the family's feeling … You know, that's being able to understand all of that

<div style="text-align:right">17:7 you hav… MEA-HOLISTIC</div>

<div style="text-align:right">17:51 Int 1: J… CONT-PER-JUDG</div>

<div style="text-align:right">17:8 to be compassiona… MEA-HOLISTIC</div>

Appendix 10: Example 3 - excerpt from categorical-content coded transcript

P7 or the translation, the literal translation of the word, but it's, it's basically –um – feeling, I want to say feeling sorry for somebody

55:1 It's...	MEA-ASS-SORRY
	MEA-EMO
	MEA-OTHER FACE

Int Okay

P7 um - but –um – in like a, limit, not limited way, but you have to know sort of like, a feeling for somebody

| 5... | MEA-EMO |
| | MEA-OTHER FACE |

Int Okay yes

P7 I think I would say. Um –given like oh you know, try to put them, maybe put themselves in their, their shoes

| 55:3... | MEA-ASS-EMP |
| | MEA-OTHER FACE |

Int Right

P7 I think your expression is

Int Yes

P7 and just see like, you know, how, how that person feels and you know, oh you know, if I, that, something happens about, something bad happens to that person, you put themselves, you put yourself in their situation and you just like 'oh actually you know that's really bad, I feel really sorry for you.

5...	LANG-MET-KNOW:SEE
	MEA-CON-K&U
	MEA-OTHER FACE

| 55:5 if I, that... | MEA-ASS-SORRY |
| | MEA-OTHER FACE |

Int Okay

P7 that that happens'. That's how I understand it.

Int Yes

P7 And –um - also part of it would be, is there anything I can do to make them, you know, feel better?

| 55:6... | MEA-ACT-EASE SUFF |

Int Okay

P7 Not about the situation, but just in general so they don't like hurt as much, whatever, it depends on situation obviously

| 55:7... | MEA-ACT-EASE SUFF |

Int Yes

P7 but, I would probably say yeah that, that's a part of it. But that, that's my understanding.

Int Okay no, that, that is useful. So in terms of –um - one of the things you said about feeling sorry for someone or, or

P7 Yeah

Int putting your, putting yourself in their shoes.

P7 Yeah

Int Is that the same thing or are they different?

P7 Um - I don't think it's the same thing

Int Okay

P7 but I think they sort of like work together

| 5: | LANG-ACT |
| | MEA-ACT |

Int Yes

P7 if that makes sense.

Int Yes

P7 Because I think if you're, really detach yourself from somebody

| 55:9... | MEA-ACT-CONNECT |

Int Yes

P7 Um – then you can just be –um – you just don't feel anything, you might not feel anything

Int Right

P7 if that makes sense. And … trying to imagine yourself in the other person's situation makes you feel more connected to how they feel as well

| MEA-ACT-CONNECT |
| MEA-CON-IMAGINE |
| MEA-OTHER FACE |

Int Yes

P7 I think

Int Yeah

P7 Um - and it, it will help you understand the situation and how they feel, kind of thing

| MEA-CON-K&U |
| MEA-OTHER FACE |

Int Okay

P7 Um – yeah they're not, they're not, I wouldn't say they're exactly the same thing

Int Okay

P7 but they, they work, I would say they worked together, like in my head they do

| LANG-ACT |
| MEA-ACT |

Int Yes

P7 anyway

Int Yeah. No they do.

P7 Um - that's, that's how I always see compassion, like, you know, just feeling for the person, trying to be out there for them if, if there is anything they need, kind of thing –um –thinking about them, even thinking about them, and just letting them know, you know, I'm thinking of you.

| MEA-EMO |
| MEA-OTHER FACE |
| LANG-ACT |
| MEA-ACK |
| MEA-PASS-THOUGHT |

| LANG-ACT |
| MEA-ACT-BEING |

Int Yes

P7 If there's anything you need please come and see me

| MEA-ACT-BEING |
| MEA-OTHER FACE |

Int Yes

P7 anything like that

Int Yes

P7 Yeah I would probably, I would probably say that's it. Or trying to understand their situation, because sometimes it's not even … a person that, you know, see every day

| MEA-CON-K&U |

Int Yes

P7 so like it's your friend or someone, or if you're a nurse it's a patient

Int Yes

P7 but that's, it's the face-to-face contact kind of like

| MEA-ACT-CONNECT |
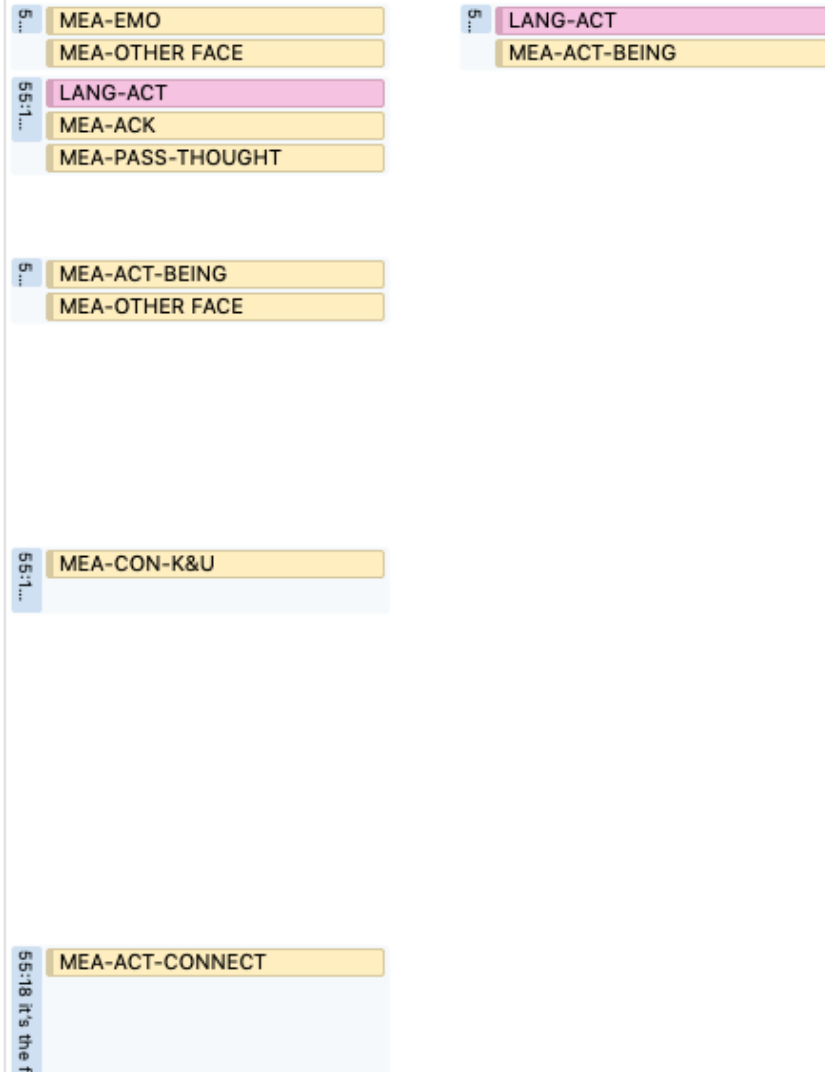
Int Yes

Appendix 11: Example 4 - excerpt from categorical-content coded transcript

P4 I think for me compassion is … being understanding in whatever situation a patient is finding, is going through

| 8:2... | MEA-CON-K&U | | 8:... | LANG-ACT |

Int Yeah

P4 You may not be - um - you may not have walked through those shoes, but trying to understand.

| 8:4... | MEA-CON-K&U | | 8:5... | LANG-MET-LIFE:JOUR |

Int Yes

P4 And walk with the patient through their pain or their sorrow or whatever they're going through

| 8:... | LANG-MET-LIFE:JOUR |

Int Okay

P4 And that's compassion, just being there and wanting to help the best way you can really

| 8:8... | MEA-ACT-EASE SUFF | | 8:... | MEA-ACT-BEING |

Int Okay. And - um – so, so, when people, often when people talk about walking with someone, they also talk about that in relation to terms like empathy

| 8:10 often when people talk abou... | MEA-ASS-EMP | | 8:9 ofte... | RES-REF-TEACHER |

P4 Yes

Int Um - do you see there being a difference between those?

P4 Um - not much difference to me really

Int Okay

P4 I think empathy is more of …it's related to compassion, but actually understanding because you have walked through similar

| 8:12 empathy is more o... | MEA-ASS-EMP | | 8:... | MEA-ASS-EMP | | 8:13 you have walk... | LANG-MET-LIFE:JOUR |

Int Right

P4   situations. Or you have, or a family member has walked through something like that.

Int   Okay

P4   but compassion, for me compassion, you don't have to have walked through or seen

Int   Yeah

P4   something like that, but just wanting to … be helpful and understanding and being with the person through the journey they're going through, yeah

Int   Yes, okay. Um – and one of the other things that people talk about when they're talking about compassion, in the same kind of language is talking about caring. And is, is that the same, or?

P4   Do you know what, this [inaudible word] thing is all intertwined.

Int   Yes it is

P4   and there is no way we can actually separate one from the other. But one can be, can be compassionate and may not be caring for the person.

Int   Right

P4   in the sense that, oh, you may be concerned about their care, but not be able to provide care for the person

Int   Okay

8:14...	LANG-MET-LIFE:JOUR		ike...
8:15 for me compass...	MEA-NOT-SAME EXP	8:16... LANG-MET-LIFE:JOUR	8:17... LANG-MET-KNOW:SEE
		8:19... MEA-CON-K&U	8... MEA-ACT-EASE SUFF
8:20...	MEA-ACT-BEING		MEA-ACT-HELPING
8:21...	MEA-COMP NOT CARE		
8:23...	MEA-COMP NOT CARE	8... MEA-CONCERN	

326
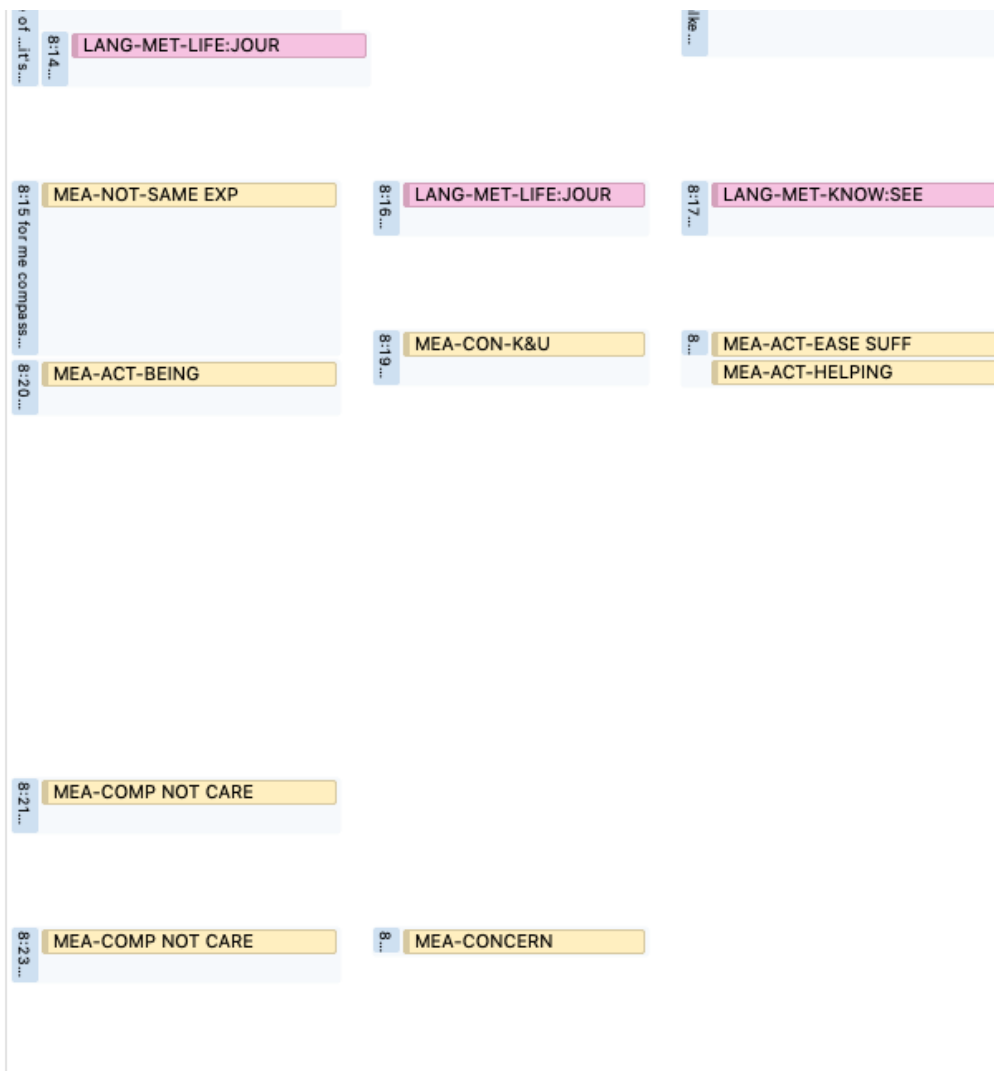
Int Okay

P4 or may be able to - um – [spearhead?] or try and provide, try and - um - make available care for the person

Int Right

P4 or give help to the person, or direct the person where the person can get help from. Let's take for example, someone might be blind

Int Right, yeah

P4 and yet through discussion, he or she is compassionate to what someone, someone… With your blindness you cannot do anything really

Int Yes

P4 but you can still, he cannot give, or he or she cannot give any care, but at the same time can kind of like lead

Int Yeah

P4 or make good, I'm looking for that word, what's that word, or help like facilitate

Int Yeah

P4 the caring to come in. So care comes in

Int Yes

P4 but at the same time, you, you, it's not compulsory that the one who's compassionate is also

8:24 make available… | MEA-ACT-HELPING

8:25 Let's take for example, someone might be blind Int Right, yeah P4 and yet th… | CONT-PER-JUDG / MEA-ACT-HELPING

8:27… | CONT-PER-JUDG

8:… | MEA-ACT-COMM

8:28 facilitate l… | MEA-ASS-CARE

8:29 it's no | MEA-COMP NOT CARE

327

Int   The one that's caring

P4   the one that's caring at the same time.

Int   Okay, yeah, yeah, no I see that, I see that. Um - so yeah it's, so, to, to compassion then relates more to the emotion

P4   emotion

Int   rather than the – um

P4   physical action of it yes.

Int   action of caring. Yeah, okay.

P4   And, but it can, but for us, for us nurses, it comes intertwined because we are in a privileged position

Int   Yes

P4   where we can … provide the care

Int   Yeah

P4   at the same time being compassionate
Int   Yes

P4   but not everyone is –um - is able to have that compassion, compassionate –um - feeling and do the care at the same time.

Int   Yes

P4   So also there's some nurses, God help us, who can just give the care, and not have compassion (Laughter)

MEA-EMO

8:30 compassion then re...

NUR-PROF-REQ

8:31 for us nurses, it comes intertwin...

MEA-COMP NOT CARE

8:32 not...

MEA-COMP NOT CARE

8:33...

Appendix 12: Summary of key case study findings

Case	Holistic-content	Holistic-form	Categorical-content	Categorical-form
P1	**Meaning of compassion:** Compassion is active. **Development of compassion:** Family and work experience influenced development of compassion.	Three story plots are evident in the narrative: 'family and compassion', 'self-awareness', and 'professional development'. Positive progression, with clear turning point following the death of her father. Story plot: rags to riches.	5 themes were identified in relation to the research questions: **Meaning of compassion:** compassion is active. **Context for compassion:** compassion is influenced by personal judgements, expectations and fear, and the behaviour of others. Knowledge and understanding is a condition of compassion. **Development of compassion:** influenced by family, work experience, and own reflections. **Self-compassion experience:** applying self-compassion is helpful, and she would recommend self-compassion to others. **Changed behaviour:** less judgemental, calmer, with recognition of new skills set.	High use of verbs supports the theme of compassion as an active process. The use of metaphors demonstrates some confusion and inconsistency in the language used to discuss compassion.
P2	**Meaning of compassion:** Compassion is a natural trait, and an holistic process. **Context for compassion:** Compassion is conditional, based on personal judgement.	Positive progression, with experience of counselling being a clear turning point. Story plot: rags to riches.	5 themes were identified in relation to the research questions: **Meaning of compassion:** Compassion is holistic. Good communication and connectivity is essential to compassion. **Context for compassion:** Compassion is influenced by personal judgements and expectations, and the care setting. **Development of compassion**: influenced by family, and counselling. **Self-compassion experience:** Applying self-compassion is helpful. Change of opinion, and now believes compassion can be learned.	High use of verbs supports the theme of compassion as an active process. Metaphor of progress as a journey, supporting an active process. Metaphor that emotions are contained physical items. Metaphor that knowing is seeing supports the concept of knowledge and understanding as a condition for compassion, and links to the making of judgements.

			Changed behaviour: able to process stresses and emotions more effectively.	
P3	**Meaning of compassion:** Compassion is active, 'other facing', and non-judgemental. **Development of compassion:** Family influenced development of compassion.	Large positive progression, noted as being life changing, with the development of self-compassion skills as a major turning point. Story plot: rags to riches.	**Meaning of compassion:** Compassion is active and non-judgemental. **Development of compassion**: influenced by family and life experience, both compassionate and cruel. **Self-compassion experience:** Applying self-compassion is a positive experience, allowing her to be more accepting and self-soothing. The experience of applying self-compassion has been life changing.	Compassion is active. Metaphor of progress as a journey.
P4	Compassion is respect. Compassion is an holistic trait. Family and cultural experience influence development of compassion.	Small positive progression, with no clear turning points. Story plot: part of the voyage and return plot.	Compassion is care. Compassion is holistic. Knowledge and understanding is a condition of compassion. Development of compassion is influenced by family, personal judgements and cultural expectations. Development (or lack) of compassion illustrated with examples of non-compassionate behaviour towards others. Minimal impact of applying self-compassion, or perceived changes to behaviour.	Compassion is active. Objectification of person who was not shown compassion. Metaphor of life as a journey.
P5	Compassion is a natural trait. Compassion is an holistic process. Family, life and work experience influence development of compassion.	Positive gradual progression. No one particular turning point, but a series of nudges through life experience.	Compassion is a natural trait. Good communication, and noticing are essential to compassion. Compassion is influenced by personal fear, and the situation of others. Knowledge and understanding is a condition of compassion. Development of compassion is influenced by work experience.	Compassion is active. Metaphor of space e.g. 'go deeper', level was 'higher'.

		Story plot: part of a quest plot.	The 'pause button' has been a valuable self-compassion tool. Applying self-compassion has increased mindfulness. Changed behaviour – now less self-critical.	
P6	Compassion is 'other facing'. Compassion needs knowledge and understanding. Compassion is conditional, based on personal judgement. Family and work experience influence development of compassion.	Positive progression, with identified turning point when became a parent. Story plot: rags to riches plot with regard to coming to maturity.	Compassion is active. Compassion is 'other facing'. Good communication is essential to compassion. Knowledge and understanding is a condition of compassion. Compassion is influenced by personal expectations, emotions, similarity of experience, and by workload. Development of compassion is influenced by family. Applying self-compassion has increased recognition of common humanity. Changed behaviour – calmer, and increased noticing.	Compassion is active. Metaphor that knowing is seeing.
P7	Compassion is an emotion. Compassion is conditional, based on personal judgement. Compassion needs knowledge and understanding. Family/friends influence development of compassion.	Progress remains the same, with no positive progression or decline. Story plot: part of a voyage and return plot.	Compassion is 'other facing'. Knowledge and understanding is a condition of compassion. Compassion is influenced by personal judgements, motivation, emotion, and personality. Compassion is influenced by social comparison, and the situation of others. Development of compassion is influenced by family and life experience. Development (or lack) of compassion illustrated with examples of non-compassionate behaviour towards others. Applying self-compassion has not changed the self-critical voice.	Compassion is active. Metaphor that knowing is seeing.

Appendix 13: Code frequency of all participants

All participants comment	
6 participants comment	
5 participants comment	
4 participants comment	
3 participants comment	
2 participants comment	
1 participant comment	

Code	P1	P2	P3	P4	P5	P6	P7	Overall
LANG-ACT	117	14	12	13	41	28	10	235
DEV-FAM	16	15	23	17	7	40	50	168
CONT-PER-JUDGE	20	24	3	10	1	6	76	140
MEA-CON-K&U	18	9	7	8	10	23	14	89
MEA-ACT	28	4	10	5	9	22	6	84
MEA-ACT-COMM	13	27	4	6	11	13	3	77
DEV-LIFE-EXP	1	9	10	5	5	7	23	60
LANG-MET-PROG:JOU	13	18	9	6	6	1	1	54
APP-+VE EXP	3	4	28	4	1		7	47
MEA-NAT TRAIT	2	6	2		34	1	2	47
CONT-PER-FEAR	10	4	2	5	12	5	4	42
LANG-MET-KNOW:SEE	2	10	2	4	8	5	10	41
DEV-WORK EXP	10	6		1	12	7	2	38
MEA-ASS-CARE	1	17	6	11	2		1	38
CONT-EX-BH OTHER	8	6	4	3	2	5	9	37
CONT-PER-EXPECT	9	10	2	2	1	12		36
CHA-CALM REACTION	6	7	1	2	7	12		35
APP-HELPFUL	8	12	1	1	6	5		33
CONT-PER-+VE REL	8	8	3	2	1	5	6	33
DEV-REF	8	9	1	1	6	5	3	33

SCEX-PAUSE BUTT	2	5		3	14	9		33
MEA-ACT-BEING	7	8		5	3	5	3	31
MEA-ACT-CONNECT	5	13		2	7		3	30
APP-REC-COMM HUM	3	2	5	2	7	10		29
APP-STILL SELF CRITIC						3	26	29
MEA-NOT JUDGE	4	9	10		6			29
MEA-OTHER FACING			4	1		12	11	28
CHA-INC-NOTICE	4	6	2	1	3	10	1	27
APP-WOULD REC	8	4	4	3	4	2		25
CONT-EX-SIT OF OTHER	3				12		10	25
CONT-PER-PERS	2	4			8	1	10	25
MEA-HOLISTIC		14		8	3			25
CONT-PER-HEA/MOOD	6	3	4	3		3	5	24
DEV-OWN NON COMP BH				8			16	24
DEV-REC	6	9	4				5	24
APP-INC MIND		1	1		15	5		22
CONT-EX-CARE SETT	2	11	2		1	6		22
CONT-EX-HEA OF OTHER		5		1	2	9	5	22
CONT-PER-EMO		1			1	10	10	22
CONT-PER-MOTIVATION	4	1			2		15	22
NUR-PROF-REQ	5	3	1	1	2		10	22
APP-ACCEPT		1	17	2	1			21
MEA-ACT-NOTICE	7	3		1	10			21
DEV-LEARN		14	1	1	2		1	19
MEA-NOT-POOR COMM	5	5	2	3	1	1	2	19
APP-DIFF TO APPLY	1	3			1	7	6	18
CONT-EX-CULT EXPECT	1	1	3	8	2	3		18
CONT-SOC-COMP	1				2	5	10	18
LANG-MET-SPACE	3	2		1	9		3	18
MEA-ASS-EMP	2	6	1	4	4		1	18
MEA-SAME FOR ALL	3	1	2	2	2	6	2	18
CONT-EX-WORKLOAD		2	3			12		17
LANG-MET-EMOTION IS CONT	3	11	1		1		1	17
MEA-ACT-TIME	3	9	3		1	1		17
CHA-ABLE TO PRO	3	13						16

	1	2	3	4	5	6	7	Total
CONT-BAR-LACK KNOW				3		11	2	16
DEV-PROXIMITY		6		2			8	16
LANG-MET-PER:ENG	9	3	4					16
MEA-CON-FAM	5	3			1	1	6	16
APP-TEA OTHER	5		8	1			1	15
CHA-LESS JUDGE	7	2	3	1		2		15
CHA-RED SELF CRITIC	1		2		10	2		15
CONT-EX-SOC EXPECT	5	2	3		2	2	1	15
CONT-PER-SIMILAR					3	10	2	15
APP-CONT-PRO	4	5		3	1	1	5	14
CONT-BAR-TIME	1	6		1	1	5		14
DEV-STRAT-SELF						4	10	14
MEA-ACT-HELPING				4	1	5	4	14
MEA-ACT-PRO	9	3	1	1				14
SCEX-COMP-TOU	2	5	2			2	3	14
DEV-COUNS		13						13
DEV-K&U	2	5	4		1		1	13
DEV-RECIP	3			5	2		3	13
MEA-NOT-AVOID	8	3		1	1			13
APP-EMO	2	3	7					12
CHA-INC-PROT TIME		8	2	2				12
CONT-EX-JUD OF OTHER	2	7	1				2	12
CONT-PER-ALC	4	7				1		12
LANG-MET-COMP: JIGSAW	2	3		2	5			12
LANG-MET-COMP: SUBSTANCE			2	3	5	2		12
LANG-MET-KNOW: WEALTH	2	6	1		2		1	12
SCEX-COMP FRIEND	3	4	4			1		12
APP-SELF-SOOTH			11					11
CHA-NO CHANGE	1			1			9	11
LANG-MET-LIFE: JOU				8		1	2	11
MEA-AMOUNT	3			1	3	1	3	11
MEA-EASE SUFF		2		3		3	3	11
MEA-NOT CONSCIOUS					8	3		11
SCEX-MED-DIFF		5	1		2	2	1	11
DEV-MIX-REL	2					6	2	10

DEV-NOT LEARNED		4		1	5			10
DEV-ROLE MODEL				1	5	3	1	10
LANG-MET-WORK: BATTLEGROUND	2	6			1		1	10
APP-OTHER NOTICE			8	1				9
APP-STILL OVER ID							9	9
CHA-INC-SELF COMP	1	1	2	2	1	2		9
CONT-EX-PER OF OTHER				1	4	1	3	9
CONT-PER-READ	1		5		3			9
CONT-PER-WID REL	2		2	1	1	2	1	9
DEV-OTHER VAR	2	1			4	2		9
LANG-MET-COMP: BODY	1		1		4	3		9
LANG-MET-LIFE: BATTLE	2	2	1		2	1	1	9
LANG-MET-PER: BUIL	2	5	1	1				9
NUR-CARE-NOT-COMP	3	3	1	2				9
CHA-INC COMP OTHERS	1	2	1	2		2		8
CHA-INC-PREP				4	2	2		8
CHA-NEW TOOLS	6	2						8
CHA-RELAX			2		4	2		8
CONT-PER-TRAIT	2	6						8
LANG-MET-SUFF: SUBSTANCE					3		5	8
LANG-METON-PUN	3				3		2	8
LANG-OBJECT-BAR					8			8
MEA-ACK	5	2					1	8
MEA-ASS-KIND	2				4	2		8
MEA-EMO				3		1	4	8
MEA-NOT-EGO		5					3	8
SCEX-MED +VE EXP						1	7	8
APP-DIFF TO EXPLAIN			2			5		7
APP-HAPPY	1		4		2			7
APP-HELP-ID EMO		7						7
CHA-COMPLETE			7					7
CONT-EX-AGE	2	1	2	1	1			7
CONT-PER-BELIEF	1		2	1		3		7
DEV-RIGHT & WRONG		2		5				7
DEV-WITNESS		4		1		2		7

Category								Total
LANG-MET-COMP: CONT	5		1				1	7
LANG-MET-TIME: MONEY	4	1		1		1		7
MEA-ACT-ADV	3				1	3		7
MEA-CON-IMAGINE							7	7
MEA-GEN-INT		3	2	2				7
MEA-NOT-CONNECT	2	2		1			2	7
MEA-ON & OFF		5			2			7
SCEX-INNER CHILD			7					7
APP-ID +VES		6						6
CHA-EMBED TOOLS		5		1				6
CHA-LESS CONTROL			6					6
CHA-MATURE				2		4		6
CONT-PER-NOT SC						6		6
DEV-GIV	6							6
LANG-MET-COMP: ENG	2	2	1	1				6
LANG-MET-THINK: COOK	3						3	6
MEA-ASS-RESPECT	2			2	2			6
MEA-ENERGY			4		1		1	6
MEA-REC-HUMAN		5	1					6
MEA-SUBJ	2		1				3	6
SCEX-REC-COM HUM	6							6
APP-NO EMO		1		1	1	2		5
CHA-INC REFLECT				2	1	2		5
CONT-EX-GENDER	2		1	1		1		5
CONT-EX-TEAM		2	1			2		5
CONT-PER-BELONG							5	5
DEV-STRAT-CRY		5						5
LANG-MET-LIFE: WORLD	2	2					1	5
MEA-ASS-LOVE				1	2	1	1	5
MEA-ASS-SORRY							5	5
MEA-COMP +VE	5							5
MEA-MULTI THING		1			3		1	5
NUR-GOOD COMM		3		1	1			5
NUR-NOT-TIME	1	2	2					5
APP-HUGE IMP			4					4

APP-INC-RET		4						4
APP-OTHER PERS						4		4
APP-SELF PERM	2	2						4
CHA-LIS TO SELF		3	1					4
CHA-OP OF LEARN		4						4
CHA-SELF TRUST & COU		4						4
CONT-EX-ORG BH	2		1		1			4
DEV-TEACHER			2				2	4
LANG-MET-REL: PROX						4		4
MEA-ASS-TRUST	3				1			4
MEA-ASS-VALUE	1					3		4
MEA-COMP NOT CARE				4				4
MEA-DIFF TO DEF		1	2		1			4
MEA-NOT NAT	3	1						4
MEA-PASS THOUGHT						3	1	4
SCEX-BREATH	1				3			4
SCEX-NOT TOUCH					1	3		4
APP-ACT EASE SUFF	2	1						3
APP-DISC FEEL			3					3
APP-COMP-INC RECR		3						3
APP-INC-SELF AWARE	1			1	1			3
CHA-PERS-SUFF	2		1					3
CONT-CARE NOT COMP		2		1				3
CONT-EX-POLIT	3							3
CONT-EX-TIME	1	2						3
CONT-PER-FAMILIARITY							3	3
CONT-PER-SHARED VIEW					1	2		3
CONT-PER-UNSAFE	1			1	1			3
DEV-MEET SPOUSE		3						3
DEV-PROCESS							3	3
LANG-MET-EMO: ENERGY			3					3
LANG-MET-EXP: LUGG	1				2			3
LANG-MET-HAPPY: TEMP			2		1			3
LANG-MET-LEARN: BUILD	1		1		1			3
LANG-MET-LIGHT: HAPP	3							3

	A	B	C	D	E	F	G	H
LANG-MET-PER: ANIMAL	1		2					3
LANG-NEED NAME		3						3
MEA-CALM			3					3
MEA-CONCERN				1	2			3
MEA-DISTRACT						2	1	3
MEA-MINDFUL	1	2						3
MEA-NOT-REFLEX	1		2					3
MEA-NOT-TIME	1		1				1	3
NUR-DIFF-NO CONT		3						3
NUR-ROLE-STU		2				1		3
SCEX-ID +VES	3							3
SCEX-ID-STREN & QUAL DIFF					1		2	3
APP-ACT EASE SUFF	2	1						3
APP-COMP-INC-RECR		3						3

Appendix 14: Code frequency of all participants according to code family

All participants comment	
6 participants comment	
5 participants comment	
4 participants comment	
3 participants comment	
2 participants comment	
1 participant comment	

Code – meaning of compassion	P1	P2	P3	P4	P5	P6	P7	Overall
MEA-CON-K&U	18	9	7	8	10	23	14	89
MEA-ACT	28	4	10	5	9	22	6	84
MEA-ACT-COMM	13	27	4	6	11	13	3	77
MEA-NAT TRAIT	2	6	2		34	1	2	47
MEA-ASS-CARE	1	17	6	11	2		1	38
MEA-ACT-BEING	7	8		5	3	5	3	31
MEA-ACT-CONNECT	5	13		2	7		3	30
MEA-NOT JUDGE	4	9	10		6			29
MEA-OTHER FACING			4	1		12	11	28
MEA-HOLISTIC		14		8	3			25
MEA-ACT-NOTICE	7	3		1	10			21
MEA-NOT-POOR COMM	5	5	2	3	1	1	2	19
MEA-ASS-EMP	2	6	1	4	4		1	18
MEA-SAME FOR ALL	3	1	2	2	2	6	2	18
MEA-ACT-TIME	3	9	3		1	1		17
MEA-CON-FAM	5	3			1	1	6	16
MEA-ACT-HELPING				4	1	5	4	14
MEA-ACT-PRO	9	3	1	1				14
MEA-NOT-AVOID	8	3		1	1			13
MEA-AMOUNT	3			1	3	1	3	11
MEA-EASE SUFF		2		3		3	3	11
MEA-NOT CONSCIOUS					8	3		11

	P1	P2	P3	P4	P5	P6	P7	Overall
MEA-ACK	5	2					1	8
MEA-ASS-KIND	2				4	2		8
MEA-EMO				3		1	4	8
MEA-NOT-EGO		5					3	8
MEA-ACT-ADV	3				1	3		7
MEA-CON-IMAGINE							7	7
MEA-GEN-INT		3	2	2				7
MEA-NOT-CONNECT	2	2		1			2	7
MEA-ON & OFF		5			2			7
MEA-ASS-RESPECT	2			2	2			6
MEA-ENERGY			4		1		1	6
MEA-REC-HUMAN		5	1					6
MEA-SUBJ	2		1				3	6
MEA-ASS-LOVE				1	2	1	1	5
MEA-ASS-SORRY							5	5
MEA-COMP +VE	5							5
MEA-MULTI THING		1			3		1	5
MEA-ASS-TRUST	3				1			4
MEA-ASS-VALUE	1					3		4
MEA-COMP NOT CARE				4				4
MEA-DIFF TO DEF		1	2		1			4
MEA-NOT NAT	3	1						4
MEA-PASS THOUGHT						3	1	4
MEA-CALM			3					3
MEA-CONCERN				1	2			3
MEA-DISTRACT						2	1	3
MEA-MINDFUL	1	2						3
MEA-NOT-REFLEX	1		2					3
MEA-NOT-TIME	1		1				1	3

Code – development of understanding of compassion	P1	P2	P3	P4	P5	P6	P7	Overall
DEV-FAM	16	15	23	17	7	40	50	168
DEV-LIFE-EXP	1	9	10	5	5	7	23	60

	P1	P2	P3	P4	P5	P6	P7	Overall
DEV-WORK EXP	10	6		1	12	7	2	38
DEV-REF	8	9	1	1	6	5	3	33
DEV-OWN NON COMP BH				8			16	24
DEV-REC	6	9	4				5	24
DEV-LEARN		14	1	1	2		1	19
DEV-PROXIMITY		6		2			8	16
DEV-STRAT-SELF						4	10	14
DEV-COUNS		13						13
DEV-K&U	2	5	4		1		1	13
DEV-RECIP	3			5	2		3	13
DEV-MIX-REL	2					6	2	10
DEV-NOT LEARNED		4		1	5			10
DEV-ROLE MODEL				1	5	3	1	10
DEV-OTHER VAR	2	1			4	2		9
DEV-RIGHT & WRONG		2		5				7
DEV-WITNESS		4		1		2		7
DEV-GIV	6							6
DEV-STRAT-CRY		5						5
DEV-TEACHER			2				2	4
DEV-MEET SPOUSE		3						3
DEV-PROCESS							3	3

Code – context	P1	P2	P3	P4	P5	P6	P7	Overall
CONT-PER-JUDGE	20	24	3	10	1	6	76	140
CONT-PER-FEAR	10	4	2	5	12	5	4	42
CONT-PER-EXPECT	9	10	2	2	1	12		36
CONT-PER-+VE REL	8	8	3	2	1	5	6	33
CONT-PER-PERS	2	4			8	1	10	25
CONT-PER-HEA/MOOD	6	3	4	3		3	5	24
CONT-PER-EMO		1			1	10	10	22
CONT-PER-MOTIVATION	4	1			2		15	22
CONT-EX-BH OTHER	8	6	4	3	2	5	9	37
CONT-EX-SIT OF OTHER	3				12		10	25
CONT-EX-CARE SETT	2	11	2		1	6		22
CONT-EX-HEA OF OTHER		5		1	2	9	5	22

Code	P1	P2	P3	P4	P5	P6	P7	Overall
CONT-EX-CULT EXPECT	1	1	3	8	2	3		18
CONT-SOC-COMP	1				2	5	10	18
CONT-EX-WORKLOAD		2	3			12		17
CONT-BAR-LACK KNOW				3		11	2	16
CONT-EX-SOC EXPECT	5	2	3		2	2	1	15
CONT-PER-SIMILAR					3	10	2	15
CONT-BAR-TIME	1	6		1	1	5		14
CONT-EX-JUD OF OTHER	2	7	1				2	12
CONT-PER-ALC	4	7				1		12
CONT-EX-PER OF OTHER				1	4	1	3	9
CONT-PER-READ	1		5		3			9
CONT-PER-WID REL	2		2	1	1	2	1	9
CONT-PER-TRAIT	2	6						8
CONT-EX-AGE	2	1	2	1	1			7
CONT-PER-BELIEF	1		2	1		3		7
CONT-PER-NOT SC						6		6
CONT-EX-GENDER	2		1	1		1		5
CONT-EX-TEAM		2	1			2		5
CONT-PER-BELONG							5	5
CONT-EX-ORG BH	2		1		1			4
CONT-CARE NOT COMP		2		1				3
CONT-EX-POLIT	3							3
CONT-EX-TIME	1	2						3
CONT-PER-FAMILIARITY							3	3
CONT-PER-SHARED VIEW					1	2		3
CONT-PER-UNSAFE	1			1	1			3

Code – nursing and compassion	P1	P2	P3	P4	P5	P6	P7	Overall
NUR-PROF-REQ	5	3	1	1	2		10	22
NUR-CARE-NOT-COMP	3	3	1	2				9
NUR-GOOD COMM		3		1	1			5
NUR-NOT-TIME	1	2	2					5
NUR-DIFF-NO CONT		3						3
NUR-ROLE-STU		2				1		3

Code – use of self-compassion exercises	P1	P2	P3	P4	P5	P6	P7	Overall
SCEX-PAUSE BUTT	2	5		3	14	9		33
SCEX-COMP-TOU	2	5	2			2	3	14
SCEX-COMP FRIEND	3	4	4			1		12
SCEX-MED-DIFF		5	1		2	2	1	11
SCEX-MED +VE EXP						1	7	8
SCEX-INNER CHILD			7					7
SCEX-REC-COM HUM	6							6
SCEX-BREATH	1				3			4
SCEX-NOT TOUCH					1	3		4
SCEX-ID +VES	3							3
SCEX-ID-STREN & QUAL DIFF					1		2	3

Code – language of compassion	P1	P2	P3	P4	P5	P6	P7	Overall
LANG-ACT	117	14	12	13	41	28	10	235
LANG-MET-PROG:JOU	13	18	9	6	6	1	1	54
LANG-MET-KNOW:SEE	2	10	2	4	8	5	10	41
LANG-MET-SPACE	3	2		1	9		3	18
LANG-MET-EMOTION IS CONT	3	11	1		1		1	17
LANG-MET-PER:ENG	9	3	4					16
LANG-MET-COMP: JIGSAW	2	3		2	5			12
LANG-MET-COMP: SUBSTANCE			2	3	5	2		12
LANG-MET-KNOW: WEALTH	2	6	1		2		1	12
LANG-MET-LIFE: JOU				8		1	2	11
LANG-MET-WORK: BATTLEGROUND	2	6			1		1	10
LANG-MET-COMP: BODY	1		1		4	3		9
LANG-MET-LIFE: BATTLE	2	2	1		2	1	1	9
LANG-MET-PER: BUIL	2	5	1	1				9
LANG-MET-SUFF: SUBSTANCE					3		5	8
LANG-METON-PUN	3				3		2	8
LANG-OBJECT-BAR					8			8
LANG-MET-COMP: CONT	5		1				1	7
LANG-MET-TIME: MONEY	4	1		1		1		7

Code	P1	P2	P3	P4	P5	P6	P7	Overall
LANG-MET-COMP: ENG	2	2	1	1				6
LANG-MET-THINK: COOK	3						3	6
LANG-MET-LIFE: WORLD	2	2					1	5
LANG-MET-REL: PROX						4		4
LANG-MET-EMO: ENERGY			3					3
LANG-MET-EXP: LUGG	1				2			3
LANG-MET-HAPPY: TEMP			2	1				3
LANG-MET-LEARN: BUILD	1		1	1				3
LANG-MET-LIGHT: HAPP	3							3
LANG-MET-PER: ANIMAL	1		2					3
LANG-NEED NAME		3						3

Code – application of compassion	P1	P2	P3	P4	P5	P6	P7	Overall
APP-+VE EXP	3	4	28	4	1		7	47
APP-HELPFUL	8	12	1	1	6	5		33
APP-REC-COMM HUM	3	2	5	2	7	10		29
APP-STILL SELF CRITIC						3	26	29
APP-WOULD REC	8	4	4	3	4	2		25
APP-INC MIND		1	1		15	5		22
APP-ACCEPT		1	17	2	1			21
APP-DIFF TO APPLY	1	3			1	7	6	18
APP-TEA OTHER	5		8	1			1	15
APP-CONT-PRO	4	5		3	1	1	5	14
APP-EMO	2	3	7					12
APP-SELF-SOOTH			11					11
APP-OTHER NOTICE			8	1				9
APP-STILL OVER ID							9	9
APP-DIFF TO EXPLAIN			2			5		7
APP-HAPPY	1		4		2			7
APP-HELP-ID EMO		7						7
APP-ID +VES		6						6
APP-NO EMO		1		1	1	2		5
APP-HUGE IMP			4					4
APP-INC-RET		4						4

	P1	P2	P3	P4	P5	P6	P7	Overall
APP-OTHER PERS						4		4
APP-SELF PERM	2	2						4
APP-ACT EASE SUFF	2	1						3
APP-DISC FEEL			3					3
APP-COMP-INC RECR		3						3
APP-INC-SELF AWARE	1			1	1			3
APP-ACT EASE SUFF	2	1						3
APP-COMP-INC-RECR		3						3

Code – perception of change	P1	P2	P3	P4	P5	P6	P7	Overall
CHA-CALM REACTION	6	7	1	2	7	12		35
CHA-INC-NOTICE	4	6	2	1	3	10	1	27
CHA-ABLE TO PRO	3	13						16
CHA-LESS JUDGE	7	2	3	1		2		15
CHA-RED SELF CRITIC	1		2		10	2		15
CHA-INC-PROT TIME		8	2	2				12
CHA-NO CHANGE	1			1			9	11
CHA-INC-SELF COMP	1	1	2	2	1	2		9
CHA-INC COMP OTHERS	1	2	1	2		2		8
CHA-INC-PREP				4	2	2		8
CHA-NEW TOOLS	6	2						8
CHA-RELAX			2		4	2		8
CHA-COMPLETE			7					7
CHA-EMBED TOOLS		5		1				6
CHA-LESS CONTROL			6					6
CHA-MATURE				2		4		6
CHA-INC REFLECT				2	1	2		5
CHA-LIS TO SELF		3		1				4
CHA-OP OF LEARN		4						4
CHA-SELF TRUST & COU		4						4
CHA-PERS-SUFF	2		1					3

Appendix 15: Codes and re-organised sub-codes from holistic-content analysis

Code family [Research question]	Code	Sub-code
MEA [RQ1]	MEA-ACT (Compassion is an active process)	MEA-ACT-CONNECT (Compassion requires connectivity) MEA-ACT-TIME (Compassion is about giving time) MEA-ACT-BEING (Compassion is about being there) MEA-ACT-COMM (Compassion needs good communication skills) MEA-ACT-HELPING (Compassion is taking action to help or ease suffering) MEA-ENERGY (Compassion is an energy or aura) MEA-BEHAVIOURS (Compassion is actively demonstrated through behaviours) MEA-NOT-CRUEL (Compassion is not cruel) MEA-ACT-ADV (Compassion is advocating for others)
MEA [RQ1]	MEA-CONDITIONS (There are conditions for compassion)	MEA-CON-K&U (Knowledge and understand are conditions of compassion) MEA-NOT-JUDGE (Compassion is non-judgemental)
MEA [RQ1]	MEA-HOLISTIC (Compassion is an holistic process)	
MEA [RQ1]	MEA-OTHER FACE (Compassion is other facing)	MEA-NOT-EGO (Compassion is not selfish or egotistic)
MEA [RQ1]	MEA-EMO (Compassion is an emotion)	

CONT-EX [RQ1]	CONT-EX-EXPECT (Compassion is influenced by external expectations)	CONT-EX-SOC-EXPECT (Compassion is influenced by social expectation)
		CONT-EX-SOC-COMP (Compassion is influenced by social comparison)
CONT-PER [RQ1]	CONT-PER-JUDG (Compassion is conditional, based on personal judgement)	CONT-PER-FEAR (Compassion and judgement are influenced by fear)
		CONT-PER-UNSAFE (Compassion affected by personal context of feeling unsafe or under threat, or a desire to feel safe)
		CONT-PER-TIME (Compassion is influenced by concern about finding time to be compassionate)
		CONT-PER-EXPECT (Compassion is influenced by personal expectations)
		CONT-EX-PERS OF OTHER (Compassion is influenced by the personality of the other – whether or not you like them)
DEV [RQ2]	MEA-NAT-TRAIT (Compassion is a natural trait)	MEA-AMOUNT (People have a finite amount of compassion)
		MEA-NOT CONSCIOUS (Giving compassion is not a conscious activity)
		DEV-NOT-LEARN (Uncertainty about whether compassion can be learned)
DEV [RQ2]	DEV-FAM (Development of understanding of compassion is based on family)	CONT-PER-+VE REL (Personal context of a positive compassion relationship)
		CONT-PER-WID REL (Personal context of the wider family/social network. More distant, but positive compassion relationships)
DEV [RQ2]	DEV-EXPERIENCE (Development of understanding of compassion is based on own experience)	DEV-WORK-EXP (Development of understanding is based on work experience)
		DEV-LIFE-EXP (Development of understanding is based on life experience)
		DEV-GIVING (Development of understanding is based on experience of giving compassion to others)
		DEV-WITNESS (Development of understanding is based on experience of witnessing compassion)

DEV [RQ2]	DEV-REFLECT (Development of understanding of compassion is based on own reflections)	
APP [RQ4]	APP-+VE EXP (The application of self-compassion has been a positive experience)	APP-HELPFUL (The application of self-compassion was helpful/useful) APP-WOULD REC (Participants would recommend self-compassion to others on nursing course and in the wider public domain) APP-TEA-OTHER (Teaching others, and role modelling self-compassion) DEV-SC SKILL (Understanding of compassion has been extended through the development of self-compassion skills)
APP [RQ4]	APP-EMO (Applying self-compassion causes emotional backdraft)	APP-NO EMO (No emotional backdraft experienced when applying self-compassion)
CHA [RQ5]	CHA-INC-COMP-OTHER (Capacity for compassion towards others has increased)	CHA-INC-SELF-COMP (Increase in self-compassion, particularly self-kindness) CHA-INC-NOTICE (Increased noticing of positive things and suffering, in self and others)
CHA [RQ5]	CHA-LESS-JUDG (Participant is less judgemental towards other people, environments, situations, or the self)	CHA-RED-SELF CRITIC (Reduction in self-criticism and self-blame)
CHA [RQ5]	CHA-CALM REACTION (Self-compassion is calming, reducing anxiety, leading to calmer reactions to stressors)	CHA-RELAX (Participant is now more relaxed) CHA-MATURE (Has become more mature following self-compassion workshops)
CHA [RQ5]	CHA-NO CHANGE (Has not experienced any change)	

Appendix 16: Codes and re-organised sub-codes from categorical-content analysis

Code family [Research question]	Code	Sub-code
MEA [RQ1]	MEA-ACT (Compassion is an active process)	MEA-COMMUNICATION & ADVOCACY (Compassion includes good communication skills – verbal and non-verbal behaviours, with and for the self or other) MEA-CONNECTIVITY (Compassion requires connectivity) MEA-BEING THERE AND GIVING TIME (Compassion is about being present and giving time) MEA-GEN-INT (Compassion includes a genuine interest in someone) MEA-NOTICING & ACKNOWLEDGING (Compassion requires the noticing and acknowledging of suffering) MEA-HELPING TO EASE SUFFERING (Compassion is taking action to help or ease suffering) MEA-ENERGY (Compassion is an energy or aura) MEA-ACT-PRO (Compassion is a process)
MEA [RQ1]	MEA-KNOWLEDGE & UNDERSTANDING (Compassion requires knowledge and understanding)	MEA-CON-K&U (Knowledge and understanding are perceived to be conditions of compassion) MEA-CON-FAM (Familiarity is seen as a condition of compassion) CONT-PER-SIMILAR (Compassion is influenced by knowledge gained through similar experiences)

		CONT-BAR-LACK KNOW (Lack of knowledge is seen as a barrier to compassion)
		DEV-K&U (Development of knowledge and challenges to that knowledge has enhanced compassion)
		MEA-CON-IMAGINE (Compassion includes the ability to imagine others' situations)
MEA [RQ1]	MEA-OTHER FACE (Compassion is perceived as an other-facing concept – given to others but not the self)	MEA-NOT-EGO (Compassion is not egocentric, self-centred, selfish, or self-focused)
MEA [RQ1]	MEA-HOLISTIC (Compassion is holistic)	MEA-MULTI-THING (Compassion is an overall concept made up a multitude of different things)
MEA [RQ1]	MEA-SAME FOR ALL (The meaning of compassion is the same whether it relates to a personal or professional context)	
MEA [RQ1]	MEA-COMP POSITIVE (Compassion is a positive experience)	MEA-CALM (Compassion is calm) MEA-MINDFUL (Compassion is mindful) MEA-NOT-ANGER (Compassion is not anger or angry behaviour) COMP-EMO (Compassion is an emotion, a feeling)
CONT [RQ1, RQ2]	CONT-PERSONAL FACTORS (Personal factors influence understanding and experience of compassion)	CONT-PER-FEAR (Fear is seen as a barrier to giving or developing compassion) CONT-PER-PERS (Compassion is affected by own personality, or the type of person they are perceived to be) CONT-PER-HEA/MOO (Compassion is influenced by the health or mood of the person on any given day) CONT-PER-EMO (Personal emotion influences the experience of compassion)

		CONT-PER-BELIEF (Compassion is influenced by personal faith, or beliefs and values)
		CONT-PER-MOTIVATION (Compassion is affected by personal motivation)
		MEA-ASS-TRUST (Compassion is influenced by trust)
MEA [RQ1] **DEV [RQ2]**	CONTEXT-JUDGE (Understanding of compassion and the development of this understanding are influenced by judgement)	CONT-PER-JUDG (Compassion, or understanding of compassion, is affected by personal judgements about oneself or others, or a challenge to those judgements)
		MEA-NOT-JUDG (Compassion is not judgemental)
		CONT-EX-BH OTHER (The behaviour of others can influence and act as a barrier to compassion)
		CONT-EX-SIT OF OTHER (Judgements about the situation of others influences the motivation for compassion)
		CONT-EX-HEA OF OTHER (Judgements about the health of others has an impact on compassion)
		CONT-EX-JUD OF OTHER (Compassion is affected by the judgements (or perceived judgements) of others)
		CONT-EX-PERS OF OTHER (The personality of the other person influences the compassion given – whether or not you like them)
		CONT-EX-SOC-COMP (The context for compassion is influenced by social comparison)
		CONT-EX-WORKLOAD (Compassion is affected by perception of workload)
		MEA-COMP NOT CARE (One can be compassionate without caring, and vice versa)

		DEV-RIGHT & WRONG (Development of compassion and associated terminology is based on judgements and understanding of rights and wrongs)
		MEA-SUBJ (Understanding of compassion is subjective)
		MEA-ASS-RESPECT (Compassion is influenced by level of respect)
		MEA-ASS-SORRY (Compassion is influenced by feeling sorry for someone)
		MEA-CONCERN (Compassion is influenced by concern for the other)
		MEA-AMOUNT (Individuals have a specific and measurable amount of compassion)
MEA [RQ1] **DEV [RQ2]**	CONTEXT-EXPECTATIONS (Understanding of compassion, and the development of this understanding is influenced by expectations of the self and other)	CONT-PER-EXPECT (Personal expectations of self and other influence compassion) CONT-EX-CULT-EXPECT (Compassion is influenced by cultural expectations) CONT-EX-SOC-EXPECT (Compassion is influenced by social expectations)
MEA [RQ1] **DEV [RQ2]**	CONTEXT-ENVIRONMENT (Compassion is experienced and influenced by the environment)	CONT-EX-CARE SET (The care setting/environment has an impact on compassion) CONT-EX-TEAM (Compassion is influenced by the size and effective of the team you are working in)
DEV [RQ2]	MEA-NATURAL TRAIT (Compassion is a natural trait)	MEA-NOT-CONSCIOUS (Compassion is not a conscious trait) MEA-NOT-NAT (Compassion is not seen as a natural trait) CONT-PER-TRAIT (A belief that people have a default personal trait in the way they react to things) MEA-ON & OFF (A perception that compassion can be turned on or off, as opposed to learning it) MEA-NOT-ON & OFF (Compassion cannot be switched on and off)

DEV [RQ2]	DEV-FAM (Development of understanding of compassion is based on family)	CONT-PER-+VE REL (Personal context of a positive compassion relationship)
		CONT-PER-WID REL (Personal context of the wider family/social network. More distant, but positive compassion relationships)
		DEV-MIX REL (Personal context of a mixed compassion relationship – both good and bad compassion experience from the same person)
		DEV-MEET SPOUSE (Meeting spouse is a key trigger in the development of compassion)
		CONT-PER-STABILITY (Having personal stability in relationships has influenced the experience and understanding of compassion)
		CONT-EX-ALC (Experience of compassion has been affected by alcoholism in others)
DEV [RQ2]	DEV-EXPERIENCE (Development of understanding of compassion is based on own experience)	DEV-WORK-EXP (Development of understanding is based on work experience)
		DEV-LIFE-EXP (Development of understanding is based on life experience)
		DEV-GIVING (Development of understanding is based on experience of giving compassion to others)
		DEV-WITNESS (Development of understanding is based on experience of witnessing compassion)
		DEV-REC (Development of understanding is based on experience of receiving compassion from others)
		DEV-OWN NON COMP BH (Development based on experience of own non-compassionate behaviour)
		DEV-RECIP (Development of understanding is influenced by experience of reciprocity)

		DEV-SELF CARE (Understanding has been developed through experiences of self-care)
DEV [RQ2]	DEV-OTHERS (Development of understanding of compassion is based on other non-family members)	DEV-PROXIMITY (Compassion is influenced by ease of access to those who would give it, or geographical proximity)
		DEV-COUNS (Understanding of compassion is influenced by own experience of counselling)
		DEV-ROLE MOD (Role modelling is important in the development of own or others understanding of compassion)
		DEV-TEACHER (Understanding of compassion developed through the actions of a teacher)
		DEV-COMMUNITY (Members of the community are involved in the development of compassion)
		DEV-GP (Experience with GP has influenced understanding and development of compassion)
		DEV-STRAT-SELF (Does not go to others for compassion, but has a strategy of self-reliance)
DEV [RQ2]	DEV-LEARN (Development of compassion and understanding of compassion can be learned)	DEV-REF (Reflection has been used to develop understanding of compassion, underpinning episodes of self-development and behaviour change)
		DEV-LEARN (One can learn to be non-judgemental or compassionate)
		DEV-NOT-LEARN (Compassion cannot be learned or taught, or is difficult to learn)
		DEV-INHER OR SELF DEV (Perception that compassion can be inherited or self-developed)
		DEV-NAT (Development of compassion has been a natural occurrence)

		DEV-+VE REINF (Understanding of compassion has been developed through positive reinforcement of compassionate behaviours)
		DEV-PROCESS (Development of compassion is an ongoing process)
		DEV-DIFF (Developing compassion behaviours and a new understanding of compassion is difficult)
DEV [RQ2]	NUR-PROF-REQ (Development of understanding in the context of compassion being seen as a professional requirement for nurses)	NUR-PROF-BOUND (Acknowledged need for professional boundaries when being compassionate)
SCEX [RQ3]	SCEX-NON-MEDITATION EXERCISES (Experience of using non-meditation exercises)	SCEX-PAUSE BUTT (Used the self-compassion technique of the pause/stop button)
		SCEX-COMP-TOU (Relating to the use of compassionate touch exercises)
		SCEX-NOT-TOU (The compassionate touch exercise was not useful or was not used)
		SCEX-REC COM HUM (Used the self-compassion exercise of recognising common humanity – that everyone has both good and bad experiences, strengths and weaknesses)
		SCEX-BREATH (Uses deep breathing exercise)
		SCEX-ID +VES (Used the self-compassion exercise of identifying positives in situations)
		SCEX-NOT-MIND (Has not used the mindfulness exercises)
		SCEX-ID-STREN & QUAL DIFF (Has found it difficult to identify one's own strengths and qualities)

SCEX [RQ3]	SCEX-MEDITATION EXERCISES (Experience of using meditation exercises)	SCEX-MED-DIFF (Meditations may be difficult for those who have not addressed personal issues/traumas)
		SCEX-COMP FRIEND (Relating to the experiences of using the compassionate friend meditation)
		SCEX-MED-INNER CHILD (Used the self-compassion meditation focused on giving compassion to yourself as a child)
		SCEX-MED-+VE EXP (Meditation was seen as a positive experience)
		SCEX-GUIDED MED (A guided meditation is easier and more effective than a non-guided one)
		SCEX-MEDITATION (Uses meditation for self-compassion, but not any specific meditation)
SCEX [RQ3]	SCEX-TOOLS (Recognition of tools for self-compassion)	APP-NEW TOOLS (Recognition that having a range of new self-compassion tools to apply in future can change practice)
		SCEX-EMBED TOOLS (Self-compassion tools are embedded in behaviour now)
		MEA-NOT-CONSCIOUS (Giving of self-compassion is no longer a conscious activity, it is done automatically)
SCEX [RQ3] APP [RQ4]	APP-CHALLENGING (Application of self-compassion tools in everyday life can be challenging)	APP-DIFF TO APPLY (Has found it difficult to apply the different elements of self-compassion in day to day life)
		APP-EMO (Applying self-compassion causes emotional backdraft)
		APP-NO EMO (Has not experienced any emotional backdraft from carrying out the self-compassion exercises)
		MEA-AMOUNT (Perception that one can only cope with a certain amount of self-compassion before it becomes uncomfortable)

APP [RQ4]	APP-POSITIVE EXPERIENCE (Applying self-compassion has been a positive experience)	APP-HELPFUL (The application of self-compassion was helpful/useful) APP-HAPPY (Applying self-compassion made the participant happier) APP-HUGE IMPACT (Applying self-compassion had a huge positive impact) APP-POWERFUL (Applying self-compassion has been a powerful experience) APP-INVALUABLE (Learning the skills to apply self-compassion has been invaluable) APP-REC-EASE SUFF (Applying self-compassion has made it easier to recognise that suffering can only be eased to the best of one's ability)
APP [RQ4]	APP-OUTCOMES (Outcomes identified from the experience of applying self-compassion)	APP-HELP-ID EMO (Applying self-compassion has helped to identify the emotion being experienced) APP-ID +VE (Applying self-compassion enables one to identify positives in a difficult situation) APP-DISC FEEL (Through applying self-compassion, one is now able to discuss feelings) APP-ACT EASE SUFF (Participant would take action to ease own suffering) APP-COMP-INC-RET (Applying self-compassion increased retention on the course) APP-COMPARTMENTAL (Applying self-compassion enables one to compartmentalise aspects of suffering, making them has less impact) APP-IMP PERSP (Applying self-compassion improves perspective) APP-INC CONFID (Applying self-compassion has increased confidence levels) APP-LESS WORRY (Applying self-compassion has resulted in less worrying) APP-REC-EASE SUFF (Applying self-compassion has made it easier to recognise that suffering can only eased to the best of one's ability)

		APP-ACCEPT (Applying self-compassion has resulting in accepting, leading to a feeling of reconciliation)
		DEV-OTH-VAR (Variables other than self-compassion could have caused these outcomes)
		DEV-SC-SKILL (Understanding of compassion has been extended through the development of self-compassion skills)
		APP-COUR TO ADV (Applying self-compassion has provided the courage to advocate and challenge on behalf of patients)
		APP-MATURE (Reports feeling more mature following self-compassion workshops)
		APP-INC COM-OTHERS (Capacity for compassion towards others has increased)
APP [RQ4]	APP-DISSEMINATION (Applying self-compassion has resulted in the participants disseminating the skills)	APP-WOULD REC (Participants would recommend self-compassion to others, both as part of the nursing course and in the wider public domain)
		APP-TEA OTHER (Participants are now teaching others, and role modelling self-compassion)
		APP-IMP TEAM (Role modelling self-compassion has improved team working)
		APP-NOTICE NEED (In applying and role modelling self-compassion, has noticed the need/desire in others to learn the skills)
APP [RQ4]	APP-SC ACTIVE (Self-compassion is an active process)	MEA-ACT (Compassion described as an active process, something that takes conscious decisions and work)
		MEA-ACT-BEING (Compassion is about being there with the issue)
		MEA-ACT-PRO (Compassion is an active process)
		MEA-NOT-AVOID (Compassion is defined as not avoiding or ignoring issues)

		APP-NOT-INERT (Application of self-compassion cannot be used to make you inert or inactive)
APP [RQ4]	APP-CONTEXT-PERSONAL FACTORS (Personal factors have influenced the experience of applying self-compassion)	CONT-PER-MOTIVATION (Application of self-compassion is influenced by personal motivation) CONT-PER-HEA/MOOD (Application of self-compassion is affected by personal health and mood) CONT-PER-EMO (Application of self-compassion is affected by personal emotion) CONT-PER-FEAR (Application of self-compassion is affected by fear) CONT-PER-PERS (Experience of applying self-compassion is influenced by own personality) CONT-PER-READ (Experience of applying self-compassion is influenced by personal readiness) CONT-PER-TRAIT (Application of self-compassion is affected by one's personal traits) CONT-PER-ABILITY (Application of self-compassion is affected by perception of one's ability to be able to do it) CONT-PER-FAMILIARITY (Experience of self-compassion is influenced by familiarity with the situation and self-compassion technique) MEA-NAT-TRAIT (Perception that the ability to give self-compassion is a natural trait)
APP [RQ4]	APP-CONTEXT-JUDGEMENTS (Application of self-compassion has been affected by judgements)	CONT-PER-JUDG (Application of self-compassion is affected by personal judgements)

		CONT-EX-SOC-COMP (Experience of applying self-compassion is influenced by social comparison)
		CONT-EX-BH OF OTHER (The behaviour of others influences the ability to be self-compassionate)
		APP-NOT-NEEDED (The personal judgement that self-compassion was not needed)
		CONT-EX-JUDG OF OTHER (Application of self-compassion is influenced by the judgement of others)
APP [RQ4]	APP-CONTEXT-EXPECT (Application of self-compassion has been affected by expectations of the self and others)	CONT-PER-EXPECT (Experience of self-compassion is influenced by personal expectations) CONT-EX-CULT (Application of self-compassion is influenced by cultural expectations) CONT-BAR-TIME (Expectation that nurses may not have time to apply self-compassion) CONT-EX-GENDER (Expectations of behaviour based on gender) CONT-EX-SOC-EXPECT (Experience of applying self-compassion is influenced by social expectations)
APP [RQ4]	APP-CONTEXT-ENVIRONMENT (Application of self-compassion has been affected by the environment)	CONT-EX-CARE SET (Application of self-compassion is affected by the care setting) CONT-EX-WORKLOAD (Application of self-compassion is influenced by workload) CONT-EX-POLIT (The wider political climate has an influence on compassion and self-compassion)

		CONT-EX-TIME (The time of day affects the experience of suffering and self-compassion)
APP [RQ4]	APP-CONT-LEARN (Applying self-compassion continues to be a learning process)	APP-CONT-PRO (Applying self-compassion is continuing a process of self-development that had already begun)
		DEV-LIFE EXP (Life experience continues to influence compassion and self-compassion)
		DEV-REF (Applying self-compassion supports reflective practice)
		DEV-K&U (Application of self-compassion has increased knowledge and understanding of the concept)
		CHA-OP OF LEARN (Changed opinion and now believes compassion can be learned)
CHA [RQ5]	CHA-CALMER (Application of self-compassion is calming and reduces anxiety)	CHA-CALM REACTION (Changed behaviour – now has calmer reaction to stressors)
		CHA-ABLE TO PRO (A change of behaviour in ability to process emotions and ease own suffering more quickly)
		CHA-OTH NOTICE (Other people noticed and commented on a change in reaction/behaviour when applying self-compassion)
		CHA-RELAX (Reports now being more relaxed)
		CHA-LESS CONTROL (No longer feels the need to be in control)

CHA [RQ5]	CHA-SELF KINDNESS (Behaviour changes demonstrating an increase in self-kindness)	CHA-RED SELF CRITIC (A reduction in self-criticism and self-blame)
		CHA-SELF SOOTH (Is able to sooth oneself through the process of self-compassion)
		CHA-INC-PROT TIME (An increase in protected time and space for self-compassion; and perception that applying self-compassion gives more time)
		CHA-INC PREP (More proactive in preparing for new tasks or situations, particularly changing the approach to study, motivating them to be better prepared for any study)
		CHA-INC SELF COMP (Recognising change of behaviour to demonstrate increased self-kindness)
		DEV-STRAT-CRY (Changed behaviour to no longer use crying as a strategy for self-kindness)
		CHA-SELF TRUST & COU (More able to trust own judgements and has the courage to act on them)
CHA [RQ5]	CHA-COMMON HUMANITY (Behaviour changes demonstrating an increase in common humanity)	CHA-REC-COMM HUM (Increased recognition of common humanity – that you are not perfect, but neither is anyone else)
		CHA-LESS-JUDG (Perceived change of behaviour to be less judgemental towards other people, environments, or situations, and therefore more able to give non-judgemental care)
		CHA-OTHER PERSP (Increased ability to try to see things from others' perspective)

CHA [RQ5]	CHA-MINDFUL (Behaviour changes demonstrating an increase in mindfulness)	CHA-INC-NOTICE (Is now noticing more in self and others – positive things and suffering)
		CHA-INC-MIND (Increased mindfulness and ability to see context more objectively)
		CHA-INC-REFLECT (Has become more reflective)
		CHA-LIS TO SELF (Now able to listen to self)
		CHA-PERSP-SUFF (A perceived change in suffering – that it was not such an obstacle; is able to 'sit with' the suffering more comfortably)
		MEA-CON-K&U (Has better understanding of suffering and how to ease it)
CHA [RQ5]	CHA-EXTENT OF CHANGE (The perceived extent of behaviour change)	CHA-COMPLETE (Reports changing completely as a result of self-compassion)
		CHA-WORK NOT HOME (Increased self-compassion applied in the workplace, but less so at home)
		CHA-NO CHANGE (Reports no change, or minimal change)

Appendix 17: Codes from categorical-form metaphors

Code	Sub-code	Linked theme
LANG - KNOW: SEE (Metaphor of knowledge and understanding as vision)		Compassion requires knowledge and understanding
LANG-PROG: JOU (Metaphor for progress as a journey)	LANG-LIFE: JOU (Metaphor for life as a journey) LANG-EXP: LUGG (Metaphor for experience as luggage) LANG-PER: ENG (Metaphor for a person as an engine)	Compassion is an active process
LANG-LIFE: BATTLE (Metaphor for life as a battle)	LANG-WORK: BATTLEFIELD (Metaphor for work as a battlefield) LANG-ORG: SHIP (Metaphor for organisations as ships)	Personal and external context for compassion
LANG-COMP: SUBS (Metaphor for compassion as a substance)	LANG-SUFF: SUBS (Metaphor for suffering as a substance) LANG – EMOTION IS CONT (Metaphor for emotion being contained) LANG-EMO: ENERGY (Emotions are physical energies)	

	LANG-PERS: BUILD (Metaphor for the person as a building)	
	LANG-COMP: CONT (Metaphor for compassion as a container)	
LANG-COMP: MULTI (Compassion is a multi-faceted concept)	LANG-COMP: JIGSAW (Metaphor for compassion as a jigsaw)	Compassion is holistic
	LANG-COMP: BODY (Metaphor for compassion as a body or parts of a body)	
	LANG-COMP: ENG (Metaphor for compassion as an engine)	
	LANG-COMP: UMB (Metaphor for compassion as an umbrella)	
LANG-SPACE (Metaphor using the concept of space)		
LANG-THINK: COOK (Metaphor for thinking as cooking)		Compassion requires knowledge and understanding

Appendix 18: A selection of active language used to describe the meaning of compassion from each participant

Touch their hand [P2]

To put yourself in someone else's position [P2]

Doing a good turn every day [P4]

Treating them gently and kindly [P6]

Actually showed that you actually wanted me to have that coffee [P2]

It's the small bits you do without thinking [P5]

Just put yourself out there [P7]

She has this kind of energy, like, joyous energy [P3]

It's something that you believe in and you apply [P3]

Compassion is how the doing is done [P1]

Just like how you go about doing things [P7]

Being active – um – actively compassionate [P3]

Compassion to me … is about being kind to people [P5]

Answered my bell when I rang it the first time [P2]

It was just a really lovely kind of wordless gesture [P1]

Just reminding people of the context of people's everyday life [P1]

Compassionate people probably look to see if they could do things better [P5]

The relatives would see that you are still making an effort, and you are still trying even if they are being grumpy and don't want to talk to you [P6]

You have to work at compassion [P1]

It's an active process you have to work at [P1]

It wasn't always a positive relationship with my Mum, and I think I've worked quite hard on that one [P1]

Putting us in situations where we can show compassion [P4]

How you treat people – um – based on how you'd want to be treated [P6]

Appendix 19: A selection of active language used to describe the application of self-compassion from each participant

I tried in the beginning [P7]

It's part of a process [P1]

It was more now like …a conscious decision to be compassionate towards myself [P4]

Consider myself a bit more [P2]

It's definitely work and you have to make a choice to engage with it [P1]]

You make sure you stop and you think [P6]

It allows you to be, move more forward … so I'm moving forward [P5]

It's changed me completely … which is the most beautiful part of this process [P3]

That's what I do, close my eyes, a few deep breaths, just think about right, stop [P5]

It's still a work in progress [P4]

Having some really practical things to do when I feel overwhelmed or not particularly in control, to create some mental space [P1]

The physical act of doing it makes you sort of take that moment [P2]

If I'm feeling a bit overwhelmed by something now I'll just, even if it means taking myself, "I'm going to the bathroom", and I will just sit for a minute [P2]

Whatever I tried to practice for myself, I tried doing it in every aspect of my life [P4]]

I'm quicker at processing [P1]

Appendix 20: Frequency of Peshkin's I's

Peshkin's I's	Frequency	Participant narrative
Researcher as compassion giver	2	P1, Transcript 1
Researcher as self-compassion evangelist	23	P1, Transcript 1 (2) P1, Transcript 2 (6) P2, Transcript 1 (1) P2, Transcript 2 (3) P3, Transcript 2 (4) P4, Transcript 1 (3) P4, Transcript 2, (2) P5, Transcript 2 (2)
Researcher as judgement maker	23	P1, Transcript 1 (3) P1, Transcript 2 (1) P5, Transcript 1 (6) P6, Transcript 1 (8) P6, Transcript 2 (2) P7, Transcript 1 (3)
Researcher as mother	2	P1, Transcript 1 (1) P4, Transcript 1 (1)
Researcher as Registered Nurse	5	P1, Transcript 1 (1) P1, Transcript 2 (3) P4, Transcript 2 (1)
Researcher as teacher	79	P1, Transcript 1 (5) P1, Transcript 2 (8) P2, Transcript 1 (5) P3, Transcript 1 (10) P3, Transcript 2 (6) P4, Transcript 1 (4) P4, Transcript 2 (2) P5, Transcript 1 (8) P5, Transcript 2 (9) P6, Transcript 1 (6) P6, Transcript 2 (7) P7, Transcript 1 (3) P7, Transcript 2 (6)

Appendix 21: Self-compassion exercises recommended for use with student nurses

The following exercises were drawn from the work of Neff (2015a), Irons (2013), Gilbert (2005), and the researcher's extensive personal experience of self-compassion, nursing and nurse education. The exercises were then applied in nurse education, drawing on examples from clinical practice.

In facilitated discussions, students can be asked to share their experiences of applying these exercises, but sharing should be optional. It is unlikely that these exercises will cause emotional backdraft, but the educator should be aware of the possibility and have strategies in place to support student wellbeing.

1. The pause button

The pause button exercise relates to the need to notice.

It is useful to provide students with a visual image of a pause button. This easy to use self-compassion strategy asks the students to notice when they are feeling uncomfortable, anxious, stressed, overwhelmed etc., and to imagine hitting the pause button. It may only take a second, but allows them to notice their feelings, to look at the situation or context that may be causing these feelings, and then act to ease their suffering. Examples of actions may be to give themselves compassion (using breathing or compassion touch), remind themselves that they are a student and not expected to be an expert, or it may be asking others for help. The important element of this exercise is the pausing.

As the course progresses and this exercise is revisited, students may be encouraged to look at Gilbert's (2005) emotional regulation system during their pause to identify which system may be leading their emotion at that time – the threat system, the drive system, or the self-soothing system.

2. Compassionate touch

Begin this exercise by asking the students to clench their fists. While they are doing this (approximately 30-60 seconds) ask them to notice how it makes them feel. Responses to this can be gained while students still have their fists clenched. Then ask them to open their hands. Again ask them to notice how it makes them feel, and how these feelings may feel different to those with clenched fists. Finally ask the students to put one hand on top of the other, and bring both hands to the centre of the chest. Again ask what they feel now, and how these feelings may differ from the other two exercises. Generally students will identify feelings of warmth and calmness, feeling more relaxed. This is compassionate touch.

Explain to students that it is common to feel stresses and anxieties physically, and they need to consider where they feel their anxiety – examples may include the chest, abdomen, head, shoulders. To use compassionate touch in practice, they just need to place their hands with compassionate intention on the area of their body where they are feeling the stress. It does not have to be for long, and in some cases can be done during the stressful situation without others being aware e.g. holding one's arm, or placing both hands on one's abdomen. It is useful for students to practice this skill in class, exploring where they feel their stress, and gaining an experiential understanding of the impact of compassionate touch.

3. Seeing yourself as you are

The 'seeing yourself as you are' exercise builds on lesson content relating to common humanity – that having both strengths and weaknesses is part of the common human

condition, and applies to everyone. All humans are perfectly imperfect. Once this concept has been explored through discussion, students are asked to write three short lists:

- up to three things that they are good at,
- up to three things that they are average at
- up to three things that they are less good at

Students do not have to share this information, but it is useful to have some discussion about which list was easier to write and why that might be.

4. Self-appreciation

Recognising the human tendency for a negativity bias, this exercise asks students to identify their strengths and qualities. Students can find this initially difficult if asked as a generic question. However, educators can prime students by asking them to think about situations they have been in, or episodes of care they have carried out or participated in. Students are asked to write down the strengths and qualities that they brought to that situation or episode of care.

Students are encouraged to share these where possible as this gives implied permission to others to also identify strengths and qualities.

5. Silver linings

In this exercise, students are asked to think about difficult situations they have experienced. Educators should advise students to think about something that was moderately difficult, not something that was very difficult or traumatic. Students should then be asked to identify one positive thing that came out of that situation. It may be something they have learned, a change in their personal practice, or a change in their circumstances that has turned out for the better in the long term.

Students are not required to share these, but the educator can encourage students to use this skill to look for potential positive outcomes in difficult situations.