Factors associated with self-compassion in clinical psychologists

C. J. E. Robinson

A thesis submitted for the degree of Doctorate in Clinical Psychology

(D Clin Psych)

Department of Health and Human Sciences

University of Essex

May 2015

Acknowledgements

At the beginning of this project I could have never guessed the journey that lay ahead, nor the personal importance that self-compassion would have for me. To everyone who has been there, hugged me and simply listened when I felt lost; the biggest thank you.

To my research supervisors, Dr Leanne Andrews and Dr Syd Hiskey. Thank you for all the hours spent reading drafts and offering ideas in the process of this research journey. Your wisdom and advice will not be forgotten, nor will your compassion and the timely reminders that I needed to connect with my own.

To Dan, who has done nothing but encourage me throughout every step of my dreams to become a clinical psychologist. Thank you for your unwavering support and love; you were undoubtedly my rock throughout. To Tabitha for being my computer buddy. Even though you sat on my keyboard and fell asleep most of the time you were always willing to be with me when I spent lonely hours at my desk.

To my beautiful friends in the 'real world'. Thank you for reminding me that happiness can always be found in true friendships, and just how lucky I am. To Jenny and Koveela, this journey would have been completely different without your love and laughter; thank you for being in it with me.

And finally, to my Mum and Dad. I am and always will be eternally grateful to have you both in my life. Thank you for showing me what courage is, what love can do, and the importance of finding my voice. Your strength and determination has inspired me and I consider myself incredibly lucky. Je t'aime beaucoup.

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At present, two dominant conceptualisations of self-compassion exist. However, a unifying consensus includes self-compassion as a basic kindness and an understanding, non-judgemental attitude towards ones inadequacies and failures (Neff, 2003a), coupled with the wish and effort to relieve ones suffering (Gilbert, 2010a).

A review of the literature reveals elevated stress levels within clinical psychologists (CP's) and a disproportionate amount of research exploring effective self-care strategies. Given the well-evidenced benefits of self-compassion for good psychological wellbeing, it seemed valuable to understand what the levels of self-compassion were within CP's and establish what factors may relate to them. The factors explored in the present research were: 1) current levels of stress, 2) current level of psychological distress, 3) age of clinician, 4) years of clinical experience, 5) level of social connectedness, 6) fear of giving compassion to others, 7) fear of receiving compassion from others and 8) fear of self-compassion.

Furthermore, no research had demonstrated UK community normative data for the Self-Compassion Scale (Neff, 2003b). Therefore this research adopted a quantitative, cross sectional design, using both online and paper methods to access a community sample and an online survey to access trainee and qualified CP's.

Analyses revealed that qualified CP's reported significantly higher self-compassion than trainees, themselves significantly higher than a community sample. A multiple regression analyses revealed that fear of self-compassion, perceived stress and social connectedness, significantly related to self-compassion scores in trainee CP's. Within the qualified CP, fear of self-compassion and perceived stress again were found to significantly relate to self-compassion. Results also demonstrated that in the UK, 1/3rd of trainee CP's and 1/5th of qualified CP's reported psychological distress significant enough to meet the clinical criteria for

an anxiety or depressive disorder. These findings are therefore discussed and clinical

implications are presented.

2. Introduction

2.1 Chapter introduction

Modern life has infiltrated all areas of our lives. We now live in a 'hurry hurry' society which has replaced the post-war focus of welfare, with the promotion of efficiency and 'the competitive edge' (Gilbert, 2010a). As a trainee clinical psychologist, one often observes that there is a consequence to an individual with such a mentality; poor emotional well-being and mental health. However as professionals we are not exempt from this pressure and in fact often carry an additional emotional load as a consequence of our role. In therapy, we often help clients learn more adaptive self-relating styles such as self-compassion and self-understanding, however; do we 'practice what we preach'? Are we self-compassionate?

The following chapter will explore and critique the current literature pertaining to self-compassion. It will establish current theoretical conceptualisations of this construct and understand how self-compassion relates to other self-concepts and psychological wellbeing. Following this, the researcher will then review the literature related to emotional well-being in clinical psychologists; understanding stress levels experienced by this group and the implications of this.

The recent Francis report (Francis, 2013) highlights the urgent need to understand how compassion is accessed and nurtured within todays National Health Service (NHS) workforce. This research seeks to address this need and will attempt to identify the levels of self-compassion reported by clinical psychology professionals and to establish what factors may influence/predict this.

2.2 Self-compassion

Although the concept of self- compassion has been long documented (approximately 2500 years) in Buddhist religious and philosophical traditions (Kang & Whittingham, 2010; Blomfield, 2011) it has become clear that it is still a relatively new concept in western societies. When asked to define "compassion", Pauley and McPherson (2011) identified that although unanimously able to identify it as a 'kindness' and 'meaningful expression'; most of their UK participants chose to describe it within the context of *giving* compassion *to others*.

To date, two main theoretical conceptualisations have been proposed. As expected with most psychological concepts (Barker, Pistrang & Elliot, 2010), a certain degree of overlap exists between the two. However both emphasise different aspects of their conceptualisation; one focusing on the development of self-compassion and the other on what factors interrelate to create the expression of self-compassion. The following section will now outline these.

2.3 Psychological theories of self-compassion

2.3.1 Compassionate mind theory

The first conceptualisation of self-compassion to be considered is that proposed by Professor Paul Gilbert and his colleagues. Sparked due to his interest and observations of Buddhist culture and its emphasis that distress can be alleviated by developing an open and enlightened mind, (Gilbert, 2009), he sought to understand how one may be able to achieve this using a western perspective. From his research, Gilbert grounds his theory within evolutionary perspectives, particularly highlighting how different psychological competencies have emerged throughout time (Gilbert, 2010b). These capabilities include the more primitive capacities for sex and hunting, to the development of more complex cognitive abilities such as mentalization and a sense of self (Gilbert 2010b). In brief, his theory of self-compassion suggests that it is the

relationship between these recently evolved psychological capacities and one's life experiences, which generates our self-relating style and as such our happiness or misery (Gilbert, 2010a).

It is important to note that Gilbert and his colleagues refer predominantly to the term "compassion". This is defined as a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it (Gilbert, 2010b). From this it is evident that *self*-compassion is not considered a distinct construct, but is theorised along with compassion *for others* as part of the wider construct of 'compassion'.

2.3.1.1 Social mentality theory

Gilbert's theory of compassion is comprised of two major sub theories; the first is the Social Mentality Theory (Gilbert, 2000, 2005, 2010a). This states that via evolution we have developed a 'multimind'; a brain with the capability for multiple 'social mentalities'. These are proposed to facilitate the achievement of bio-social goals, such as establishing good relationships. The theory proposes that by enabling an individual to orient their attention and focus their ways of thinking and behaving in a specified way; they can achieve their specific goal. As such, a variety of social mentalities exist in order to achieve various specified goals. Of many, this includes a caring mentality which focuses attention, thoughts and behaviours on the distress of others with the aim to relieve it (Gilbert, 2010a).

2.3.1.2 The three systems theory

In order to pursue biosocial goals, Gilbert proposes that the different mentalities of our mind are 'switched' on or off accordingly, by three underlying, neurological, emotion-regulation systems (Gilbert, 2010b). Drawing from neurobiological research (Depue & Morone-Strupinsky, 2005), this theory identifies; the threat system, the drive system and the soothing system (Figure 1).
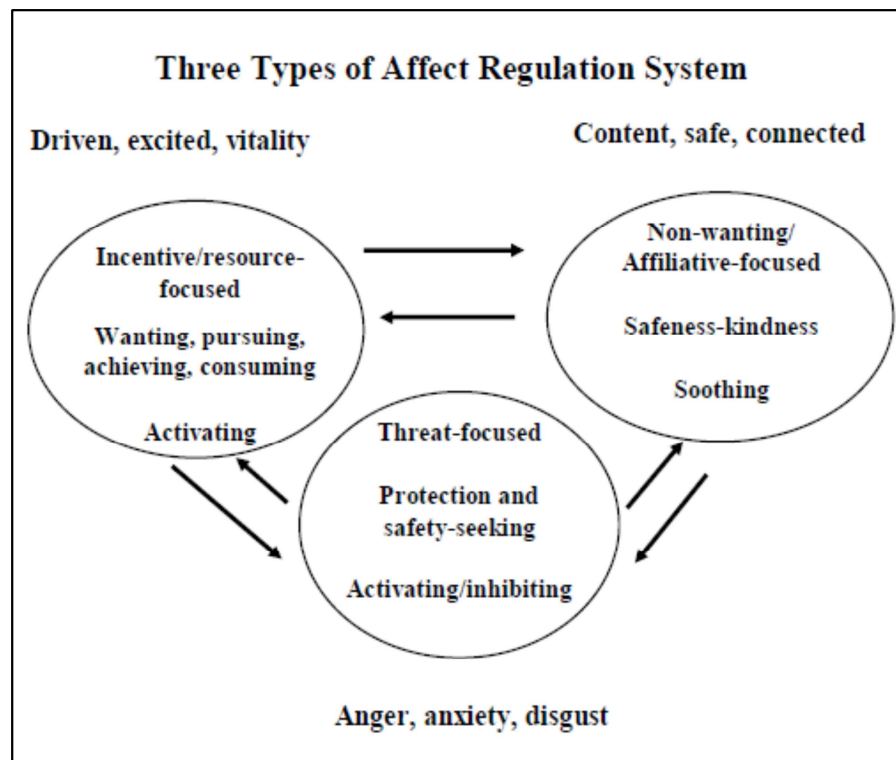
Figure 1. The three systems (Gilbert 2010b)

Gilbert (2010b) proposes that by directing our thoughts and attention to threatening stimuli around us, the threat system produces anxiety thus warning us of danger. As such, this system activates a protective social mentality which causes a behavioural response to keep oneself safe. The drive system is responsible for producing emotions such as motivation and directing our thoughts and attention toward achieving our desired goals. As such, this system activates the competitive social mentalities. Finally, the soothing system is associated with releasing endorphins (Lee & James, 2012) and by directing our thoughts and attention to experiences of safeness, kindness and compassion; it also creates those feelings. This is therefore more associated with the caring social mentalities and is the system whereby an individual can generate self-compassion (Gilbert 2010a). It is important to note that whilst each system is designed to achieve different things, together they balance accordingly to provide the various emotions included in a typical emotional repertoire (Gilbert, 2010b).

Of significance is that due to the brains plasticity, these systems develop differentially at a neural level and in response to an individual's life experiences (Gilbert, 2009). Drawing from attachment theory, Gilbert proposes that should an individual experience soothing and care as a child; their soothing system is likely to have experienced more neurological activation in response to this and therefore laid down more neural pathways (Pipp & Harmon, 1987). With more neural connections, at times of distress, the individual is therefore more able to 'switch on' their caring social mentality which directs their thoughts, attention and behaviours towards producing feelings of safeness, kindness and compassion directed towards the self; thus self-soothing and self-compassion is generated (Gilbert, 2009).

In contrast, it therefore follows that should an individual not receive much reassurance or care as a child, and indeed experienced abuse or threatening behaviour, the soothing system is likely to be less developed, and the threat system (which aims to protect an individual) is likely more dominant. As the more developed neural system, the more probable that it is this system that will be activated in times of distress to regulate oneself. Alongside this, Gilbert also offers that individuals can develop beliefs about themselves to match their threat-based coping strategies (Gilbert 2010b). This can often result in a self-critical self-relating style which is unsurprisingly related to low levels of self-compassion (Gilbert & Procter, 2006).

2.3.1.3 Compassionate mind summary

By socially contextualising his evolutionary and neurobiological theories, Gilberts' model therefore suggests how individual differences in the capability to be self-compassionate can be observed in different people. However, he suggests that this capability is not everlasting and that by an individual practicing their engagement with the soothing system and a caring social mentality; they can bring about changes and start to lay down the new neural pathways which supports the dominance of a soothing system that can foster compassion for themselves. This

has been translated into a model for therapy: Compassion Focused Therapy (Gilbert, 2010b) and aims to support an individual to create what Gilbert proposes as the attributes of compassion; sensitivity, sympathy, distress tolerance, empathy, a care for wellbeing and a non-judgemental attitude (Gilbert 2010a).

2.3.2 Self-compassion theory

As with Gilbert, Dr Kristen Neff and her colleagues acknowledge that compassion for the self forms part of the more general Buddhist construct of 'compassion'. However it should be noted that they refer and focus on a conceptualisation of *self*-compassion in their literature. In contrast to Gilbert, Neff's theory places less emphasis on an individual's neurological capability for a self-compassionate self-relating style. Instead, she highlights the cognitive development associated with attachment theory and draws more heavily from Buddhist practice when outlining what she proposes to be included / excluded in its *presentation*. As such her theory does not imply a single factor of self-compassion but instead outlines 6 separate, yet inter-correlated core factors, which make up her proposed construct (Neff, 2003a). These include (1) the presence of self-kindness and the absence of self-coldness, (2) a sense of common humanity; perceiving ones experiences of distress or suffering as part of human experience vs isolation and, (3) mindfulness; being able to hold painful thoughts and emotions in a balanced awareness vs over-identification with these emotions (Neff, 2003a).

Neff promotes the idea that compassion directed towards the self is just as important as compassion directed to others. Acknowledging that this rejects the western ideas of a "stiff upper lip" response to distress, she defines her construct of self-compassion as; being open to, and moved by, one's own suffering, experiencing feelings of caring and kindness towards oneself and taking an understanding, non-judgemental attitude towards ones inadequacies and failures (Neff, 2003a).

2.3.2.1 Self-kindness vs. self-coldness

Acknowledging the innate, neural attachment system, Neff privileges a different aspect of this theory in her understanding of self-compassion; the cognitive development of our sense of self and our "internal working models".

Bowlby's theory (1988) suggests that infants develop strong emotional bonds to their parents, which enable the parents to attune with their child's needs for safety, care and security. It is via this process that children develop a sense of their parents as a "secure base", from which they can explore and be open to the world around them, returning to this base for comfort when threats are perceived. Bowlby states that repetitions of this process enable a child to develop an "internal working model". Neff suggests that this creates an 'unconscious, deep-seated mental portrait of who we are and what we can come to expect from other people' (Neff, 2011).

Neff offers that our internal working model has significant influences for how we relate to ourselves. If we do not experience that we are worthy of care and kindness and instead experience others as critical, harsh and cold towards us, then we are much less likely to relate ourselves with self-kindness and are more likely to adopt a cold self-critical self-relating style (Neff, 2003a). As such, it is less probable that we would experience a secure base and are less likely we would feel safe being open and exploring of our world and experiences. In an important point however, Neff articulates that an internal working model is not concrete and changes can be made (Neff 2011). By giving the self kindness, nurturance and understanding (self-compassion), she suggests that an individual can develop their own 'secure base' and begin to feel safe enough to be open to thinking about their experiences, particularly their distress (Neff, 2011).

2.3.2.2 Common humanity vs isolation

Drawing from a Buddhist perspective and the work of Brown (1999), Neff (2003b) asserts that we are all intimately connected; however an individual's common response in times of difficulty is to isolate themselves and feel disconnected from the world around them. She proposes that often many individuals can perceive that they are the only one experiencing failures or distress and see this as separating them from others (Neff, 2011).

Within this proposed component of self-compassion, Neff emphasises the universality of human kind and the recognition that an individual's experiences are all part of a common human experience (Neff 2003b). This involves the acknowledgment that as humans we are all fallible and at times can all feel inadequate and make errors (Neff 2011).

As such, to be self-compassionate Neff proposes that we must relate to ourselves with this notion of a common humanity held in mind during periods of difficulties; reminding ourselves that this is a shared, not isolating, experience. She adds that by reminding ourselves of the connectedness of human experience we can help put our emotions in perspective (Neff, 2011)

2.3.2.3 Mindfulness vs over identification

Neff advocates that the final aspect of self-compassion is the concept of mindfulness. She suggests that in times of distress individuals often may become carried away by their feelings which can exaggerate their suffering (Neff, 2003b). Terming this 'over identification', she proposes that one immerses themselves in their subjective emotional experience to such a degree that it is difficult to distance themselves enough to take an objective perspective.

Using Scheff's (1981) idea of "mental space", Neff proposes that in order to extend self-kindness, a core element of her self-compassion theory, an individual must be able to engage in a metacognitive activity which allows them to create a mental space by reflecting more objectively on their experience. Again this acknowledges the development of cognitive

capacities such as reflection and mentalisation, which develop as part of the attachment system. Neff proposes that for self-compassion to take place one must be able to engage in mindfulness; a clear seeing and non-judgemental acceptance of ones thoughts and experiences in the present moment, without trying to push them away or running away with them either (Kabat-Zinn, 1994; Hayes, Strosahl & Wilson, 1999; Neff, 2011).

Neff summarises the inclusion of mindfulness in her conceptualisation of self-compassion by stating that to fully experience self-compassion, individuals must not avoid their painful feelings but instead acknowledge them in a non-judgemental and receptive way (Neff, 2003b). She proposes that one can only respond to their distressed feelings with self-compassion when they are aware there is distress to respond to. By neither ignoring, or over-identifying with painful experiences, individuals can allow themselves the "mental space" required to extend themselves kindness and compassion in these moments.

2.3.2.4 Core components summary

In summary, Neff proposes that it is the interrelation of these six core aspects; the presence of self-kindness, a sense of common humanity and mindfulness competencies and the absence of self-criticism, isolation and emotional over-identification, that creates her construct of self-compassion. By holding ones painful and difficult thoughts in mind with understanding, kindness and a sense of common humanity; negative feelings can be transformed into a more positive state (Neff 2003b).

2.3.3 Theories of self-compassion summary

Having apparently observed how individuals in the western societies tend to treat themselves, it appears that both Gilbert and Neff introduce the emerging dialogue between Eastern traditions and Western psychology (Molino, 1998; Watson, Batchelor & Claxton, 1999) in order to establish a new way to manage our distress.

The concept of 'compassion' is proposed to be "universally understood, yet hard to define" (Gumley & Macbeth, 2011). The above conceptualisations reflect this in that they both identify a number of variables that are theoretically justified as indicators of a construct of self-compassion, yet both emphasise different aspects. Gilberts account highlights its neural development and can offer suggestions for different levels of self-compassion observed, within a broader context of compassion, whereas Neff promotes the cognitive development of a sense of self and the phenotypic presentation of self-compassion.

The important consensus is self-compassion as a form of self-kindness, incorporating an understanding and non-judgemental approach to the regulation of one's difficult emotions. Within the last decade, research in the field of self-compassion has focused on understanding this construct further, including what factors are associated with, and the consequences of, experiencing both higher and lower levels. As both conceptualisations offer useful ideas, research yielded by both conceptualisations will be reviewed to understand this further.

2.4 Self-compassion in research

Upon inspection of the literature, a dominance of Neff's' theory becomes apparent. Using her conceptualisation, the Self-compassion Scale (SCS) (Neff 2003b) has been used to assess the relationship of this self-compassion on psychological wellbeing and its relationship to other self-constructs.

2.4.1 Self-compassion and psychological wellbeing

A review of the literature indicates that self-compassion is consistently associated with good psychological and emotional wellbeing. Indeed, research has shown that it significantly positively correlates with measures of self-esteem (Neff, 2003a; Neff, 2003b; Neff & Vonk, 2009). However unlike self-esteem, self-compassion it is not socially contingent and does not rely on the meeting of idealised standards or evaluation of the self in comparison to others in

order to produce positive emotion (Neff, 2003b). Indeed it is its deliberate acknowledgement of suffering and perceived inadequacies, and the acceptance of this with self-kindness and common humanity that enables difficult feelings to be partially transformed into a positive state. As it does not rely on an unrealistic view of the self, Neff therefore advocates self-compassion as a healthier way to relate to oneself, and has demonstrated that SCS scores continue to be significant predictors of positive emotional wellbeing, even after self-esteem is partialled out of data analysis (Neff, 2003a; Neff & Vonk, 2009)

Research has demonstrated that self-compassion is associated with adaptive functioning in student samples such as buffering against anxiety (Neff, Hseih & Dejitthirat, 2005), less anxiety depression and greater life satisfaction (Neff 2003b; Neely, Schallert, Mohammed, Roberts & Chen, 2009). It has also demonstrated negative significant correlations with stress (Gilbert, McEwan, Matos & Rivis, 2011) and anger (Neff & Vonk, 2009). In their meta-analysis of 14 self-compassion and psychopathology studies, MacBeth and Gumley (2012) found that self-compassion was associated with lower levels of mental health symptoms and that this was a large effect size r- -.54 (95% CI -0.57 to 0.51, $z = -34.02$, $p<.0001$).

An interesting caveat of self-compassion research explores the relationship of self-compassion and academic factors. This demonstrates that self-compassion is positively associated with perceived academic competence ($r = .35$, $p <.01$) and negatively associated with fear of failure ($r = -.51$, $p <.01$) (Neff et al, 2005) and academic burnout ($r = .37$, $p <.01$) (Kyeong, 2013). This suggests the potential of self-compassion to particularly support students in schools and universities.

A theme within the self-compassion literature to emerge is that of the relationship between self-compassion and perceived connectedness. This is defined as a sense of companionship and belongingness that promotes feelings that one can identify themselves with other individuals

(Kohut, 1984). The literature demonstrates significant relationships between the two constructs; individuals with higher self-compassion scores report higher perceived social connectedness to others. Higher social connectedness itself is associated with low anxiety and higher self-esteem (Lee & Robbins, 1998), and it has been demonstrated that the ability to feel socially safe, connected and supported is significantly associated with lower depression, anxiety and stress scores. (Rockliff, Gilbert, McEwan, Lightman & Glover, 2008).

Social connectedness as measured by the Social Connectedness Scale (Lee & Robbins, 1995) demonstrated a significant positive relationship with self-compassion in Neff's (2003a) original research and in both their samples of 235 adolescents and 287 young adults (Neff & McGehee, 2010). Another study identified that following a self-compassion focused intervention, those who experienced an increase in self-compassion also experienced an increase in their sense of social connectedness (Neff, Kirkpatrick & Rude, 2007). This was operationalised via the number of connected vs separating words that students used when writing about a perceived weakness. A further finding is that individuals scoring higher in self-compassion were also described by their partners as more emotionally connected and less detached (Neff & Beretvas, 2012). One can understand this positive relationship when considering the theoretical and empirical evidence for the 'common humanity thinking' sub construct of self-compassion; if one perceives one's experiences as part of a wider, shared human experience, it is likely that one will feel more connected to others.

To date, a low level of self-compassion and self-criticism has not attracted any diagnostic specifications in its own right, however some suggest its transdiagnostic status (Schanche, 2013). Working to develop self-compassion has become a focus for Gilberts (2010b) Compassion Focused Therapy (CFT). Using a mixture of psychoeducation, formulation and compassion-focused skills training, this has evidenced improvements in psychological wellbeing for a group of individuals supported in a community mental health service (Judge,

Cleghorn, McEwan & Gilbert, 2012), eating disorder psychopathy (Ferreira, Matos, Duarte & Pinto-Gouveia, 2014), psychosis (Gilbert & Procter, 2006; Mayhew & Gilbert, 2008; Braehler et al, 2012), trauma (Beaumont, Galpin and Jenkins, 2012) and even physical health difficulties such as those suffering with chronic acne (Kelly, Zuroff & Shapira, 2009). Still at an early stage in its evidence base, some, but not all of the above studies have measured self-compassion, (for example Judge et al, 2012), or assess only self-reassurance, (Gilbert & Procter, 2006), which may not holistically assess the proposed elements of self-compassion. It is therefore worth considering these findings with the possibility that the improvements reported by some of these interventions may not be due to an increase in self-compassion, but could be due to other factors. For example in the Judge et al, (2010) study this could be due to the benefits of cohesiveness in being part of a group (Yalom, 2005). The research outlined above suggests that increases in self-compassion would reduce psychopathology but more research is needed to demonstrate this within CFT.

2.4.2 Self-compassion and demographic variables

An intriguing finding from the literature is the relationship of demographic variables and self-compassion, particularly age and gender. Always explored as part of other studies looking at self-compassion, a mixed picture emerges. In community and student samples, age is found to be positively and significantly associated with self-compassion (Neff & Vonk, 2009; Neff & Pommier, 2012; Barnard & Curry, 2011) indicting that self-compassion may increase with age. However, in the Neff and Vonk (2009) study, this association was small ($r=.22$) in a large community sample ($n=2187$) and only a 17% response rate was yielded in the Barnard and Curry (2011) which raises the generalizability of these claims. Indeed other studies have evidenced no significant association of age with self-compassion in community samples (Neff & McGehee, 2010).

A more consistent finding can be highlighted in the relationship of self-compassion with gender, as a majority of the research indicates that women report significantly lower levels than men (Neff, 2003a; Neff et al, 2005; Neff, Pitsungkargam & Hseih, 2008; Neff & Vonk, 2009; Raes, 2010; Neff & McGhee, 2010). However these results are predominantly found in undergraduate student samples with a high female to male ratio. Furthermore, some studies have not found any significant difference between women and men (Neff 2003a; Neff, Kirkpatrick & Rude, 2007; Neff & Pommier, 2012). In particular, the Neff et al (2008) study only found a gender difference within their USA undergraduate samples, and no difference was revealed within their Thai and Taiwanese undergraduates, indicating that this gender difference may be culturally specific.

In a very recent meta-analysis, Yarnell et al (2015) evidenced that in the 88 studies they identified as exploring gender and self-compassion scores, men did report slightly higher levels than women. However they found this to be a small effect size ($d =.18$) and suggest that gender differences in self-compassion scores should not be over emphasised.

2.4.3 Self-compassion normative data

The literature now also presents normative data for the SCS. These are evidenced in both student SCS *M*= 18.25 (Neff, 2003b), SCS *M*= 3.03 (Iskender, 2009), SCS M= 2.81 (Herzberg et al, 2012) and community samples; SCS *M* = ranging from 2.85 – 2.90 (Jazaieri et al 2012), SCS *M*= 2.8 (Neff & Pommier, 2012), SCS *M* =2.58 (Neff & Germer, 2013).

More recently even cross cultural differences have been evidenced. Based upon Markus and Kitayama's (1991) self-construal theory, Neff et al, (2008) highlighted that countries with a higher prevalence of people of Buddhist religion and a collectivistic, interdependent culture translated into higher self-compassion scores (Thailand SCS = 3.41) than western, individualised, independent cultures (USA SCS = 3.14). Interestingly USA SCS scores were

higher still than self-compassion scores in a Taiwanese sample (SCS = 2.92). According to the self-construal theory, Eastern societies construe themselves as part of a broader social context (Markus & Kitayama, 1991) therefore the authors proposed this low score in the Taiwanese sample could be due to the cultures Confucian emphasis on self-improvement, creating a possibly more self-judgemental relational style.

A curious revelation from the literature is that although many studies across the US and UK have explored levels of self-compassion in different populations, until very recently there had not existed any UK community data. As such, any previous UK research was compared to SCS scores of a US community norm for comparisons. Due to the confounding factors inherent with different cultures (Barker et al, 2010); for example expression of emotions, societal norms in relation to discussing ones difficulties, this results in the potential for unreliable conclusions of 'high' and 'low' levels of self-compassion to be drawn. To date, only one study has very recently published a community norm in the UK. With a large sample of *n*= 821, Williams, Dalgleish, Karl and Kuyken (2014) established some UK community data for the SCS. However the papers aim was confirmatory factor analysis of the SCS in this sample and in their results, they failed to report a total SCS score. Furthermore, the subscale scores that were reported had been calculated by summing up each subscale and taking an average of this across the sample. This is not the instructions set out by Neff (2003b) and as such makes it difficult to compare these scores with other data, alongside raising some validity issues. The sample also reported a low average age (*M* =25.7, *SD*= 9.8) which may not be very representative of a community sample. As such research is still needed to provide a reliable and robust community UK norm for future comparative purposes in self-compassion research.

2.4.4 Self-compassion research summary

Thus far, the research has presented a number of important factors. This first is the positive influence self-compassion can have for both groups and individuals. The second is that this promotes good psychological wellbeing in a variety of samples including clinical, community and academic environments. Furthermore a number of factors emerge from the literature as having strong relationships with self-compassion, including social connectedness and demographic variables. However, somewhat of a significant gap exists within the UK research field; no reliable community normative data.

2.5 Fear of self-compassion

Whilst empirical data suggests that having higher levels of self-compassion is beneficial for an individual, recent studies also reveal that some can struggle to be self-compassionate, reporting that they are often more unkind and more harsh towards themselves than they are toward others (Neff, 2003a). In a study exploring the efficacy of exercises aimed at increasing self-compassion, Gilbert and Procter (2006) noted that some participants questioned if they deserved to be self-compassionate whilst others reported that they believed it to be a weakness. Moreover some described that their initial attempts to be self-compassionate resulted in feelings of fear and resistance. More recently, studies have associated lower levels of self-compassion with a self-critical, self-relating style; a characteristic that is proposed to be developed during an individual's formative years, often in response to aversive experiences (Mayhew & Gilbert, 2008).

Some initial research has attempted to further understand these seemingly negative responses to self-compassion and has consequently proposed that a multidimensional 'fear of compassion' may exist. For example, it has been suggested that a fear of extending compassion to another may develop if this action indicates a threat to an individual's own interests (Gerdhart, 2010).

The same is proposed when confusion exists between extending compassion or inadvertently condoning a person's detrimental behaviour (Jazaieri et al, 2012).

Some authors also suggest that experiences of receiving compassion may trigger feelings of grief, for sought-after help that was never previously received (Gilbert et al, 2011a). A fear of receiving compassion from others has also been supported by interviews in clinical nurse populations (Gustin & Wagner, 2013) and by biological indicators of threat. When asked to imagine an individual expressing compassion toward them, individuals with a tendency to be self-critical and an insecure attachment style, experienced a physical threat response; reduction in heart rate variability (Rockliff et al, 2008). Therefore, not only may we experience a fear of self-compassion, as demonstrated by Gilbert and Procter (2006), but we may also fear receiving compassion *from* others and giving compassion *to* others.

Based upon the above research findings and their personal clinical observation, Gilbert, McEwan, Matos and Rivis (2011a) recently explored these three proposed fears of compassion. In their study they compared the experience of compassion for 53 therapists attending a three day CFT workshop and 222 psychology and criminology undergraduate students. The study developed a self-report quantitative measure; the Fears of Compassion Scale. From this, they evidenced initial means for all three fears of compassion (fears of *self*-compassion, fears of receiving compassion *from others* and fears of giving compassion *to others*).

This research identified that for both groups, fear of giving compassion to self was highly positively correlated with fear of receiving compassion from others; indicating a general fear of experiencing compassionate feelings directed towards the self. Receiving compassion *from others* was also associated with poorer emotional wellbeing in the therapist group, as this was also significantly positively correlated with levels of stress and depression. A fear of *self*-compassion was only significantly positively correlated with depression (Gilbert et al, 2011a).

The same pattern was found with students however they also reported significantly higher levels of anxiety. This finding; that the higher the reported fear of compassion, the higher their reported psychopathology, was further replicated by Gilbert, et al (2011b) in their sample of 185 students.

This body of research further demonstrates a somewhat anticipated finding; that a fear of self-compassion correlates significantly with lower levels of self-compassion. This was evidenced in therapist and student samples (Gilbert et al, 2011a) and also a community sample (Jazaieri et al, 2012). Indeed, in contrast to the Gilbert et al (2011a) study, Jazaieri et al (2012) also evidenced that fear of receiving compassion *from others* was also significantly negatively correlated with self-compassion; indicating that a fear of receiving compassion, regardless of the source, was related to lower self-compassion scores in a community sample. Given the above documented positive effects of self-compassion, a fear of this has implications for an individual's emotional wellbeing.

Since this study, further research has also demonstrated means for these fears of compassion. From this, it emerges that therapist fears of compassion on all three subscales are demonstrated to be lower (ranging from *M*= 8.15- 10.51) than student populations (ranging from *M*=14.64 – 19.20) (Gilbert et al, 2011a; Gilbert et al, 2011b), a US community sample (ranging from *M* = 10.60 – 15.55) and as would be expected, much lower than a clinical sample of moderately and severely depressed clients (*M*= 32.6 - 39.18) (Gilbert, McEwan, Catarino, Baiao & Palmeira, 2014). Given that compassion forms a major part of the therapist role is unsurprising that lower fears are reported by this group.

These studies provided empirical evidence that whilst it is generally understood to be a positive thing; individuals can have fears related to experiencing compassionate emotions. Interestingly, although reduced in comparison, even therapists reported fears despite their work aiming to

foster self- compassionate feelings in other people. This seems an interesting caveat of research given that fears in this area could lead to lower self-compassion. Within the field of research on therapists, the evidence suggests that this could have a profound impact on personal wellbeing and stress, which is also reported to possibly impact clinical working (Norcross & Barnett, 2007). However, a number of limitations exist in the Gilbert et al (2011a) therapist sample. Primarily, the sample is drawn from a convenience sample of only 53 therapists, a small number. Furthermore they were all likely to have a special interest in self-compassion due to their attendance at a three day CFT workshop. Therefore these findings must be considered preliminary as they may be biased by the personal interests of the therapists and social desirability when part of this group. Given that no other research has explored fears of compassion in therapists since and its evidenced impact on emotional wellbeing and levels of self-compassion, further research is required to ascertain reliability and norms for this group.

2.6 Compassion in the NHS

In recent years, the topic of compassion has also attracted increasing interest within the socio-political arenas of the National Health Service (NHS). Whilst previously only discussed within the remit of Older Adult services, developing a culture of compassionate care is now emphasised across the NHS with 'compassion' highlighted as one of the main constitutional values (Department of Health [DoH], 2013). Translating into clinical practice, this is defined as treating individuals, carers and relatives with sensitivity and kindness (DOH, 2013).

However in 2009, the Kings Fund 'The Point of Care' report (now The Point of Care Foundation) highlighted that compassionate care was being prevented by the increasing emphasis on achieving financial targets, managing risk and measuring outcomes. In this report, Firth-Cozens and Cornwell (2009) identified that in the current NHS culture, individual stress, depression and burnout due to high workloads and perceived lack of support were also contributing to a decrease in compassionate care.

These findings seemingly suggest that whilst the NHS requires its staff to be compassionate, the organisation itself does not necessarily treat its staff in the same vein. Furthermore, reported levels of stress and burnout suggest that staff also do not treat themselves with the compassion they are expected to provide others. In their research, Gustin and Wagner (2013) identified a theme that self-compassion was considered as source for compassionate care; that this was not an invention 'given' from care givers to patients' but that self-compassion was co-created and fundamental in the interpersonal phenomenon that occurs with compassionate care. In addition to this, Heffernan, Griffin, McNulty and Fitzpatrick (2010) propose that individuals whom are in the caring profession but without the ability of self-compassion, are ill-prepared to show compassion to those they support. Even today, reports that NHS staff are still only 'surviving, not thriving' (Fitzsimons, 2015) cause concern; does there exist an unidentified gulf between the NHS ideals and the reality of today's NHS workforce?

Unfortunately, although this was identified, minimal response to this within the NHS led to a sad repeat of these findings more recently. In his report, Robert Francis QC (2013) made the concept of 'compassion' the core aspect of his public inquiry. He identified that the 'bullying' and 'unethical behaviour' of senior managers to fulfil contractual targets, led to the grave and harrowing shortcomings in care evidenced at Mid Staffordshire Trust hospitals (Francis, 2013). This, he suggests, fostered a culture of denial in which perceived professional shortcomings where ignored and that staff were unable to be open to constructive feedback.

In this report, Francis (2013) outlined 290 recommendations to be taken forward. Within this, he suggests a role for measuring 'cultural health' within the NHS. Whilst bearing in mind the stark need for 'compassion' itself to not become incentivised (Smajdor, 2014), this research seeks to contribute to this goal of measuring health particularly within the arena of self-compassion, focusing on one discipline particularly; Clinical Psychology.

2.7 Clinical psychology

Clinical psychologists (CP) can have a wide-ranging role within many different services. Nonetheless, all have the aim of supporting individuals or groups of people to reduce their psychological distress and foster good emotional wellbeing and mental health (British Psychological Society [BPS], 2015). Whilst often referred to as 'therapists', CP's differ to counsellors and therapists whom often work within one therapeutic stance, as they are trained in a variety of therapeutic and assessment modalities alongside their work within the field of neuropsychology (Division of Clinical Psychology [DCP], n.d.). Working with all age groups and both physical and psychological difficulties (NHS Careers, 2015), the role of a CP in the United Kingdom (UK) requires an extensive 6 year training; 3 years undergraduate psychology degree and a 3 year Doctorate in Clinical Psychology Training (DClinPsych).

Whilst a small number of self-funded places exist in the UK, the Doctorate in Clinical Psychology is predominantly funded and salaried by the NHS/ Health and Social Services Executive (HSSE). As such, it is expected that prospective applicants gain additional post-graduate clinical experience prior to application for a place on training. It has been suggested that on average, it takes applicants 3 years of postgraduate clinical experience before they are offered a place to train, thus taking the total number of years to train to approximately 9-10 years on average (Bond, 2013).

Due to the desirability of the role and its salaried/ funded financials, competition to train as a CP in the UK NHS is fierce. For the intake commencing training in 2008, 2527 applications were made for 621 places, resulting in approximately ¼ (24.6%) of applicants gaining a place on training. By the 2014 intake, this figure had risen to 4044 applications for 609 places and therefore only 15 % of applicants gained a place on training (Clearing House for Postgraduate Courses in Clinical Psychology [CHPCCP], 2014; Queens University Belfast, 2014; York & Hull University, 2015).

With the increasing competition to train, applicants are required to have more knowledge and clinical experience in order to stand out from the 'masses'. Commensurate with this is the likely self-evaluation that occurs when applying for new roles or training and the consequential social comparison when meeting other applicants (Knight, 2002; Badali & Habra, 2003). Once successfully enrolled on the Doctorate in Clinical Psychology, this self-evaluation continues on a constant basis and is encouraged by the personal and professional development guidance from the British Psychological Society (BPS): "to reflect upon and improve their own clinical practice" (BPS, 2010a) "within a context of continued high standards in professional work" (BPS, 2006). Some authors have identified that it is within reflective arenas that trainees can experience high levels of shame (Hahn, 2001) and narcissistic injury (Halewood & Tribe, 2003) which, if left unresolved may affect personal emotional wellbeing. This, alongside "evaluation stress"; defined as the continuous evaluation of clinical and research competencies, academic assignments and some examinations (Pakenham & Stafford-Brown, 2012), can lead to high levels of stress and poor emotional wellbeing within this population.

Following qualification, this evaluation continues as CP's are required to demonstrate their personal and professional development (PPD) via internal NHS appraisal systems and externally via the Health Care Professions Council (HCPC) PPD continuous portfolio for professional audit in order to maintain registration (HCPC, 2014a). This, taken together with the evolving 'target culture' of the NHS can leave little room for personal reflection and other self-care practices, again leading to high stress, negative affect and poor emotional wellbeing.

2.8 Stress in clinical psychologists

A review of the literature reveals that some, albeit a minimal amount, of research has taken place with the aim of identifying stress levels in the clinical psychologist population (including trainees). Given the paucity of research available, all literature related to stress or indicators of

it; such as anxiety and depression, was reviewed. Exploring the world-wide platform for English-language studies, evidence of research in Australia, America and the UK exists.

2.8.1 Stress in trainee clinical psychologists

In answer to the question "to what extent do you consider that you have been under stress as a result of clinical training?" Cushway (1992) identified that nearly half (48%) of UK clinical psychology trainees (CPT's) reported themselves as "moderately stressed" and over a quarter (27%), "very stressed". Whilst elevated in its own right, this was compared to previously documented stress levels of other training professionals such as medical students and civil servants and still found to be comparatively high. In the same study, trainees also completed the General Health Questionnaire-28 (GHQ-28), a quantitative measure of psychological distress developed for research with a cut off denoting "caseness". This is defined as meeting clinical criteria for common mental disorders of anxiety or depression in the GHQ manual (Goldberg & Williams, 2006). From a total of $n= 287$ trainees and sampled from all three training cohorts and all Clearing House DClinPsych courses in the country, 59% of this sample reached or scored beyond the caseness cut off.

As a measure of state, rather than trait, the GHQ assesses psychological distress at a particular point in time. No normative data for the GHQ-28 has been published; therefore the literature was reviewed to ascertain how CPT caseness at this time compared to a UK community sample. Minimal data exists however one UK population study; (Hatch, Mishra, Hotopf, Jones & Kuh, 2009) revealed a caseness frequency of 16.8% ($n = 2073$) in their stratified cohort sample of 53 year olds in the year 1999. A similar prevalence is indicated (19.3%), when compared to results of the GHQ-28 in a smaller UK community sample ($n = 432$) (Purcell, Pathé & Mullen, 2005). Given the minimal GHQ-28 UK community data available at this time, the data from the Health Survey for England (1995) (reported in Prescott-Clarke & Primatesta, 1997), using the GHQ-

12, a shortened version of the GHQ-28 with similar validity and reliability evidenced (Hankins, 2008) was also inspected. This large population survey ($n = 16055$) of adults of all ages, identified a caseness frequency of 17.3 % in their cross sectional sample. Taken together, these community samples suggest that by comparison, a much raised prevalence of distress in UK CPT's existed. One must note that these comparisons are tentative however as differences in scoring methods exist. Furthermore, whilst Cushway (1992) used a cut off of 5 or above to indicate caseness, the above population studies used a cut off score of 6 or above.

Reviewing international CPT's, In samples of Australian CPT's, Pakenham and colleagues also identified high levels of caseness using the GHQ-28 in two groups of first year trainees as 64% and 82% reached caseness levels ($n=56$) (Stafford-brown & Pakenham, 2012). This was replicated in a later study in which 75% of first and second year trainees reached caseness levels ($n= 56$) (Pakenham, 2014).

Other measures have also been used to identify stress. In their UK study, Kuyken, Peters, Power and Lavender (1998) elucidated high levels of stress using the Perceived Stress Scale (PSS-10) (Cohen & Williamson, 1988). Within their initial study, a sample of 302 first and second year trainees from 15 of the DClinPsych training courses, revealed stress levels at $M=$ 17.37. The authors concluded this as much higher than a USA normative community figure ($M= 13.02$) (Cohen & Williamson, 1988). However, given this comparison is between two samples that were taken in actuality 10 years apart, and alongside inherent cultural differences between the UK and USA, more recent and reliable comparisons are needed. Moore (2008) also used a version of the PSS (PSS-14) in their more recent research with UK trainee clinical psychologists; however this study did not report the perceived stress scores.

Within their study, Kuyken et al (1998) explored trainee levels of anxiety, depression, self-esteem and work adjustment using subscales of Employee Assistance Programme Inventory

(EAPI) (Anton & Reed, 1994), as a measure of psychological adaptation. This revealed that 25% of their sample evidenced "a tendency towards significant problems" within these areas (defined as scoring within 1 S.D. above the mean) but did not quite reach the cut off for actual 'significant problems' as defined by the scale. Using the EAPI, this pattern of a tendency towards significant difficulties in UK trainees was replicated with by Brooks, Holtum and Lavender (2002) and again by Kuyken, Peters, Power and Lavender (2003).

It is worth considering that 25% represents a much lower indicator of stress when compared to the approximate, 59%, 75% and 64% - 82% previously evidenced using the GHQ-28 (Cushway,1992; Stafford-brown & Pakenham, 2012; Pakenham, 2014). Kuyken et al (1998) also acknowledged this and suggested that measuring stress as a function of 'psychological adaptation' thus breaking down the concept of 'caseness' may represent a more holistic assessment. However a number of methodological issues must also be acknowledged when considering differences between scores. The data yielded by Kuyken and his research colleagues represents only half of all UK training courses and largely excludes third year trainees. Furthermore, their data was collected within the first few months of training, in which many first year trainees may have not experienced enough of training to ascertain a valid notion of these areas in relation to their training.

Given the emphasis on supporting and managing *other* people's emotional wellbeing, this literature suggests that that stress levels for most, if not a subgroup of trainees, could be worryingly high. Although some comparison issues exist, this also suggests that levels of distress could be much higher than in community samples. For these reasons, some authors have attempted to understand the particular reasons why stress levels may be so elevated in this group.

2.8.1.2 Trainee clinical psychologist stressors

Reviewing the literature indicates that some stressors are more pertinent to CPT's and others more so for qualified CP's. Together with, "evaluation stress", stressors proposed and identified for CPT's include; role switching within the dual status of student and clinician, time constraints and volume of academic/ research demands (Pakenham & Stafford-Brown, 2012; Myers et al, 2012). Stressors also include the 'Glamourized expectations' of training and the realisation that for some clients, change can only be minimal (Skovholt & Ronnestad, 2003). Further stressors reported include the nature of the client's difficulties and professional self-doubt / uncertainty (Cushway & Tyler, 1996) alongside a proposed struggle to tolerate clinical ambiguity (Pica, 1998). Practical issues such as an increase in travelling to placements and poor supervision have also been reported (Cushway 1992).

Throughout the literature, authors have also attempted to understand what factors may predict stress levels and a number of interesting themes have emerged. Some authors suggest that stress levels may be influenced by the trainee's cognitive appraisal, such as their perceived sense of control over Doctorate in Clinical Psychology demands and their appraisal of their ability to cope with these demands (Kuyken et al, 2003). However as no further research has replicated this and by using two purpose designed questionnaires, the study raises some questions in relation to reliability and validity of these findings. Using a well-established measure; Ways of Coping Questionnaire (Folkman & Lazarus, 1988), Kuyken et al (2003) also evidenced that trainees using an avoidant coping mechanism also experienced higher levels of anxiety, depression and low self-esteem.

Of interest is a long standing hypothesis, often discussed within CP groups; that individuals choosing this career may be attempting to resolve psychological distress from their formative years (Guy, 1987). Indeed, Nikcevic, Kramolisova-Advani and Spada, (2007) found that 40 UK

third year psychology undergraduates with clinical ambitions reported significantly more perceived abuse in their childhood compared with their psychology peers with no clinical ambitions for their future careers and business undergraduate students. Although no differences were observed in levels of anxiety and depression at that time, one may wonder how previous adversity related to stress levels in later life. In other research, more practical outlets such as greater sleep and greater perceived social support have been evidenced as significantly related to lower stress (Myers et al, 2012).

In her research, Cushway (1992) identified that gender may influence stress levels with women also reporting significantly higher levels of caseness than men. They also identified a non-significant trend for older trainees to report less stress. This finding was replicated by Myers et al (2012) in their US sample of 488 graduate clinical psychology students, demonstrating a significant relationship between age and perceived stress; the older the clinical psychology graduate student, the less perceived stress. Yet in contrast, the aforementioned Kuyken et al (1998) study found that older trainees did not differ from their younger colleagues in levels of perceived stress. Furthermore, the older group reported greater external stressors and perceived less control over the stressors of the course. From this, the authors concluded that older trainees may have an increased capacity to manage stress; so as to not report any higher levels of perceived stress, despite reporting more stressors.

An interesting source of stress to emerge from the literature is that of connectedness with other training colleagues. Initially, trainees are members of their year cohort and more widely their university. This can be a stressful time due to the demands of their course and has been observed by the researcher in her own experience to often be accompanied with a sense that one got their place on training due to 'luck' or having to work a lot harder than others to achieve the same goal. This sense of being a fraud has also been identified in other health professional

groups, including nursing (Jones, 2009), clinical nurse specialists (Arena & Page, 2007) and G.P.'s (Lancelot, 2009). This has been labelled the 'impostor phenomenon' and can often result in an acute sense of isolation (Clance & Imes, 1978). Furthermore to this possible sense of professional isolation, feelings of disconnection from others is also evidenced to be a common problem among today's general students (Covington, 1992; Damon, 1995; Roeser, Midgely and Urdan, 1996) with perceived poor social connectedness being found to relate to higher levels of depression, anger and low self-esteem (Baumeister & Leary, 1995). As being a student again is a large part of the trainee role, it seems possible that this too may cause a sense of isolation and disconnection from their peers and therefore be an added stressor.

2.8.2 Stress in qualified clinical psychologists

Similarly to their trainee colleagues, a paucity of research exists in identifying stress levels in qualified clinical psychologists. Review of the literature revealed that one systematic review of stress in UK CP's already exists, completed by Hannigan, Edwards and Burnard (2004). This was therefore used in the present review however given that it is now over 10 years old, more recent literature was also consulted.

In continuation from their research with CPT's , Cushway and colleagues reported similar rates of stress when asking qualified CP's "to what extent do you consider you have been under stress as a result of your job?". Again, a quarter of the sample reported they were very stressed and half reported they felt moderately stressed (Cushway & Tyler, 1994). Interestingly, caseness levels in this study were lower than CPT's (59%) with 29.4% of the qualified CP sample exceeding the cut off. Given that their small sample (n=101) and a sampling procedure all from one geographical locality in the UK, one could consider these findings with caution. However, similar rates have been demonstrated by Darongkamas, Burton and Cushway (1994), in using a sample of 321 UK clinical psychologists, evidencing 24% of CP's reaching caseness

levels of distress. In this study, care was taken to select 60 random psychology departments geographically representing all over the UK. However the study gained a 65% response rate of a self-selecting sample thus one must therefore also bear in mind that this caseness frequency may not be wholly generalizable.

In other research, caseness frequency appears slightly more increased. For example, in a sample of 108 CP's working in Scotland, Sampson (1991) reported that 33 % of their sample reaches the cut off for caseness. In a further study by Cushway and colleagues, they evidenced a higher 40% average caseness in a UK sample of 154 CP's (Cushway, Tyler & Nolan, 1996). Although once again, as a self-selecting sample and all being from the same geographical locality; interpretations must be held with caution.

Due to the above methodological issues, caseness rates reported in UK CP's remains unclear. However comparisons from a similar time period with UK community reported caseness discussed above (ranging from 16-19%) (Prescott-Clarke & Primatesta, 1997, Purcell et al, 2005; Hatch, et al 2009) again indicates that psychological distress reported by qualified CP's may be higher than typical for the UK. Nonetheless, all caseness frequencies reported are still less than those reported for trainees (64% - 82%). As a result it has been proposed that perceived stress may be less likely to translate into psychological distress, as measured by the GHQ, for qualified CP's, than CPT's (Cushway & Tyler, 1996).

2.8.2.1 Qualified clinical psychologist stressors

As mentioned above, review of the literature reveals that qualified CP's may report slightly different stressors to their training colleagues. The literature identifies that some CP stressors include pressure of workload and other organisational factors such as management and lack of resources (Cushway & Tyler, 1994). Research with CP's also reported a perception of being devalued within their teams, unsupported (McMahon, 2011), struggling with too many demands

on their role (Cushway et al, 1996) and feeling isolated in their work (Barnett, Johnston & Hillard, 2006).

Some stressors identified also appear to be shared with CPT's such as professional self-doubt and client distress (Hellman, Morrison & Abramowitz, 1986; Cushway et al,1996) and the bi-directional nature of therapy; therapist affects client, affecting therapist (Stevanovic & Rupert, 2004).

Once again, some research has attempted to understand what factors may predict levels of stress. Some research indicates that it may be due to the psychological model primarily used in clinical work, with CP's primarily using psychodynamic models reporting more stress than those primarily using Cognitive Behavioural Therapy (CBT) models (Darongkamas et al, 1994). However within this sample of UK CP's, this was measured using two purpose-designed questionnaires. With no psychometric properties reported and with no indication of the questions asked, it is difficult to ascertain the validity of these findings. Indeed in early research, Ackerley, Burnell, Holder, and Kurdek (1988) found no relationship between clinical model and levels of burnout in their sample of 562 licenced US psychologists working in mental health services.

Personality traits such as perfectionism have also been proposed as stressors in CP's. In their recent study, D'Souza, Egan and Rees (2011) demonstrated in their sample of 87 Australian CP's, those whom scored highly in a measure of perfectionism were statistically more likely to experience higher stress levels.

In a similar pattern to CPT's, Hellman et al (1986) also identified that in a sample of 227 US psychologists, older psychologists reported less stress than their younger colleagues. This was replicated in a sample of 521 counselling psychologists as age significantly predicted burnout (Vrendenburgh, Carlozzi & Stein, 1999). Age also significantly predicted burnout in Rupert &

Morgan (2005), study of doctoral psychologists in America. Once again, the research of qualified CP's suggests that female CP's present with higher frequencies of caseness (42%) than their male colleagues (34%) (Cushway & Tyler, 1994), however whether this reached significance was not reported.

Alongside age and gender, a further theme to emerge was years of clinical experience. Where collected, this also appeared to affect stress. In their study Cushway and Tyler (1994) evidenced that the younger, less experienced CP were more likely to reach caseness criteria. This was replicated by Cushway et al (1996) which found that CP with less clinical experience demonstrated higher GHQ-28 scores than their more experienced colleagues. This replicates early research also evidencing that years of service was significantly negatively correlated with burnout (Ackerley et al, 1988). Indeed, this replicates a similar pattern identified in health colleagues more widely as Schaufeli (1999) found that staff with more clinical experience were less likely to experience "burnout".

As with their training colleagues, a sense of connectedness with CP colleagues also appears to emerge as an influence for stress levels. Subsequently, post-qualification other factors appear to influence a sense of social disconnection. A clinical psychologist is often a member of either a clinical psychology –only department or increasingly so as part of a multi-disciplinary team (MDT). Whilst working in a team was found to be related to better emotional wellbeing (Carter & West, 1999), the Kings Fund report (2009) highlighted that many MDT staff were in fact working as part of a "pseudo- team", often not meeting regularly, having unclear objectives, few opportunities for shared decision- making and not enough trust to share their thoughts (Firth-Cozens & Cornwell, 2009). Indeed, clinical psychologists will often be the only representative from their discipline within a team thus may feel isolated and less connected to their MDT colleagues.

When compared to their trainee colleagues, CP's appear to report slightly reduced stress and psychological distress (24 -40% caseness). However that at least one quarter of qualified CP's meet clinical criteria for anxiety or depression, remains a concern, especially when considered in the context of their role as therapist and now, the emerging role of CP's within leadership arenas such as management (BPS, 2010b).

2.8.3 Impact of stress

The personal impact of such stress in both CPT's and qualified CP's has in some way been alluded to above; raised caseness levels of anxiety and depression and poorer emotional wellbeing (Myers et al, 2012). Professionally, it appears that CP's report a largely negative impact of their stress on their quality of care for clients. In the UK, CP's have reported feeling exhausted, overwhelmed, distressed, worried and stuck in relation to their work with clients (Crowley & Avdi, 1999) all indicators of burnout. Further have reported a reduced ability to remain psychologically and emotionally present (Cain, 2000; Gilroy, Carroll & Murra, 2001), raising issues in relation to the clinicians professional competency (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012). In their study of 11 UK qualified CP's, Charlemagne-Odle, Harmon and Maltby (2014) found that a theme to emerge was that when stressed, they were ineffective with clients due to their indifference towards their clients difficulties. This replicated similar findings of a US study in which psychologists acknowledged that their own stress affected the quality of care they could provide to clients (Guy, Poelestra & Stark, 1989). Heartmath (2006) further proposes that in times of high stress, the clinician may attend more to perceived threats instead of focusing on positive events, which can have implications for the objectivity required in therapy sessions.

However given the above, it is important to note that some positive outcomes of experiencing stress are also reported by CP's. These include reduced stigmatizing attitudes of mental ill-

health and increased appreciation, alliance, increased empathy for clients, (Cain, 2000; Gilroy et al, 2001) and higher job satisfaction (Boakes, 1998).

2.8.4 Barriers in seeking support for stress

The above literature highlights that although trained to support others, psychologists also require support themselves (Kleespies et al, 2011). The Doctorate in Clinical Psychology training provides the valuable opportunity to learn and cultivate self-care skills as a psychologist (Kuyken et al, 2003) and it is advocated to be of high importance to develop such career sustaining behaviours at this time (Pakenham 2014). However, it would appear that like other professionals, psychologists may struggle to "practice what you preach" and the literature indicates that actual and perceived barriers to accessing this support exists.

Some authors suggest that clinical psychology training programmes do not necessarily include enough education and experience of self-care practices to help manage both current and later stressors of the role (Schoener ,1999; Schwebel & Coster,1998). One may argue that some U.K. DClinPsych courses do go some way in providing this with reflective groups; a dedicated space in which trainees can reflect and discuss current difficulties. However, upon review of the literature, what emerges is that minimal research explores this. In the only UK study, Knight, Sperlinger and Maltby (2010) evidenced that whilst 75% of qualified CP's had valued their reflective group, up to 50% also reported very high stress as a result of attending them. A sub-sample (25%) reported that they had not perceived any value of the group and also experienced significant distress. It must be noted that this was taken from 18 cohorts from the same training programme; therefore the generalisability of these findings may be questioned, however this does indicate that the reflective group arena, for some reason, may not be useful for all trainees.

A recent American Psychological Society (APA) survey identified a number of possible barriers to psychologists seeking support; a minimization or denial of issues, inadequate social

support and lack of available resources (American Psychological Society [APA], 2010). Research from the US further indicates that a possible barrier to seeking support and self-care utilization in CPT's is in how much the training course emphasises self-care in its programme (Goncher, Sherman, Barnett & Haskins, 2013).

Within the UK, Walsh and Cormack (1994) aimed to elucidate what barriers may exist for qualified CP's in seeking support. Using questionnaires and then a focus group, their mixed methods research found that a sample of 95 CP's perceived that seeking and receiving support was costly; defined as 'psychologically threatening'. Indeed this may have been reflected in the study's 58% response rate. Themes from the focus group indicated that this involved three broad categories; a fear of being 'the client'; an organizational and professional threat, characterised by a perception of professional insecurity and finally a fear that seeking support would fuel this. The final themes revealed that this threat was managed by a 'gatekeeping process' in which psychologists assessed colleagues trustworthiness and their ability to carry additional burden.

Further thematic analysis of open-questions in the questionnaire demarcated 'legitimate' and 'illegitimate' areas for a CP to seek support. Legitimate areas included support in research, client work and dissatisfaction with the job, and illegitimate areas included seeking support for perceived personal difficulties and if accepting support increased a perceived threat to job security. This therefore suggests that seeking support may be problematic and that this may be due to the attitudes and beliefs held by CP's.

However this research was based in only one geographical locality in the UK (the south-west) and with a 58% response rate, the findings must be considered and generalized with caution. Nonetheless, these findings have potential implications for the understanding of stress in clinical psychologists; some may appear to seek support however only do so for certain areas.

This therefore indicated that they still experience unresolved personal difficulties which could negatively impact emotional wellbeing.

2.8.5 Stress in clinical psychologists: conclusions

Research exploring the prevalence and nature of stress in both CPT and qualified CP groups indicate that stress levels may be worrying high. Surprisingly, although this was initially identified within the UK and across the world over 20 years ago, the field of research appears to have stalled largely at the same position; its identification.

Significantly, review of this literature also highlights the absence of a universal definition of stress and it was noted that many articles did not define their construct of stress and if they did; differences in definition and operationalization made comparisons across the literature problematic. However, this considered, some common factors associated with stress levels did appear to emerge; including connectedness with other psychology colleagues, age and years of clinical experience. Furthermore it seems that whilst some psychologists may access support, an illusion of the 'invulnerable psychologist' (Norcross & Barnett, 2007) may only enable them to do so for what they deem as legitimate areas leaving many difficulties unresolved and with the potential to affect their personal wellbeing and professional competence.

Given the evidenced benefits of self-compassion on emotional wellbeing and the high stress observed in the CP population, it seems useful to explore the research pertaining to this. Indeed an emerging relationship is demonstrated between high indicators of stress and low self-compassion in therapists (Gilbert et al, 2010) and trainee doctors (Olson & Kempar, 2014). However, the literature reveals that minimal research that has explored self-compassion in this group, a curious find, given that within the role of a clinical psychologist; compassion forms a key part of a therapeutic relationship (Gilbert, 2010b). As limited research exists that pertains

specifically to clinical psychologists and self-compassion, an initial review within the wider mental health professional literature yields some key points.

2.9 Self-compassion and the wider Mental Health Professionals group

In their study explicitly exploring how practicing self-compassion affected counsellors, Patsiopoulos and Buchanan (2011) reported a range of benefits including an increased ability to manage occupational stress and challenges, an improved overall sense of wellbeing, job satisfaction and burnout prevention. All participants also identified that they believed this had improved their ability to work effectively with clients by lowering unrealistic self-expectations and enabling them to balance counsellor and client needs. This provides some preliminary evidence to suggest that having good levels of self-compassion is not only beneficial to the individual therapist but may also act as a therapeutic competency thereby potentially benefitting clients.

Further research has explored changes in self-compassion due to other stress management interventions. For example Shapiro, Astin, Bishop & Cordova (2005) and Newsome, Waldo and Gruszka (2012), both explored the effects of an 8 week Mindfulness-Based Stress Reduction (MBSR) programme for health care professionals. This included a psycho- educative component about mindfulness and included meditation and experiential exercises to practice. Both groups included psychologists, although did not identify their exact discipline, i.e. clinical, nor how many and a mixture of other professions including medical doctors and nursing and physiotherapists and education professionals. Nonetheless, both of these studies evidenced significant increases in self-compassion following the MBSR intervention; $p< .05$ (Shapiro et al, 2005), $p<.001$ (Newsome et al, 2012) and significant reductions in perceived stress within the Newsome et al, 2012 study, $p<.001$. This replicates the findings of Shapiro, Brown and Biegel (2007) in their study of masters-level psychology graduates ($n= 54$). Following an 8

week MBSR intervention, significant increases in self-compassion and significant decreases in perceived stress were observed ($p<.001$).

2.10 Self-compassion and Clinical Psychologists

Review of the literature reveals that whilst it has not be explored specifically, self-compassion has been measured as part of a mindfulness study and two Acceptance and Commitment Therapy (ACT) interventions, in CPT's.

In their study, Rimes and Wingrove (2011) conducted an eight week Mindfulness Based Cognitive Therapy (MBCT) course with 20 trainee clinical psychologists on a UK Doctorate in Clinical Psychology training programme. The study identified that following MBCT, the trainees reported increased levels of self-compassion and mindfulness and noticed a decrease in their rumination. It further identified that it was only the 1st year trainees whom exhibited a statistically significant increase in self-compassion and a statistically significant decrease in perceived stress when compared to the 2nd and 3rd year trainees, indicating possible differences in ability to alter a self-relating style.

Additionally, Stafford-Brown and Pakenham (2012) also aimed to reduce stress in clinical psychology trainees using Acceptance and Commitment Therapy (ACT). An Australian sample of 56 trainees was allocated to either an ACT group or a wait-list control condition as part of a pilot programme. At the start of this study, 73% of the total sample met criteria for "caseness"; defined as meeting clinical criteria for an anxiety / depressive disorder, providing yet further evidence of the high psychological distress experienced in this group. Following a four week ACT programme the researchers identified that "caseness" levels reported in the ACT group halved and a significant improvement in self-compassion was reported. Without the intervention, in the control group, "caseness" levels continued to increase.

Following the benefits observed in this pilot group, Pakenham (2014) went on to review the effectiveness of an ACT group for self-care, now embedded as part of the clinical psychology training course curriculum. A total of 32 trainees took part in a 12 week course, including workshops and experiential exercises. However in contrast to previous findings, no significant increase in total SCS scores was observed, although a significant increase within the Self-Kindness subscale of the SCS (Neff, 2003b) was found. Further to this, a significant increase in client-therapist alliance, as measured by the Working Alliance Inventory Short-form (Tracey & Kokotovic, 1989), was also observed, indicating that improvements in self-relating and self-care could potentially benefit client working.

Whilst neither of the above studies specifically adopted self-compassion focused interventions to help alleviate stress, both reported a significant increase in self-compassion, as measured by the Self-compassion scale (Neff, 2003b). As mindfulness is theoretically and empirically evidenced as involved in the experience of self-compassion, it is plausible that any intervention that facilitates mindfulness, including MBCT and ACT, will also increase self-compassion. Only until very recently has research published some levels of pre-intervention self-compassion scores within this population; SCS M = 2.96 -3.23 (Stafford-Brown & Pakenham (2012), SCS M = 3.27, SD = .57 (Pakenham, 2014). However this was pertaining to Australian trainees and both had relatively small sample sizes which impair generalisability.

As the only UK study (Rimes & Wingrove, 2011) had not published any pre-intervention SCS scores, personal communication with the author demonstrated pre-intervention self-compassion scores of M=18.1, SD=3.1; M= 20.6, SD=2.6; and M= 19.0, SD=2.8 for the first, second and third year trainees respectively. This identified that the self-compassion scores reported by these trainees were found to be around the norm (M= 18.25, SD= 3.75) as defined by Neff (2003b) using an American community sample. However this is the only study to measure self-

compassion in UK CPs and with such a small sample size (n=20), more data would be required to draw more reliable and valid conclusions.

A fourth and final qualitative study has explored the experience of a 6 session, 1 hour weekly, Loving-Kindness Meditation (LKM) course on a group of UK CPT's (*n*=5) and cognitive behavioural therapists (CBT) in training (*n*=7). Using interviews and Interpretative Phenomenological Analysis, Boellinghaus, Jones and Hutton (2013) identified that following the LKM, participants felt more self-compassionate and understanding of their difficult feelings. Furthermore they reported being more self-aware and noted it felt easier to tolerate uncertainty whilst being with clients in therapy. Finally an interesting finding was that they felt more connected to others and perceived them as less of a 'threat' and able to become closer to them. It is unclear what 'threat' exactly meant here however the experiences of this training seemed positive in the main. Unfortunately no other measure of self-compassion took place therefore it is unclear if these improvements were due to improvements in self-compassion per se.

Review of this literature demonstrates a lack of research focusing on self-compassion and clinical psychologists, indeed no research at all was identified in relation to qualified CP's. Furthermore, the limited UK data identifies the need to understand how self-compassionate CP's are before engaging in self-compassion focused interventions as a way to manage stress and emotional wellbeing within this group.

2.11 Chapter summary

This chapter has reviewed the literature in relation to self-compassion and has found that it evidences a positive influence on emotional wellbeing and mental health. In addition to this, it has highlighted the concerning levels of stress evidenced within the clinical psychology population and the impact this can have both personally and professionally for clinicians and in

some cases their clients. Whilst some research has attempted to explore interventions to reduce stress, this appears to be a considerably disproportionate response to the evidence that around to one quarter of CP's and up to three quarters of CPT's experience distress to the extent that they would meet clinical criteria for an anxiety and/or depressive disorder.

Many of the above researchers have advocated that the levels of stress must be clarified within this population Pakenham & Stafford-Brown (2012), and that research is needed to inform the most effective stress management within this group Myers et al (2012). This review reveals that no recent research has reviewed these stress levels within the UK, since 2004. This is somewhat surprising given the economic and organisational changes affecting the NHS during this time.

Now that compassionate care has become an item on the UK NHS political agenda, calls have been made to understand this more and consider how it manifests within our health care systems (Francis, 2013). It has been proposed that each healing intention of a healthcare professional, starts from within themselves (Schmidt, 2004) thus it seems important to understand the levels of self-compassion within the group as part of the wider aim of supporting compassionate care.

2.12 Research aims and hypotheses

Given the above review, the objectives of this research are therefore as follows:

2.12.1 Research objectives:

1. Given that none exist, to establish norms of current levels of self-compassion reported in a UK community sample. This will also enable comparison of the CP population SCS scores with a current UK population.

2. To establish the current levels of self-compassion in UK trainees and qualified clinical psychologists.

3. To identify which factors most predict levels of self-compassion within these two groups.

4. To compare the levels of self-compassion, fear of compassion, social connectedness, perceived stress and "caseness" between trainees and qualified clinical psychologist groups.

5. To update our knowledge of psychological distress currently experienced within UK clinical psychologists.

6. To compare psychologist self-compassion scores with those from a UK community sample.

This research aims to therefore establish the current levels of self-compassion within the UK CP population and understand factors that predict them. Based on the above literature review, these factors will be:

1) Current levels of stress

2) Current levels of psychological distress

3) Age of clinician

4) Years of clinical experience

5) Level of social connectedness

6) Fear of compassion to others

7) Fear of compassion to the self from others

8) Fear of self-compassion.

2.12.2 Hypotheses:

This review has demonstrated from many studies that self-compassion is related to positive emotional wellbeing and negatively related with measures of stress, anxiety, anger and other mental health psychopathology. Due to the negative relationship evidenced between self-compassion and stress, and the research that CPT's report higher levels of stress than qualified CP's, the researcher could expect that CPT's therefore may report higher levels of both stress and psychological distress, and therefore lower levels of self-compassion than their qualified colleagues.

Additionally, the studies presented above also highlight how fears of compassion are positively related to measures of stress. Alongside the theoretical understanding of how fear of compassion could result in low self-compassion, the researcher could again expect that higher fears of compassion could relate to lower self-compassion.

Finally, the above studies demonstrate that many of the factors that are related to low levels of stress in clinical psychologists; such as high social connectedness, older age, and years of experience, are also, related to higher reported self-compassion. For this reason, the researcher could expect that social connectedness, age and years of experience may also be related to higher levels of self-compassion. Moreover, given that qualified clinical psychologists are also likely to be older and have more years of clinical experience; this also provides more indication to the researcher that they could expect qualified CP's to report higher self-compassion than CPT's.

The hypotheses for this research are therefore as follows:

(1) That qualified clinical psychologists will report higher levels of self-compassion than trainee clinical psychologists.

(2) That higher scores of self-compassion will be predicted by higher age of clinician, more years of clinical experience, and higher social connectedness.

(3) That lower self-compassion scores will be predicted by higher fears of compassion scores, higher GHQ scores and higher scores of perceived stress.

It is hoped that establishing self-compassion levels within this group will best inform the most effective future self-care interventions. This would not only benefit qualified CP's within the arena of PPD but also have significance for UK Doctorate in Clinical Psychology course teaching. Not only would this be useful for workforce psychological wellbeing but also for the aforementioned possible client benefits.

Given the limitation of previous stress and CP research; a lack of a universal definition of stress, it is important that this research defines it clearly. Therefore this research draws from Lazarus and Folkman's (1984) transactional theory of stress, which places cognitive appraisal as central to this experience. This outlines that stress is not simply a result of the objective stressors experienced by an individual; such as amount or type of stress, but is experienced when a situation is appraised as very demanding or threatening and an individual perceives that they have insufficient resources to cope with it.

3. Method

3.1 Chapter introduction

The following chapter will outline the design, measures and procedures adopted to conduct this research. It is split into four sections; first presenting the epistemological stance taken by the researcher and the overall research design, followed by the methodology for an initial community norming study and finally the methodology for the main study.

3.2 Epistemological position

Within psychology, there exists an ongoing ontological, epistemological and methodological debate. Ontological differences are discussed in relation to the nature of reality and how it exists (Mertens, 2015). This leads to epistemological distinctions in terms of how we come to gain knowledge of these realities (Barker, Pistrang & Elliot, 2010) which in turn, informs how to methodologically achieve this. The importance of determining one's own position in relation to this debate is crucial when engaging in research, as it is these differing perceptions of reality and knowledge that shape and influence the approach chosen to understand psychological phenomenon (David & Sutton, 2011).

Many epistemological positions exist and it is argued that all have value when attempting to address a research question (Anderson, Hughes & Sharrock, 1986). Historically within psychology, one of the most dominant approaches is the empirical position of 'Positivism'.

3.2.1 Positivism

A positivist epistemological position to research is embedded within a realist ontological framework. This states that there exists a reality, even if it is not yet known (Killam, 2013) and that it exists independently of an individual's beliefs, language, cultural and historical background (Jovanovic, 2010). Initially articulated by August Comte (1830), a positivist approach suggests that knowledge is revealed via observation only, therefore "inferred

constructs" such as individual motives and beliefs are not acknowledged. As such, positivism adopts an etic and objective perspective to research, taking existing theories and applying them to new populations in a 'top-down' process, in order to further knowledge (Lett, 1990).

As such, positivism adopts for social sciences the same scientific inquiry used in physical science disciplines (Bryman 1988). This emphasises the quantifiable nature of reality (Darlaston-Jones, 2007) which enables statistical analyses of variables alongside an explicit, systematic reporting in how these are measured (Barker et al, 2010). As such, decontextualized results are produced which can be generalised or compared to other groups for further inquiry (Johnson & Onwuegbuzie, 2007).

Jovanovic, (2010) suggests that a realist ontology and positivist epistemology has gained a somewhat "monopolistic status" within the history of psychological research and in many respects the current research does resonate with a positivist position. For example the experience of self-compassion is being quantified and considered as something that can be 'measured' by way of a self-report measure. The same is true of the other variables within this study and it is believed that quantitative statistical methods can be employed to ascertain if a relationship between these constructs exists.

However by a suggested failure to recognise the influences of individual culture and history, and a negation of human ability to interpret their world (Barker et al, 2010), some propose that positivist methodologies reveal somewhat meaningless understandings of psychological phenomenon (Shirazi, n.d.). It is argued that its suggestion of an invariant reality (Alvesson & Skőldberg, 2009) creates a "positivist paradox" (Porter, 1995), in that the position deprives itself of the proper subject matter of psychology; subjectivity and meaning (Jovanovic, 2010).

Given the emergence of such criticism, a noticeable paradigmatic shift occurred in the mid-20th Century towards a post-positivist position (Trochim, 2006). Whilst many variants exist, the two

most relevant post-positivist positions to this research are that of critical realism and social constructionism.

3.2.2 Social Constructivism

The more extreme post-positivist position is 'Social constructivism' which is embedded within a relativist ontological framework. This rejects the positivist assumption of an independent reality, in favour of the existence of multiple realities that are socially constructed between the individuals whom experience them (Gergen, 2009). These constructions are shaped by an individual's social, cultural and historical context (Alvesson & Skőldberg, 2009) therefore within the social constructivist position, one does not 'find' knowledge, as in positivism; one 'constructs' it (Killam, 2013).

The implications for research based within this epistemological position is that both the individual of inquiry and researcher are actively involved in the co-construction of new knowledge, placing the researcher in a central, emic position to the research (Killam, 2013). Unlike a positivist 'etic' perspective, an emic stance advocates that a researcher places theory to one side and instead encourages the participant to speak and allow themes and patterns to emerge from their narratives (Lett, 1990). In contrast to the value-neutral position of positivism, salience is given to this active researcher role alongside the interpretation of language used by individuals, in order to construct new knowledge (Darlaston-Jones, 2007).

Based in Buddhist cultural and religious beliefs, one may argue that self-compassion is itself a social-construction, thus lends itself well to be measured using relativist and constructivist methodologies. However criticism of this position suggest that not all constructions are accurate, consistent or equally useful (Barker et al, 2010). Furthermore it may be that clear patterns from multiple constructions do not emerge (Alvesson & Sköldberg (2009).

3.2.3 Critical Realism

Unlike social constructivism, another post-positivist position; critical realism, allies itself more centrally toward the positivist opinion; that there exists an independent reality which we should attempt to investigate. Pioneered predominantly by Bhaksar (1975) this position differs from positivism in three crucial areas. First, it proposes that whilst we can seek to understand this independent reality, we must do this critically and cautiously due to the imperfect methods we have developed thus far (Alvesson & Sköldberg, 2009). As such, research findings must be tentative as we cannot know reality with 100% certainty (Cook & Campbell, 1979). This position also promotes that new understandings should be "inter-subjectively testable", in that other researchers should be able to replicate the study and gain similar findings (Popper, 1963).

Second, critical realists argue against positivism by proposing that the exploration of only the observable is too superficial; it is also important to identify and understand the hidden, unobservable mechanism underlying this (Alvesson & Sköldberg, 2009). Finally, as with social constructivist approaches, critical realism acknowledges that reality is shaped by social concepts, such as gender, history, race and religion. However this is recognised within a realist ontology which does not promote the proposed 'endless relativism' of constructivist positions (Alvesson & Skőldberg, 2009). This advocates that the researcher also cannot take a totally objective, etic perspective as their interpretations are also shaped by their own influences and theory-laden (Easton, 2010). Consequently, efforts are made to control potentially confounding variables (Killam, 2013) which emphasises the importance of methodological considerations.

Taking a more 'centrally aligned position' (Crotty, 1998), one may argue that critical realism is open to many of the criticisms identified in both the positivist and constructivist ideas. However being critical and open to evaluation is a basic tenet of this position (Sayer, 1992) therefore such critiques are encouraged to facilitate more accurate understanding.

3.2.4 Present study

The predominant aim of this research was to identify the levels of self-compassion experienced within clinical psychology professionals and to understand what factors may predict this. This was conducted using self-report questionnaires to establish self-compassion norms in these groups and begin to understand the underlying mechanisms which produce these levels (Bhaskar, 1998). It is also believed that individuals can report on their subjective experience, but in agreement with Sellars (2013) it is also considered that the 'self' of which one can be conscious of at a given moment is only part of what is potentially available to introspection, when answering such questions. As such, this research is embedded within a critical realist epistemological position with further considerations are outlined below.

A critical realist position recognises that all methods have limitations when attempting to identify and measure a construct. With this in mind, significant efforts have been made to ensure the validity and reliability of each questionnaire and therefore the interpretation made of the data. It is acknowledged that these questionnaires have been selected based on an alignment of the researchers own conceptual and operational definitions of variables and those of the questionnaire authors.

Although sympathetic to the subtle differences in the definition of self-compassion outlined in the introduction, at the time of this study the researcher was limited in the choice of self-compassion measures available. The Self-Compassion Scale, Neff, (2003b) attempts to measure self-compassion, as defined by its theoretical and cultural underpinnings, by asking individuals to complete a self-report questionnaire.

Given its relatively recent emergence within western psychology it cannot be assumed that the term self-compassion has universal, transcultural meaning. It is acknowledged that this research

takes place within a western cultural context, and efforts have been made to consider and reduce any potential influences to the data yielded.

The researcher aims to provide initial information relating to self-compassion which can be generalised to the wider clinical psychology professional group. In line with a critical realist position, these findings will be tentative and it is hoped that multiple methods and triangulation across these are used to develop these findings in future research (Mingers 2001).

3.3 Design

The present research involved two phases, both quantitative and cross sectional in design. Initially a preliminary norming study was conducted, the purpose of which was to establish normative self-compassion scores in a UK community population as measured by the 26 item Self-Compassion Scale (SCS) (Neff, 2003b). With the emergence of the Williams et al (2014) paper, during the present research's data collection phase, this study's results will now add to this normative data. Taken together, these norms will facilitate a statistical comparison with the UK trainee and qualified clinical psychologist self-compassion scores in the main study.

The purpose of a cross sectional design in the main study was to determine levels of the outcome variable; self-compassion, in both trainee and qualified clinical psychologists. This was then used to determine how the predictor variables scores, taken from the measures listed below, related to self-compassion scores.

3.4 Preliminary Self-Compassion Scale UK norming study

3.4.1 Participants

In total 217 participants were recruited into this norming study. Participants in this target population were all drawn from a community sample, aged 18 years or older. Adolescents and children younger than this age limit were excluded as comparison of this sample would be

made with an all-adult clinical psychologist sample. Individuals whom did not live permanently in the UK were also excluded. No upper age limit was set with the aim to capture adult participants of all ages, gender, occupation, years of occupational experience, current living situation and marital status. In order to reflect the UK's growing multicultural community, it also aimed to capture a range of religious faiths and ethnicities. However as the survey was written in English, participants were required to have a good level of fluency in the language in order to take part.

3.4.2 Participant recruitment

Participants were recruited using convenience sampling methods predominantly via an online link to the survey posted on a social networking site; Facebook[TM]. As the aim of this norming was to access a UK community sample, this method was chosen due to its strength in reaching a wide geographical area in the UK, its ability to access as large a sample size as possible and its ease in completion. A snowball sampling method was also adopted to gain further participants.

A limitation to this method was its potential bias in excluding individuals that do not have access or choose to use the internet or social networking sites. As such, 100 paper copy questionnaires were also disseminated via research supervisors, friends and family with the aim to reach a wider demographic. Again snowball sampling methods were used to access as many adults within this group as possible.

As this study was to establish a normative level of self-compassion, therefore a measure of central tendency, a power analysis was not required to establish a sample size. To optimize the likelihood of participation and gain as large a sample size as possible, a participant incentive of a free prize draw to win £40 of retail vouchers was also advertised as part of the survey information page.

Table 1 highlights how many questionnaires were returned in each format and how many were

excluded.

Table 1. Returned questionnaires

	Returned Included (*n*)	Returned Excluded (*n*)
Online	160	-
Paper	57	2
Total	217	2

Two paper participants were excluded as one only returned the demographic questionnaire and

one only completed 10/26 questions of the SCS leaving 16 questions blank.

3.4.3 Measures

Demographic Questionnaire. (Appendix A).

This is a short purpose designed questionnaire created by the researcher to ask relevant

demographic information such as age, gender, occupation and marital status. Whilst measures

were taken to promote as random a sample as possible, the limitations of convenience and

snowballing sampling are that potential clustering of data; particularly location, ethnicities and

ages may take place. Therefore participant completion of the demographic questionnaire

enabled the researcher to be aware of the spread of this data to provide context to the study

results.

The Self-Compassion Scale Neff (2003b). (Appendix B).

To date, there exists only a limited number of validated measures to assess self-compassion. A

review of the literature revealed a predominant use of one measure; the Self-Compassion Scale

(Neff, 2003b). However further inspection of the literature identified the Forms of Self-

Criticism and Self-Reassurance Scale (FSCRS) (Gilbert, Clarke, Hempel, Miles & Irons, 2004).

Upon initial screening for face validity, this 22 item self-report questionnaire appears to assess

similar constructs to the self-compassion scale and demonstrates good psychometric properties with Cronbach's alphas of $\alpha =.86$ for both the self-criticism and self-reassurance subscales in student populations (Gilbert et al, 2004). However the FSCRS appears to emphasise self-criticism over self-reassurance, and has been used by some research just to operationalise and measure self-criticism (Kelly & Carter, 2013).

A qualitative measure, The Narrative Compassion Scale (MacBeth, 2011) is a second measure to recently emerge from the literature. This is a semi-structured interview with an aim to measure an individual's experience of compassion towards the self and others. To date, this measure has only been employed with individuals with complex mental ill health and whilst identifying initial utility, it has not yet been used in other populations. Given the aim of this research is to access as large a sample as possible, using an interview schedule is not practical within the resources available. This, along with its only very preliminary use, motivated the researcher to not use this measure.

In the present research, the Self-Compassion Scale (SCS) (Neff, 2003b) was selected to operationalise the variable of self-compassion. Based upon the predominant theory of this research; Neff's theory of Self-compassion (Neff, 2003a), this 26 item self-report questionnaire measures levels of self-compassion by asking respondents to rate how they typically act towards themselves using a 5 point likert scale. Items include *"I'm intolerant and impatient towards those aspects of my personality I don't like"* and *"I'm tolerant of my own flaws and inadequacies"* with response options ranging from *"Almost Never"* to *"Almost Always"*.

It can be completed quickly and with relative ease. Scores on this scale are collated to create individual mean scores for six subscales (self-kindness, self-judgement, common humanity, isolation, mindfulness and over-identification) which combine to make a total self-compassion score. Research has demonstrated that the SCS has a good factor structure which accounts for

the inter-correlations for the 6 subscales (Neff, 2003b). The ubiquitous use of this scale is advantageous in facilitating comparisons with other research, however as such, it will be regarded critically.

Although emergent from Buddhist culture and belief, the SCS was developed with a western society in mind as primary respondents (Neff, 2003b). This scale has been used widely in research and has evidenced good internal reliability across the age span of adults in community samples; working age adults α = .95-.96 (Jazaieri et al, 2012) and older adults α = .87 (Allen, Goldwasser & Leary, 2012) however these have been based exclusively in the USA. A recent and first UK community sample (n = 821) has also evidenced good reliabilities with SCS subscale alphas reported ranging from α = .76 - .86 (Williams et al, 2014).

The SCS was found to evidence some discriminant validity as it was not correlated with social desirability (r= .05, p =34) and narcissism (r= -.08, p=.23) (Neff, 2003b). Concurrent validity has also been evidenced with the Social Connectedness Scale (r= .41, p<.01) (Neff, 2003b).

A review of the literature indicates that initially Neff (2003b) suggests scoring the SCS by calculating a mean of each subscale then summing to create a total score. Later, it is noted that this changes and she suggests calculating the means for all data as this is easier for comparative purposes (Appendix B). As such this leaves the current literature presenting some summed scores and some mean scores for total SCS, making comparisons problematic. In order to manage this, the researcher will therefore score the SCS using both methods, for comparative purposes.

Within research a general guideline exists with relation to internal consistency as a measure of reliability. This states that an acceptable value of Cronbach's alpha (α) falls around .7 to .8 (Field, 2013). Using this guideline, the total SCS score evidenced excellent reliability with a Cronbach's α = .91 within this sample. Subscale scores also indicated good reliabilities ranging

from α = .77 to α = .80. This was with the exception of the Mindfulness subscale, which fell slightly below with a Cronbach's α = .67. However it is known that alpha values can be affected by the number of items in the scale (Cortina, 1993); with only 4 items in the mindfulness subscale, this may account for the lower reliability in this case.

3.4.4 Procedure

The online survey was created using Moodle^{TM} software. Upon clicking the link, participants were presented with a participant information sheet (Appendix C). At the end of this page, participants were required to click a tab to reach the consent form page should they wish to take part (Appendix D). All elements of the consent form, which included the exclusion criteria, had to be confirmed individually before progressing to the questions. Participants where then presented with the demographic questionnaire followed by the SCS. Participants were made aware in the information sheet that no personally identifiable information would be required therefore all questionnaire responses would be anonymous. They were also informed that should they choose to leave the study at any point, they could close the browser window at any point and no data would be saved. Following completion of the questions, participants were then presented with a de-brief page, providing them with details of supporting organisations they could contact should they wish to (Appendix E). At this point they were also presented with the offer of entering a free-prize draw by submitting their email address.

The survey was screened for omissions and errors, and a trial run of the survey took place on multiple internet platforms (Google Chrome^{TM}, Firefox^{TM}, Safari^{TM} and Internet Explorer^{TM} 9) to ensure universal compatibility. All trial data was removed prior to the survey going live. A link to the survey along with a research invitation was posted onto the researchers' page on the social networking site FaceBook^{TM}. Friends and family of the researcher were then invited to 'share' this research invitation on their pages should they wish to and also copy and paste the

survey link into an email to send to other individuals they believed would be interested. A link was also placed on the University of Essex Research Enterprise online webpage.

Paper packs (100) were prepared and included the same information as the online survey; a copy of the information sheet, consent form and demographic questionnaire (Appendices F, G and H), the Self-compassion scale, de-brief page (Appendix I) and opportunity to enter the free prize draw by submitting their email address on separate paper slips. These packs were disseminated by the researcher and research supervisors to friends and family they believed may be interested in the research but without access to the internet or to pass on to other interested individuals. Participants were required to complete these by hand. When completed, these were returned to the researcher at the University using an enclosed FREEPOST envelope.

3.4.5 Data Analysis

Data were analysed using SPSS ^{TM} Version 19. Data was checked for normality and means and standard deviations were chosen to demonstrate the normative level of self-compassion in the community sample. A 'frequencies distribution' was conducted to demonstrate the demographic data and to also enable a statistical exploration of any influence of some demographic variables, Age and Gender, on main study variables.

3.5 Main study

3.5.1 Participants

Participants in the target population were trainee clinical psychologists currently studying on a UK DClinPsych course and qualified clinical psychologists presently working within the NHS or Health and Social Services Executive (HSSE) if based in Northern Ireland. As such, this study excluded all non-NHS/HSSE clinical psychologists. This was to ensure that working conditions would be as similar as possible in order to facilitate more accurate comparisons between trainee and qualified groups.

3.5.2 Sample size

A sample size estimation was calculated using Version 3 BETA of the Statistics Calculator power calculation software (Soper, 2013). Existing literature was reviewed to identify previously documented effect sizes for the relevant relationships to this research. Effect sizes for Social Connectedness, Fear of self-compassion, Fear of giving compassion, Fear of receiving compassion, Stress and Age are presented in Appendix J.

As previous literature had not identified effect sizes between self-compassion and years of clinical experience or self-compassion and psychological distress as measured by the General Health Questionnaire (Goldberg & Williams, 1988), the researcher could not report or use these. Additionally, whilst two studies have used both the Perceived Stress Scale-10 (Cohen & Williamson, 1988) and the SCS, no effect sizes for these relationships were reported (Shapiro, Brown, Thoresen, Plante, 2011; Bond et al, 2013). However, as part of their systematic review, MacBeth and Gumley (2012) stated all effect sizes to date between other measures of stress and self-compassion. Although none used the Perceived Stress Scale, it was considered useful to take an average of the relevant effect sizes of the other stress scales reported to help inform a sample size estimation.

Effect sizes for the range of independent variables listed in Appendix J range from $r= .01$ (no effect size) to $r= -.54$, $p<0.01$ (large effect size). However the majority of effect sizes indicated a medium effect, therefore an estimate for a medium (0.3) effect size was made.

Based on sample size estimates for multiple regression with 8 factors, in order to achieve a medium effect size ($f^2 = 0.15$), with an alpha of 0.05 and power of 0.80; this would require 108 participants. Taking the trainee clinical psychologist group and qualified clinical psychologist group separately, this would require 108 participants in each group thus 216 participants in total.

Rudestam and Newton (2007) suggest that one should predict a removal of approximately 20% of cases due to incomplete data sets. With this in mind, the researcher aimed to recruit approximately 130 participants per group.

3.5.3 Participant recruitment

In total, 221 trainees and 120 qualified CP's took part in the study. This met the required sample size calculated for a medium effect size ($n = 108$, per group).

Participants were recruited using convenience sampling methods via an online link to the research survey. As with the above community sample, this method was chosen due to its ability to access the UK nationwide with relative ease and speed. Specific methods of recruitment are outlined below for each group.

3.5.4 Trainee clinical psychologists

As all DClinPsych programmes must be accredited by the Health Care Professions Council (HCPC), some uniformity exists across all courses in that all trainees must successfully complete a teaching syllabus, core placements and a doctoral thesis. The researcher therefore approached all UK DClinPsych training programs ($n=32$) as identified in Appendix K. This was predominantly via their telephone details located via the Leeds DClinPsych Clearing House for Postgraduate Courses in Clinical Psychology website ($n=30$). As two DClinPsych courses were not listed on this website, their details were located separately on their course university webpage.

The researcher was required to provide a brief summary of the project, proof of ethical approval and a copy of all the questions included in the survey, for review as requested by some courses ($n =29$). Within this, one training course also asked the researcher to gain NHS Research and Development (R & D) approval in their respective NHS trust, which was sought

and gained (Appendix L). Three courses chose to disseminate a research invitation without review.

Where required, permission was granted via these review processes and the researcher emailed respective course administrators ($n=$ 25) a research invitation and link to the online survey. This was then disseminated to each training cohort (years 1, 2 and 3) via email by the course administrator.

Following review and approval, three courses stated that due to their own university research protocols, they were prohibited from directly emailing their trainees invitations to take part in research. As such, and in agreement with these courses, the researcher prepared a research poster inviting trainees to take part, which was displayed in the trainee common room for two of these universities (Appendix M). One university advertised the research, along with the survey link, on its internal research enterprise webpage for trainees to access should they wish. Finally, one university was unable to take part at all due to their research protocol, which prohibited any other agencies, except their own students, conducting research within their university.

Trainees were recruited to an online survey only. Postal methods were not required as all trainees had internet access and an email account due to their university membership. As such, it was predicted that all trainees would have an equal opportunity to take part in the research should they wish. Using an online survey methodology was also more practical in accessing trainees across the UK in a more efficient and economical way.

To optimize the likelihood of participation, a participant incentive of a free prize draw to win £80 of retail vouchers was advertised as part of the survey information page.

3.5.5 Qualified clinical psychologists

Qualified clinical psychologists were recruited a number of ways. An online advertisement for research participation was placed on the 'Academic and Research' online forum of an independent website aimed at clinical psychologists; www.clinpsy.org.uk. This forum is widely used to invite participants for research, therefore was deemed appropriate. An online advertisement was also placed on the BPS Division of Clinical Psychology online research board, again as this is used by clinical psychologists.

An email invitation, along with the survey link was also disseminated with permission to the correspondence list of the UK Compassionate Mind Foundation. This was an independent website for research and training in compassion used by clinical psychologists and other interested mental health practioners. As a final recruitment method, a link to the online survey was posted onto the social networking site; Facebook^{TM}, which qualified clinical psychologists also accessed.

As it was hoped to recruit qualified clinical psychologists nationwide, a snowball sampling method were also employed due to its strength in accessing a large geographical area with ease, speed and efficiency. Trainees were also provided with a link to the qualified clinical psychologist online survey at the end of their questionnaires and offered the possibility of disseminating this to current and previous supervisors and qualified colleagues that they believed may be interested.

As with trainees, postal survey methods were not used for the same reasons outlined above. Whilst qualified clinical psychologists would not have internet access or an email account via a university, they would have both via their place of work and as a member of the NHS/HSSE.

3.5.6 Measures

One purpose-designed demographic questionnaire and five standardised questionnaires were used in this research and are outlined below. Each measure was chosen having evidenced good psychometric properties and common use in previous relevant literature. Each was screened for face validity alongside a research supervisor in order to minimise any bias on the part of the principle researcher. All measures were also screened for ease and speed with which they may be completed. This was in consideration of potential participants' completing the questionnaires without a researcher present to support this and also the time-pressures participants many experience from their job or clinical training.

Demographic questionnaires. (Appendices N and O).

These were two individual purpose-designed questionnaires; one for trainees and a separate one for qualified clinical psychologists, which asked the participants basic demographic information such as age, geographical location of workplace and marital status. It also asks questions deemed relevant to this study such as *"how many years clinically relevant experience did you have before starting training?"* and *"at present, do you carry out any activities for the main purpose of emotional self-care? i.e. cognitive techniques, mindfulness, go to the gym"*. Again, due to the limitations of using convenience and snowball sampling methods and possible clustering of data, this questionnaire provided information that enabled the researcher to understand the context and influence of any demographic variables on scale scores.

The Self-Compassion Scale (Neff, 2003b). (Appendix B).

Details as above for the norming study. As well as its use in community samples, the Self-Compassion Scale (SCS) has also been widely used with mental health professionals (e.g. Shapiro, Astin, Bishop & Cordova, 2005; Shapiro, Brown & Biegel, 2007). Given a trainee

clinical psychologist's dual role of student and clinician, the literature was screened for evidence of good reliabilities within both of these populations.

Outside of the UK the scale has demonstrated good reliabilities with trainee clinical psychologists in Australia, α =.95 (Stafford-Brown & Pakenham, 2012) and students in the US α =.91(Neff, Kirkpatrick & Rude, 2007). The SCS has also been used with UK students and evidenced good subscale reliabilities; α =.75 - .79 (Mills, Gilbert, Bellew, McEwan & Gale, 2007) and full scale reliability α = .89 (Gilbert et al, 2011a). The literature demonstrates its use with trainee clinical psychologists in the UK, however no reliabilities within these small samples were reported (Moore, 2008; Rimes & Wingrove, 2011).

To date the SCS has not been used with qualified clinical psychologists as a discrete population, however in their study, Gilbert et al (2011a) evidenced good reliability with UK 'therapist' group which included some qualified clinical psychologists; α = .90. The above therefore suggests that the SCS is an appropriate measure to use with these groups.

Again total SCS scores evidenced excellent internal consistency within these samples, with a Cronbach's α = .91 in the trainee group and α =.95 in the qualified CP group. Within the qualified group, SCS subscale scores all evidenced acceptable alphas ranging from α = .75 to α = .90. Within the trainee group, a similar pattern emerged as with the community sample in that all subscales demonstrated acceptable internal consistencies α = .70 -.84, with the exception of the Mindfulness subscale α =.63.

The Fears of Compassion Scale (Gilbert, McEwan, Matos & Rivis, 2011a). (Appendix P).
Only one scale to operationalise the variable of fear of compassion is currently in existence to date; the Fears of Compassion Scale (FoCS). This 38 item self-report questionnaire measures respondents' fear of compassion by asking them to rate how much they agree with each statement on a 5 point likert scale. The FoCS yields three subscales; fear of expressing

compassion *to others*, fear of receiving compassion *from others* and fear of expressing kindness and compassion *towards oneself* (self-compassion). Each subscale produces a 'level of fear' mean score. Questionnaire items include *"Being too compassionate makes people soft and easy to take advantage of", "I often wonder whether displays of warmth and kindness from others are genuine"* and *"I fear that if I am more self-compassionate I will become a weak person"*.

This measure has been used in other self-compassion research with both UK therapist and student populations (Gilbert et al, 2011a; Gilbert, McEwan, Gibbons, Chotai, Duarte & Matos, 2011b). It demonstrates good psychometric properties with subscale Cronbachs alphas ranging from $\alpha = .72- .83$ (Gilbert et al, 2011), $\alpha =.85 - .94$ (Gilbert et al, 2011b) and $\alpha =.95$ (Kelly, Vimalakanthan, & Carter, 2014) in student populations. Cronbach's alphas in therapist population is also good, with subscale reliabilities ranging from $\alpha = .76 - .86$ (Gilbert et al, 2011a). To date this measure has not been used exclusively with trainee or qualified clinical psychologists.

In the present study, all three fears of compassion scales demonstrated good internal consistency. Within the trainee sample, the following Chronbach's alpha's were observed; Fear of Giving Compassion $\alpha = .78$, Fear of Receiving Compassion $\alpha = .88$ and Fear of Self-Compassion $\alpha = .90$. Within the qualified sample; Fear of Giving Compassion $\alpha = .76$, Fear of Receiving Compassion $\alpha = .89$ and Fear of Self-Compassion $\alpha = .88$.

The Social Connectedness Scale – Revised. (Lee, Draper & Lee, 2001). (Appendix Q).
The Social Connectedness Scale was chosen to operationalise the predictor variable of social connectedness in the present research. This self-report questionnaire measures the extent to which an individual perceives they are connected to those around them including peers and friends. Respondents are required to rate how much they agree with each statement using a 6

point likert scale ranging from *"Strongly Agree"* to *"Strongly Disagree"*. Higher scores yielded from the questionnaire indicate a respondent's perception of more social connectedness.

The scale is available in many different forms. The original 8 item scale (Lee & Robbins, 1995; 1998) was revised to reduce responding bias as all statements were negatively worded and it was suggested that it failed to capture the full experience of connectedness. (Lee, Draper & Lee, 2001). As such, its existing statements were revised and a new 20 item measure was developed, although an 8 –item scoring option was still available within this; the Social Connectedness Scale – Revised (SoCS-R) (Lee et al, 2001). However, since its inception, recent research has evidenced a limitation of the revised measure in that 5 of its items double loaded also on to the factor of extraversion. Therefore they were dropped from the measure and the most recently developed version; the Social Connectedness Scale – 15 item questionnaire was produced (Lee, Dean, Jung, 2008).

In the present research, the 8 item scoring option of the SoCS –R was selected. This was due to the researchers wish to be sympathetic to the most recent developments of the 20 item SoCS- R in that 5 items were removed. The 8 item scoring option does not include any of the 5 items that were latterly removed and therefore it is deemed the most appropriate and valid measure of social connectedness to use in this research. Items include *"I don't feel related to most people"* and *"I have little sense of togetherness with my peers"*.

The scale has been used, in its 20 item revised state (Lee et al, 2001) in previous self-compassion research (e.g. Neff et al, 2007; Neff & McGeehee, 2010). Within this, it has demonstrated good reliability in student populations ranging from $\alpha = .91$ to $\alpha = .93$ (Neff & Germer, 2012; Smeets, Neff, Alberts, & Peters, 2014). The scale demonstrates good discriminant validity with measures of social avoidance ($r = -.57$, $p < 0.006$) and loneliness

(r = -.80) (Lee et al, 2001). The SoCS-R appears to have not been used in its 8-item scoring

option within the self-compassion literature therefore this study will be the first.

Within the present trainee sample, the SoCS-R demonstrated excellent internal reliability,

α = .93. This was also observed within the qualified CP sample, α = .94.

Permission to use the measure was obtained via its author; Dr Richard Lee.

The Perceived Stress Scale (Cohen & Williamson, 1988). (Appendix R).

Many measures have been used to operationalise an individual's stress levels which are relevant

to this research. A number were reviewed for use in this research, for example the Depression,

Anxiety and Stress Scale (Lovibond, & Lovibond, 1995), the Mental Health Professionals

Stress Scale (Cushway, Tyler & Nolan, 1996) and the General Health Questionnaire- 28

(Goldberg & Hillier, 1979). In the present research, the researcher favoured a tool which

attempted to capture the individual's idiosyncratic perception of their stress, as opposed to

measuring proposed biological or behavioural markers of the construct. This also enabled the

researcher to acknowledge that individuals in similar contexts may experience different

perceived levels of stress, due to other influences.

In the present research, the 10 item Perceived Stress Scale (PSS-10) was selected to

operationalise the variable of stress as a predictor variable. This self-report questionnaire

requires a respondent to rate the degree to which they perceive their lives as stressful. Example

items include *"In the last month, how often have you been upset because of something that

happened unexpectedly?" "In the last month, how often have you felt nervous and "stressed?".*

Respondents are asked to rate how much they agree with this statement using a 5 point likert

scale with response options ranging from *"Never"* to *"Fairly Often"*. A total perceived stress

score is then derived from the responses; the higher the score yielded, the more stressed the

respondent perceives themselves to feel.

The PSS also exists in its original form; 14 items (PSS-14) (Cohen, Kamarck, & Mermelstein, 1983) and a short form; 4 item version (PSS-4) (Cohen & Williamson, 1988). The PSS-10 was created by dropping the 4 items from the PSS-14 with the lowest factor loading, and demonstrated slightly better reliability; $\alpha = .78$ and factor structure in a community sample (Cohen & Williamson, 1988) . At the time of developing this study, the internal reliability of the 4 item version was reduced (Cohen & Williamson, 1988), therefore the PSS-10 was selected for this research.

The PSS-10 has demonstrated good convergent validity when compared with other measures of stress (Cohen & Williamson, 1988) and the PSS-14 was found to measure a different and independent construct when compared with the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977) indicating discriminant validity. As such, the construct validity of the PSS-10 measure was considered to be satisfactory. The measure has been used with UK trainee CP's however no reliability coefficients were reported. The PSS-10 has however demonstrated good reliabilities within other similar groups; counselling psychologists; $\alpha = .87$ (Shapiro et al, 2007). In the present research, the PSS demonstrated good internal consistency within the trainee sample, $\alpha = .87$ and within the qualified CP sample, $\alpha = .84$.

To date, only the PSS-14 has been used in previous self-compassion research (for example see Neff & Germer, 2012; Newsome, Waldo & Gruszka, 2013) and with UK trainee clinical psychologists (Rimes & Wingrove, 2011) as such, comparisons of this data will be made tentatively with these studies. Permission to use the measure was obtained via its author; Dr Sheldon Cohen.

The General Health Questionnaire -12 (Goldberg & Williams, 1988). (Appendix S).

The majority of previous trainee/ clinical psychologists and stress research within the UK to date, has measured stress by defining it as 'psychological distress' and using the General Health

Questionnaire -28 (GHQ-28) to identify 'caseness' (Cushway,1992; Cushway & Tyler, 1994; Cushway, Tyler & Nolan, 1996; Wall et al, 1997; Hannigan, Edwards & Burnard, 2004). It has also been used with Australian trainees (Stafford-Brown & Pakenham, 2012). 'Caseness' is defined by the GHQ manual as "just significant clinical disturbance". A 'caseness' score can be compared with suggested 'default thresholds' to discriminate cases from non-cases. The GHQ is a self-report questionnaire, used to identify psychiatric disorders in the general population or community non-psychiatric clinical settings such as primary care services.

Following a review of all available stress measures, the researcher decided that for this study, the PSS-10 was the most appropriate measure. However, given that an aim of this research is to update our knowledge of stress experienced within UK clinical psychologists, it seemed most sensible to use the same measure that was previously used to identify current 'caseness' levels within this population. This would therefore facilitate more reliable comparisons.

However, the GHQ-28 could not be included in this study as it asks questions relating to suicidal ideation and intent. This makes it inappropriate for use in an anonymous online survey as the researcher would be unable to action any support in response to such potential disclosures. A shorter form of the scale, the General Health Questionnaire-12 (GHQ-12), however does not contain items relating to suicidal ideation and intent. It also takes less time to complete and has demonstrated comparable psychometric properties to the longer GHQ versions with Cronbachs alphas of $\alpha = 0.73$ and $\alpha = 0.87$ (Hankins, 2008). As such, the 'caseness' scores derived from the GHQ-12 in the present research will be used to compare to the 'caseness' scores identified in previous literature using the GHQ-28.

This 12 item self-report questionnaire asks respondents to reflect on their current level of psychological distress and asks them to consider if they think this differs to their 'normal' state. They are then asked to rate how much each statement relates to them using a 4 point likert scale

with example response options ranging from *"Not at all"* to *"Much more than usual"* and *"More so than usual"* and *"Much less able"*. The GHQ-12 identifies a continuous overall total score of psychological distress; the higher the score, the more severe the reported psychological distress.

The GHQ-12 has demonstrated good convergent validity with other measures of psychological distress (Mari & Williams, 1985) and evidence good specificity (78.5%) and sensitivity (93.5%) coefficients (Goldberg & Williams, 2006). This version has also recently been used in UK clinical psychologist populations (Ruths et al, 2012) and UK counselling trainee populations (Kumarya & Baker, 2008), however neither reported 'caseness' levels as part of their studies.

Within the present research the GHQ-12 demonstrated good internal reliability in both the trainee sample, α = .87 and the qualified CP sample, α = .81

3.5.7 Procedure

As with the community sample, the online survey was created using Moodle^{TM} software. As before, prior to dissemination the survey was screened for errors and omissions. A trial run of the survey took place on multiple internet platforms and computer systems (NHS and home computers) to ensure universal compatibility. Once again, all trial data was removed prior to the survey going live.

Upon clicking the link, participants were presented with a participant information sheet (Appendices T and U). It was estimated that it would take approximately 20-30 minutes to complete the survey and participants where made aware of this at this point. At the end of this page, participants were required to click a tab to reach the consent form page should they wish to take part (Appendices V and W). All elements of the consent form, which included the

exclusion criteria, had to be confirmed individually before progressing to the questions. A limitation of completing the questionnaires remotely is that the researcher has reduced control over who is completing them. As such, participants were asked to confirm that they were either a trainee clinical psychologist or a qualified clinical psychologist working within the NHS twice; once following the participant information sheet and once again as part of giving informed consent. This was to minimise the chance of members of other disciplines accidently completing the battery of questionnaires.

Following confirmation of all aspects of the consent form, participants were presented initially with the demographic questionnaire. As in the community sample, no personally identifiable information was required therefore all questionnaire responses were anonymous. The demographic questionnaire was followed by 5 standardised questionnaires in the following order; Self-compassion Scale, Perceived Stress Scale, Fears of Compassion Scale, General Health Questionnaire and Social Connectedness Scale. Participants were able to select their answer by clicking once with their computer mouse over their chosen response.

Participants were made aware in the information sheet that should they choose to leave the study at any point, they could close the browser window at any point and no data would be saved. Following completion of the questions, participants were then presented with a de-brief page, providing them with details of supporting organisations they could contact should they wish to (Appendix X). At this point participants were also presented with the offer of submitting their email address to find out the study findings once complete, and to also enter the free-prize draw.

An additional limitation of remote, online completion is the absence of the researcher to ask any questions for purposes of clarification and comprehension. As this may influence the validity of some responses or possibly dissuade participants from taking part, the contact details of the

principle researcher and the research supervisors were made available as part of the information page and final page.

Given the recent emergence of self-compassion and its benefits within the clinical psychology field and the current social and political emphasis on 'compassion' within the NHS (Firth-Cozens & Cornwell, 2009), it was proposed by the researcher that for clinical psychologists, possessing self-compassion may be considered a socially desirable quality. This refers to a propensity to answer questions in what is deemed a socially acceptable way (Crowne & Marlow, 1960). Barker et al (2010) recommend that should this response set be anticipated, a social desirability scale should be embedded as part of the questionnaire battery. This was considered in terms of the present research; however it was also acknowledged that as clinicians trained to employ a vast array of empirical questionnaires, it was likely that such a measure would be recognised by the clinical psychologist participants, thus rendered useless. Furthermore, previous research has found that social desirability did not correlate with SCS scores (Neff, 2003a). As such this was not included however social desirability will be considered when interpretations of the data are made.

3.5.8 Data Analysis

Data were analysed using SPSS^{TM} Version 19. Data was checked for normality and the mean and standard deviation were chosen as the appropriate measures of central tendency to identify levels of self-compassion in both the trainee group and qualified group.

In order to establish if any statistically significant difference exists between trainee levels of self-compassion and qualified levels, a between-subjects t-test was used. In order to ascertain how both CP groups scores compared with the community sample, additional t-tests were carried out. Finally, in order to ascertain which factors predicted levels of SCS scores, a multiple regression was carried out for both groups; one for trainee CP's and one for qualified

CP's. Further between-subjects analyses were also used to ascertain how trainee CP's and qualified CP's scores compared with relation to the predictor variables; all three fears of compassion, GHQ-12, PSS-10 and SOCS-R.

3.5.9 Data collection

The data collection period lasted approximately 6 months from March to October, 2014. Once a participant submitted their responses to the questionnaires, their data was automatically entered into a spreadsheet and stored by Moodle^{TM}. As outlined in the research information page, participants were aware that it would not be possible to remove their responses once submitted due to the anonymity of the data. Following the end of the data collection phase and closure of all surveys, this data was transferred into an SPSS database ready for data analysis.

Data collected in the community sample via paper copies, were returned to the researcher via a postal address at the university. These were opened upon receiving and any email entries to enter the free prize draw were removed immediately and stored in a locked cupboard. Participant consent forms and completed questionnaires were stored in a second, separate locked cupboard, both of which only the researcher had access to. This was to ensure that should a participants name form part of their email address, it would not be possible to deduce a participants questionnaire responses, thus maintain anonymity.

3.6 Ethical considerations

Ethical approval was sought and gained from The University of Essex Ethics Committee (Appendix Y). As the norming study recruited only from a community sample this was sufficient ethical approval. This initial study did however adhere to all other ethical considerations as outlined in this section.

Under recent changes in research ethics guidance (National Research Ethics Service, 2012), NHS ethical approval is not required for NHS/HSSE staff however R & D approval is still required. Liaison with a University Ethics NHS Sponsor revealed that as trainees were recruited via their university membership and not as NHS staff, R & D approval was not required. As qualified clinical psychologists were recruited by methods outside of contacting them via their NHS role, R & D approval was again not required. The present research's application for ethical approval was reviewed in full and approved by the University NHS Sponsor, with all of the above participant recruitment procedures outlined.

During the data collection phase this was with the exception of one DClinPsych programme, as it was initially insisted that R & D approval be sought (Appendix L). Despite the disagreement with this by both the principle researcher and research supervisors, an application was completed in order for the data collection to be as inclusive of all UK trainees as possible. Following data collection, a discussion with the R & D department in question revealed that in hindsight, they too agreed that R & D approval to access their trainees in their student role was unnecessary.

In order to ensure compliance with ethical guidance, the BPS guidelines on conducting psychological research online (BPS 2007) and internet-mediated research (BPS, 2013) were consulted. As both the norming study and main study used social media, the recent Health and Care Professions Council guidance in using social media (HCPC, 2014b) was also consulted throughout the process to ensure that this research was also in its accordance. As such, the following was implemented.

Informed consent was sought from all participants via the use of an online information sheet and consent form. These required the reading and confirmation of individual sections to indicate each piece of information has been independently read and understood. Given that one

major difference in online research is that the researcher and participant do not meet, the researcher also provided their university email address on the information page so that potential participants can ask the researcher any questions, prior to giving their consent and taking part in the study. Both the information sheet and consent form appeared prior to the delivery of the questionnaires and were required to be fully completed, in order to access the survey. This was to ensure that the participant had best understood the task of the survey.

All data was collected and recorded in lines with the Data Protection Act (1998). As per the permission conditions for the social connectedness scale- revised (Lee et al, 2001), anonymous data from this scale and basic demographic information of gender, age and ethnicity, will be made available to the author of the scale only, Dr Richard Lee, for possible future data analyses purposes. This was explicitly stated on the information sheets (Appendices T and U) as part of providing informed consent.

It has been identified that a possible barrier to clinical psychologists seeking help or discussing their own well-being includes issues of privacy and confidentiality concerns, fear of loss of professional status and shame, guilt or embarrassment (APA, 2010). The researcher attempted to reduce the possibility of this by making the survey anonymous and therefore did not ask participants for any personally identifying information.

The only potentially personally identifiable data produced by this research was the email addresses provided by participants by their own volition should they have wished to enter the free prize draw or submit their interest to find out the study results. In order to maintain confidentiality the email addresses submitted via the online survey were stored in a separate password protected file thus not attached to their data. In the paper packs of the community sample, email addresses were submitted on a separate piece of paper and stored in a separate

locked cupboard. This was only accessible by the researcher and no other persons (such as research supervisors).

At the end of the research and following the notification of the prize draw winner and dissemination of study findings, all email addresses will be deleted immediately. It was hoped that by taking these measures and increasing anonymity as much as possible, this reduced any possible threat to self-image, which has been identified as a possible form of ethical harm (Barker et al, 2010).

In order to respect the right of all potential participants to their privacy, the choice to take part in all the online surveys was optional. It was assumed that as this survey could be anonymously completed online instead of meeting with a researcher, potential participants would find it easier to refuse participation should they wish to. Via the information sheet, it was also clearly explained how participants could exit the online survey once started, should they wish to.

Given the significant consideration to the selection of appropriate measures for the online design of this study, it was anticipated that it would be unlikely that a participant would become distressed whilst completing the questionnaires. However, the final page presented in both the community study and main study provided appropriate and relevant contact information to organisations that could provide support if required.

The BPS proposes that when adopting online methodologies, the researchers should consider providing the option of feedback via telephone or e-mail should a participant be distressed (BPS 2007). As such, the principle researchers email address was presented alongside the email addresses of the research supervisors as part of the debrief page. No participants used this availability.

4. Results

4.1 Chapter Introduction

This chapter will present the results yielded from the questionnaires used in this cross sectional research. It will first present the process of data screening and results for the community norming sample and, as informed by the research aims will then go on to describe the results in the trainee and qualified clinical psychologist's samples. Comparisons between these two groups and the community sample will also be explored. Finally, a summary of the results will be presented and the research hypotheses will each be addressed in turn.

4.2 Community Sample

4.2.1 Data input

Data from the online survey was transferred into a password protected Microsoft Excel[TM] File ready for importing into SPSS Version 19 for data analysis. All paper copies of the Self Compassion Scale (SCS) and demographic questionnaire were entered into a separate Excel file by hand, and each entry was visually double checked.

4.2.2 Data screening and missing variables

The first stage of data screening included an eyeballing of the data for missing values. Hand data entry of the SCS revealed that 2 participants had answered some questions with two scores, for example '2-3'. In these cases a mean score was taken of both reported responses; for example '2.5', and replaced these scores. Participant 1 did this six times and participant 36 did this once.

As the online survey was designed to not permit any missed questions, further inspection of the data revealed that three participants completing the survey via paper copies did not provide an answer to one question each. Upon further review, there was no apparent pattern to this as one participant missed question 3, one missed question 7 and the third missed question 26. As such

these missing values were replaced with the mean score produced by the respective questions within the paper responding group. Due to the number of participants, screening for missing data was also supported by conducting a 'Missing Values Analysis' on SPSS. This confirmed that all missing data had now been replaced.

4.2.3 Scoring

All appropriate question items (questions 1, 2, 4, 6, 8, 11, 13, 16, 18, 20, 21, 24, 25) were reverse scored as directed by the SCS instructions. In the cases in which a mean score had been taken, for example; '3.5', these were also reverse scored where appropriate, for example: to '1.5'. In the main, Total SCS and subscale scores were derived by calculating the mean, as suggested by Neff's SCS latest instructions (Appendix B). However a summed total SCS score (Neff 2003a) is also presented throughout for comparative purposes with previous literature.

4.2.4 Data analyses

4.2.4.1 Assumptions of parametric analyses

Initial exploratory data revealed apparently big differences in age between the paper group (M=56.34, SD= 16.69) and online group (M = 35.71, SD= 13.17). Given that previous research indicates a potential impact of age on self-compassion scores, it was decided to carry out a statistical test to establish if any significant difference in SCS scores existed between the paper and online participants. This would reveal if the sample could be analysed as a whole and reduce the influence of mixed distributions (Turkey, 1960) and outliers (Field, 2013).

In order for parametric tests to be reliable, certain assumptions of the data must be met. These include assumptions of normality, and homogeneity of variance (Field, 2013). Both paper and online SCS scores were therefore analysed for parametric assumptions. This was initially as two

separate groups, to inform which statistical test would be the most appropriate (parametric /
non-parametric) in comparing these scores.

The findings are presented in detail in Appendix Z. The assumption of a normal distribution,
dictates that for each variable of interest, values of skew and kurtosis should equal 0. As such a
'Normality test with plots' analysis was run to ascertain this. From this, skewness and kurtosis
z-scores were calculated in order to allow for across variable comparison and are presented in
Table Z1. For a variable to indicate a normal distribution, z-scores must fall between -1.96 and
+1.96 (Field, 2013).

Inspection of this data reveals Skewness and Kurtosis distributions falling within range, and
non-significant Shapiro-Wilks statistics ($p > .05$), indicating normality (Field, 2013). Levene's
test also revealed that the variances between both the online and paper group were equal ($p >$
.05) thus meeting the assumption of homogeneity of variance. Visual inspection of histograms,
Q-Q plots and Box and Whisker plots also confirmed normal distributions.

A parametric, independent t-test was therefore conducted to ascertain if paper SCS scores
differed significantly from online SCS scores. This revealed that mean total SCS scores were
lower for online participants ($M= 2.97$, $SE=.05$) than for paper participants ($M = 3.06$, $SE=.09$)
however this difference, - .093, CI [-2.606, 0.103], was not significant $t(215) = -.936$, $p = .350$
(two-tailed) and demonstrated a small effect size, $d = 0.13$.

All community sample data was therefore merged together for the purpose of analysis and to
confirm that it met the assumptions for parametric analyses as a whole group.

Table 2. Community sample parametric tests for the Self-compassion Scale.

	Mean (SD)	Skewness	Kurtosis	Shapiro-Wilks Sig.[a]
Total SCS	2.96 (.64)	.81	.59	0.685
Self-kindness	2.81 (.79)	1.77	.61	0.017*
Self-Judgement	3.02 (.80)	.66	-1.06	0.096
Common Humanity	3.12 (.93)	-.07	-1.26	0.013*
Isolation	2.99 (.95)	-.81	-1.95	0.003*
Mindfulness	3.25 (.76)	-.49	-1.02	0.017*
Over Identification	3.14 (.92)	-.58	-1.74	0.011*

* $p > 0.05$, [a] Based on Mean

Data from Table 2 identifies that as a total SCS score, the assumptions of parametric tests have been met; the data falls within the acceptable range for skewness and kurtosis (-1.96 to +1.96). and the Shapiro-Wilks statistic is non-significant ($p > .05$). Visual inspection of the histogram, Q-Q plots and Box and Whisker plot also confirms this as a normal distribution (Appendix AA).

With relation to the subscale scores, the distribution of the data appears to be more skewed and kurtotic however still remains within acceptable limits (-1.96 to +1.96). The Isolation subscale presents as the most kurtotic at +1.95. just within the limit (Field, 2013) and indicative of a more leptokurtic distribution. However, the Shapiro-Wilks statistic is significant for most subscales ($p < .05$); Self-Kindness, Common Humanity, Isolation, Mindfulness and Over-Identification, indicating possible non-normality. Field (2013) highlights how tests based on null-hypothesis significance testing, such as the Shapiro-Wilks test, can indicate significance even due to small differences from a normal distribution. Given the present large sample size, $n = 217$, the researcher is therefore confident that this may be impacting upon these findings. Indeed visual inspection of the histogram, Q-Q plots and Box and Whisker plots indicate a

normal distribution, therefore, it was considered that the Shapiro-Wilks results were likely type 1 errors and the assumptions of parametric analyses had been adequately met.

As a normal distribution makes it less likely that the mean is affected by extreme scores, these findings also indicate that the mean and standard deviation is the most appropriate measure of central tendency to report the normative data.

4.2.4.2 Demographic data

The data was next analysed to ascertain the demographic characteristics of this sample. A 'Frequencies' analysis was used to explore these categorical variables (Field, 2013). Table 3 identifies that a majority of the sample were female (72%) and most of the sample were either married or single.

Table 3. Community sample gender and marital status

	(n)	(%)
Gender		
Male	61	28.1
Female	156	71.9
Marital status		
Single	98	45.2
Married	104	47.9
Divorced	15	6.9

Interval data such as age was also analysed for assumptions of parametric analyses and found to be non-normally distributed (Appendix AB). As such the medians, ranges and inter-quartile ranges (IQR) are presented in Table 4. This indicates similar median ages of both males and female, with the measures of dispersion highlighting a wide range of ages in the sample.

Table 4. Community sample age data.

	Mdn	*Range*	*IQR*
Males	33	64	27 - 61
Females	36	68	27 – 53.75
Total	35	68	27 - 54

Note. Mdn = Median, IQR = Inter-quartile Range

The remaining demographic data was analysed using frequency analyses. A review of occupational data revealed that the majority of the sample were in Full time employment (57.1%), Part time employment (14.3%), Retired (13.8%) or a Student (10.6%). Other occupations identified, although less so, were Homemaker (2.3%) and 'Other' (1.8%). Median values reported indicated 15 years of experience (*IQR* = 7- 31, *Range* = 64).

Table 5. Community sample ethnicity and religion data

	n	(%)		*n*	(%)
Ethnicity			Religion		
White (UK)	197	90.8	Christian	109	50.2
White Irish	2	.9	Jewish	1	.5
Other White background	9	4.1	Muslim	1	.5
White and Asian	2	.9	Sikh	1	.5
Multiple Ethnicity	3	1.4	No religion	98	45.2
Indian	1	.5	Other religion NOS	3	1.4
Pakistani	1	.5	Would rather not say	3	1.4
Chinese	1	.5			
Would rather not say	1	.5			

Inspection of ethnicity and religion data (Table 5) revealed that the majority of the sample identified their ethnicity as White, from the UK (90.8%) and their religion as Christian (50.2%) followed by 'no religion' (45.2%) as the second most common category.

Review of the frequency data for county of living revealed a good spread of geographical locations of data (Appendix AC) across the community sample. The majority of participants were recruited from the counties of North Yorkshire (24.9%) and Essex (19.8%), however counties in Scotland, Wales and Northern Ireland were also represented.

4.2.4.3 Research objective 1: UK community sample data for the Self-Compassion Scale (Neff, 2003b)

All UK Community sample data for the SCS and subscales is presented in Table 6. This demonstrates means and standard deviations for males and females as separate groups followed by a total community SCS score.

Table 6. Self-compassion Scale UK normative data

	Males		Females		Total Sample	
	M	*SD*	*M*	*SD*	*M*	*SD*
Total SCS Mean	3.04	.63	2.98	.65	2.99	.64
Self-kindness	2.69	.79	2.86	.79	2.81	.79
Self-Judgement	2.90	.88	3.07	.76	3.02	.80
Common Humanity	2.98	1.00	3.18	.90	3.12	.93
Isolation	2.90	1.06	3.03	.91	2.99	.96
Mindfulness	3.33	.83	3.22	.73	3.25	.76
Over Identification	2.85	.91	3.26	.91	3.14	.92
Total Summed SCS[a]	18.35	3.83	17.90	3.93	18.02	3.89

Note. Total SCS = Total Self-Compassion Scale Scores.
[a] = calculated by reverse scoring Self-judgement, Isolation, Over Identification and summing to all other subscales.

UK norms for total SCS scores as derived from this community sample were *M*= 2.99, *SD*= .64.

A *t*-test was used to ascertain if SCS scores differed by gender. This revealed that men reported higher total SCS scores (*M*= 3.04, *SE* =.08) than women (*M*= 2.98, *SE* = .05). However, this difference was non-significant $t(215) = -.702, p = .483$ (two tailed) and with minimal effect *d* =

0.09. Homogeneity of variance between males and females was indicated (Levene's test, $p =$ .606). Further t-tests were carried out on all subscales revealing further non-significant differences in all, except the Over Identification subscale. This revealed that women reported higher levels of over-identification ($M = 3.25$, $SE = .07$) than men ($M=2.85$, $SE = .12$) and that this difference, -.407, CI [0.137, 0.677], was significant $t(215) = -2.968$, $p<0.005$ (two tailed) with a medium effect size $d = 0.4$.

4.3 Trainee and Qualified Clinical Psychologists

4.3.1 Data input

Upon survey closure, data from the online survey was transferred into a password protected Microsoft Excel File ready for importing into SPSS Version 19 for data analysis.

4.3.2 Data analyses: demographic variables

Trainee and qualified clinical psychologist's data were analysed to establish the demographic characteristics of each sample. Interval data such as age, years of clinical experience and number of hours of Self-compassion teaching was screened for parametric assumptions and found to be non-normally distributed (Appendix AD). As such Medians and IQR's are presented for these variables. Total years of clinical experience for trainees was calculated using the number of years of experience pre-training plus the number of years spent on training. As one may anticipate, Table 7 demonstrates that trainees were younger than qualified CP's and had fewer years of clinical experience. However a range of at least 30 years in both groups indicates that a good spread of ages was achieved and ranges of 14 and 31 indicate a good variety of years of clinical experience also.

Table 7. Psychologist age and years of clinical experience

	Trainees	Qualified
Age		
Mdn	28	37.5
IQR	26 - 30	32 – 44.75
Range	30	32
Clinical experience (Years)		
Mdn	4	12
IQR	3 - 6	9 - 18
Range	14	31

Note. Mdn = Median, IQR = Inter-quartile Range

Table 8. Psychologist gender and marital status

	Trainees		Qualified	
	(*n*)	(%)	(*n*)	(%)
Gender				
Male	31	14	15	12.5
Female	190	86	105	87.5
Marital status				
Single	159	71.9	42	35
Married	57	25.8	70	58.3
Divorced	3	1.4	7	5.8
Missing data	2	.9	1	.8

Note. n = frequency.

Again categorical variables were inspected using a 'frequencies' analyses. Inspection of gender

and marital status data revealed that most of the trainee sample was female (86%) as was most

of the qualified CP sample (87%) (Table 8). Comparisons with Clearing House for Postgraduate

Courses in Clinical Psychology (CHPCCP) equal opportunities data indicates that this is representative of the trainee population; 86% (CHPCCP, 2013) however very slightly underestimating the number of male qualified CP's registered with the HCPC (18%) (HCPC 2015). Most of the trainee sample reported their marital status as single (72%) whereas the majority of qualified CP's were married (58%), although a large proportion did report they were single (35%).

Full ethnicity and religion data can be found in Appendix AE. This demonstrated that within the trainees group, the majority of the sample considered themselves to be White British (81%) with White Irish (5%) with 'Other White background' (5%) also reported more than other categories. The same pattern was also found within the qualified CP group; White British (87%), White Irish (4%) and 'Other White background' (6%). Other ethnicities included Chinese, Pakistani, Indian, Black British, White and Black Caribbean, indicating some representation from a variety of ethnicities.

The majority of trainees reported that they had 'no religion' (65%) or were Christian (24%). Again this pattern was the same within qualified CP groups; 'no religion' (67%), Christian (27%). Given that self-compassion stems from Buddhist religion and culture, it is worth noting for the purpose of providing context to later results that 2% of trainees and 1% of qualified CP's identified themselves as Buddhist.

Table 9 presents service information for trainees and qualified CP's. This identified that both groups are predominantly working as part of an MDT; trainees (80%) and qualified CP's (72%). Further information reveals that many trainees work with at least one or two other psychology colleagues (32%); this refers to qualified CP's and other trainees and assistants. Furthermore, 37% report they work with 3 to 5 other psychology colleagues and 21% reported they worked with between 6 to 10 other psychology colleagues . Some trainees (2%) indicated

that they work with no other psychology colleagues, which is somewhat concerning, given their learning and student role.

Within qualified CP's a similar pattern emerges in that 28% work with at least one or two other CP's, 19% work with between 3 to 5 other CP's and 23% work with 6 to10 other CP's. In contrast to trainees however, nearly 16% reported they worked with no other CP colleagues.

Table 9. Psychologist service related demographics

	Trainees		Qualified	
	(*n*)	(%)	(*n*)	(%)
Service Type				
CP only	45	20.4	34	28.3
MDT	176	79.6	86	71.7
Number of PC's in team				
0	4	1.8	19	15.8
1 - 2	70	31.7	32	26.7
3 – 5	81	36.7	23	19.2
6 - 10	46	20.8	28	23.3
11 - 15	12	5.4	8	6.7
16 – 20	6	2.7	6	5
21+	2	.9	4	3.3
Self-Care				
Yes	188	85.1	97	80.8
No	33	14.9	22	18.8
Missing data			1	.8

Note. *PC* = Psychology Colleagues, *MDT* = Multi-disciplinary Team.

Table 9 also indicates that a large proportion of both samples also reported that they completed activities for the purpose of self-care; trainees (85%), qualified CP's (81%).

Analyses of the trainee data revealed a fairly even spread of participants across all three cohorts of training: Year One (35%), Year Two (36%) and Year Three (29%). In relation to course information, further analyses revealed that the median number of hours of self-compassion teaching was 3 hours, (*IQR*= 0 – 6), with a Range of 20 hours, suggesting that this can vary significantly between courses.

A final check of the demographic questions identified that up 49% of trainees and 63% of qualified CP's used self-compassion theory and ideas in their clinical work with clients.

4.3.3 Data analyses: study variables

4.3.3.1 Data screening and missing variables

As with the community sample, data screening included an eyeballing of the data for missing values and was supported by a 'Missing Values Analysis' on SPSS. Within the trainee CP sample, this revealed that one participant had missed question 4 on the Social Connectedness Scale (SoCS-R). Within the qualified CP sample, one participant had omitted question 5 on the same scale. Both of these were replaced with the respective series means for these questions (Field, 2013).

4.3.3.2 Scoring

As before, the SCS was reverse scored where indicated (questions 1, 2, 4, 6, 8, 11, 13, 16, 18, 20, 21, 24 and 25) and total SCS and subscale scores were derived by adding up scales and calculating the mean, as suggested by Neff's SCS scoring instructions (Neff, 2003b; Appendix B). Items in the Perceived Stress Scale (PSS) (questions 4, 5, 7 and 8) and all items in the SoCS-R were also reverse scored as per its scoring instructions. The General Health Questionnaire-12 (GHQ-12) was scored according to the GHQ 'classic scoring' methods. This involves weighting the columns to scores of '0, 0, 1, 1'. A number of possible scoring methods

exist, including typical Likert scoring '0, 1, 2, 3' and a further, modified GHQ scoring method; Chronicity GHQ method (CGHQ), which involves scores of '0, 0, 1, 1' and '0, 0, 0, 1' depending on the positive or negative wording of the question. This was devised by Goodchild and Duncan- Jones (1985) and has evidenced improved sensitivity to longer term (chronic) distress (Goldberg & Williams, 2006). However it is the 'classic' GHQ method that is advocated as the optimal choice in maintaining sensitivity and specificity for the GHQ-12 and is proposed as the best method to identify 'caseness' by the questionnaire author (Goldberg et al, 1997). Given the aims of this research, this method was therefore chosen. All three Fear of Compassion subscales did not require reverse scoring.

4.3.3.3 Assumptions of parametric analyses

Once again, in order for parametric tests to be reliable, certain assumptions including linearity, normality, homogeneity of variance and independence must be met in order to inform which statistical test would be most appropriate to use (Field, 2013). As such, all variables were analysed to establish if these assumptions had been met.

4.3.3.4 Linearity and independence

In the first instance, scatterplot matrices' was created to ascertain that all variables (Age, Years of clinical experience, Perceived Stress, Fear of Giving Compassion, Fear of Receiving Compassion from others, Fear of Self-Compassion, Psychological distress and Social Connectedness) to be included in the main data analyses were linearly related. Upon visual inspection, there is no curving of the scatterplots present although some outliers are indicated. A curved formation would indicate non-linearity therefore the researcher is confident that this assumption has been met (Appendix AF) (Field, 2013).

It is assumed that respondents from the same areas did not confer when completing their questionnaires. Furthermore, given the wide geographical spread of responses the data is assumed to be from independent sources.

4.3.3.5 Assumptions of normality and homoscedasticity

The trainee data (Table 10) demonstrates that only total SCS scores were normally distributed and all other variables violated these assumptions, as in many cases z-scores fell out of range (-1.96 to +1.96). Shapiro-Wilks significance levels indicate that all scores significantly deviated from normality ($p > .05$). Again, this particular significance may be a Type 1 error due to the impact of a large sample size as discussed above (Field, 2013). Visual inspection of histograms, Q-Q plots and Box and Whisker plots (Appendix AG) further confirmed the non-normality of all predictor variables and the normality of total SCS scores, indicating that the Shapiro-Wilks may be a type 1 error in this case. As such it was concluded that all variables were non-normally distributed except for the total SCS within the trainee CP group.

Inspection of qualified CP data (Table 11) presents a similar pattern however PSS scores also appear to be normally distributed, with visual inspection of the histogram and Q-Q plots confirming this.

Table 10. Trainee parametric test data for all variables

	Skewness	Kurtosis	Shapiro-Wilks Sig.*
Total SCS	1.69	.92	.039
Age	11.14	14.45	.000
Years of clinical experience	8.47	12.04	.000
PSS	2.39	-1.48	.001
GHQ-12	6.22	.07	.000
FoGC	2.84	.01	.001
FoRC	8.60	5.37	.000
FoSC	8.97	6.58	.000
SoCS-R	-5.70	.67	.000

Note. Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale-Revised.
* *p* > 0.05.

Table 11. Qualified parametric test data for all variables

	Skewness	Kurtosis	Shapiro-Wilks Sig.*
Total SCS	-1.05	.12	.338
Age	2.68	-1.44	.000
Years of clinical experience	4.64	.48	.000
PSS	-.79	-.24	.666
GHQ-12	7.16	4.69	.000
FoGC	1.83	.94	.01
FoRC	6.84	8.10	.000
FoSC	5.58	3.08	.000
SoCS-R	-2.55	-1.46	.000

Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale-Revised.
* *p* > 0.05.

4.3.3.6 Heteroscedasticity

Although clear that the data was in the main, non-normally distributed, heteroscedasticity was also briefly explored using Levene's test, due to between-groups analyses that will follow. This confirmed that the variance was unequal between trainee and qualified CP's for the variable of total SCS based on the mean $F(1, 339) = 5.907$, $p = .016$, and unequal for the variables of age, years of experience and the GHQ-12, based on the median ($p < .05$). Variances were equal for PSS, FoGC, FoRC, FoSC and SoCS-R scores between groups ($p > .05$) (Appendix AH).

4.3.3.7 SCS subscale scores

SCS subscale scores were also inspected for assumptions of parametric analyses in both groups (Appendix AI) and found to meet them.

4.4 Data transformations

Given the violations of parametric assumptions indicated in the predictor variables for both trainee and qualified groups, a log transformation and a square root transformation were both performed in order to ascertain if this could improve the distributions. These were indicated as appropriate choices due to the nature of the skew and kurtosis of the data and were executed on all variables due to planned between- groups analyses (Field, 2013). The results of both transformations are presented in Appendix AJ. Neither transformation improved the data sufficiently, only improving approximately 2 / 7 variables for qualified CP's and 2-3/ 8 variables for trainee CP's. Some variables were also made more skewed and kurtotic than their untransformed counterpart. As such it was agreed for data analysis to continue with the untransformed data and for this to inform each statistical analysis.

4.5 Research objective 2: Levels of self-compassion in UK trainee and qualified clinical psychologists.

Hypothesis 1: That qualified clinical psychologists will report higher levels of self-compassion than trainee clinical psychologists.

The means and standard deviations for the total SCS scores and subscale scores are presented in Table 12. Given that both total and subscale scores were normally distributed for both trainee and qualified groups, *t*-test statistics are also presented for comparisons between each group, for each scale.

These revealed that Total SCS and the Mindfulness subscales indicated unequal variances between the two groups. As such this was managed by selecting *t*-statistics for 'Equal variances not assumed' for these variables, with their adjusted degrees of freedom also reported. The degrees of freedom for all other comparisons was *df* = 339. Given the directional hypothesis proposed; that qualified CP's would have higher levels of self-compassion than trainees, all probabilities are reported at the one-tailed level.

Table 12. Contrast of Trainee and Qualified CP levels of Self-compassion.

	Trainee CP's	Qualified CP's			95% CI		
	Mean (*SE*)	Mean (*SE*)	*t*(339)	*p*[c]	*LL*	*UL*	Cohen's *d*
Total SCS	3.21 (.04)	3.36 (.07)	1.86[a]	0.03*	-.008	.297	0.24
Self-kindness	3.23 (.05)	3.41 (.08)	2.05	0.02*	.007	.351	0.25
Self-Judgement	2.96 (.05)	2.77 (.08)	-1.987	0.02*	-.373	-.002	0.20
Common Humanity	3.41 (.05)	3.51 (.08)	1.14	0.13	-.077	.288	0.14
Isolation	2.87 (.06)	2.73 (.08)	-1.444	0.08	-.337	.052	0.16
Mindfulness	3.55 (.04)	3.67 (.07)	1.45[b]	0.07	-.042	.278	0.18
Over Identification	3.04 (.05)	2.93 (.08)	-1.226	0.11	-.298	.069	0.11
Total Summed SCS	19.32 (3.48)	20.17 (4.36)	1.84	0.03*	-.062	1.76	0.24

Note. Total SCS = Total Self-compassion Scale scores, CP = Clinical Psychologist, CI = confidence interval, LL = lower limit, UL = upper limit.
*, *p* < .05.
[a] = *adjusted df* = 201.82, [b] = *adjusted df* = 216.51 [c] = one-tailed

An independent t-test revealed that qualified CP's reported higher SCS scores (*M* = 3.36, *SE* = .07) than trainees (*M* = 3.21, *SE* = .04) and that this difference, .144, CI [-.008, .297], was significant *t*(201.82) = 1.87, *p*<.05. Qualified CP's also had significantly higher Self-Kindness and significantly lower Self-Judgement scores than trainees. No other between group comparisons reached significance, however the same pattern continued, in that qualified CP's scored higher on the indicators of self-compassion; Common humanity and Mindfulness subscales, than trainees and lower on Isolation and Over-Identification subscales.

As a final analyses, an independent Analysis of Variance (ANOVA) was run in order to ascertain how year of training impacted SCS scores. As with the other analyses, an ANOVA analysis requires assumptions of parametric analyses to have been met in order for its results to

be an accurate representation of the data. It was found that there was no significant effect of year of training on total SCS scores $F(2,218) = 1.914$, $p = .15$.

4.6 Research Objective 3: To identify which factors predict levels of self-compassion in both trainee and qualified clinical psychologists

4.6.1 Regression analyses

A multiple regression analysis was selected to ascertain what factors may predict SCS scores. Given the early stages of this area of research, it was decided that not enough theory and evidence exists to inform the order of entry within a hierarchical model. Furthermore, known limitations of 'Stepwise methods' which include producing spurious results that can often lack ecological validity (Field, 2013), led the researcher to adopt the 'Enter' method also known as the Forced Entry method.

4.6.2 Assumptions of multiple regressions

Multiple regression analyses share the assumptions of parametric analyses discussed above which enables the generalisation of the sample data to the population level. However within a regression analysis, it is the residuals (errors) of the data that must be normally distributed; the predictors themselves do not have to be. Furthermore, there must not exist any strong relationships between the predictor variables, also referred to as multicollinearity ($r > .9$) and the predictors should have some variation in their values thus demonstrating 'Non-zero variance' (Field, 2013). Initial analyses indicate that this data is linear and independent however in the main, the predictor variables scores are non-normally distributed and it is unclear about the distribution of the residuals. As such, an 'Enter' method multiple regression was conducted and the model checked for violations of the above assumptions to assess its suitability and fit.

A further assumption is that all predictor variables entered into the model, have some form of relationship with the outcome variable (Hinton, 2004). Therefore in preparation for the multiple regression, a correlational analyses was carried out to ascertain the relationship between all predictor variables and the outcome variable (SCS scores) and to establish which variables would be included in the multiple regression analysis.

In the following section, Trainee CP correlations and multiple regression analyses will be analysed and inspected first, followed by the qualified CP analyses and results.

4.7 Trainee results

4.7.1 Correlations

As all predictor variables in the trainee group did not meet the assumptions of parametric analyses, their relationship with SCS scores was assessed using Spearman's Rho, noted as a robust non-parametric correlation for larger sample sizes (Field, 2013) and are presented in Table 13. Again as directional hypotheses were made, these are analysed at the one-tailed level. In order to remind of the internal reliability of each predictor variable scale, Cronbachs alphas are also presented.

Inspection of these correlations reveal that within the trainee sample, the predictor variables of Age and Years of clinical experience do not appear to have a significant or strong relationship with SCS scores Age, $r = .042$, $p = .266$, Years of clinical experience $r = -.054$, $p = .212$. As they would therefore not add any predictive value to the regression model they will not be included in the multiple regression analyses.

Table 13. Trainee CP predictor and outcome variable correlations

	Total SCS	PSS	Age [a]	Clinical Experience[a]	FoGC	FoRC	FoSC	GHQ-12	SoCS-R
Total SCS	1.000	-.557***	.042	-.054	-.172**	-.451***	-.616***	-.422***	.454***
PSS		1.000	-.078	.022	.080	.385***	.409***	.711***	-.381***
Age [a]			1.000	.487***	-.172**	-.004	-.151*	-.078	-.105
Clinical Experience[a]				1.000	-.095	.071	.000	.009	.015
FoGC					1.000	.292***	.353***	.030	-.204***
FoRC						1.000	.675***	.292***	-.605***
FoSC							1.000	.336***	-.478***
GHQ-12								1.000	-.255***
SoCS-R									1.000
Cronbachs alpha (α)	.91	.87			.78	.88	.90	.87	.93

Note. Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale- Revised.
All significances One Tailed
[a] = in years, * = *p*<.05, ** = *p*<.01, *** = *p*<.001.

4.7.2 Multiple regression

4.7.2.1 Normal distribution and homoscedasticity

For the significance testing of a multiple regression model to be accurate, it is the sampling distribution; the distribution of the possible values of the mean that could be expected from a given population, and residuals of the outcome variables that must be normally distributed (Field, 2013). As such, a histogram of the outcome variable (total SCS) residuals and P-P plot were created and inspection of both demonstrated a normal distribution (Appendix AK). As such the assumption of normality for this multiple regression was met.

A scatter plot of the standardised residuals (*ZRESID) against the standardised predicted values of the outcome variable (* ZPRED) graph was requested and identified a fairly random array of plots, indicating homoscedasticity. The absence of a curve formation again confirmed the data was linear. Inspection of the partial plots of the outcome variable (SCS scores) against PSS and FoSC predictor variable also indicates their negative linear relationship (Appendix AK).

Therefore whilst in the first instance the predictor variables did not appear to meet assumptions of parametric analyses, further analyses appropriate to a multiple regression confirmed that they did. This indicated that significance testing yielded by a multiple regression could be considered an accurate representation of the data.

4.7.2.2 Model diagnostics

Further checks can be made in order to assess bias and ascertain how good a model fits the sampled data. This is achieved by inspecting the impact of outliers, independence and multicollinearity.

4.7.2.3 Influential cases / outliers

During initial data screening, scatter plot matrices and box-plots indicated the presence of some outliers within the predictor variables. As such a z-score analyses was run to indicate extreme z score outliers $>\pm3.29$ (Field, 2013). It is typically expected that 1% of data will fall within outlier range, and 5 cases out 221 participants were identified. This represents = 0.02% thus falling within range. In order to ensure that these outliers did not influence the regression, the impact of these were investigated further. Cooks distance is a measure of the overall influence an individual case can have on a model and it is considered that a distance greater than 1 may be problematic (Cook & Weisberg, 1982). Inspection of the data revealed that Cooks distance < 1 in all reported cases (Minimum = .000, Maximum = .103).

Mahalanobis distances provide a second check of outlier influence by assessing the distance of cases from the mean of predictor variables (Field, 2013), It has been suggested in samples of $n = 200$ with at least five predictor variables, values above 25.82 at $p<.001$ level, would be problematic (Barnett and Lewis, 1978). Inspection of this data reveals distances of Minimum = .424 and Maximum = 23.74 ($M = 5.97$, $SD = 4.53$) thus falling within this range. Stevens (2002) suggests that if Cooks < 1 then outliers should be kept in the data set and as such they were. It was however noted that the majority of trainee outliers was found within the variable of FoSC ($n=3$).

4.7.2.4 Independence

Independence of the model residuals was assessed using the Durbin-Watson test. Thresholds for this statistic indicate that values less than 1 or greater than 3 may be problematic and indicate correlation (Durbin & Watson, 1951). The Durbin-Watson statistic for this sample was 2.13, indicating independence of errors.

4.7.2.5 Multicollinearity

Finally, perfect multicollinearity of predictor variables was assessed by inspecting the correlation matrix, which found no strong correlations ($r >.9$). It was noted that PSS scores and GHQ-12 scores did significantly correlate with a large effect size $r =.718$, $p<.005$, however this is somewhat unsurprising given that it is likely stress and psychological distress would overlap. It was also noted that FoRC scores also significantly correlated with FoSC, $r= .747$, $p< .005$, again not surprising as these predictors both relate to receiving compassion in some form; either from others or from the self. Field (2014) suggests that less than perfect multicollinearity is often unavoidable in samples, and as neither of these correlations were greater than .9, they were therefore not considered as multicollinear. However, it is known that high correlations between predictors can limit the size of R; the measure of the correlation between the predicted values of the regression model and actual observed values, therefore this will be considered in the discussion.

The Variance Inflation Factor (VIF) and tolerance statistics produced by regression output can offer a second check for multicollinearity. It has been suggested that if VIF statistics are greater than 10 and tolerance statistics are below 0.2, this can be a strong indicator of multicollinearity and as such bias within the model (Bowerman, & O'Connell, 1990; Menard, 1995).

The present research demonstrated that all tolerance statistics >0.2 and all VIF statistics were much smaller than 10. Taken together with the above correlations, the assumption of multicollinearity was met.

4.7.2.6 Regression analysis for trainee SCS scores

> *Hypothesis 2: That higher scores of self-compassion will be predicted by higher*
>
> *age of clinician, more years of clinical experience, and higher social*
>
> *connectedness.*
>
> *Hypothesis 3: That lower self-compassion scores will be predicted by higher*
>
> *fears of compassion scores, higher GHQ scores and higher scores of perceived*
>
> *stress.*

Within the trainee sample, the total variance (R^2) explained by the model was 55.7%, indicating that over half of the variance in SCS scores; whether a participant scored high or low, was explained by these predictors. Inspection of the Adjusted R^2 (.554) indicated that this sample value was quite representative of the whole trainee population due to minimal differences between them. As a final check, an ANOVA further confirmed that this regression model was significantly better at predicting SCS scores than compared to not fitting a model and using only an outcome variable mean $F(6, 214) = 44.821$, $p<.001$.

Table 14. Multiple regression of trainee SCS outcomes

	b (upper and lower confidence limits)	SE B	β	p
Constant	3.785 (3.34, 4.23)	.226		.000**
PSS	-.031 (-.044, -.018)	.007	-.331	.000**
FoGC	.000 (-.012, .013)	.006	.002	.483
FoRC	.006 (-.007, .018)	.006	.067	.189
FoSC	-.036 (-.046, -.027)	.005	-.516	.000**
GHQ-12	-.004 (-.028, .019)	.012	-.025	.354
SoCS-R	.008 (.000, .016)	.004	.110	.032*

Note. Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale-Revised.
b = beta, SE B = standard error of beta, β = Standardised Beta,
* $p < .05$, ** $p < .001$

The regression results are presented in Table 14. As directional hypotheses were made at the beginning of this research, all significance values are reported at the One-Tailed value. Fear of self-compassion made the greatest, significant unique contribution (with all other variables held constant) in explaining the variance of SCS scores ($\beta = -.516$, $p < .001$), with a large effect size followed by Perceived stress ($\beta = -.331$, $p < .001$) with a medium effect size. As both standardised Betas were negative, this indicates a negative relationship in that, higher scores of fear of self-compassion and perceived stress is related to lower SCS scores. These results further identified that Social Connectedness also made a significant unique contribution to SCS scores ($\beta = .110$, $p < .05$), this was with a smaller effect size than FoSC

and PSS. Social connectedness indicated a positive relationship, in that higher SoCS-R scores were related to higher SCS scores.

Inspection of the confidence intervals for betas demonstrate small intervals indicating that the betas within this sample are likely to be representative of the wider trainee population. No other predictor variables reached significance, indicating that only these variables made significant contributions to the model.

4.8 Qualified results

4.8.1 Correlations

Given that the SCS and PSS predictor variables were normally distributed for the qualified sample, a Pearson's 'r' correlation was carried out for this initial inspection and is presented in Table 15 alongside the Spearman's rho calculations for all other non-normally distributed variables.

Inspection of these correlations reveal again that Age ($r = .060$, $p = .257$) and Years of clinical experience ($r = .034$, $p = .355$) do not appear to have a significant, nor strong, relationship with SCS scores. Furthermore, and in contrast to trainees, within the qualified sample, there also appears to be no relationship between Fear of giving compassion and SCS scores ($r = -.089$, $p = .166$). As such, these predictors will not be included within the following multiple regression analyses.

Table 15. Qualified CP predictor and outcome variable correlations

	Total SCS	PSS[b]	Age[a]	Clinical Experience[a]	FoGC	FoRC	FoSC	GHQ-12	SoCS-R
Total SCS	1.000	-.542***	. 060	.034	-.089	-.560***	-.768***	-.382***	.473***
PSS		1.000	.140	.178*	.127	.458***	.452***	.582***	-.385***
Age [a]			1.000	.791***	.066	.047	-.090	-.039	-.061
Clinical Experience[a]				1.000	-.013	.059	-.088	-.009	-.062
FoGC					1.000	.297***	.271***	.180*	-.208*
FoRC						1.000	.710***	.336***	-.666***
FoSC							1.000	.430***	-.486***
GHQ-12								1.000	-.226**
SoCS-R									1.000
Cronbachs alpha (α)	.95	.84			.76	.89	.88	.81	.94

Note. Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale- Revised.
All significances one-tailed.
[a] = in years, [b] Pearson's 'r'.
* = $p<.05$, ** = $p<.01$, *** = $p<.001$.

4.8.2 Multiple regression

4.8.2.1 Normal distribution and homoscedasticity

Once again, visual inspection of the histogram and P-P plot of the outcome variable (SCS scores) residuals demonstrated a normal distribution (Appendix AL). A *ZRESID vs *ZPRED graph also demonstrated another sufficiently random array of scatterplots, indicating that the assumption of homoscedasticity had also been met. Again, the absence of a curved formation confirmed the linearity of the data, with inspection of the partial plots once again indicating a negative linear relationship of PSS scores and FoSC scores with SCS scores.

As with the trainee sample, this data did not appear to meet assumptions of parametric analyses in the first instance, however these analyses confirm that a multiple regression is appropriate for further analyses.

4.8.2.2 Model diagnostics

Once again, the impact of outliers, independence and multicollinearity were checked in order to assess the model of fit produced by the multiple regression.

4.8.2.3 Influential cases / outliers

Once again a z-score analyses was run to indicate extreme z score outliers $>\pm3.29$ (Field, 2013). This indicated 3 possible values within an outlier range, representing 2.5% of the overall sample thus just exceeding the 1% considered as acceptable. As such, Cooks distance was once again used to ascertain the overall influence of an individual case on the regression and all were found to be < 1 (Minimum = .000, Maximum = .091).

Mahalanobis distances again provided a second check of outlier influence with Minimum = .286 and Maximum = 24.184. It has been suggested in samples of $n = 100$ with at least five

predictor variables, values above 23.17 at $p<.001$ level, would be problematic (Barnett & Lewis, 1978). Within this sample, the maximum value indicates that some cases just exceed the boundary for this which could be concerning. However Stevens (2002) makes the point that possible outliers detected by Mahalanobis distances will not necessarily be influential; indeed the mean and standard deviation of the Mahalanobis distance in this sample is low (M=4.95, SD = 4.25); and as such reference to Cooks distance must be made. If this is <1, as in this data, then data should remain in the analysis as they do not have a strong effect on the regression. It was noted that these cases where found within FoRC (n= 3).

4.8.2.4 Independence

Once again the Durbin-Watson test statistic was consulted and found to be 2.007. This is well within the boundaries of 1> and <3 (Durbin & Watson, 1951), indicating independence of SCS residuals.

4.8.2.5 Multicollinearity

Finally, multicollinearity was assessed by inspection of the correlation matrix and once again did not reveal any strong correlations ($r > .9$). As with the trainee sample, it was found that FoRC were significantly correlated with FoSC ($r = .744$, $p = 001$), the implications of which also will be discussed further. The VIF and tolerance statistics were also inspected and again revealed that all tolerance statistics were >0.2 and all VIF statistics were much smaller than 10. As such it was considered that the assumption of multicollinearity had been met in this sample.

4.8.2.6 Regression analysis for qualified CP SCS scores

> ***Hypothesis 2: That higher scores of self-compassion will be predicted by higher age of clinician, more years of clinical experience, and higher social connectedness.***

Hypothesis 3: That lower self-compassion scores will be predicted by higher

fears of compassion scores, higher GHQ scores and higher scores of perceived

stress.

Within the qualified sample, the total variance (R^2) explained by the model was 62.9%. It is

an interesting finding that the qualified model explains more of the variance in SCS scores

than trainees, given that it has one less predictor included; FoGC. Inspection of the Adjusted

R^2 (.613) indicated that this was quite representative of the whole qualified population, given

there was little difference between the two values. Finally, the ANOVA data indicated that

this regression model was significantly better at predicting SCS scores than compared to

relying on the outcome variable mean $F(5, 114) = 38.71$, $p < .001$.

Table 16. Multiple regression of qualified CP SCS outcomes

	b (upper and lower confidence limits)	SE B	β	p
Constant	3.880 (3.173, 4.587)	.357		.000
PSS	-.028 (-.047, -.010)	.010	-.215	.002*
FoRC	.002 (-.017, .022)	.010	.024	.403
FoSC	-.061 (-.079, -.043)	.009	-.611	.000**
GHQ-12	-.002 (-.045, .041)	.022	-.007	.460
SoCS-R	.011 (-.002, .025)	.007	.124	.051

Note. Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale-Revised.
b = beta, SE B = standard error of beta, β = Standardised Beta,
 * p < .05, ** p < .001

Once again as directional hypotheses were made at the beginning of this research, all significance values are reported at the One-Tailed value in Table 16. As with the trainee sample, Fear of self-compassion made the greatest, significant unique contribution in explaining the variance of SCS scores (β = -.611, p=.000) with a large effect size, followed by Perceived stress (β = -215, p< .05) with a smaller sized effect. Again, Betas were negative, indicating a negative relationship with SCS scores. Unlike the trainee sample, the contribution of Social connectedness did not reach significance, however it was narrowly missed (β = .124, p = .051).

Finally, inspection of the confidence intervals for betas demonstrate small intervals indicating that the betas within this sample are likely to be representative of the wider qualified population. No other predictor variables reached significance, suggesting that only these variables made significant contributions to the model.

4.9 Research objective 4: To update our knowledge of psychological distress currently experienced within UK clinical psychologists.

In order to achieve the above objective, the prevalence of trainee and qualified CP's meeting 'caseness' criteria were established using a frequencies analysis. Exploration of the GHQ-12 literature revealed that different studies use different thresholds for 'caseness'. As recommended by the GHQ manual, it is advisable to look up the best threshold value within a paper using a similar participant group. The literature was reviewed and only one study was found to use the GHG-12 with clinical psychologists. Unfortunately in their study Ruths et al (2012) did not report 'caseness'; only a continuous GHQ-12 distress score. Looking to similar sample groups, it was found that Kumary and Baker (2008) reported 'caseness' levels within their sample (n=109) of UK counselling trainees however they failed to report their caseness cut off criteria. As such the literature was reviewed to look for relevant samples

using this measure and it was found that the GHQ-12 has been recently used to identify distress in UK medical students (James, Yates, & Ferguson, 2013). Within this and previous medical student research (Guthrie et al, 1998; Moffat, McConnachie, Ross, & Morrison, 2004) a score of 4 or more indicated a suitable cut off for caseness. In addition to this, the GHQ manual suggests that the best threshold cut off for the GHQ- 12 is 3/ 4 (Goldberg & Williams, 2006). Given the similarities of the medical student role and that of trainees, a cut off of 4 was therefore selected for use within this study. As no evidence of use of the GHQ-12 and qualified clinical psychologists could be found, it was decided to keep the cut off at 4 for qualified CP's also. This would additionally enable more reliable comparisons between the groups on caseness scores.

A frequencies analysis indicated that 36%, (n =79) over one third, of trainees met the criteria for caseness and were experiencing psychological distress. This was higher than the qualified CP sample, however still 21% (n =25) met the criteria for caseness, approximately one fifth of the total sample.

4.10 Research Objective 5: To compare the levels of fear of compassion, social connectedness, perceived stress and GHQ-12 scores between trainees and qualified clinical psychologist groups.

As all predictor variables were non-normally distributed, a Mann-Whitney analysis was used to compare trainee with qualified CP scores for each variable. This non-parametric test was selected as it reduces the bias often introduced by outliers in a non-normal distribution, by ranking the data (Field, 2013).

Inspection of Table 17 identifies that qualified CP's were significantly older than their trainee colleagues and had significantly more years of clinical experience. However, trainees demonstrated significantly higher GHQ-12 scores than the qualified sample (p<.005),

indicating that they were significantly more distressed. No other statistically significant differences between variables were observed.

Table 17. Contrast of Trainee and Qualified CP predictor variables.

	Trainee CP's		Qualified CP's					
	Mdn	*IQR*	*Mdn*	*IQR*	*U*	*z*	*p*	*r*
Age	28	26-30	37.5	32-44.75	3,070.50	-11.747	.000*	-.64
Clinical experience	4	3-6	12	9-18	1,450.50	-13.654	.000*	-.74
PSS	17	13–22	17	13-20	14,488.50	1.415	.157	.07
GHQ-12	2	1-5	1	0-3	16,281.00	3.544	.000*	.19
FoGC	7	5-11	7	5-11	13,230.00	-.035	.972	.00
FoRC	6	3-10	8	3-12	12,322.00	-1.081	.280	.06
FoSC	7	4-12	6.5	2-12	14,345.50	1.251	.211	.07
SoCS-R	40	34-46	40	32-45	14,078.50	.944	.345	.05

Note. PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale-Revised.
U = Mann-Whitney test statistic, * *p*<.005.

4.11 Research Objective 6: To compare psychologist self-compassion scores with those from a UK community sample.

As a final analysis, two independent *t*-tests were run in order to establish if community SCS scores differed with trainee SCS scores and qualified CP SCS scores. This revealed that the community sample (*M* = 2.99, *SE* = .04) had significantly lower SCS scores than the trainee sample (*M* = 3.21, *SE* = .04), and that this difference = -.218, was significant, *t*(436) = -3.73, *p*<.000 (two tailed) and was a medium sized effect *d*=.34

The same difference was evidenced with the qualified CP sample; the community sample (*M* = 2.99, *SE* = .04) had significantly lower SCS than the qualified sample (*M* = 3.36, *SE* = .07,

(mean difference = -.363), $t(335) = -4.711$, $p<.000$ (two tailed), however this was a large sized effect $d = .58$.

4.12 Summary of results

This chapter outlines the results of this research. These indicate that qualified CP's report significantly higher total SCS scores than trainees, and that together these are both significantly higher than a UK community sample.

Furthermore, qualified CP's report significantly higher scores than trainees on the self-kindness subscale and trainees appear to report significantly more self-judgement than qualified CP's. Finally, the results presented here suggest that trainees report significantly higher levels of psychological distress than qualified CP's, as measured by the GHQ-12. This is further confirmed by 'caseness' levels reaching 36% in trainees compared with 21% in qualified CP's.

The original hypotheses identified in the introduction were:

Hypothesis 1: That qualified clinical psychologists will report higher levels of self-compassion than trainee clinical psychologists.

An independent t-test revealed that qualified CP's reported higher SCS scores ($M = 3.36$, $SE = .07$) than trainees ($M = 3.21$, $SE = .04$) and that this difference, .144, CI [-.008, .297], was significant $t(201.82) = 1.87$, p .05. These findings therefore support the hypothesis.

Hypothesis 2: That higher scores of self-compassion will be predicted by higher age of clinician, more years of clinical experience, and higher social connectedness.

A multiple regression analyses did not include the variables of Age or Years of Clinical experience in either trainee or qualified groups as no correlation between the predictor and outcome variables was observed.

In the trainee sample, Social Connectedness did significantly contribute to the model (β = .110, p < .05 (one tailed). The contribution of Social connectedness did not quite reach significance with the qualified sample, although this was close (β = .124, p = .051).

Evidence exists therefore only in part for this hypothesis.

Hypothesis 3: That lower self-compassion scores will be predicted by higher fears of compassion scores, higher GHQ scores and higher scores of perceived stress.

In the trainee sample, both Fears of giving compassion (β = .002, p = .966) and Fears of receiving compassion (β = .067, p = .378) did not significantly contribute to the model. Fears of Self-Compassion was found to make the greatest significant contribution (β = -.516, p < .001), indicating that higher scores of fears of self-compassion were related to lower scores of self-compassion.

Within the qualified sample, Fears of giving compassion was excluded from the regression as it evidenced no relationship with total SCS scores within this sample. As with the trainee group, Fears of receiving compassion made no significant contribution to the model (β = .024, p = .403) and Fears of self-compassion made the greatest contribution out of all the variables (β = -.611, p < .001).

As Fears of giving compassion and Fears of receiving compassion appeared to have no predictive value over total SCS scores in both groups, this research only in part supports this hypothesis.

GHQ scores did not make significant unique contributions to SCS scores in either the trainee sample (β = -.025, p = .354) or the qualified CP sample (β = -.007, p = .460). This therefore refutes the hypothesis in relation to GHQ scores.

Both multiple regression analyses did however confirm a significant negative relationship with PSS scores; Trainees ($\beta = -.331$, *p*< .001), Qualified CP's ($\beta = -215$, *p*< .05). This research therefore supports this hypothesis in relation to perceived stress scores.

5. Discussion

5.1 Chapter introduction

This chapter will summarise and discuss the findings yielded from the present study. It will discuss these in relation to previous research and consider their theoretical and clinical implications. Recommendations for future research will be suggested throughout and an account of the strengths and limitations of the research will be discussed.

5.2 Summary of project

The broad aims of this research were to; (1) gain normative data in a UK community sample for the Self-Compassion Scale (SCS) (Neff, 2003a), (2) as measured by the SCS, to identify levels of self-compassion reported by trainee and qualified UK clinical psychologists and (3) to ascertain which factors may predict these levels in both groups. This was to address the salient gaps in the current self-compassion and clinical psychologist self-care literature and to also respond to the recent NHS research agenda by supporting the understanding and promotion of compassionate care (Francis, 2013).

A summary and discussion of these results will now be presented. Community data will be presented first followed by trainee and qualified clinical psychologist (CP) findings. Each research hypothesis will also be presented and discussed where appropriate.

5.3 UK Community Self-compassion Scale Data

The results presented here provide the first normative data for a UK community sample. Again, this data was scored using two methods in order to facilitate comparisons with previous literature. As such, within the present study the total SCS scores were $M = 2.99$ and summed scores $M = 18.02$. This indicates that currently, the UK population reports being moderately self-compassionate. As no other UK total SCS scores have been published, the

results from this research were compared with community samples in the United States (US), another western society. This indicated that the UK SCS scores were found to be similar to Neff's (2003a) original community sample (*M*=18.25) and to other US community samples reported (ranging from *M*=2.81 – 2.95) (Herzberg et al, 2012; Neff & Pommier, 2012; Jazaieri et al 2013).

Given Neff et al's (2008) more recent research exploring SCS in other cultures, the present results suggests that this UK sample reported less self-compassion than their 2008 US sample (*M*=3.14) and much less than their Thai sample (*M*=3.41). Instead this study yielded similar results their Taiwanese sample (*M*=2.92); a Confucian culture that emphasises self-improvement, something that itself is proposed to result in a more self-judgemental, self-relating style (Neff et al, 2008).

However given the difference of Neff et al's (2008) SCS scores compared to the other community research, it seems as though her study reports elevated self-compassion scores in the US sample. This may be due to her use of undergraduates instead of a community sample in the study. Furthermore, it may reflect other differences due to the time difference of 4 years between 2008 research and the other US community samples reported in 2012, Differences commensurate with this, such as socio-political or economic changes, could impact an individual's ability to be self-compassionate.

However the present result was also found to be less compassionate than a self-selecting convenience sample (*n*=119) in Zurich (*M*= 3.31), another western culture (Krieger, Altenstein, Baettig, Doerig & Holtforth, 2013). This may suggest that alongside exploration of the differences *between* eastern and western cultures, differences *within* western culture may yield interesting information in relation to the factors that influences Self-compassion in western culture specifically.

Community self-compassion scores were explored by gender using *t*-test analyses and found that males did report higher SCS scores than females, however that this difference was not significant. However, an important consideration is that this sample was predominantly female (72%) and although differences in sample size was considered during the analysis, this may have made it more difficult to detect a significant difference. However, analysis of SCS subscales revealed that females reported significantly higher scores of over-identification than males (*p*<.005) suggesting they may be more likely to become caught up with their feelings and be less able to take an objective perspective in a difficult situation (Neff, 2003a). No other subscales reported gender differences. This finding adds to the mixed picture on gender and self-compassion. Following their recent meta-analysis, Yarnell et al (2015) did establish that overall a sex difference may exist, but that this is only with a small effect (*d*=.18). As such the present study's results may be quite representative.

An aim of this research was to address the gap evidenced that no UK community data for the SCS existed. Whilst the Williams et al (2014) study had demonstrated some SCS subscale scores in a UK sample, their idiosyncratic and unique scoring methods raises issues of validity and makes comparisons with other research unfeasible. As this research took direction from both Neff's (2003a) original scoring methods and her most recent scoring method (Appendix B), comparisons between this and the Williams et al (2014) research were not made as they would be unusable.

Using the appropriate scoring methods, this research suggests that given the similarities evidenced with the majority of other US community samples, the previous comparisons made by UK research to US community samples were likely quite valid. However, the existence of UK normative data from a substantial sample size now enables more accurate comparisons for other UK SCS research.

This research presents that currently, the UK population reports being moderately self-compassionate. However this is only the first study to demonstrate UK norms and although the methodology of this research was carefully considered, further research should also report UK norms, in order to ascertain the reliability of these findings and produce a more robust normative figure.

5.4 Clinical psychologist psychological distress and perceived stress

This research revealed that 36% of trainees and 21% of qualified CPs met the criteria for caseness; clinical criteria for an anxiety or depressive disorder, as measured using the GHQ-12. Further analysis revealed that trainees reported significantly more psychological distress than qualified CP's ($p<.005$).

When the present study's trainee data is compared with GHQ-12 data from a recent UK counselling trainee sample (n=109) (Ruths et al, 2012), this reveals that those meeting the criteria for caseness in the present research is far less than in the Ruths et al study; 59% of their sample reached caseness levels. Unfortunately, this research did not report the cut off criteria used and also scored their GHQ using the Likert method (0, 1, 2, 3). This is different to the present study which adopted the Classic GHQ method (0, 0, 1, 1) and taken together this suggests that comparisons between the two studies are problematic.

Indeed, caution must be exercised when considering this caseness frequency compared to previous CP caseness literature as this ubiquitously uses a different measure, the GHQ-28, and again unknown scoring options may influence the published results. However, this does reveal that when compared to Australian trainees (caseness = 64-82%) (Stafford-Brown & Pakenham, 2012), and previous UK trainee CP research (59%) (Cushway (1992), the present research suggests far fewer trainees meeting caseness criteria.

The same pattern presents with the qualified sample of caseness levels (21%) in the present study, as previous research documents slightly higher caseness prevalence of 29%- 40% (Sampson, 1991; Tyler & Cushway, 1994; Cushway et al, 1996).

It therefore could be proposed that the present research demonstrates fewer trainees and qualified CP's reaching the clinical criteria for anxiety or depression in the current UK samples. However given the differences in measures and scoring, it is likely that this biases these comparisons.

Indeed it is useful to explore how the present studies results compare with a UK community population. A recent meta-analysis of all UK community population studies (n = 7) using the GHQ-12, was reviewed to understand how the present studies CPT and qualified CP caseness levels compared to these samples. A weighted prevalence estimate of 19.2% [CIs 17.1%– 21.3%] caseness was reported by these samples (Goodwin et al, 2013). This provides a somewhat robust comparison with the present study as these studies all adopted the same scoring method (Classic GHQ) and caseness cut off score (4) as the present research. This meta-analysis caseness estimate included research available from 1990 to 2013, which could introduce bias due to cohort effects, environmental and socio-economic changes. However review of the most recent study; the English and Welsh Civil and Social Justice Survey (2007) (reported in Balmer, Pleasence & Buck, 2010), again suggests a low caseness of 14% (n=3040). Therefore the present results indicate that although qualified CP's may be reporting slightly more distress than a community sample, CPT's are reporting significantly higher psychological distress than a UK community sample.

Exploration of the perceived stress scores in this research demonstrates Median values of 17 in both the trainee and qualified CP samples. This therefore represents no difference between the two groups in perceived stress, which is interesting given the significant difference in

scores of psychological distress above. Furthermore, within this research perceived stress and psychological distress correlate highly (trainee CP's = r =.711, p<.001; qualified CP's = r =.58, p<.001) indicating the close relationship of the two variables. A score of 17 replicates the findings of Kuyken et al's (1998) UK trainee CP study (M= 17.37), and is also comparable to a US undergraduate student sample (n=285), scoring M=17.4 -18.4 (Roberti, Harrington & Storch, 2006).

However the PSS asks many questions in relation to an individual's subjective cognitive appraisal of their ability to cope with events in the last month. Whereas the GHQ-12 appears to ask more questions in relation to the objective indicators of distress, such as negative thoughts and lack of sleep. As such it may be that whilst both trainees and qualified CP's both appraise their ability to cope at a similar level, trainees report more actual indicators of distress. This could suggest one of two important issues; the first may be that trainees have a desire to report that they believe they are coping well. This could be due to social desirability and the illusion of the 'invulnerable psychologist' (Norcross & Barnett, 2007). Indeed within this sample 85% of trainees reported they carry out activities for self-care. This may indicate either a social desirability bias, or that for some, their self-care strategies are possibly not effective.

The literature also suggests that they may perceive that their distress is an illegitimate reason to seek support (Walsh & Cormack, 1994) and therefore do not; thus perpetuating their distress. Given the competition to train as a CP being so fierce and a sense of the 'imposter phenomenon' (Clance & Imes, 1978), it may be that they do not wish to admit that after competing and receiving a place on the DClinPsych, they do not feel they are coping with it.

Second, it may be that perceived stress is less likely to translate into psychological distress for qualified CP's. This is a finding demonstrated in a previous qualified CP research

(Cushway & Tyler, 1996) and possibly confirms that CP distress peaks during clinical training (Sampson, 1990). It may be that qualified CP's have more adaptive strategies at managing difficulties or, that not having the multiple demands of the Doctorate training simply results in less indicators of distress.

Nonetheless, regardless of previous findings this research identifies that over 1/3rd of trainees and 1/5th of qualified CP's are currently experiencing enough psychological distress to meet the criteria for an anxiety or depressive disorder. As discussed in the introduction, the implications of such elevated levels of psychological distress may lead to more severe anxiety and depression (Myers et al, 2012) and feelings of being overwhelmed and exhausted (Crowley & Avdi, 1999). Furthermore, there is the possible impact on professional competencies such as a reduced capacity to be objective and remain emotionally and psychologically present with clients (Cain, 2000; Gilroy et al, 2001; Heartmath, 2006). For these reasons it becomes clear that this reported distress warrants further attention, research and action.

5.5 Clinical psychologist social connectedness

The results yielded from this research identified that both trainee and qualified CP's reported the same levels of social connectedness; Trainees (*Median* = 40, *IQR* =34-46), Qualified CP's (*Median* = 40, *IQR* =32-45). As discussed in the method, this research is the first to use the Social Connectedness Scale-Revised, 8 item option in the self-compassion literature. Indeed from review of the literature it appears to be the first to be transparent in its use of revised edition of the 8-item scale as it appears other research adopts the original 8-item version (Lee & Robbins, 1995; 1998). Higher score indicates more perceived connectedness and a maximum total score of 48 is possible. Taking this, the scores in both the trainee and qualified sample indicate high levels of perceived social connectedness in this study.

5.6 Clinical psychologist fear of compassion

The results in the present study indicated that trainees and qualified CP's both had the same levels of Fear of Giving compassion exactly (FoGC) (*Median = 7, IQR= 5-11*). This was found to be low, and also lower than previously demonstrated in UK therapists (*M = 10.51*), a USA community sample *M=10.6 – 12.36* (Jazeira et al 2012) and a lot less than in students; *M= 21.18* (Gilbert et al, 2011a), *M=19.70* (Gilbert et al, 2012). Given that supporting and being compassionate is a core role of a CP (Gilbert, 2010b), that these results are low is not surprising. That they are lower than previous therapists is more curious, however given that the group of therapists in the Gilbert et al (2011a) study was not described, it is likely that this is not a direct comparison of clinicians. It may be that variances in clinician training could foster this difference. Further it may be that receiving up to 20 hours of teaching in self-compassion, as some trainees in this research had, could result in lower FoGC scores due to greater understanding.

The results for fears of receiving compassion (FoRC) and fear of self-compassion (FoSC) were also found to be low in these samples; FoRC: Trainee CP's (*Median = 6, IQR = 3-12*), Qualified CP's (*Median = 8, IQR= 3-10*) ; FoSC: Trainee CP's (*Median = 6, IQR = 4-12*), Qualified CP's (*Median = 6.5, IQR= 2-12*). FoRC in the present research was found to replicate the low fears evidenced in the Gilbert et al (2010) therapist sample (FoRC *M = 8.81*), although in the present research, trainees reported slightly less FoRC. This may be due to the student role that trainees have; thus making receiving compassion from others more acceptable to them within this learning context and therefore it is feared less. In contrast, qualified CP's who may believe they shouldn't need help or support may find it hard to receive it. Future research would benefit from exploring this relationship.

In the present research, FoSC was again found to be lower than in previous therapist samples (FoSC $M = 8.15$), in student samples (Gilbert et al, 2011a; Gilbert et al; 2012) and a community sample (Jaziera et al, 2012).

Whilst these results are still low, they do establish in a large sample that some fears related to compassion exist. It would be useful for future research to understand what these fears are exactly, in order to best inform effective self-care and prevent these fears from CP's seeking support and supporting themselves. Further, it would be useful to understand what fears relate to giving compassion to others; does this differ when CPs respond from a professional perspective compared to a personal perspective? How does this influence their therapeutic relationship?

5.7 Clinical psychologists and self-compassion

This was the first study to explore levels of self-compassion in CP's. It was hypothesised that trainees would differ to qualified clinical psychologists in levels of self-compassion; that qualified psychologists would report higher scores of self-compassion.

The results identified that qualified CP's did report significantly higher self-compassion scores than the trainee CP sample and this was a small-to-medium sized effect ($d= .24$). This therefore confirmed the first hypothesis. Exploring the Means, both the trainees ($M=3.21$) and qualified CP sample ($M=3.36$) reported within the moderate range of a self-compassionate relating style.

Examination of the SCS subscale data revealed that qualified CP's were significantly more able to relate to themselves with kindness and significantly less likely to be judgemental of themselves than the trainee sample. This pattern may help suggest the difference in psychological distress indicated between trainees and qualified CP's above. For example, whilst both the qualified and trainees CP's perceived the same amount of stress, the qualified

CP's may be more kind towards themselves during these difficult times, thus preventing this transforming into psychological distress. Further, a trainee's tendency to be more judgemental of themselves likely creates more psychological distress itself.

However, this may also reflect the stage of career of the trainee CP, one in which they may find lower levels of self-compassion beneficial; to motivate them to do as best as they can throughout their training. Being self-compassionate would likely benefit the clinical aspects of their role, by supporting them to tolerate ambiguity more and be more present with the client. However, it could be that being overly self-compassionate would not be conducive to passing assignments and meeting the demands of training. Indeed, without the academic demands of training, qualified CP's can engage in a more self-compassionate self-relating style which would not adversely affect a more evaluative aspect of their job.

This raises an interesting and important question therefore; does an optimal level of self-compassion exist? If so, would this be a totally self-compassionate state? Would it vary with circumstance? Certainly, Gilbert's compassionate mind theory suggests that being totally self-compassionate could significantly reduce an individual's ability to achieve their goals (via a reduced drive system) and likely make them vulnerable to danger by not responding appropriately to signals of threat (reduced threat system) (Gilbert, 2010b). Indeed, all three systems; soothing, drive and threat, must coexist to provide an individual with a typical emotional repertoire (Gilbert, 2010b) that equips them in both surviving and thriving in life.

In contrast, Neff's self-compassion theory (2003a) does not make statements or account for other emotions such as drive and motivation, moreover it acknowledges them within the context of using self-compassion to approach and be open to all types of emotion. However the total absence of self-coldness, isolation and over-identification raises the question about the utility of some negative emotions such as shame and embarrassment in motiving one to

make positive changes; such as preparing for an interview instead of speaking on the spot. Is it that a delicate balance of self-compassion must be struck? As discussed above with trainee CP's, does this vary with the environment? Future research in the self-compassion field would benefit from exploring the idea of an optimal level of self-compassion in place of taking for granted that being <u>totally</u> self-compassionate is the best self-relating style. Indeed, exploring the attitudes towards, and fears of, self-compassion would also benefit from further detailed exploration within these groups.

The sample size was large enough to detect significant differences between the other SCS subscales, and this was not found. However an observed trend was that all positive subscales were higher in qualified CP's and all negative subscales were higher for trainees. Further, it was noted that the highest subscale score for both groups was within the Mindfulness subscale. This may be in a response to its increasing presence within the field of clinical psychotherapy models and also its frequent use in experiential teaching methods (Shapiro, 2009).

The total SCS score reported in the present research replicates the total SCS scores evidenced previously in Australian trainees; $M= 3.23$ (Stafford-Brown and Pakenham, 2012), $M=3.27$, (Pakenham, 2014). Using Neff's initial scoring method, this trainee sample demonstrated: $M= 19.32$. Therefore when compared to the only other UK trainee research (Rimes & Wingrove, 2011), this is found to be similar to the Year 2 trainees $M=20.6$ and Year 3 trainees $M= 19.0$ evidenced in the study, but slightly higher than their Year 1 trainee SCS scores, $M= 18.1$.

Within the present study's trainee sample ($n=221$), year of training was not found to significantly influence SCS scores. This is in contrast to the differences in SCS scores observed in the above Rimes and Wingrove (2011) study, however their small sample

(n=20) would likely be more susceptible to skewness, kurtosis and outliers which could significantly skew the means reported in their research (Field, 2013). As such, the differences between the two pieces of research may be due to substantially different sample sizes and influences of bias commensurate with this.

When compared to similar mental health professional groups, the present trainee SCS scores appeared to replicate similar findings to a group of masters level USA counselling psychologists (n =54) (M=18.06 – 19.14) (Shapiro et al, 2007). Qualified CP SCS scores in this research (M=20.17) appeared to be higher than when compared to a small sample (n=38) of mixed health professionals, including medical doctors and nurses, physiotherapists, psychologists (M= 16.48 – 19.51) (Shapiro et al, 2005). Again, sample sizes in the last study may influence the difference evidenced between mixed health professionals and the CP-only participants in this research; however these findings do also suggest that SCS scores may vary between professional groups

Although methodologically this research has been carefully considered to produce reliable results, future research will need to continue exploring self-compassion in UK CP's, to understand if differences in SCS scores emerge and the reasons for this. Nonetheless, this research indicates that CP SCS scores are within the moderate range, indicating that they could be supported to increase.

5.8 Factors related to self-compassion scores in clinical psychologists

A multiple regression was used to ascertain which variables predicted self-compassion scores in these groups. Based upon the literature, it was hypothesised that lower scores of SCS scores would be predicted by higher scores on fears of compassion, higher scores of psychological distress (GHQ) and higher scores of perceived stress. It was further

hypothesised that higher scores of self-compassion would be predicted by higher age of clinician, more years of clinical experience and higher scores of social connectedness.

In trainee samples, higher fear of self-compassion made the most significant unique contribution to the model, predicting self-compassion scores with a large sized effect. Perceived stress scores also made a significant contribution and were also found to significantly relate to SCS scores with a medium sized effect. As both standardised Betas were negative, this indicated a negative relationship in that, higher scores of fear of self-compassion and perceived stress were related to lower SCS scores. Finally, higher social connectedness was also found to significantly contribute, predicting lower self-compassion scores with a small sized effect. No other factors made a significant contribution.

Within the qualified regression analysis, a similar pattern was observed, in that Fear of self-compassion (large effect size) and perceived stress scores (small to medium sized effect) both made the greatest contribution to the model, significantly relating to SCS scores. Unlike the trainees, social connectedness did not significantly relate to SCS in this sample, however this only narrowly missed significance ($p=.051$).

Taken together, that fear of self-compassion exerted a large effect size in predicting lower SCS scores can be understood; if an individual is afraid of self-compassion then it is likely they will experience minimal amounts of it. However this does indicate a potentially problematic barrier in trying to support CP's in developing their self-compassion as a self-care strategy. The results therefore suggest that this fear would need to be considered and addressed in the first instance.

These results also suggests that a delicate balance must be struck; that for some whom perceive their ability to cope as poor (as demonstrated by high PSS scores), may find it more difficult to be, and develop, self-compassion. However, scores of psychological distress (as

measured by the GHQ) was not found to significantly contribute to SCS scores thus suggesting that more objective indicators of distress do not relate to self-compassion scores. However, within both the trainee and qualified CP samples, PSS and GHQ-12 scores were found to be highly correlated and this is known to limit the size of R. It could be that these highly correlated variables limited the regression models ability to identify a significant contribution of GHQ-12 scores (Type II error) which could indicate 'overfitting' of the model (Chatterjee, Hadi & Price, 2000). The relationship between self-compassion, perceived stress and psychological distress requires more research to understand this further.

Whilst social connectedness was found to predict SCS in trainees, it just missed reaching significance as a predictor of SCS in qualified CPs. This may be due to the professional social context of qualified CP's which weakens this relationship. For example, in addition to their work place, trainees are also members of their training cohort at the university. This may facilitate more common humanity thinking as they can perceive their journey through training as similar to their training colleagues. Conversely qualified CP's typically do not regularly meet with other qualified CP's as frequently as a training cohort which may reduce their perception of shared experiences with other CP's.

Furthermore the data in this research revealed that a higher percentage of qualified CPs (16%) worked as the only CP in their team, compared to 2% of trainees, again which may influence their ability to perceive a common humanity. Given these results, it seems as though having some form of regular connection with others would therefore improve self-compassion in trainees. As significance was narrowly missed within the qualified CP sample, future research may benefit from exploring this relationship further to ascertain if and how social connectedness and self-compassion relate in this group.

Despite some literature identifying that age and years of clinical experience influenced CP stress levels (Hellman et al, 1986; Ackerley et al, 1988; Cushway, 1992; Cushway & Tyler, 1994, Cushway et al 1996), and the emerging relationship demonstrated between indicators of stress and self-compassion in therapists (Gilbert et al, 2010) and trainee doctors (Olson & Kempar, 2014), one may expect that both age and clinical experience themselves would also have some relationship with SCS scores in CP's. However neither were found to correlate with SCS scores in this study, therefore these factors were not included within the multiple regression analyses. The lack of relationship between age and clinical experience with self-compassion may therefore suggest the impact of some other moderating variables alongside stress, which has not been assessed within this research. Given the literature, this may be due to coping styles (Kuyken et al, 2003) or personality characteristics such as perfectionism (D'Souza et al, 2011) and therefore would benefit from further exploration. That age was not correlated with SCS added to the existing mixed literature on this relationship (Neff & Vonk, 2009; Neff & McGehee, 2010).

Within the qualified sample fear of giving compassion was also excluded from the regression analysis as it evidenced no relationship with self-compassion in this sample. The reasons why these two variables did not relate in this specific group, yet did within the trainee sample, remains unclear. It may be that as a qualified CP, it becomes more typical to split the self from the other, possibly by way of a coping strategy to manage the emotional aspects of therapy. This therefore may facilitate that giving compassion to others and giving compassion to the self become more separate. However compassion is central to the role of the CP (Gilbert, 2010b) and self-compassion is theorised to be part of this (Neff, 2003a; Gilbert 2010a) . Furthermore it is advocated by many that supporting others begins with supporting yourself (Schmidt, 2004) and is the source of compassionate care (Gustin &

Wagner, 2013; Olson & Kemper, 2014) thus suggesting that the relationship between these two constructs requires further understanding.

In both the trainee and qualified samples, neither fear of giving compassion nor fears of receiving compassion from someone else, were found to significantly contribute to the model.

5.9 Hypotheses summary

These results therefore found support for the hypothesis that qualified CP SCS scores would be significantly higher than trainee SCS scores. They further found support for the hypotheses that higher perceived stress and higher fear of self-compassion scores would be significantly related to lower SCS scores in these groups. The results for social connectedness only in part supported the hypothesis that it would significantly relate to higher SCS scores, as this only reached significance in trainees, although it nearly reached significance for qualified CP's. Finally, these results refute the hypotheses that age, years of clinical experience, fear of giving compassion, fear of receiving compassion and psychological distress significantly predicted SCS scores in this sample.

5.10 Clinical psychologist comparisons with the community sample

The results identified that both trainee and qualified CP's in this study reported significantly higher SCS scores than the present community sample. Within the trainee sample this represented a medium sized effect and within the qualified sample this was with a large sized effect. Whilst on one hand this could be a surprising result, given the CP stress levels and stressors identified within the literature, these could also be considered within the context of group differences; in knowledge of other cultural beliefs. For example the recent research by Pauley and McPherson (2011) identified that within the UK, members of the community tend to view compassion in the context for giving it *to others.* Indeed, based on the

researcher's observation only, 'self-compassion' seemingly does not appear very much in the UK community vernacular. Indeed within the present research some participants known to the researcher fed back that it had been strange to consider this in relation to themselves and they were unsure what 'self-compassion' was. However Russell (1991) makes the point that many cultures have idiosyncratic words for their feelings, which do not necessarily translate to other cultures. Given that the concept of self-compassion stems from Buddhist traditions and Eastern philosophies, it may be that this has not yet translated into the western vernacular.

This is in contrast to the clinical psychology field where the last 20 years have seen a big increase in the use of self-compassion due to its use in therapy (CFT) and demonstrated relationship with psychological wellbeing. As such, it may be that due to the CP's increased knowledge of self-compassion this results in higher reported self-compassion. This may be due simply to increased knowledge, implementing it themselves and being more self-compassionate, or due to bias, for example being deliberately self-presentational as self-compassionate.

Given the continued increase in globalization and world-wide travel, it may be that more community individuals will become aware of self-compassion and its benefits. This could influence future SCS scores in the community and would be an interesting source of future research. Indeed the concept of mindfulness appears to be doing this currently, with many self-help books now available.

5.11 Strengths and limitations of present study

The strengths and limitations of this study will now be critically evaluated in line with the epistemological position of this research.

5.11.1 Sampling

In order for sample results to be generalizable to the target population, they must be unbiased and all members of the target population given the chance to take part (Barker et al, 2010). This was not possible within the qualified CP sample as the researcher did not have the time nor the resources to apply for R & D approval in every NHS trust across the UK. It was also not feasible to invite each member of the UK community. However with the exception of one DClinPsych course; all trainees across the UK were offered the opportunity to take part. This is first research to achieve this in a UK nationwide sample for approximately 20 years.

However within both the CP study and community study, one anticipated challenge was participant recruitment, particularly with qualified CP's due to their workload and possible disinterest in taking part in research. In order to manage this, the researcher chose convenience and snowball sampling methods for both the community and CP study, in order to access as many potential participants as possible. This was successful in that substantial sample sizes were recruited (Community $n = 217$, Trainees $n = 221$, Qualified CP's $n = 120$), and met the requirements of the sample size estimation for a medium effect size in the CP study; $n = 108$ per group. However snowball sampling methods could present some bias in the results as participants may only forward the research on to others they know share a similar interest (Barker et al, 2010). As CP's are becoming more aware of self-compassion and compassion focused therapies as part of their clinical work, alongside some known special interest groups for the topic, this could be likely within the CP study. As such the findings in this initial research must be considered with this in mind.

A second limitation of convenience sampling methods is the potential for some sub-populations within the target population to be excluded, thus yielding less representative results. This was considered and efforts to monitor this were via the inclusion of a detailed demographic questionnaire in both the community and CP study. As the SCS has evidenced

different levels of self-compassion across different cultures (Neff et al, 2008), it was hoped that information from the demographic questionnaire could capture and facilitate statistical analyses to monitor any influences of ethnicities or religious beliefs on SCS scores.

However, most participants in both the community and CP study reported their ethnicity as White British or as being Christian or 'no religion'; very few identified themselves as within the other ethnic or religious groups. As such statistical analyses of the differences in SCS scores between various faiths and ethnic groups would be inaccurate due to the vastly different sample sizes. Indeed future research may benefit from looking at SCS scores from specific ethnic and religious groups within the UK community population, in order to further this understanding.

Another limitation of these sampling methods is the influence of possible self-selecting bias. This suggests that participants whom chose to take part may differ from those who do not take part, for example in levels of motivation or interest (Barker et al, 2010). This again would therefore affect the generalisability of the sample data to the target population of CP's or the UK community. One way to manage this is to assess attrition rates. However due to the anonymity of the research, if an individual did not wish to take part they simply did not open the browser link; therefore this was not possible with the online participants in the present research. However an indication of attrition within the community study comes from the paper copies; out of 100 copies disseminated, 59 in total were returned. The researcher is aware that all available paper copies were handed out therefore suggesting that approximately 40% of possible community participants did not return them. This may be due to forgetfulness or may be due to another, as yet unidentified influence, such as fear of discussing emotions or understanding the nature of the questions.

Upon inspection of the gender data, a potential limitation is that the majority of the respondents within the community sample were female (72%). It has been evidenced that women respond more to questionnaires than men (Goodwin, 2009) however this could have implications for the generalisability to a community sample. This was a similar prevalence to the Williams et al (2014) study (74%), suggesting a difficulty in recruiting males to respond to a self-compassion questionnaire.

Within the CP study, the higher frequencies of female participants observed was found to be fairly representative of the current trainee and qualified population (CHPCCP, 2013; HCPC, 2014) and similar previous UK trainee research (Kuyken et al, 1998; Brooks et al, 2002; Kuyken et al, 2003).

The sampling process revealed that a wide geographic spread of data was achieved, with counties in all 4 countries of the UK identified by both the community and CP samples. However the majority within the community sample came from Yorkshire and Essex, and whilst this represents both the north and south of the country, future research may try and gain more participants from other areas of the UK.

5.11.2 Design

Within the community study, due to the possible cohort effects that can influence results in cross sectional designs, efforts were made to be as inclusive as possible by ensuring paper copies of the SCS and demographic questionnaire could be available. From this, it was hoped that individuals whom may have been excluded due to an online methodology could take part. The results indicate that a good range of ages was actually achieved (*Mdn* = 35, *Range* = 68) with the youngest participant aged 18 and the oldest (a paper completing participant) aged 85. This age range is found to be much more inclusive than the Williams et al (2014) study (*M* = 25.7, *SD* = 9.8).

As this was only an initial assessment of SCS scores across the community and clinical psychologist population, the researcher is aware that the methodology chosen (online and paper) could exclude those with physical disabilities such as movement disorders or blindness. Indeed, whilst an online methodology demonstrates strengths and as such was chosen for the present research, a number of limitations coexist. Many of these have been discussed above and include sampling bias such as self-selecting and convenience, internet access issues and due to the anonymity and respect for privacy; difficulties assessing attrition rates. A further is the unavailability of a face to face meeting with a researcher. As discussed in the method, this was considered and motivated the contact details of the research team to feature on the first page, prior to study participation so that questions could be asked. However, it is considered that individuals may not have felt able to use the facility thus contributing to attrition and possible self-selecting bias. As such, the online methodology relies upon an individual's introspective ability, without the researcher to ask questions of. Whilst on one hand this is a limitation, on the other it does reduce the impact of researcher bias (Barker et al, 2010) and remains within a critical realist epistemological stance.

Finally, within this design socio-economic status (SES) was not assessed. This is known to relate with depression and anxiety (Lorant et al, 2007; Green & Benzeval, 2013), which in turn are evidenced as relating to Self-compassion (MacBeth & Gumley, 2012). In order to be more representative an option to disclose SES and disabilities alongside adapted versions of the questionnaire should be available for use in future research.

5.11.3 Measures

Whilst all measures in the study presented strengths in their ability to gain a respondents opinion, appropriateness for online research and good psychometric properties, a number of

limitations exist. Indeed an area for consideration are the possible validity issues of self-report responses as some individuals may experience difficulties in being introspective or self-aware (Barker et al, 2010). Furthermore some participants may not be truthful as their responses are motivated by other goals, for example social desirability. Given the political importance afforded to the concept of compassion in today's NHS, it was considered that some trainee and qualified CP's may consider possessing self-compassion a socially desirable, even a required, professional characteristic. Furthermore, reporting a fear of this may also be reduced by social desirability. However as discussed, a measure of social desirability was deliberately not included as it was considered that most CP's would recognise it; thus rendering it unusable. Instead, the researcher made all online and paper surveys anonymous, with the hope that this may reduce any socially desirable response sets. Given that a role of a CP is to support and encourage their clients to be more self-compassionate, it was hoped that this would enable any CP's who may be embarrassed by how they treat themselves as clinicians, to also take part.

However it must be noted that only one appropriate measure of self-compassion was available at the time of this research the SCS (Neff, 2003b). Its previous ubiquitous use within this field likely reflects the monopoly of the positivist position within psychological research discussed above (Trochim, 2006). Nevertheless, a critical realist position argues that most constructs can only be partially captured by their associated measures (Barker et al, 2010) and as such the researcher presents these findings as one indication of self-compassion levels within these groups. With the emergence of more measures of self-compassion, these should also be used in future research to capture this concept within the UK community and in CP's.

Furthermore, since the commencement of this research, there has been some criticism for the factor structure of the SCS within a UK population. This suggests that the SCS may be better

at providing robust subscale scores instead of one overall SCS score, due to their confirmatory factor analysis indicating the lack of fit to a six-factor hierarchical model (Williams et al, 2104). However, given that this study did not calculate subscale scores correctly, this may influence their findings.

Within the present research, the internal consistencies of the SCS in both the community and CP study were of acceptable levels, however it was observed that Cronbach's α for the Mindfulness subscale was lower in the community sample α = .67 and the trainee samples α = .63, yet the qualified CP sample was good α = .81. Some debate exists about the value of clinical cut offs for α values (Lance, Butts & Michels, 2006), and it is possible that this represents a less unidimensional subscale within these samples. However given that it is only made up of 4 questions, this too could influence smaller alpha's (Cortina, 1993). These findings along with the Williams et al (2014) study suggest that it may be helpful to conduct more research in the UK community to establish the psychometric properties of the SCS within this population further.

Finally, due to the ethical implications of including a measure with questions in relation to suicidal ideation and intention in an anonymous survey, the GHQ-28 was not used in this research. However this makes comparisons across the literature slightly problematic, therefore the present results must be considered, as was always the intention of the researcher, to act as indications of comparisons with previous research and to demonstrate the prevalence of caseness in these samples. Further a limitation of the general literature is the lack of a uniform scoring method and cut off criteria for the GHQ-12, and use of the same version of the SoCS-R that again makes comparisons across the literature somewhat unreliable and less valid. This is not something that could be controlled by the researcher, however in future research, it is recommended that all research is transparent about these details and use similar measures where appropriate.

The results presented here are therefore considered with the above possible biases in mind.

5.12 Implications

5.12.1 Theoretical implications

Across the literature, two dominant theories of self-compassion exist and the researcher perceives that both offer theoretically justified indicators of this construct. As outlined in the present review, the important consensus is that self-compassion is a form of self-kindness, and non-judgemental approach to the regulation of one's painful experiences.

The concept of self-compassion had previously been extended to mental healthcare professionals however this research contributes further by being the first to capture levels of self-compassion within clinical psychologists. This is important as the results reveal that although providing compassion to others is a core aspect of their role (Gilbert, 2010a), CP's only report moderate levels of self-compassion themselves. This, taken together with the demonstrated levels of psychological distress reported in this group; suggest that CP's own self-relating may not always 'practice what they preach'.

A second theoretical implication is the large effect that fear of compassion has on SCS scores. Whilst this makes common sense, this research is the first to demonstrate this relationship using the SCS and Fears of Compassion Scale. It empirically highlights that whilst self-compassion is considered to be positive for emotional wellbeing; the real life application may be quite difficult. Upon reflection of the two theories, this appears to be missing from Neff's (2003a) conceptualisation. In contrast Gilberts' (2010a) compassionate mind theory incorporates this within its three systems theory; that fears of positive emotions could develop as part of the threat system. It would be useful for future research to explore this relationship further.

Finally, whilst Gilberts (2010a) theory emphasises it more explicitly, both Neff and Gilbert's theories acknowledge the Buddhist idea that self-compassion forms part of the wider construct of compassion. However the results presented here add to these conceptualisations by suggesting a subtle difference that can exist within this. This research presents that only fear of self-compassion, (a self-self relationship), influences self-compassion. Self-other relationships do not exert this influence (fear of giving compassion to others or receiving compassion from others). This may indicate that although self-compassion is part of compassion, the way an individual *relates* to it is different to how they relate to compassion when in the context of another person. This would benefit from further research to understand these differences further.

5.12.2 Clinical implications

5.12.2.1 The UK community

The results from this research indicate that moderate levels of self-compassion are currently reported in this group. Specifically, it suggests that within the current UK community sample, individuals are more likely to be judgemental of themselves when experiencing personal distress, than treat themselves kindly. This may have implications for the assessment of mental health, indicating that a consideration of self-compassion could be useful; particularly in ascertaining how the individual relates to themselves and their experience of distress. It has been demonstrated how self-judgement could undermine clinical working (Gilbert & Procter, 2006), which may not otherwise be identified until a therapeutic impasse is reached. As part of initial assessment, early identification may prevent this.

Furthermore, previous research identifies that within the UK community, individuals tend to understand compassion in the context of giving compassion *to others.* This taken together

with the present research results could have implications for the wider education of the UK community in relation to self-compassion and what it is. This increased awareness could help individuals identify for themselves if they have beliefs that they are on their own in their inadequacies and failures and help them consider the shared common humanity instead. Furthermore, this may promote treating oneself with kindness instead of judgement and criticism.

5.12.2.2 Clinical psychologists

The findings from this study suggest that although self-compassion scores reported by both trainees and qualified CP's significantly differ, both fall within the moderate range. This suggests that although many may be aware of the benefits of this self-relating style, this does not necessarily translate into a highly self-compassionate group. Furthermore the results present that psychological distress in a subgroup of both trainee and clinical psychologists could be worryingly high.

These results suggest that CP's have scope to develop a more self-compassionate self-relating style and given the specific findings in relation to stress, it could be that interventions or self-care strategies that focus on developing this may contribute to lower perceived stress in these groups. Within the trainee groups, the results from this research particularly suggest that they may benefit specifically in focusing on nurturing self-kindness and compassionately acknowledging and working to alleviate their judgmental self-relating style.

Previous research has demonstrated that trainees with an avoidant coping style experience significantly higher anxiety, depression and low self-esteem (Kuyken et al, 2003). It could be that self-compassion could be particularly beneficial to this group, as it would actively encourage CP's to face their difficult feelings, acknowledge them and compassionately work

towards relieving them. Furthermore other previous CP literature demonstrates that those with a perfectionistic personality characteristic experience higher stress levels (D'Souza et al, 2010). Research has also demonstrated that self-compassion is positively correlated with perceived academic competence and negatively associated with fear of failure (Neff et al, 2005). It could be that by engaging with self-compassion and a more non-judgemental and mindful self-relating attitude, an individual could begin to accept their perceived inadequacies as part of the wider human condition. This could support them to reduce their need to aim for the best and tolerate 'good enough'; learning to compassionately engage with the uncomfortable feelings this may initially bring about.

However within both trainee and CP groups, this research highlights that higher fear of self-compassion relates to lower SCS scores. This suggests that should an intervention take place, it would be valuable to assess participant attitudes and fears towards self-compassion first. Otherwise it is likely that further self-care strategies would be rendered useless. Given the previous literature on barriers to accessing support in CP's, it seems that also assessing attitudes to self-care would yield useful information.

The results from this research also offer that interventions to specifically focus on improving a CP's sense of social connectedness could also improve self-compassion. This relationship was demonstrated with trainees and only just missed significance within the qualified CP sample. This suggests the value in nurturing professional relationships and remaining connected to peers. Future research could consider how to implement this given that current resources in the NHS may not facilitate face to face weekly meetings. It may be that the effectiveness of virtual groups could be explored with relation to this.

Furthermore, this research highlights the prevalence of psychological distress, highlighting that within a subgroup; $1/3^{rd}$ of trainees and $1/5^{th}$ of qualified CP's currently meet the clinical

criteria for an anxiety of depressive disorder. Given the additional emotional load carried as a CP, this is evidenced to personally impact the individual, and also affect client working and perceived competence (Ying, 2009). This therefore has significant implications for both training programmes and PPD.

Within training programmes, this suggests that due to the multiplicity of training, where possible, unnecessary stressors should be managed or removed. The literature evidences a relationship between how much a training course emphasises self-care in its programme and how many trainees seek support (Goncher et al, 2013). Using Gilbert's theory, the adoption of a non-judgemental compassionate approach in advocating this, may support trainees to move out of their threat system and the threat system coping strategies (avoidance) into their soothing system (Gilbert et al 2010b). This could motivate the desire to alleviate their difficulties with understanding and kindness and may encourage trainees whom may not otherwise seek support.

Furthermore, many researchers suggest that the training course of a CP is the prime time to learn and introduce regular self-strategies (Kuyken et al, 2003; Pakenham 2014). However it has been suggested that many training courses rely on the individual to do this themselves (Wise et al, 2012); which with the multiple demands of training, a trainee may not prioritise. Furthermore, research suggests that anticipating that the reflective groups may provide this space is not always the case for some (Knight et al, 2010). It could be that introducing a self-compassionate influence to this may reduce the distress, by promoting the cultivation of safe, reflexive spaces in which trainees can develop a tendency to be open to their inadequacies as much as their successes. Future research would benefit from exploring this.

That 1/5th of qualified CP's report clinical levels of psychological distress is also concerning, particularly given the CP's emerging role within leadership arenas such as management and

the additional load this encapsulates alongside their clinical work (Gilbert, 2010b). This research suggests that CP's have the potential to further develop their self-compassion. Taken together with self-compassion research; it is likely that this would have a beneficial impact on their emotional wellbeing. It could be that developing self-compassion, by being more mindful and considering that their difficulties are shared by many others, then enables CP's to perceive more that they can cope, thus reducing perceived stress. Furthermore, it is likely that learning self-compassion strategies could benefit the strategies they teach in their clinical work, as UK CP's report a strong theme in 'learning by doing' (Nel, Pezzolesi & Stott, 2012). Future research would be required to evaluate the efficacy of this.

Finally, within the context of the Francis (2013) report, these results highlight the level of distress experienced by some NHS staff. This confirms that some staff are 'surviving, not thriving' (Fitzsimons, 2015) and could have implications for the ability of some staff to provide compassionate care. This research identifies that the 'cultural health' of this sample of CP's is only moderately self-compassionate. As some suggest self-compassion as the source of compassionate care (Gustin &Wagner, 2013), then it is likely that providing care to others would also likely benefit from some self-compassion self-care PPD practices. However once again, this should be embedded at the organizational level and not relied upon the individual to do, given the likely lack of resources to do this.

Whilst encouraging the introduction of ways to teach and support trainee and qualified CP self-compassion, the researcher is reluctant for this to be introduced as a clinical competence per se. This could likely introduce an evaluative component to self-compassion which unless contained appropriately could lead away from the very nature of self-compassion as understanding and non-judgemental to a critical and cold self-evaluation.

5.13 Future research recommendations

5.13.1 UK Community research

It is established that a way to increase the accuracy of generalisability is via replication (Barker et al, 2010). As such one recommendation is to continue monitoring SCS scores in the UK population. This will also ascertain the reliability of these findings. Given the limitation of this study was that the sample was predominantly female, and the potential impact of gender on SCS scores (Yarnell et al, 2015) future research should also attempt to gain equal numbers of male participants. Further, the results yielded in this research, alongside the existing research, indicate that as well as comparisons between eastern and western cultures, comparisons within western cultures will likely provide useful information in relation to how self-compassion is expressed in western society.

Given the continued onset of globalization and travel opportunities afforded to more and more members of the UK community, it is likely that more eastern philosophies and cultural beliefs continue to permeate the UK vernacular, as has been demonstrated by mindfulness (Shaprio, 2009). As such it would be useful to monitor SCS in thus population and identify if this changes.

Finally, the exclusion criteria of this research removed adolescents and children. This was to create an adult community sample and also reflected that the measures used, have not been validated in these groups. The researcher is aware that the SCS has been used with adolescents (Neff & McGehee, 2010) but further analysis is required to ascertain how valid this measure is, given cognitive development and being able to understand self-relating styles. However this reveals a gap in the literature and understanding if and how SCS scores change during adolescence and adulthood may provide further useful information

5.13.2 Clinical psychologist research

A number of future research recommendations have already been presented throughout, however some related more to the research design will be presented here. Within a critical realist position, it is advocated that results should be "inter-subjectively testable" (Popper, 1963) in that other researchers should be able to replicate the study and gain similar findings. As such one recommendation for future research is to continue monitoring the SCS scores in this population and understand how they change. Given that the NHS may face further cuts in funding, it seems important to understand how organizational; changes impact SCS scores and also monitor the impact on providing compassionate care, in line with the Francis (2013) report. Furthermore, as suggested by some, the organizations ability to provide the appropriate, nurturing, context for this compassionate care should also be explored (Mills, Wand & Fraser, 2014).

As stated previously, all research methods have strengths and limitation and in line with the critical realist position, the researcher suggests that multiple methods of assessing self-compassion should be adopted. This methodological triangulation (Barker et al, 2010) will facilitate a greater understanding of all indicators of compassion and help add to a greater theoretical understanding of this construct.

5.14 Research summary

In summary, this research identified that the current UK community population reports moderate levels of self-compassion. This revealed a tendency of the population to be judgemental of themselves in times of difficulty rather than to relate to themselves with kindness. A trainee and qualified CP population also reported within the moderate levels of self-compassion, although this was still found to be significantly higher than the community sample.

The present research also identified that the factors related to self-compassion in CP's were fears of self-compassion and perceived stress. It further identified that perceived social connectedness was also significantly related to self-compassion in trainee CP's. As a final outcome, this research also demonstrated that currently in the UK, 1/3rd of trainee CP's and 1/5th of qualified CP's reported psychological distress significant enough to meet the clinical criteria for an anxiety or depressive disorder.

For approximately 25 years, researchers have been suggesting that training in self-care and coping strategies should be a core part of CP training programs (Cushway 1992: Nichols, 1988; Payne and Firth-Cozens, 1987; Myers et al, 2012; Pakenham & Stafford-Brown, 2012; Stafford-Brown & Pakenham, 2012; Pakenham, 2014), yet this is still not universally part of DClinPsych curriculums. Nominal research has explored the effectiveness of stress management interventions and if it has, this is predominantly with trainees, using mindfulness (Moore, 2008; Rimes & Wingrove, 2011) and ACT, (Stafford-Brown & Pakenham, 2012; Pakenham, 2014). However this research suggests the potential value in adopting self-compassion. It is hoped that as part of the Francis (2013) compassionate care agenda, the findings of this study will motivate courses and the NHS to instil self-compassion training as a core aspect to CP training and PPD.

In the words of Guatama Buddha; "If your compassion does not include yourself, it is incomplete." (Blomfield, 2011).

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7. Appendices

Appendix A: Community sample: Online demographic questionnaire

1) Please state the month that you are completing this questionnaire in.
2) Are you a U.K. resident?   *Yes/ no*
   (If no then please do not continue)
3) Please select which county you currently live in.   (*List of counties to select from*)

4) Please enter your age.
5) Please select your gender   *(Male/ Female)*
6) Please state your main, current occupation
   - a. *Homemaker*
   - b. *Retired*
   - c. *Student*
   - d. *Full time employed*
   - e. *Part time employed (up to...)*
   - f. *Other*

7) Please state the number of years of employment experience you have (rounded to the nearest year).
8) What is your **current** marital status?   *Options:*
   - a. *Single*
   - b. *Married*
   - c. *Divorced*

9) Please select your ethnicity
   Options:
   - a. **White**
     - i. *English/Welsh/Scottish/Northern Irish/British*
     - ii. *Irish*
     - iii. *Gypsy or Irish Traveller*
     - iv. *Any other White background, please describe*
   - b. **Mixed / multiple ethnic groups**
     - i. *White and Black Caribbean*
     - ii. *White and Black African*
     - iii. *White and Asian*
     - iv. *Any other Mixed / Multiple ethnic background, please describe*
   - c. **Asian / Asian British**
     - i. *Indian*
     - ii. *Pakistani*
     - iii. *Bangladeshi*
     - iv. *Chinese*
     - v. *Any other Asian background, please describe*

      d. ***Black / African / Caribbean / Black British***
          i. *African*
          ii. *Caribbean*
          iii. *Any other Black / African / Caribbean background, please describe*
      e. ***Other ethnic group***
          i. *Arab*
          ii. *Any other ethnic group please describe*
      f. ***Would rather not say***

10) What is your religion?

      a. *No religion*
      b. *Christian (including Church of England/ Ireland/ Scotland, Catholic, Protestant, Methodist and all other Christian denominations)*
      c. *Buddhist*
      d. *Hindu*
      e. *Jewish*
      f. *Muslim*
      g. *Sikh*
      h. *Any other religion, please describe*
      i. *Would rather not say*

Appendix B: Self-Compassion Scale (Neff, 2003)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	**2**	**3**	**4**	**5**

_____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.

_____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.

_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.

_____ 5. I try to be loving towards myself when I'm feeling emotional pain.

_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.

_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.

_____ 8. When times are really difficult, I tend to be tough on myself.

_____ 9. When something upsets me I try to keep my emotions in balance.

_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.

_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____ 14. When something painful happens I try to take a balanced view of the situation.

_____ 15. I try to see my failings as part of the human condition.

_____ 16. When I see aspects of myself that I don't like, I get down on myself.

_____ 17. When I fail at something important to me I try to keep things in perspective.

_____ 18. When I'm really struggling, I tend to feel like other people must be having an

easier time of it.

_____ 19. I'm kind to myself when I'm experiencing suffering.

_____ 20. When something upsets me I get carried away with my feelings.

_____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.

_____ 23. I'm tolerant of my own flaws and inadequacies.

_____ 24. When something painful happens I tend to blow the incident out of proportion.

_____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.

_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale in your research. You can e-mail me with any questions you may have. I would also ask that you please e-mail me about any results you obtain with the scale, and would appreciate it if you send me a copy of any article published using the scale. The appropriate reference is listed below.

Best,

Kristin Neff, Ph. D.
Associate Professor
Educational Psychology Dept.
University of Texas at Austin
1 University Station, D5800
Austin, TX 78712

e-mail: kristin.neff@mail.utexas.edu
Ph: (512) 471-0382
Fax: (512) 471-1288

Reference:
Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity, 2, 223-250.*

Coding Key:
Self-Kindness Items: 5, 12, 19, 23, 26
Self-Judgment Items: 1, 8, 11, 16, 21
Common Humanity Items: 3, 7, 10, 15
Isolation Items: 4, 13, 18, 25
Mindfulness Items: 9, 14, 17, 22
Over-identified Items: 2, 6, 20, 24

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3. 4 = 2, 5 = 1) - then compute a total mean.

(This method of calculating the total score is slightly different than that used in the article referenced above, in which each subscale was added together. However, I find it is easier to interpret the scores if the total mean is used.)

Appendix C: Community sample: Online Participant Information Sheet

Name of study: Self-compassion in the UK general population.

Summary of study:

This study aims to measure levels of self-compassion experienced by the UK general population. It will ask questions related to how you think and react to your emotions.

Why is this research being conducted?

In the past few years there has been a growing interest in how we treat ourselves when we find times difficult. To date, research has demonstrated that *self*-compassion is related to psychological wellbeing. As such, it seems valuable to ascertain levels of self-compassion in the general population.

The majority of self-compassion research has been in the USA and whilst some UK research has looked at self-compassion as part of their studies, no research to date has established this within the UK general population.

Why have I been invited?

You have been invited as you are a member of the adult UK general population and are aged 18 or above. You will have either responded to an advert placed on the University of Essex REO website or have been sent the link by a friend who thinks you may be interested.

What will be involved?

You will be asked to complete a short questionnaire. All responses will be anonymous however at the end of the questionnaire you will be asked to complete some questions about you. You will also be given the opportunity to enter a free prize draw to win £40 of Marks and Spencer's vouchers. The survey will take approximately 10 minutes to complete.

Do I have to take part?

No. Participation in this research is completely voluntary. Should you not wish to take part or begin completing the questionnaire then decide to withdraw just simply close the browser window to exit. No data provided up to this point will be saved. If you know of anyone who may be interested in completing this questionnaire instead then please feel free to email them this link to access it.

Are there any disadvantages or risks to me?

The questions will require you to think about yourself and some will also ask you how you feel currently. As a result, you may notice negative emotions you're feeling which may lead to a temporary dip in mood. If you do feel like this and would like support, there is a contact list of organisations that can help at the end of this questionnaire. If this feeling persists and begins to interfere in your daily life I advise that you speak to your G.P. and together explore other options available.

What are the possible benefits of taking part?

As this research is the first to assess levels of self-compassion in a UK general population, it is hoped that the information you provide will help advance future research of self-compassion in this country. This aims to support the development of more appropriate and effective future treatments for individuals with mental ill-health.

How do I give my consent to take part?

By completing the consent page that will follow.

What will happen to my responses?

Your responses will be collected anonymously and entered into a secure database ready for data analysis. If you wish to submit your email to enter the free prize draw for £40 of Marks and Spencer's vouchers your email will be stored confidentially in a separate password protected database, away from the main study data. Following the notification of the prize draw winner, this database will be deleted.

Other information about the research:

This study has been reviewed and approved by the University of Essex Ethics Committee.

Can I discuss any further questions that I have about this study?

Yes. Should you wish to ask any questions then the principal investigator is available to contact:

Claire Robinson

Trainee Clinical Psychologist   Email: crobinc@essex.ac.uk

This research is being supervised by Dr Leanne Andrews and Dr Syd Hiskey. If you would like to contact them directly, please see the contact details below:

Dr Leanne Andrews: Dr Syd Hiskey
Academic Supervisor   Clinical Psychologist

School of Health and Human Sciences   The King's Wood Centre
The University of Essex   Colchester General Hospital,
CO4 5JY.
Wivenhoe Park   Tel: 01206 228908
Colchester CO4 3SQ

                                                Tel: 01206 874466

Email: landre@essex.ac.uk

Thank you for taking the time to read this research information sheet.

Appendix D: Community sample: Online consent form

Name of study: Self-compassion in the UK general population.

Please
tick to
confirm

1) I confirm that I have read and understood the participant information for the above study and have had the opportunity, should I wish, to ask further questions about this.

☐

2) I understand that all information I give will remain anonymous

☐

3) I understand that should I provide my email address for the free prize draw that this will be kept in a separate, secure database and deleted once used for notification of the winner.

☐

4) I understand that taking part is entirely my choice and that I am free to withdraw at any time, without question.

☐

5) I confirm that I currently live permanently in the United Kingdom.

☐

6)
7) I confirm that I am aged 18 or above

☐

8) I agree to take part in the above research.

☐

Appendix E: Community sample: Online de-brief page

Final Page:

Thank you for taking the time to complete this research. I am hopeful that your responses will contribute towards future research of self-compassion in this country, with an aim to support the development of more appropriate and effective future treatments for individuals with mental ill-health.

If you would like to enter the free prize draw to win £40 of Marks and Spencer's vouchers please enter your email address here:

If you know anyone whom you believe would be interested in taking part in this research, then please COPY and PASTE the link below and email them it.

link

If you feel that completing these questionnaires has left you feeling upset and you would like to speak with someone for some support, then the following contact details may be helpful to you:

G.P.
If negative feelings persist and affect your daily life, I would recommend that you visit your G.P. and together you can look at options for support.

Depression Alliance

A registered charity providing a network of self-help groups to support individuals experiencing depression.
Website: www.depressionalliance.org

CALM

CALM is the Campaign Against Living Miserably, for men aged 15-35.
Website: www.thecalmzone.net

Samaritans

Confidential telephone support for people experiencing feelings of distress or despair.
Phone: 08457 90 90 90 (24-hour helpline)
Website: www.samaritans.org.uk

Sane

Charity offering support and carrying out research into mental illness.
Phone: 0845 767 8000 (daily, 6pm-11pm)
SANEmail email: sanemail@org.uk
Website: www.sane.org.uk

Mind

Supports and promotes the needs of people with mental health problems.
Phone: 0300 123 3393
Website: www.mind.org.uk

The Mental Health Foundation

Provides information and support for anyone with mental health problems or learning disabilities.
Website: www.mentalhealth.org.uk

Rethink Mental Illness

Providing support and advice for people living with mental illness.
Phone: 0300 5000 927
Website: www.rethink.org

If you have any questions regarding the research please email the principle researcher

Claire Robinson: crobinc@essex.ac.uk.

Alternatively if you wish to speak to one of the research supervisors please contact

Dr Leanne Andrews: landre@essex.ac.uk

Or

Dr Syd Hiskey: syd.hiskey@nepft.nhs.uk

Thank you for your time.

Appendix F: Community sample: Paper Information Sheet

PARTICIPANT INFORMATION SHEET

Name of study: Self-compassion in the UK general population.

Summary of study:

This study aims to measure levels of self-compassion experienced by the UK general population. It will ask questions related to how you think and react to your emotions.

Why is this research being conducted?

In the past few years there has been a growing interest in how we treat ourselves when we find times difficult. To date, research has demonstrated that *self*-compassion is related to psychological wellbeing. As such, it seems valuable to ascertain levels of self-compassion in the general population.

The majority of self-compassion research has been in the USA and whilst some UK research has looked at self-compassion as part of their studies, no research to date has established this within the UK general population.

Why have I been invited?

You have been invited as you are a member of the adult UK general population and are aged 18 or above. You will have been given this questionnaire by a friend or a family member who thinks you may be interested in taking part.

What will be involved?

You will be asked to complete a short questionnaire. All responses will be anonymous however at the end of the questionnaire you will be asked to complete some questions about you. You will also be given the opportunity to enter a free prize draw to win £40 of Marks and Spencer's vouchers. The survey will take approximately 10 minutes and once completed you will be required to return the consent form and questionnaire back to the University of Essex in the FREEPOST envelope enclosed.

Do I have to take part?

No. Participation in this research is completely voluntary so please don't feel obliged. If you know of anyone who may be interested in completing this questionnaire instead then please feel free to pass this on to them.

Are there any disadvantages or risks to me?

The questions will require you to think about yourself and some will also ask you how you feel currently. As a result, you may notice negative emotions you're feeling which may lead to a temporary dip in mood. If you do feel like this and would like support, there is a contact list of organisations that can help at the end of this questionnaire. If this feeling persists and begins to interfere in your daily life, I advise that you speak to your G.P. and together explore other options available.

What are the possible benefits of taking part?

As this research is the first to assess levels of self-compassion in a UK general population, it is hoped that the information you provide will help advance future research of self-compassion in this country. This aims to support the development of more appropriate and effective future treatments for individuals with mental ill-health.

How do I give my consent to take part?

By signing the enclosed consent page and returning this with your questionnaire to the University of Essex in the FREEPOST envelope enclosed.

What will happen to my responses?

Your questionnaires and consent forms will be stored in a locked cupboard to which only I (the principle researcher) and my supervisors have access. Your responses will be entered into a secure computer database ready for data analysis. If you wish to submit your email address to enter the free prize draw for £40 of Marks and Spencer's vouchers this will be stored in a second cupboard away from your consent forms and the main study data. This will ensure that it is not possible to work out which questionnaire responses are yours should any identifiable information form part of your email address, thus anonymity is maintained. Your email address will be entered into a separate password protected database. Following the notification of the prize draw winner, this database will be deleted.

Other information about the research:

This study has been reviewed and approved by the University of Essex Ethics Committee.

Can I discuss any further questions that I have about this study?

Yes. Should you wish to ask any questions then the principal investigator is available to contact:

Claire Robinson
Trainee Clinical Psychologist   **Email:** crobinc@essex.ac.uk

This research is being supervised by Dr Leanne Andrews and Dr Syd Hiskey. If you would like to contact them directly, please see the contact details below:

Dr Leanne Andrews: Dr Syd Hiskey:
Academic Supervisor   Clinical Psychologist
School of Health and Human Sciences   The King's Wood
Centre
The University of Essex   Colchester General
Hospital, CO4 5JY.
Wivenhoe Park   **Tel:** 01206 228908
Colchester CO4 3SQ   **Email:**
syd.hiskey@nepft.nhs.uk
Tel: 01206 874466
Email: landre@essex.ac.uk

Thank you for taking the time to read this research information sheet.

Appendix G: Community sample: Paper consent form

<u>**CONSENT FORM**</u>

Name of study: Self-compassion in the UK general population.

Please
tick to
confirm

1) I confirm that I have read and understood the participant information for the above study and have had the opportunity, should I wish, to ask further questions about this. ☐

2) I understand that all information I give will remain anonymous ☐

3) I understand that should I provide my email address for the free prize draw that this will be kept in a separate, locked cupboard away from my questionnaires so that it is not possible to identify my responses. ☐

4) I understand that my email address will be inputted into a secure computer database and deleted once used for notification of the winner. ☐

5) I understand that taking part is entirely my choice and that I am under no obligation to do so. ☐

6) I confirm that I currently live permanently in the United Kingdom. ☐

7) I confirm that I am aged 18 or above. ☐

8) I agree to take part in the above research. ☐

Date: _____

Appendix H: Community sample: demographic questionnaire

DEMOGRAPHIC QUESTIONNAIRE

1. Are you a U.K. resident? (Please circle)   Yes / No

(If 'No' then please do not continue)

2. Please state the **month** that you are completing this questionnaire in: _____

3. Which county do you currently live in? : _____

4. How old are you? : _____

5. Please select your gender: Male / Female

6. Please select your **main current** occupation:

     a. Homemaker   d. Full time employed

     b. Retired   e. Part time employed

     c. Student (College, University)   f. Other

7. Please state the number of years of employment experience you have, to the nearest year: _____

8. What is your **current** marital status?

     a. Single

     b. Married

     c. Divorced

9. Please select your ethnicity:

a. White English/Welsh/Scottish/ Northern Irish/British
b. White Irish
c. Gypsy or Irish Traveller
d. Other White background
e. White and Black Caribbean
f. White and Black African
g. White and Asian
h. Asian British
i. Black British
j. Other Mixed / Multiple ethnic background

k. Indian
l. Pakistani
m. Bangladeshi
n. Chinese
o. Other Asian background
p. Black African
q. Black Caribbean
r. Other Black background
s. Arab
t. Other ethnic group, not specified
u. Would rather not say

10. Please select your religion:

a. Christian (including Church of England/ Ireland/ Scotland, Catholic, Protestant, Methodist and all other Christian denominations)
b. Buddhist
c. Hindu
d. Jewish
e. Muslim
f. Sikh
g. Other religion, not specified
h. No religion
i. Would rather not say

Thank you for completing this questionnaire. Please return it along with your second questionnaire and your consent form to The University of Essex in the FREEPOST, self-addressed envelope enclosed.

Appendix I: Community sample: Paper de-brief page

ORGANISATION CONTACT DETAILS

Thank you for taking the time to complete this research. I am hopeful that your responses will contribute towards future research of self-compassion in this country, with an aim to support the development of more appropriate and effective future treatments for individuals with mental ill-health.

If you feel that completing these questionnaires has left you feeling upset and you would like to speak with someone for some support, then the following contact details may be helpful to you:

G.P.

If negative feelings persist and affect your daily life, I would recommend that you visit your G.P. and together you can look at options for support.

Depression Alliance

A registered charity providing a network of self-help groups to support individuals experiencing depression.

Website: www.depressionalliance.org

CALM

CALM is the Campaign Against Living Miserably, for men aged 15-35.

Website: www.thecalmzone.net

Samaritans

Confidential telephone support for people experiencing feelings of distress or despair.

Phone: 08457 90 90 90 (24-hour helpline)   Website: www.samaritans.org.uk

Sane

Charity offering support and carrying out research into mental illness.

Phone: 0845 767 8000 (daily, 6pm-11pm)

SANEmail email: sanemail@org.uk   Website: www.sane.org.uk

Mind

Supports and promotes the needs of people with mental health problems.

Phone: 0300 123 3393   Website: www.mind.org.uk

The Mental Health Foundation

Provides information and support for anyone with mental health problems or learning disabilities.

Website: www.mentalhealth.org.uk

Rethink Mental Illness

Providing support and advice for people living with mental illness.

Phone: 0300 5000 927   Website: www.rethink.org

If you have any questions regarding the research please email the principle researcher

Claire Robinson: crobinc@essex.ac.uk.

Alternatively if you wish to speak to one of the research supervisors please contact

Dr Leanne Andrews: landre@essex.ac.uk

Or

Dr Syd Hiskey: syd.hiskey@nepft.nhs.uk

Thank you for your time.

Appendix J: Psychologist study: Effect size table

Table J1. Effect sizes of predictor variables and SCS derived from existing relevant literature.

Factor	Study	Measure	Participants	Study Design	Effect Size
Social Connectedness	Neff (2003a)	SoCS	Students	Cross sectional	.41**
		SoCS	Students		.35*
	Neff et al (2007)			Cross sectional	.29*[a]
Fear of self-compassion	Gilbert et al (2011)	FoC	Therapists	Cross sectional	-.54**
Fear of giving compassion to others	Gilbert et al (2011)	FoC	Therapists	Cross sectional	-.01
Fear of receiving compassion from others	Gilbert et al (2011)	FoC	Therapists	Cross sectional	-.22**
Stress	MacBeth and Gumley (2012)	SF-12v2, DASS-S	Students and Therapists	Cross sectional	-.34[b]
Age	Neff and Pommier (2012)	-	Students, older adults and meditators	Cross sectional	.25***
Psychological Distress	-	GHQ	-	-	-
Years of clinical experience	-	-	-	-	-

Note. SoCS = Social Connectedness Scale (Lee & Robbins,1995; 1998), FoC = Fears of Compassion Scale (Gilbert et al, 2011), SF-12v2 = Mental Health Summary; Symptoms of Stress Inventory (Ware, Kosinski & Keller, 1996), DASS-S – Depression, Anxiety and Stress Scale – Stress subscale only (Lovibond & Lovibond, 1995), GHQ = General Health Questionnaire (Goldberg, 1978). *$p<0.05$ **$p<0.01$ ***$p<0.001$, [a] when controlling for anxiety, [b] denotes average effect size.

Appendix K: List of all DClinPsych training programmes

Table K1. List of all UK DClinPsych Programmes, 2013

Name of DClinPsych Programme
Bangor University - North Wales
University of Bath
University of Birmingham
Coventry and Warwick
University of East Anglia
University of East London
University of Edinburgh - NHS Scotland
University of Essex - Tavistock
University of Exeter
University of Glasgow - NHS Scotland
University of Hertfordshire
University of Hull & York
Institute of Psychiatry, King's College London
Lancaster University
University of Leeds
University of Leicester
University of Liverpool
University of Manchester
Newcastle University
North Thames - University College London
Oxford
Plymouth University
Queens University, Belfast
Royal Holloway, University of London
Salomons, Canterbury Christ Church University
University of Sheffield
University of Southampton
South Wales
Staffordshire and Keele
University of Surrey
Teesside University
Trent - Universities of Lincoln and Nottingham

Note. DClinPsych = Doctorate in Clinical Psychology. *n* =32

Appendix L: R & D Approval for the Oxford University DClinPsych programme

Oxford Health **NHS**

NHS Foundation Trust

Professor John Geddes
Director of R&D
Dept of Psychiatry, University of Oxford
Warneford Hospital
Oxford OX3 7JX
Tel: 01865 226451   Fax: 01865 204198
e-mail: john.geddes@psych.ox.ac.uk

Our Ref: OxH_1040 University Ethical Review   12th August 2014.

136 Maldon Road
Great Baddow
Chelmsford
Essex
CM2 7DQ

Dear Claire

RE: Self compassion in Clinical Psychologists
PID No: OxH 1040

I am pleased to confirm that Oxford Health NHS Foundation Trust will grant NHS Permission (management approval) for this research study until the study end date of 28th February 2015, as described in your application to the University of Essex Research Ethics Committee). NHS Permission is granted as of the date of this letter. This confirmation is dependent on formal approval from the University of Essex Research Ethics Committee.

Every NHS Trust is required to meet and report on performance standards, one of which is first participant recruited to a study within 30 days of receiving NHS Permission. In addition to this, a study is expected to recruit its sample size within its recruitment period. In your University ethics application it is stated that Trust involvement will end on 28th February 2015 and that 5 participants are required.
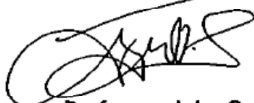
I must remind you of your responsibilities as a researcher including adherence to the principles of the Research Governance Framework (RGF), Good Clinical Practice (GCP) and the Data Protection Act. Please note that the Trust is required to monitor research to ensure compliance with the RGF and other legal and regulatory requirements. This is achieved by random audit of research.

NHS Permission is dependent upon submission to the R&D Department of:

- date of first participant recruited
- quarterly response to request for recruitment figures
- any amendments to the conduct of the study
- final report on completion of the study

I wish you every success with the study.

Yours sincerely

Professor John Geddes
Director of R&D

cc. Dr Leanne Andrews.

Oxford Health NHS Foundation Trust
Chancellor Court, 4000 John Smith Drive, Oxford Business Park South, Oxford OX4 2GX
Telephone: (01865) 778911 www.oxfordhealth.nhs.uk
Delivering high quality research to improve health care for all

Appendix M: Trainee research invite poster

Research: Self-compassion in Clinical Psychologists

If you're a trainee clinical psychologist and have some minutes to give to research about clinical psychologists – then this is for you!

I'm Claire, a trainee clinical psychologist at The University of Essex. For my doctoral thesis I am looking at the levels of self-compassion we have as clinical psychologists and what factors may influence/ predict these levels.

If you're interested in taking part and entering the free prize draw to **win £80 of Amazon vouchers**– Then please access it at the link below:

https://moodle.essex.ac.uk/mod/feedback/view.php?id=179751

Thank you for your time in reading this

Appendix N: Trainee demographic questionnaire

1) Please select the month that you are completing this questionnaire in.
2) Please select which county you currently work in.
3) Please enter your age.
4) Please select your gender.
5) Which year of training are you currently in?
6) Which type of service are you currently mainly on placement in?

MDT / Clinical psychology-only

team

7) How many other clinical psychology practioners (including other trainees and assistants) are in your team?
8) How many years clinically relevant experience did you have before starting training *(rounded to the nearest year?)*

Clinically relevant experience = Working using psychological ideas and theory with a clinically relevant population. For example, completing behavioural activation work as a support worker would count as this.

9) Do you currently use the theory of self-compassion or self-compassion focused interventions in your clinical work?

10) Approximately, how many hours of university teaching have you received on the topic of self-compassion to date?

11) *At present*, do you carry out **any** activities for the **main purpose** of emotional self-care? i.e. cognitive techniques, attend groups, mindfulness, go to the gym.

12) What is your current marital status?   Options: as in norming study
13) Please select your ethnicity   Options: as in norming study
14) What is your religion?   Options: as in norming study

Appendix O: Qualified clinical psychologist demographic questionnaire

1) Please select the month that you are completing this questionnaire in.
2) Please select which county you currently work in.
3) Please enter your age.
4) Please select your gender.
5) Please state which country you completed your DClinPsy training.
6) How many years of clinically relevant experience did you have prior to starting training?

   Clinically relevant experience = Working using psychological ideas and theory with a clinically relevant population. For example, completing behavioural activation work as a support worker would count as this.

7) Including experience from before training, during training and post-qualification, approximately how many years of clinically relevant experience do you have to date? Which type of service do you predominantly work in?
                                                                 MDT / Clinical psychology-only team

8) How many other clinical psychology practioners (including other trainees and assistants) are in your team?

9) Do you currently use the theory of self-compassion or self-compassion focused interventions in your clinical work?

10) *At present*, do you carry out **any** activities for the **main purpose** of emotional self-care? i.e. cognitive techniques, attend groups, mindfulness, go to the gym.

11) What is your current marital status?   Options: as in norming study
12) Please select your ethnicity   Options: as in norming study
13) What is your religion?   Options: as in norming study

Appendix P: The Fears of Compassion Scale (Gilbert, McEwan, Matos & Rivis, 2011).

The Fears of Compassion Scale

Different people have different views of compassion and kindness. While some people believe that it is important to show compassion and kindness in all situations and contexts, others believe we should be more cautious and can worry about showing it too much to ourselves and to others. We are interested in your thoughts and beliefs in regard to kindness and compassion in three areas of your life:

1. Expressing compassion for others
2. Responding to compassion from others
3. Expressing kindness and compassion towards yourself

Below are a series of statements that we would like you to think carefully about and then circle the number that best describes how each statement fits you.

SCALE

Please use this scale to rate the extent that you agree with each statement

Don't agree at all   0   1   2   3   4   Completely agree

Some-what agree

Scale 1: Expressing compassion for others

1	People will take advantage of me if they see me as too compassionate	0	1	2	3	4
2	Being compassionate towards people who have done bad things is letting them off the hook	0	1	2	3	4
3	There are some people in life who don't deserve compassion	0	1	2	3	4
4	I fear that being too compassionate makes people an easy target	0	1	2	3	4
5	People will take advantage of you if you are too forgiving and compassionate	0	1	2	3	4
6	I worry that if I am compassionate, vulnerable people can be drawn to me and drain my emotional resources	0	1	2	3	4
7	People need to help themselves rather than waiting for others to help them	0	1	2	3	4
8	I fear that if I am compassionate, some people will become too dependent upon me	0	1	2	3	4
9	Being too compassionate makes people soft and easy to take advantage of	0	1	2	3	4
10	For some people, I think discipline and proper punishments are more helpful than being compassionate to them	0	1	2	3	4

Scale 2: Responding to the expression of compassion from others

1	Wanting others to be kind to oneself is a weakness	0	1	2	3	4
2	I fear that when I need people to be kind and understanding they won't be	0	1	2	3	4
3	I'm fearful of becoming dependent on the care from others because they might not always be available or willing to give it	0	1	2	3	4
4	I often wonder whether displays of warmth and kindness from others are genuine	0	1	2	3	4
5	Feelings of kindness from others are somehow frightening	0	1	2	3	4
6	When people are kind and compassionate towards me I feel anxious or embarrassed	0	1	2	3	4
7	If people are friendly and kind I worry they will find out something bad about me that will change their mind	0	1	2	3	4
8	I worry that people are only kind and compassionate if they want something from me	0	1	2	3	4
9	When people are kind and compassionate towards me I feel empty and sad	0	1	2	3	4
10	If people are kind I feel they are getting too close	0	1	2	3	4
11	Even though other people are kind to me, I have rarely felt warmth from my relationships with others	0	1	2	3	4
12	I try to keep my distance from others even if I know they are kind	0	1	2	3	4
13	If I think someone is being kind and caring towards me, I 'put up a barrier'	0	1	2	3	4

Scale 3: Expressing kindness and compassion towards yourself

1	I feel that I don't deserve to be kind and forgiving to myself	0	1	2	3	4
2	If I really think about being kind and gentle with myself it makes me sad	0	1	2	3	4
3	Getting on in life is about being tough rather than compassionate	0	1	2	3	4
4	I would rather not know what being 'kind and compassionate to myself' feels like	0	1	2	3	4
5	When I try and feel kind and warm to myself I just feel kind of empty	0	1	2	3	4
6	I fear that if I start to feel compassion and warmth for myself, I will feel overcome with a sense of loss/grief	0	1	2	3	4
7	I fear that if I become kinder and less self-critical to myself then my standards will drop	0	1	2	3	4
8	I fear that if I am more self-compassionate I will become a weak person	0	1	2	3	4
9	I have never felt compassion for myself, so I would not know where to begin to develop these feelings	0	1	2	3	4
10	I worry that if I start to develop compassion for myself I will become dependent on it	0	1	2	3	4
11	I fear that if I become too compassionate to myself I will lose my	0	1	2	3	4

self-criticism and my flaws will show

12	I fear that if I develop compassion for myself, I will become someone I do not want to be	0	1	2	3	4
13	I fear that if I become too compassionate to myself others will reject me	0	1	2	3	4
14	I find it easier to be critical towards myself rather than compassionate	0	1	2	3	4
15	I fear that if I am too compassionate towards myself, bad things will happen	0	1	2	3	4

Appendix Q: The Social Connectedness Scale – Revised. (Lee, Draper & Lee, 2001)

Note. 8 – Item scoring method used

SOCIAL CONNECTEDNESS SCALE-REVISED

Directions: Following are a number of statements that reflect various ways in which we view ourselves. Rate the degree to which you agree or disagree with each statement using the following scale (1 = Strongly Disagree and 6 = Strongly Agree). There is no right or wrong answer. Do not spend too much time with any one statement and do not leave any unanswered.

Strongly Disagree 1	Disagree 2	Mildly Disagree 3	Mildly Agree 4	Agree 5	Strongly Agree 6

		Strongly Disagree					Strongly Agree
1.	I feel comfortable in the presence of strangers..........	1	2	3	4	5	6
2.	I am in tune with the world..................................	1	2	3	4	5	6
*3.	Even among my friends, there is no sense of brother/sisterhood..	1	2	3	4	5	6
4.	I fit in well in new situations..............................	1	2	3	4	5	6
5.	I feel close to people...	1	2	3	4	5	6
*6.	I feel disconnected from the world around me..........	1	2	3	4	5	6
*7.	Even around people I know, I don't feel that I really belong..	1	2	3	4	5	6
8.	I see people as friendly and approachable.................	1	2	3	4	5	6
*9.	I feel like an outsider...	1	2	3	4	5	6
10.	I feel understood by the people I know......................	1	2	3	4	5	6
*11.	I feel distant from people....................................	1	2	3	4	5	6
12.	I am able to relate to my peers...............................	1	2	3	4	5	6
*13.	I have little sense of togetherness with my peers.....	1	2	3	4	5	6
14.	I find myself actively involved in people's lives.....	1	2	3	4	5	6
*15.	I catch myself losing a sense of connectedness with society..	1	2	3	4	5	6
16.	I am able to connect with other people......................	1	2	3	4	5	6
*17.	I see myself as a loner.......................................	1	2	3	4	5	6
*18.	I don't feel related to most people............................	1	2	3	4	5	6
19.	My friends feel like family....................................	1	2	3	4	5	6
*20.	I don't feel I participate with anyone or any group...	1	2	3	4	5	6

Strongly Disagree   Strongly Agree

* reverse score

Social connectedness scale-revised has two scoring options. The original scale consists of 8 items and the revised item consists of 20 items.

   a) original = reverse score items 3,6,7,11,13,15,18,20 and sum 8 items.

   b) revised scale = reverse score items 3,6,7,9,11,13,15,17,18,20 and sum all 20 items.

Appendix R: The Perceived Stress Scale (Cohen & Williamson, 1988)

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.

Name _____ Date _____

Age _____ Gender (*Circle*): **M   F**   Other _____

0 = Never   1 = Almost Never   2 = Sometimes   3 = Fairly Often   4 = Very Often

1. In the last month, how often have you been upset
   because of something that happened unexpectedly?................................. 0   1   2   3   4

2. In the last month, how often have you felt that you were unable
   to control the important things in your life?..................................... 0   1   2   3   4

3. In the last month, how often have you felt nervous and "stressed"?........... 0   1   2   3   4

4. In the last month, how often have you felt confident about your ability
   to handle your personal problems? 0   1   2   3   4

5. In the last month, how often have you felt that things
   were going your way?... 0   1   2   3   4

6. In the last month, how often have you found that you could not cope
   with all the things that you had to do? 0   1   2   3   4

7. In the last month, how often have you been able
   to control irritations in your life?... 0   1   2   3   4

8. In the last month, how often have you felt that you were on top of things?.. 0   1   2   3   4

9. In the last month, how often have you been angered
   because of things that were outside of your control?........................... 0   1   2   3   4

10. In the last month, how often have you felt difficulties
    were piling up so high that you could not overcome them? 0   1   2   3   4

Please feel free to use the *Perceived Stress Scale* for your research.

Appendix S: The General Health Questionnaire -12. (Goldberg & Williams, 1988).

GENERAL HEALTH QUESTIONNAIRE

GHQ-12

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

1	-	been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2	-	lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	-	felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4	-	felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5	-	felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6	-	felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7	-	been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8	-	been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9	-	been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10	-	been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11	-	been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12	-	been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

© David Goldberg, 1978

Appendix T: Online Trainee clinical psychologist demographic questionnaire

Summary of study:

This study aims to look at levels of self-compassion experienced by clinical psychologists and what factors may predict these levels. It will ask questions related to self-compassion, social connectedness, stress, general health and demographics.

Why is this research being conducted?

Given previous research and the levels of stress identified within clinical psychology practitioners along with the well-evidenced benefits of self-compassion for good psychological wellbeing, it seems valuable to understand what the levels of self-compassion are within this group and what factors may influence/predict them. It is hoped that the findings of this research will provide evidence to promote beneficial self-care strategies and have significance for UK DClinPsych course teaching.

Why have I been invited?

You have been invited as you are a trainee clinical psychologist currently studying on a UK DClinPsych course and along with qualified clinical psychologists form part of the UK clinical psychologist population. At this point in your training I am interested to find out what your reported levels of self-compassion are and if possible, see how your responses compare to qualified clinical psychologist responses.

What will be involved?

You will be asked to complete a series of questionnaires, all of which are answered by selecting the answer that most suits you. All responses will be anonymous however at the end of the questionnaires you will be asked to complete some questions about your basic demographics, including some questions about your teaching. You will also be given the opportunity to enter a free prize draw to win £80 of Amazon Vouchers and submit your interest in finding out the study results prior to publication. The questionnaires will take approximately 20-30 minutes to complete.

Do I have to take part?

No. Participation in this research is completely voluntary and a decision to not take part will bear no consequences to your current study, training or role. Should you not wish to take part or begin completing the questionnaires then decide to withdraw just simply close the browser window to exit. No data provided will be saved.

Are there any disadvantages or risks to me?

The questions will require you to think about yourself and your typical responses to yourself. Some will also ask you how you feel currently. As a result, you may notice negative

emotions you may be feeling which may lead to a temporary dip in mood. If you do feel like this and would like support, there will be a contact list of organizations that can help at the end of this questionnaire. If this feeling persists and begins to interfere in your daily life I advise that you speak to your G.P. and look together at other options available.

This study will require some of your time (up to 20-30 minutes) which will be voluntary and unpaid.

What are the possible benefits of taking part?

As this research is focused solely on the experience of clinical psychologists it is hoped that the findings will help us reflect as a discipline about how we feel and how we respond to our feelings. In future terms this may motivate the teaching of appropriate and possibly more effective self-care practices which in turn will help both our personal and professional emotional wellbeing.

How do I give my consent to take part?

By completing the consent page that will follow. PLEASE ONLY CONTINUE WITH THIS QUESTIONNAIRE IF YOU ARE A CURRENT TRAINEE CLINICAL PSYCHOLOGIST ON A UK DCLINPSYCH COURSE.

What will happen to my responses?

Your responses will be collected anonymously and inputted into a secure database ready for data analysis. They will be written up into a clinical psychology doctoral thesis and published as a journal article. Some data may also be used in future data analysis.

If you wish to submit your email to enter the free prize draw for £80 of Amazon vouchers or to find out the study results once the research is completed your email will be stored confidentially in separate password protected databases, away from the main study data. Following the notification of the prize draw winner and dissemination of study findings, these two databases will both be deleted.

Other information about the research:

This study has been reviewed and approved by the University of Essex Ethics Committee.

Can I discuss any further questions that I have about this study?

Yes. Should you wish to ask any questions then the principal investigator is available to contact:

Claire Robinson

Trainee Clinical Psychologist   Email: crobinc@essex.ac.uk

This research is being supervised by Dr Leanne Andrews and Dr Syd Hiskey. If you would like to contact them directly, please see the contact details below:

Dr Leanne Andrews: Dr Syd Hiskey
Academic Supervisor   Clinical Psychologist

School of Health and Human Sciences   The King's Wood Centre
The University of Essex   Colchester General Hospital, CO4 5JY.
Wivenhoe Park   Tel: 01206 228908
Colchester CO4 3SQ
Tel: 01206 874466
Email: landre@essex.ac.uk

Thank you for taking the time to read this research information sheet.

Please read and confirm to continue:

I confirm that I am a trainee clinical psychologist currently studying on a UK DClinPsych course

Yes ☐   No ☐

Appendix U: Online Qualified clinical psychologist demographic questionnaire

Summary of study:

This study aims to look at levels of self-compassion experienced by clinical psychologists and what factors may predict these levels. It will ask questions related to self-compassion, social connectedness, stress, general health and demographics.

Why is this research being conducted?

Given previous research and the levels of stress identified within clinical psychology practitioners along with the well-evidenced benefits of self-compassion for good psychological wellbeing, it seems valuable to understand what the levels of self-compassion are within this group and what factors may influence/predict them. It is hoped that the findings of this research will provide evidence to promote beneficial self-care strategies and have significance for both personal and professional development (PPD) teaching and UK DClinPsych teaching.

Why have I been invited?

You have been invited as you are a qualified clinical psychologist currently working within the National Health Service (NHS) and along with trainee clinical psychologists, form part of the UK clinical psychologist population. At this point in your career I am interested to find out what your reported levels of self-compassion are and if possible, see how your responses compare to current trainees.

What will be involved?

You will be asked to complete a series of questionnaires, all of which are answered by selecting the answer that most suits you. All responses will be anonymous however at the end of the questionnaires you will be asked to complete some questions about your basic demographics, including some questions about your previous teaching. You will also be given the opportunity to enter a free prize draw to win £80 of Amazon Vouchers and also submit your interest in finding out the study results prior to publication. The questionnaires will take approximately 20-30 minutes to complete.

Do I have to take part?

No. Participation in this research is completely voluntary and a decision to not take part will bear no consequences to your job or role. Should you not wish to take part or begin completing the questionnaires then decide to withdraw just simply close the browser window to exit. No data provided up to this point will be saved. If you know of any other qualified clinical psychologists, currently working in the NHS, that may be interested in completing this questionnaire instead then please feel free to email them the link to access it.

Are there any disadvantages or risks to me?

The questions will require you to think about yourself and your typical responses to yourself. Some will also ask you how you feel currently. As a result, you may notice negative emotions you may be feeling which may lead to a temporary dip in mood. If you feel like this and would like support, there will be a contact list of organizations that can help at the end of the questionnaire. If this feeling persists and begins to interfere in your daily life, I advise that you speak to your G.P. and look together at other options available.

This study will require some of your time (up to 20-30 minutes) which will be voluntary and unpaid.

What are the possible benefits of taking part?

As this research is focused solely on the experience of trainee and qualified clinical psychologists it is hoped that the findings will help us reflect as a discipline about how we feel and how we respond to our feelings. In future terms this may motivate the learning of appropriate and possibly more effective self-care practices which in turn will help both our personal and professional emotional wellbeing.

How do I give my consent to take part?

By completing the consent page that will follow. PLEASE ONLY CONTINUE WITH THIS QUESTIONAIRE IF YOU ARE A QUALIFIED CLINICAL PSYCHOLOGIST CURRENTLY WORKING WITHIN THE UK NHS.

What will happen to my responses?

Your responses will be collected anonymously and inputted into a secure database ready for data analysis. They will be written up into a clinical psychology doctoral thesis and published as a journal article. Some data may also be used in future data analysis.

If you wish to submit your email address to enter the free prize draw for £80 of Amazon vouchers or to find out the study results once the research is completed your email will be stored confidentially in separate password protected databases, away from the main study data. Following the notification of the prize draw winner and dissemination of study findings, these two databases will both be immediately deleted.

Other information about the research:

This study has been reviewed and approved by the University of Essex Ethics Committee.

Can I discuss any further questions that I have about this study?

Yes. Should you wish to ask any questions then the principal investigator is available to contact:

Claire Robinson

Trainee Clinical Psychologist   Email: crobinc@essex.ac.uk

This research is being supervised by Dr Leanne Andrews and Dr Syd Hiskey. If you would like to contact them directly, please see the contact details below:

Dr Leanne Andrews: Dr Syd Hiskey
Academic Supervisor   Clinical Psychologist

School of Health and Human Sciences   The King's Wood Centre
The University of Essex   Colchester General Hospital, CO4 5JY.
Wivenhoe Park   Tel: 01206 228908
Colchester CO4 3SQ
Tel: 01206 874466
Email: landre@essex.ac.uk

Thank you for taking the time to read this research information sheet.

Please read and confirm to continue:

I confirm that I am a qualified clinical psychologist currently working within the NHS.

Yes ☐   No ☐

Appendix V: Trainee clinical psychologist online consent form

Name of study: Self-compassion in Clinical Psychologists.

Please tick to confirm

1) I confirm that I have read and understood the participant information for the above study and have had the opportunity, should I wish, to ask further questions about this. ☐

2) I understand that all information I give will remain anonymous ☐

3) I understand that should I provide my email address for the free prize draw or for dissemination of study findings that this will be kept in separate, secure databases and deleted once used for their respective purposes. ☐

4) I understand that taking part is entirely my choice and that I am free to withdraw at any time, without question or this affecting my current training. ☐

5) I confirm that I am a Trainee Clinical Psychologist currently studying on a UK DClinPsych course. ☐

6) I agree to take part in the above research. ☐

Appendix W: Qualified clinical psychologist online consent form

Name of study: Self-compassion in Clinical Psychologists.

Please tick to confirm

1) I confirm that I have read and understood the participant information for the above study and have had the opportunity, should I wish, to ask further questions about this.

☐

2) I understand that all information I give will remain anonymous

☐

3) I understand that should I provide my email address for the free prize draw or for dissemination of study findings that this will be kept in separate, secure databases and deleted once used for their respective purposes.

☐

4) I understand that taking part is entirely my choice and that I am free to withdraw at any time, without question or this affecting my role.

☐

5) I confirm that I am a qualified Clinical Psychologist currently working within the UK NHS.

☐

6) I agree to take part in the above research.

☐

Appendix X: Trainee and qualified online final page

Final Page:

Thank you for taking the time to complete this research. I am hopeful that your responses will contribute towards positive changes within our discipline. If you feel that completing these questionnaires has left you feeling upset and you would like to speak with someone for some support, then the final following page will contain contact details that may be helpful to you

If you would like to enter the free prize draw to win £80 of Amazon vouchers please enter your email address here:

 If you would like to find out the research results at the end of this study, please enter your email address here:

If you know a qualified a clinical psychologist, currently working in the NHS, whom you believe would be interested in taking part in this research, then please **COPY** and **PASTE** the link below and email them it.

Thank you for taking the time to complete this research. If you feel that completing these questionnaires has left you feeling upset and you would like to speak with someone for some support, then the following contact details may be helpful to you:

NHS Trust Occupational Health Departments

To initiate a referral to your trust Occupational Health Department for support, please speak to your line manager.

Depression Alliance

A registered charity providing a network of self-help groups to support individuals experiencing depression.
Website: www.depressionalliance.org

CALM

CALM is the Campaign Against Living Miserably, for men aged 15-35.
Website: www.thecalmzone.net

Samaritans

Confidential telephone support for people experiencing feelings of distress or despair.
Phone: 08457 90 90 90 (24-hour helpline)
Website: www.samaritans.org.uk

Sane

Charity offering support and carrying out research into mental illness.
Phone: 0845 767 8000 (daily, 6pm-11pm)
SANEmail email: sanemail@org.uk
Website: www.sane.org.uk

Mind

Supports and promotes the needs of people with mental health problems.
Phone: 0300 123 3393
Website: www.mind.org.uk

The Mental Health Foundation

Provides information and support for anyone with mental health problems or learning disabilities.
Website: www.mentalhealth.org.uk

Rethink Mental Illness

Providing support and advice for people living with mental illness.
Phone: 0300 5000 927
Website: www.rethink.org

If you have any questions regarding the research please email the principle researcher.

Claire Robinson: crobinc@essex.ac.uk.

Alternatively if you wish to speak to one of the research supervisors please contact

Dr Leanne Andrews: landre@essex.ac.uk

Or

Dr Syd Hiskey: syd.hiskey@nepft.nhs.uk

Thank you for your time.

Appendix Y: University of Essex Ethics Committee ethical approval

University of Essex

School of Health and Human Sciences
T 01206 872854
F 01206 873765
E hhs@essex.ac.uk

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom
T 01206 873333
F 01206 873598

www.essex.ac.uk

17 December 2013

MISS C. ROBINSON
136 MALDON ROAD
GREAT BADDOW
CHELMSFORD
ESSEX
CM2 7DQ

Dear Claire,

Re: Ethical Approval Application (Ref 12065)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by Dr Wayne Wilson on behalf of the Faculty Ethics Committee.

Yours sincerely,

Mel Wiltshire
Ethics Administrator
School of Health and Human Sciences

cc.   Sarah Manning-Press, REO
        Leanne Andrews, Supervisor

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University of Essex

Application for Ethical Approval of Research Involving Human Participants

This application form should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research should not commence until written approval has been received (from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then passed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1.	Title of project:	Self-compassion in Clinical Psychologists

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
Do you object to the title of your project being published?   Yes ☐ / No ☒

3. This Project is: ☐   Staff Research Project   ☒   Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Claire Robinson	Doctorate in Clinical Psychology, School of Health and Human Sciences
Dr Leanne Andrews (University supervisor)	Doctorate in Clinical Psychology, School of Health and Human Sciences
Dr Syd Hiskey (Field supervisor)	Clinical Psychologist, NEPFT NHS

5.	Proposed start date: 1st January 2013

6.	Probable duration: Approximately one year until February 2015

7. Will this project be externally funded?   Yes ☐ / No ☒

If Yes,

8.	What is the source of the funding?

9. If external approval for this research has been given, then only this cover sheet needs to be submitted

    External ethics approval obtained (attach evidence of approval)   Yes ☐ / No ☒

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): ....……………..……………..

Name(s) in block capitals: CLAIRE ROBINSON ....…………………….....

Date: 03/11/2013...

Supervisor's recommendation (Student Projects only):

I have read and approved both the research proposal and this application.

Supervisor's signature: .DR LEANNE ANDREWS..

Outcome:

The Departmental Director of Research (DoR) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the FEC ☐

This application is referred to the FEC because it does not fall under Annex B ☐

This application is referred to the FEC because it requires independent scrutiny ☐

Signature(s): ....……………………………

Name(s) in block capitals: ....…..…………………………

Department: ....……………………………

Date: ....………………………………..

The application has been approved by the FEC ☐

The application has not been approved by the FEC ☐

The application is referred to the University Ethics Committee ☐

Signature(s): ....…………………………

Name(s) in block capitals: ....…..……………………

Faculty: ....…...……………………………

Date: ....…………………………………

Research and Enterprise Office (smp)   March 2010   Page: 2 of 8

Details of the Project

1.	Brief outline of project (This should include the purpose or objectives of the research, brief justification, and a summary of methods. It should be approx. 150 words in everyday language that is free from jargon).

Given the levels of stress identified within clinical psychology practioners and the well-evidenced benefits of self-compassion for good psychological wellbeing, it seems valuable to understand what the levels of self-compassion are within this group and what factors may influence/predict them. This study aims to achieve this. Given previous literature, the factors proposed to be explored are; 1) current levels of stress, 2) current level of psychological distress, 3) Age of clinician, 4) Years of clinical experience, 5) Level of social connectedness, 6) Fear of giving compassion *to* others, 7) Fear of receiving compassion *from* others and 8) Fear of *self*-compassion. It is hoped that the findings of this research will provide evidence to promote beneficial self-care strategies and have significance for UK DClinPsych course teaching.

This study will involve two phases, both cross sectional in design. Initially, a preliminary standardisation study is proposed, in order to gain UK normative data for the Self-Compassion Scale based within a community population. It is proposed that this will use both postal and online survey methods. The findings from this will then help inform the main study, which will employ an online survey method only.

Participant Details

2. Will the research involve human participants? (indicate as appropriate)

Yes ☒ No ☐

3.	Who are they and how will they be recruited? (If any recruiting materials are to be used, e.g. advertisement or letter of invitation, please provide copies).

For the initial standardisation study, participants will be recruited using convenience sampling methods. The researcher proposes to disseminate the Self-Compassion Scale (see appendix 1) along with an information sheet (see appendix 2) a consent form (see appendix 3), a short demographic questionnaire (see appendix 4) and final page (see appendix 17) via an online link to the University of Essex REO research webpage. The researcher proposes to also disseminate a link to the online survey via a social network site; facebook.com. Snowball sampling methods will also be used in order to access as many participants as possible. Friends and family will also be given paper copies of the questionnaires along with a paper copy of the information sheet (see appendix 5), a paper copy of the consent form (see appendix 6) and a freepost envelope to give to people they believe would be interested in the study however do not have/ prefer not to use the internet.

In the main study, trainee clinical psychologists will be recruited via an email invitation to take part in the online survey, disseminated via their respective DClinPsych course team administrator. The link will include the participant information sheet (see appendix 7), consent form (see appendix 8), all questionnaires including a demographic questionnaire (see appendix 11) and a final page (see appendix 18). It is proposed to ask the administrators to send out the link twice, with a month between each dissemination, to prompt as many trainees to complete the questionnaires as possible. Due to their specifications, one DClinPsych course has requested that their trainees be approached via a leaflet advertisement, with the online survey link, so that this can be placed in their pigeon holes at their university.

Qualified clinical psychologists will be recruited via online research study advertisements on the British Psychological Society Division of Clinical Psychology Research Board, the Academic and Research Forum of "clinpsy.org.uk" and via the email list of the Compassionate Mind Foundation; an independent website for research and training used by clinical psychologists and other interested mental health practioners. As a final recruitment method a link to the survey will also be posted via the social network website; facebook.com. It is proposed to also use snowball sampling methods in order to access as many qualified clinical psychologists as possible. This will include asking trainee clinical psychologists to forward the survey link to any qualified clinical psychologists they believe will be interested in taking part in the research. The survey link for qualified clinical psychologists will include a participant information sheet (see appendix 9), consent form (see appendix 10), all questionnaires including a demographic questionnaire (see appendix 12) and a final page (see appendix 18).

It is also proposed that if an inadequate sample size is gained from the above methods, as defined by the proposed sample size estimation, the researcher will approach NHS Research and Development (R&D) approval to access NHS clinical psychologists via their NHS email address. As this is with NHS staff and not clients, it has been advised that only R & D approval is required and not full NHS REC Ethical approval. Potential participants will receive the link to the survey via dissemination from the clinical psychology lead in the trust to their responding line. Again it is proposed that snowball sampling methods will be used to access as many qualified clinical psychologists as possible. Two trusts will be approached; the North Essex Partnership Foundation Trust and the Leeds and York Partnership NHS Foundation Trust in order to have a trusts based in different geographical region.

Will participants be paid or reimbursed?

Participants will not be paid in either the standardisation study or the main study. However, in the standardisation study, participants will be offered the opportunity to enter a free prize draw to win £40 of Marks and Spencer retail vouchers. In the main study participants will be offered the opportunity to enter a free prize draw to win £80 of Amazon vouchers. Reimbursement is not necessary as no financial outlay is required to take part.

4. Could participants be considered:

    (a) to be vulnerable (e.g. children, mentally-ill)?   Yes ☐ / No ☒

    (b) to feel obliged to take part in the research?   Yes ☐ / No ☒

    If the answer to either of these is yes, please explain how the participants could be considered vulnerable and why vulnerable participants are necessary for the research.

Informed Consent

5. Will the participant's consent be obtained for involvement in the research orally or in writing? (If in writing, please attach an example of written consent for approval):

Yes ☒   No ☐

How will consent be obtained and recorded? If consent is not possible, explain why.

In the main study and for those participants completing the standardization study electronically, consent will be obtained following the presentation of a participant information sheet (please see appendices 2, 7 and 9). It will be deemed that consent has been given once the participant has read their participant information sheet, confirmed they have read and understood this and then ticked each section of their consent form (see appendices 3, 8 and 10), including the final statement that the participant consents to take part in the research. A participant will not be able to gain access to the questionnaire section of the survey until informed consent is confirmed.

For participants completing the paper questionnaires of the standardization survey, consent will be obtained via their ticking and confirmation of each statement and the signature provided on their consent form (see appendix 6). They will be required to post this back to the principle researcher, along with their questionnaire responses, in the FREEPOST, self-addressed envelope provided.

Please attach a participant information sheet where appropriate.

Confidentiality / Anonymity

6.   If the research generates personal data, describe the arrangements for maintaining anonymity and confidentiality or the reasons for not doing so.

The personal data generated by this research will be managed in the following ways.

The only personal data potentially generated by the standardization study are participants email addresses should they wish to enter the free prize draw for £40 of Marks and Spencer's vouchers. This will only be the case should identifiable data, such as their name, form part of their email address.

In the paper standardization study, it is proposed that the researcher will store the consent form and questionnaire data in a separate locked cupboard to the locked cupboard that will store their email addresses. This will ensure that it is not possible to deduce a participants questionnaire responses thus anonymity is maintained.

For participants completing the standardization study online please see below.

Within the main study the only personal data generated is once again a participants email address should the participant wish to a) enter the free prize draw to win £80 of Amazon vouchers or b) to submit an interest to hear about the study findings once the research is complete. As with participants completing the standardization study online, participants will be required to type in their email address in a specified box, to enter. This email address data will be stored in separate password protected databases, away from questionnaire responses, to again ensure data anonymity. Once the free prize draw winners have been selected and notified these databases will be deleted immediately. Once the researcher has disseminated the research findings, this database of email addresses will also be deleted immediately.

Data Access, Storage and Security

7. Describe the arrangements for storing and maintaining the security of any personal data collected as part of the project. Please provide details of those who will have access to the data.

> Questionnaire data collected for the paper version of the standardization study will be stored in a secure, locked cupboard. Paper consent forms will be stored in a second locked cupboard and paper email addresses for the free prize draw will be stored in a third locked cupboard. This will be to ensure that it is not possible to work out which questionnaire responses belong to which participant thus maintaining anonymity. These three cupboards will be based in a locked room at The University of Essex and only the principle investigator and the research supervisor will have access to them.
>
> Electronic questionnaire data collected for the online version of the standardization study and all main study data will be automatically inputted into their respective secure, password protected databases, as the data is collected. Personal data; their email addresses, which will be submitted only if they wish to enter their free prize draw or have some of the research findings disseminated following the study completion, will all be automatically inputted into separate password protected databases. These databases will be deleted immediately once they have been used for their respective purposes.
>
> All databases will be located on a secure password protected computer server which only the principle researcher has the individual username and password in order to access.

It is a requirement of the Data Protection Act 1998 to ensure individuals are aware of how information about them will be managed. Please tick the box to confirm that participants will be informed of the data access, storage and security arrangements described above. If relevant, it is appropriate for this to be done via the participant information sheet ☒

Further guidance about the collection of personal data for research purposes and compliance with the Data Protection Act can be accessed at the following weblink. Please tick the box to confirm that you have read this guidance
(http://www.essex.ac.uk/records_management/policies/data_protection_and_research.aspx) ☒

Risk and Risk Management

8. Are there any potential risks (e.g. physical, psychological, social, legal or economic) to participants or subjects associated with the proposed research?

   Yes ☒   No ☐

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:
As this research will take place remotely; participants will complete their questionnaires online/by hand, wherever they choose to, without the physical presence of the researcher, all questionnaires have been carefully screened to ensure that no questions ask about significant risks such as suicidal ideation and intent. This is because as a remote, anonymous study relying on snowball sampling methods the researcher would be unable to identify the participant in order to provide appropriate support or action any risk management procedures should a participant disclose such information.

The questionnaires in both the standardization and main studies will require participants to think about how they currently feel, including their perception of their current stress levels and psychological distress and how they also react to themselves in periods of distress. The measures have been selected carefully to ensure they are appropriate for an online design thus participants should not feel distressed when completing them. However it is explained clearly in the participant information sheet that they may notice negative emotions which may cause a temporary dip in their mood. Participants are required to read this information sheet in order to gain access to the consent form. It is advised in the information sheet that should participants experience this on an ongoing basis and it begins to affect their daily lives that they approach their G.P. so they can together look at options to support them.

The principle researchers' contact details and those of the research supervisors are also provided on the information sheet and final pages so that participants can contact to ask questions about the nature and content of the questionnaires should they have any concerns. The procedure for how to withdraw from the study is also explained clearly in the participant information sheet and as it only requires that participants close their browser window to exit, with no personally identifiable data having been provided, it is hoped that this enables them to do so more easily should they wish to.

In order to minimize any low mood following questionnaire completion, a list of contact details for appropriate organizations that can provide support and advice via the telephone are presented at the end of the questionnaires as part of the final pages. |

9. Are there any potential risks to researchers as a consequence of undertaking this proposal that are greater than those encountered in normal day-to-day life?

Yes ☐   No ☒

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:

10. Will the research involve individuals below the age of 18 or individuals of 18 years and over with a limited capacity to give informed consent?

    Yes ☐   No ☒

    If Yes, a criminal records disclosure (CRB check) within the last three years is required.

    Please provide details of the "clear disclosure":

Date of disclosure:
Type of disclosure:
Organisation that requested disclosure:

11. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of the Faculty and/or University Ethics Committees

    N/A.

Appendix Z: Community sample: Paper and online tests of parametric assumptions

Table Z1. Community sample tests of parametric assumptions in paper and online samples.

	Format	Mean(SD)	Skewness	Kurtosis	Shapiro-Wilks Sig.	Levene's test Sig[a].
Total SCS	Online	2.97 (.63)	.70	.329	0.931	0.819
	Paper	3.06 (.68)	.00	-.95	0.294	
Self-kindness	Online	2.84 (.76)	1.65	-.34	0.039	0.173
	Paper	2.71 (.85)	1.018	-.58	0.288	
Self-Judgement	Online	2.92 (.75)	.83	-1.146	0.131	0.477
	Paper	3.11 (.91)	.42	-.74	0.328	
Common Humanity	Online	3.11 (.89)	.427	-.75	0.062	0.068
	Paper	3.12 (1.04)	.59	1.109	0.112	
Isolation	Online	2.93 (.94)	.94	-1.37	0.022	0.846
	Paper	3.22 (.98)	.17	1.31	0.143	
Mindfulness	Online	3.22 (.73)	.348	1.099	0.023	0.441
	Paper	3.32 (.84)	-.55	-.33	0.220	
Over Identification	Online	2.82 (.92)	.88	-1.15	0.032	0.909
	Paper	2.97 (.93)	-.34	-1.26	0.321	

Note. Online (n=160), Paper (n= 57)
[a] = Based on mean.

Total SCS scores: Histograms, Q-Q plots and Box and Whisker diagrams
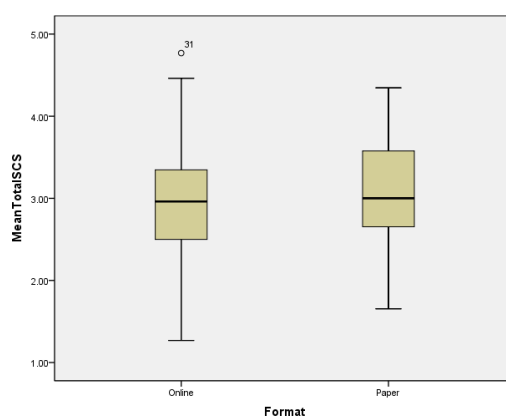
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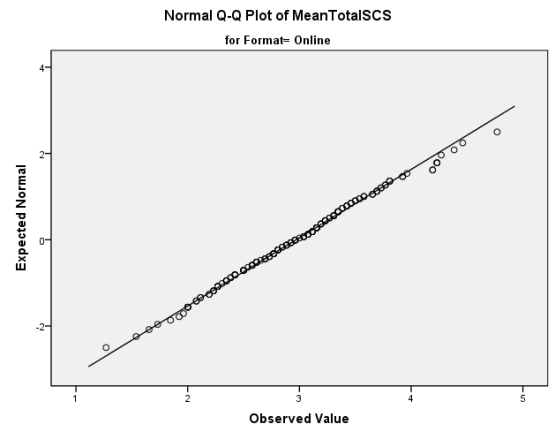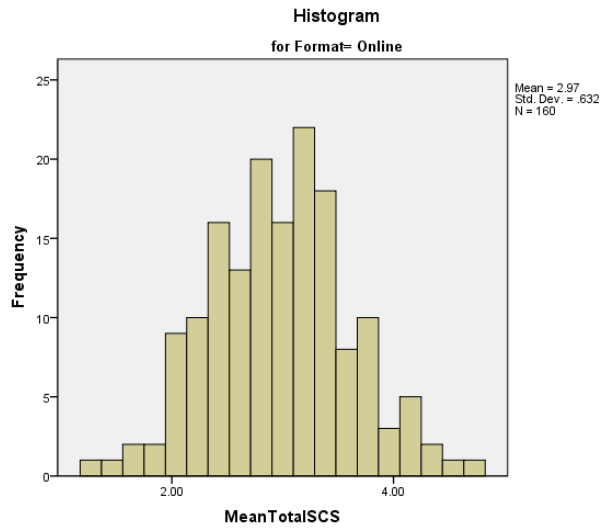
Paper participants
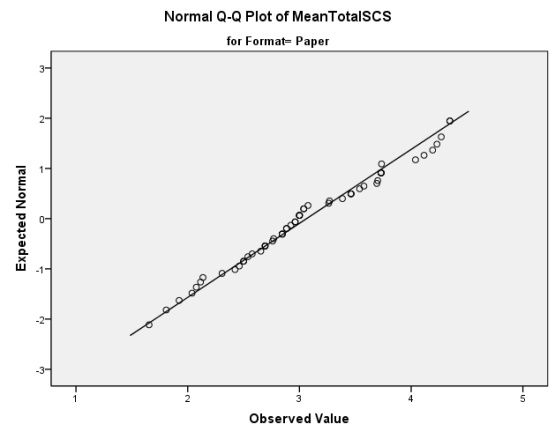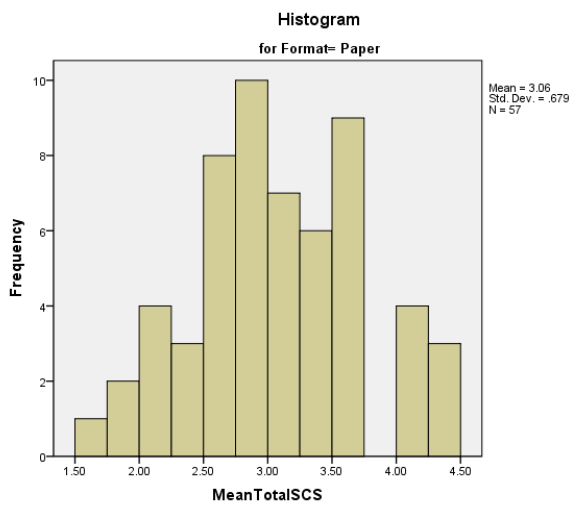
Appendix AA: Community sample SCS: Histograms, Q-Q plots and box plots

Total SCS
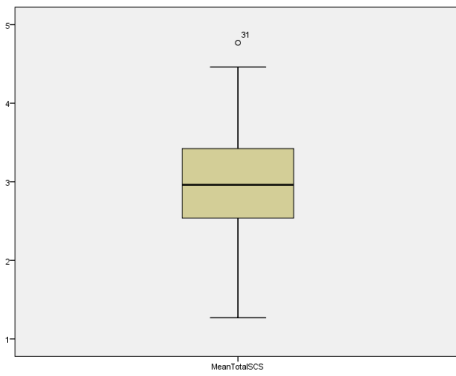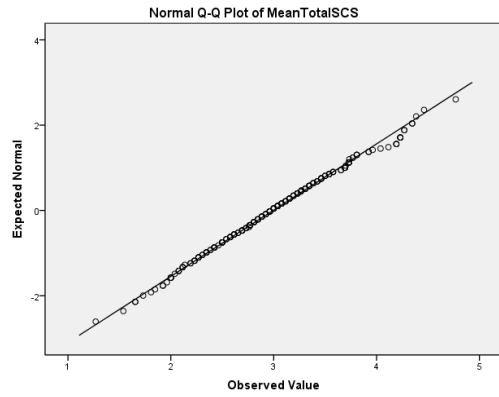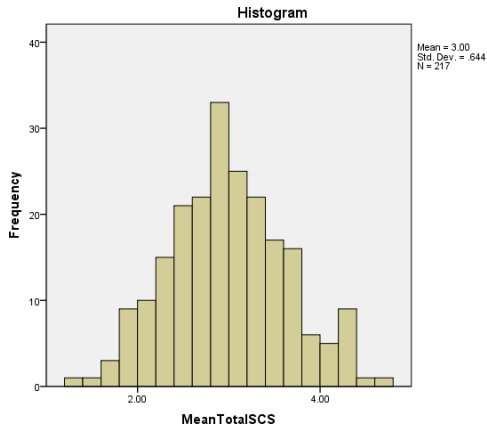
Self-kindness subscale

Self-judgement subscale

Histogram

Mean = 3.02
Std. Dev. = .80
N = 217

Normal Q-Q Plot of NEWSELFJUDGEMENT

Common humanity subscale

Histogram

Mean = 3.12
Std. Dev. = .933
N = 217
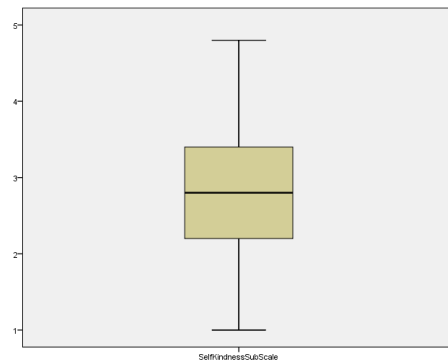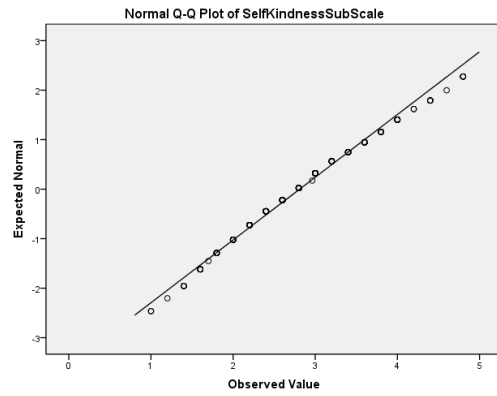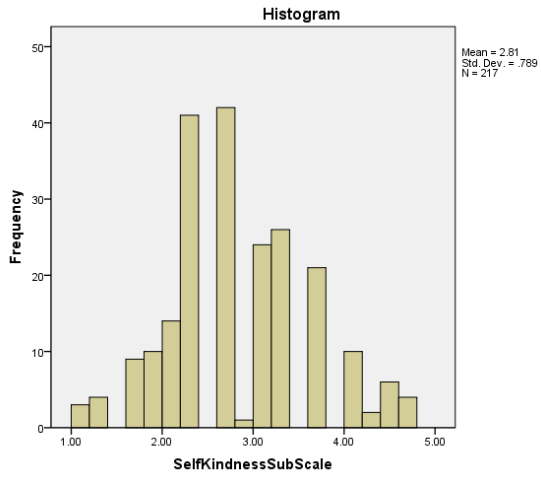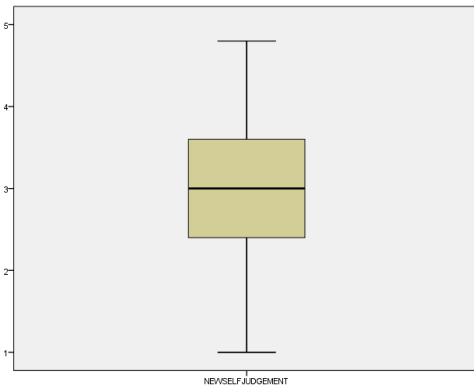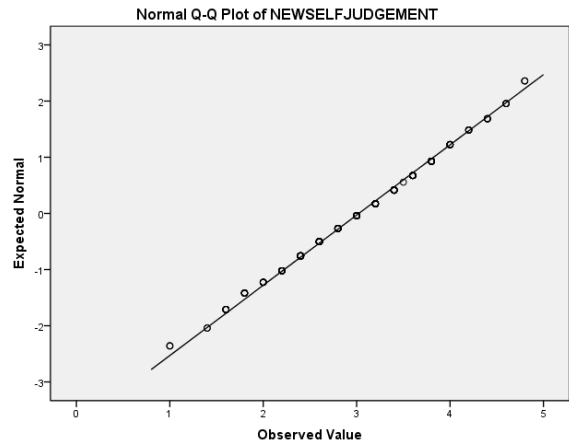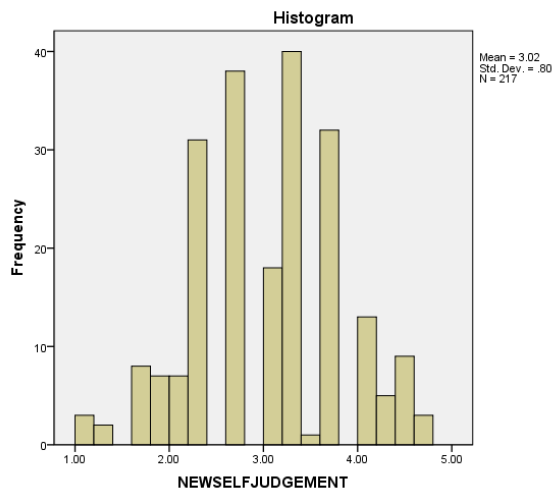
Normal Q-Q Plot of CommonHumanitySubScale
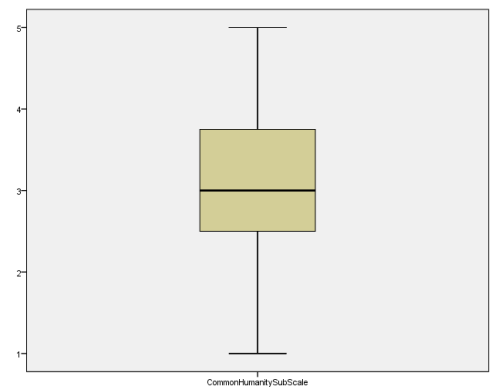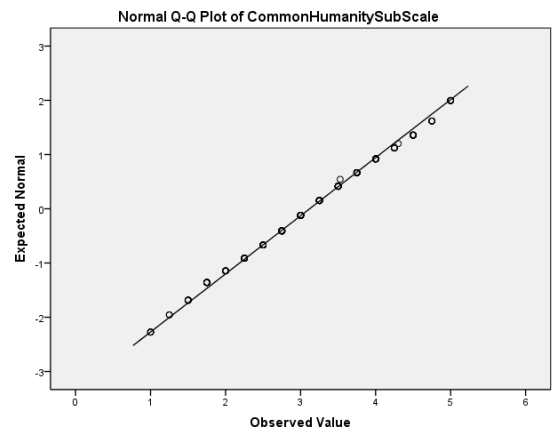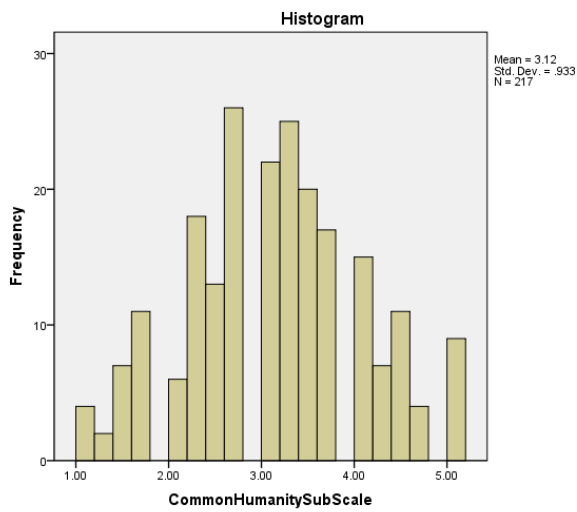
Isolation subscale
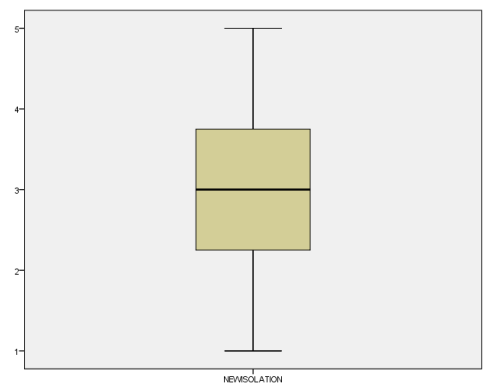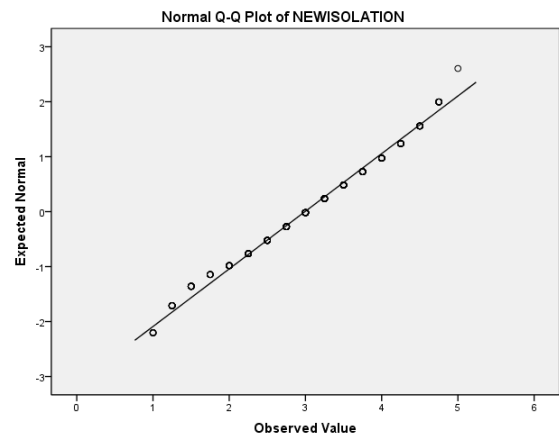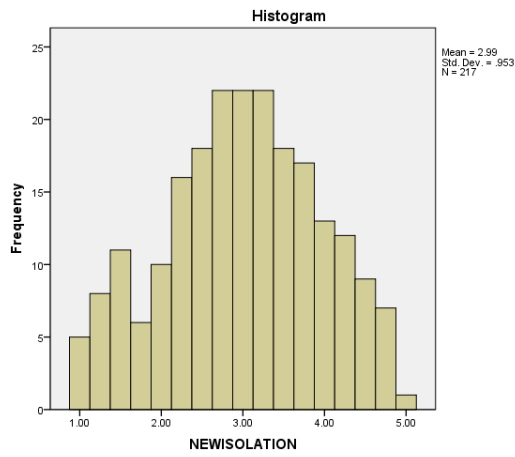
Mindfulness subscale

Over-identification subscale

Histogram

Mean = 3.14
Std. Dev. = .923
N = 217

Normal Q-Q Plot of NEWOVERIDENTIFICATION
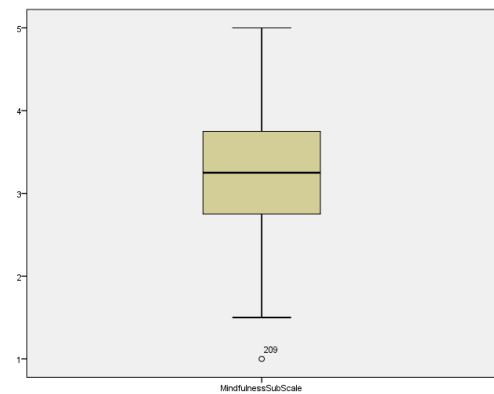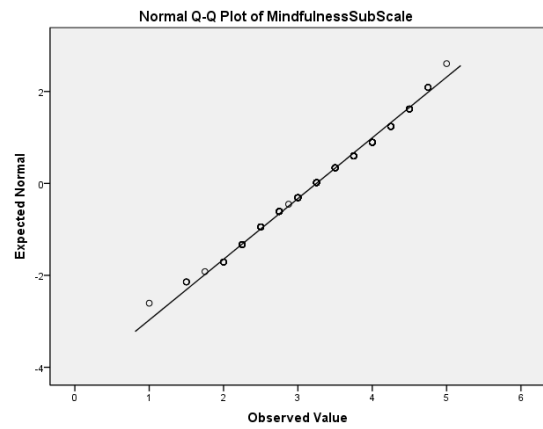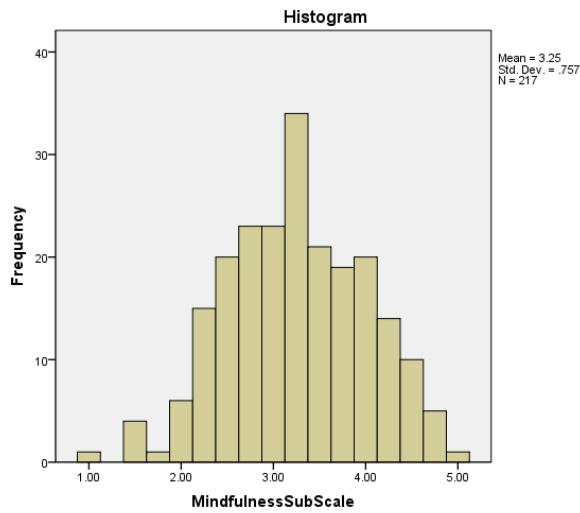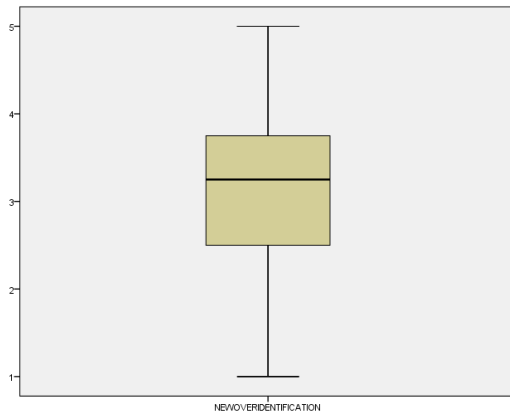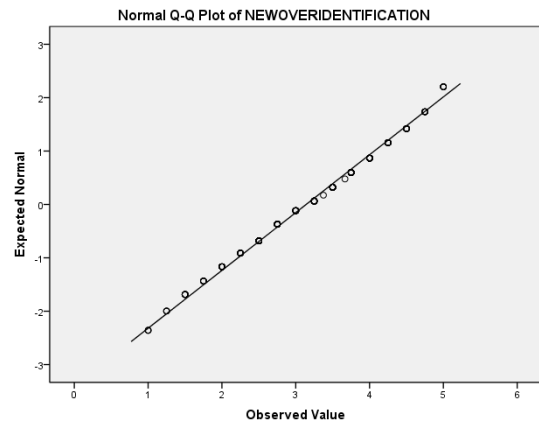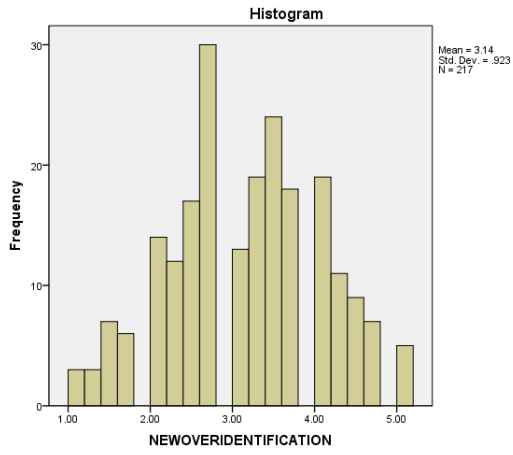
Appendix AB: Community sample: demographic parametric checks

Table AB 1. Community sample parametric assumptions, demographic variables

	Skewness	Kurtosis	Shapiro-Wilks Sig.
Age	4.5	-1.71	.000
Years of employment	4.08	-2.11	.000

Histograms, Q-Q plots and Box and Whisker plots

Age
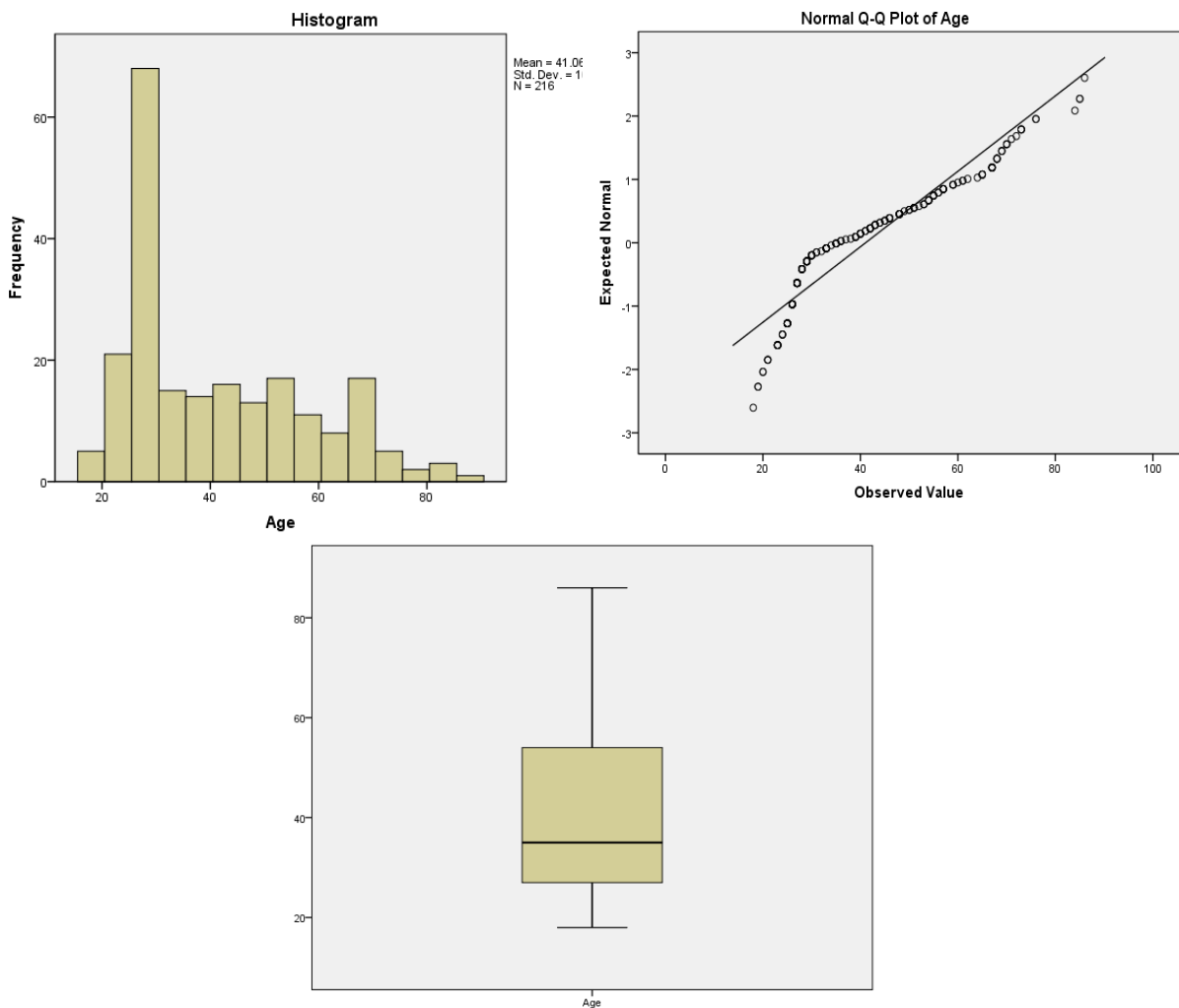
Years of employment
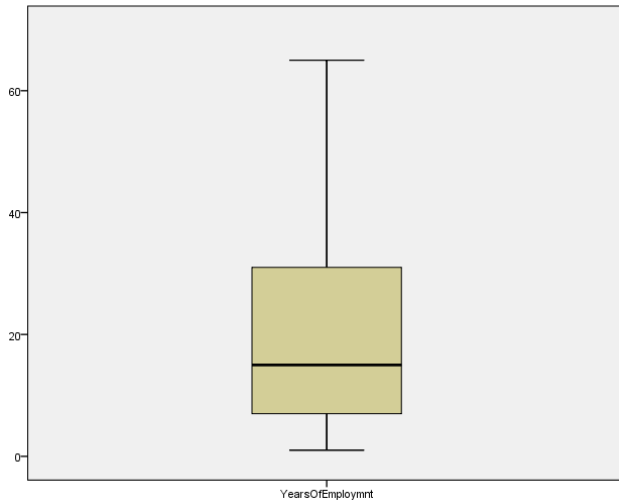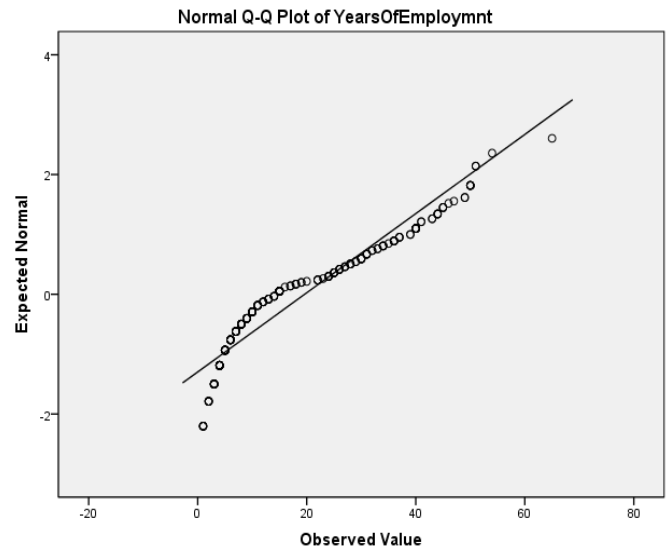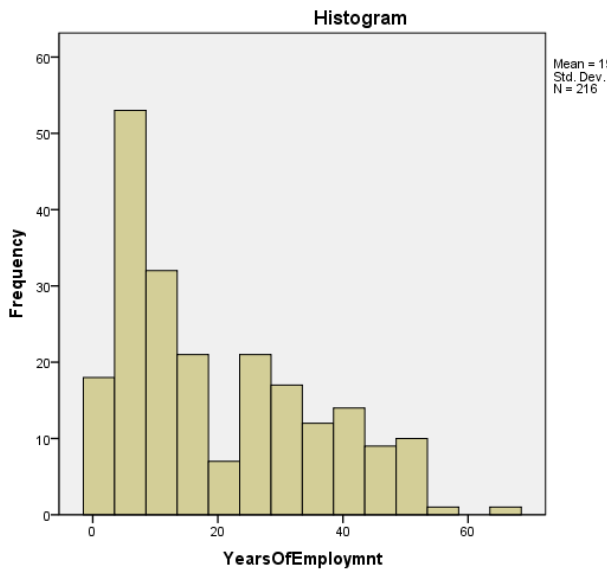
Appendix AC: Community sample: Geographical spread of participants

County	Frequency	Percent
Armagh	1	.5
Ayrshire	1	.5
Bedfordshire	1	.5
Berkshire	1	.5
Buckinghamshire	1	.5
Cambridgeshire	1	.5
Carmarthenshire	1	.5
Cheshire	2	.9
East Yorkshire	3	1.4
ENGLAND	7	3.2
Essex	43	19.8
Flintshire	1	.5
Glamorgan	1	.5
Gloucestershire	2	.9
Hampshire	4	1.8
Hertfordshire	4	1.8
Kent	1	.5
Lanarkshire	1	.5
Lancashire	5	2.3
Leicestershire	2	.9
London	13	6.0
Merionethshire	2	.9
Midlothian	3	1.4
North Yorkshire	54	24.9
Northumberland	15	6.9
Oxfordshire	5	2.3
Somerset	3	1.4
South Yorkshire	2	.9
Staffordshire	1	.5
Suffolk	8	3.7
Surrey	5	2.3
Sussex	1	.5
Tyrone	1	.5

UK	1	.5
Warwickshire	1	.5
West Lothian (Linlithgowshire)	3	1.4
West Yorkshire	5	2.3
Wigtownshire	1	.5
Yorkshire	6	2.8
Total	217	100.0

Appendix AD: Psychologist sample: demographic data parametric checks

Table AD 1 Trainee and qualified demographic parametric tests

	Skewness	Kurtosis	Shapiro-Wilks Sig.
Trainees			
Age	11.14	14.45	.000
Years of clinical experience	8.47	12.04	.000
Hours of SC teaching	9.57	7.03	.000
Qualified CP's			
Age	2.68	-1.44	.000
Years of clinical experience	4.64	.48	.000

Note. SC= Self-compassion

Trainee CP histograms, Q-Q plots and Box and Whisker plots

Age
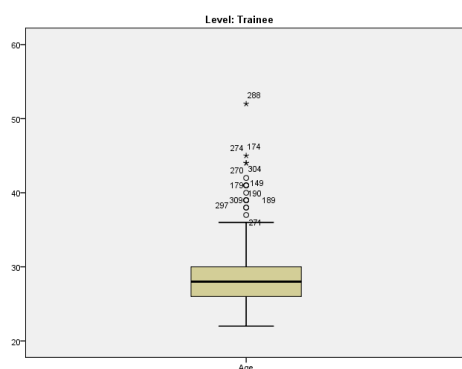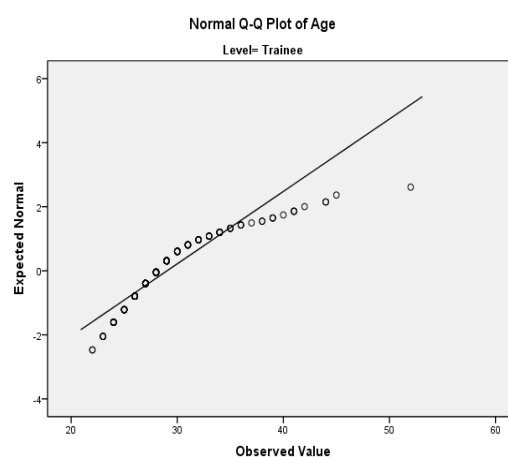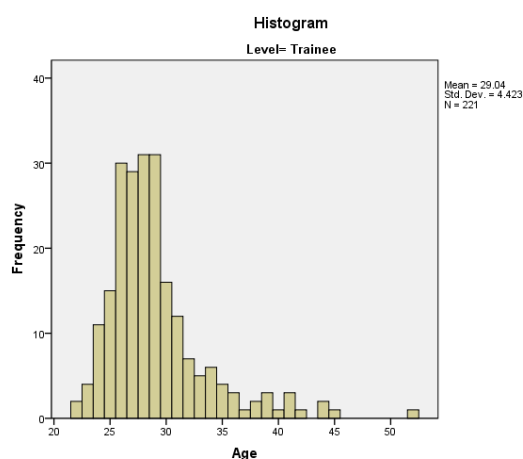
Years of clinical experience
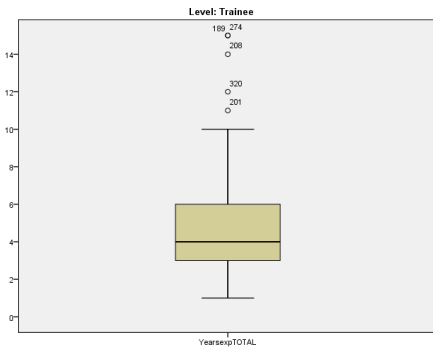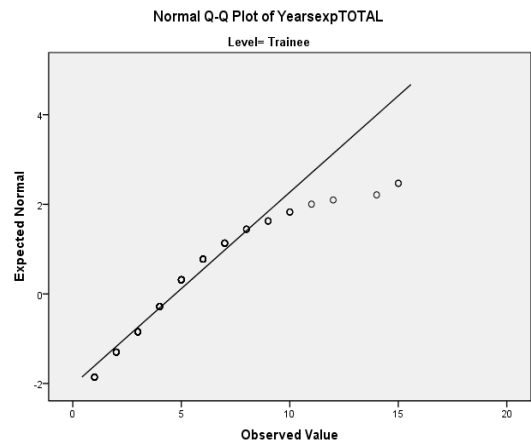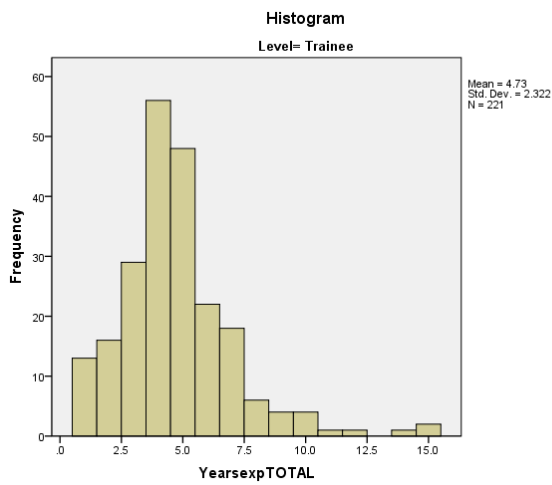
Trainees only; number of hours of Self-compassion teaching
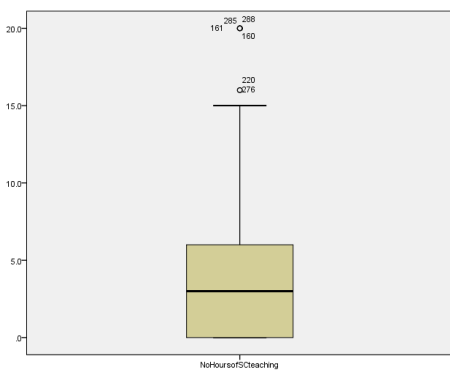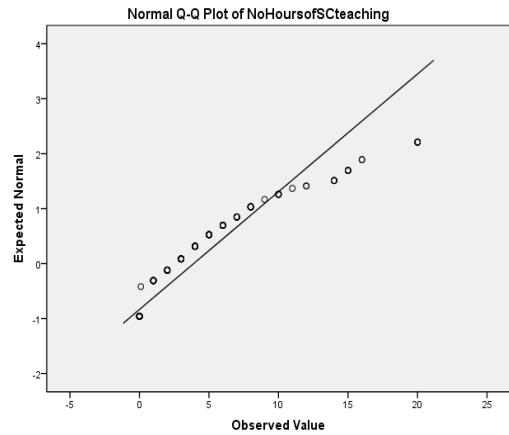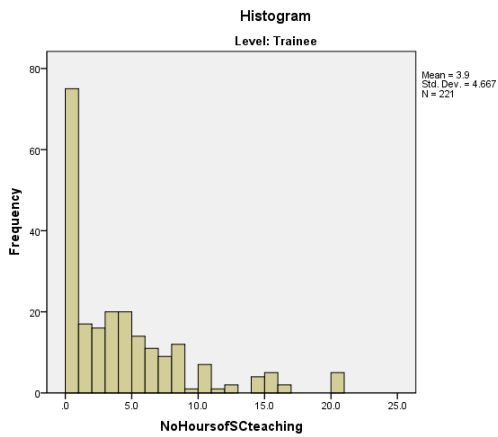
Qualified CP histograms, Q-Q plots and Box and Whisker plots

Age
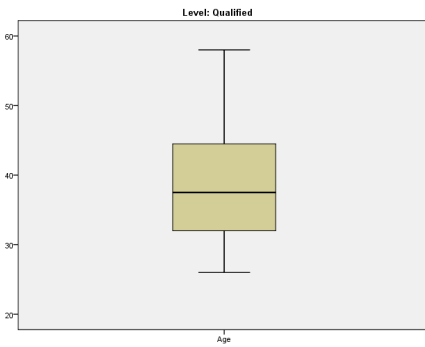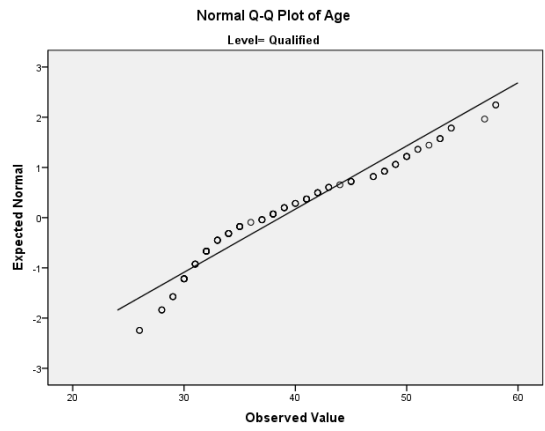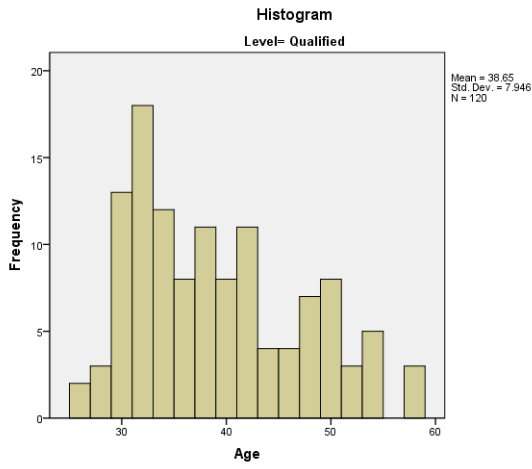
Years of clinical experience
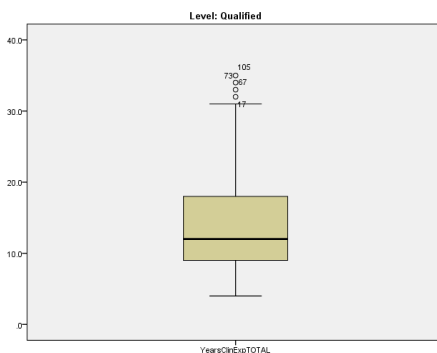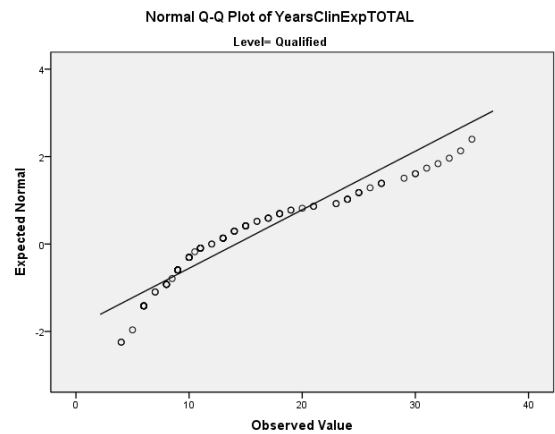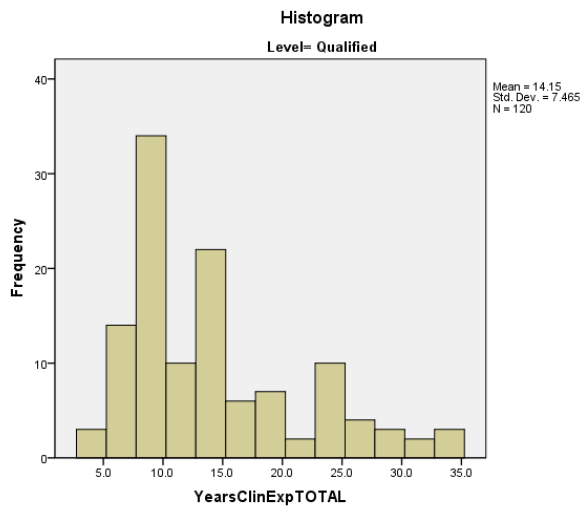
Appendix AE: Psychologist demographic data; ethnicity and religion

Table AE1 Trainee ethnicity and religion data

	n	(%)		*n*	(%)
Ethnicity			Religion		
White (UK)	180	81.4	Christian	53	24
White Irish	12	5.4	Jewish	2	.9
White and Asian	2	.9	Buddhist	4	1.8
White and Black Caribbean	1	.5	Jewish	2	.9
Other White background	12	5.4	Muslim	1	.5
Gypsy or Irish traveller	1	.5	Sikh	2	.9
Multiple Ethnicity	3	1.4	No religion	143	64.7
Black British	1	.5	Would rather not say	7	3.2
Asian British	4	1.8	Missing data	4	1.8
Indian	1	.5			
Pakistani	1	.5			
Chinese	1	.5			
Arab	1	.5			
Missing data	1	.5			

Table AE2 Qualified CP ethnicity and religion data

	n	(%)		*n*	(%)
Ethnicity			Religion		
White (UK)	104	86.7	Christian	32	26.7
White Irish	5	4.2	Jewish	1	.8
White and Asian	2	1.7	Buddhist	1	.8
Other White background	7	5.8	Other religion NOS	2	1.7
Multiple Ethnicity	1	.8	No religion	80	66.7
Other ethnic group NOS	1	.8	Would rather not say	3	2.5
Missing data	-	-	Missing data	1	.8

Note. NOS = Not otherwise specified.

Appendix AF: Psychologist Scatterplot matrix of all study variables

Figure AF 1. Trainee matrix of all study variables.

Level: Trainee

Figure AF 2. Qualified CP matrix of all study variables.

Level: Qualified

Appendix AG: Psychologist predictor and outcome variables; Histograms, Q-Q plots and Box plots

Self-compassion Scale

Trainees
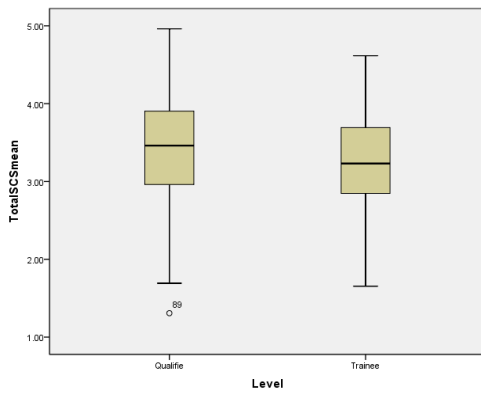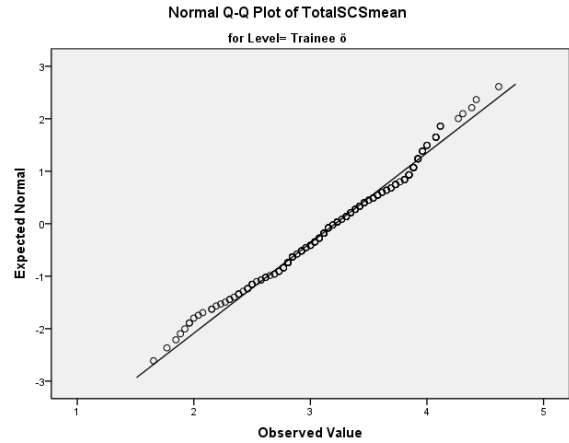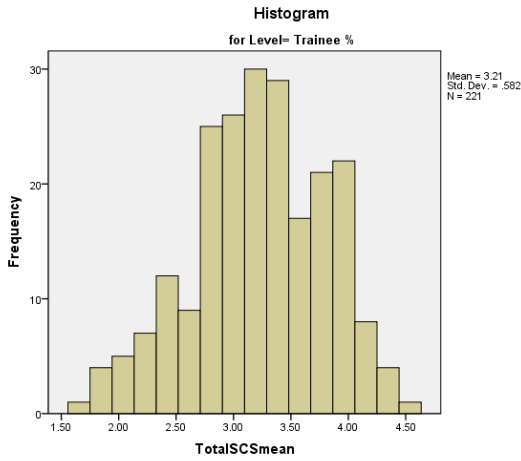
Qualified CP's
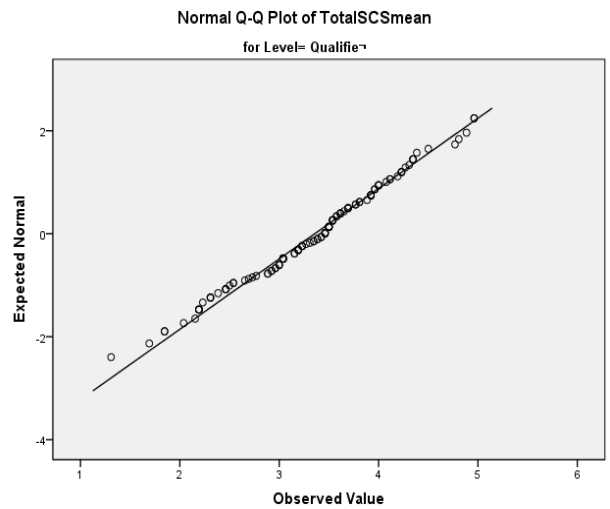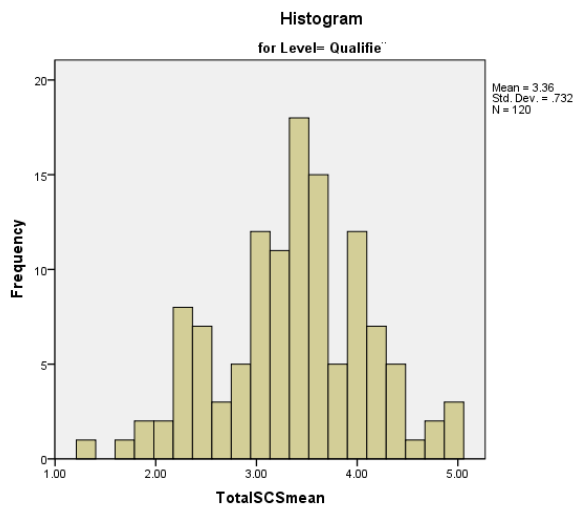
Perceived stress scale

Trainees
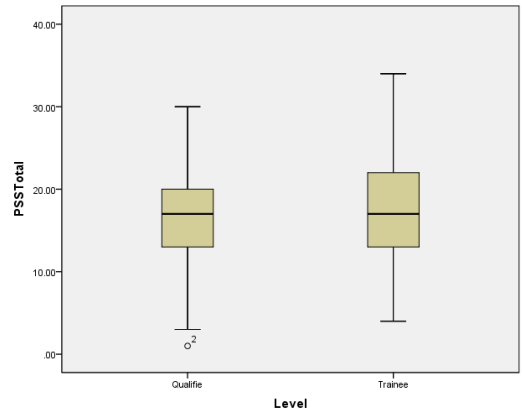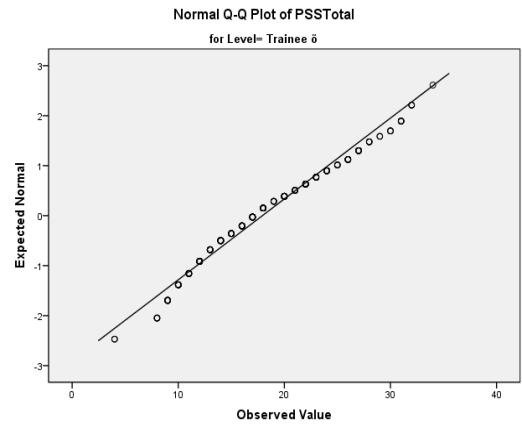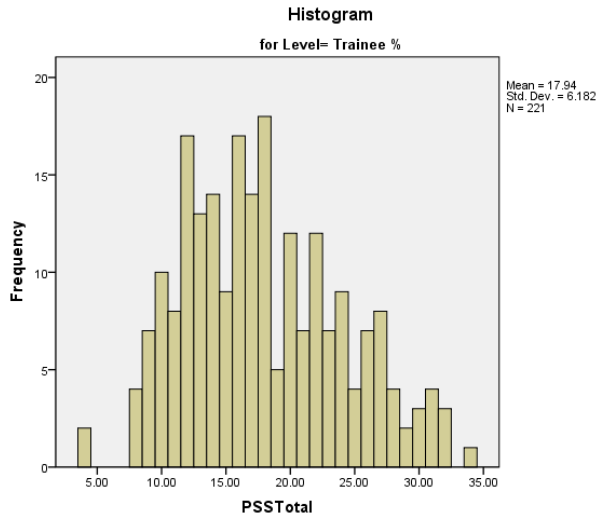
Qualified CP's
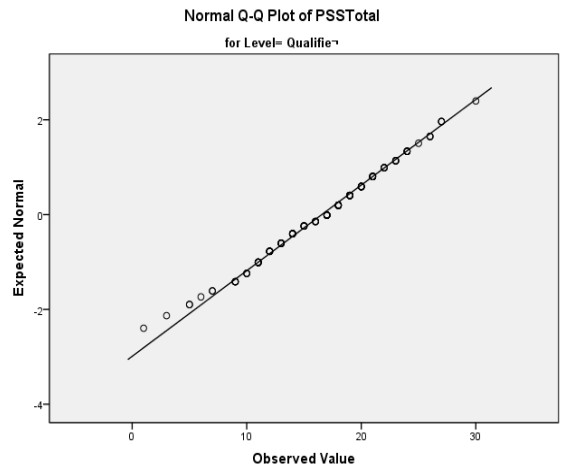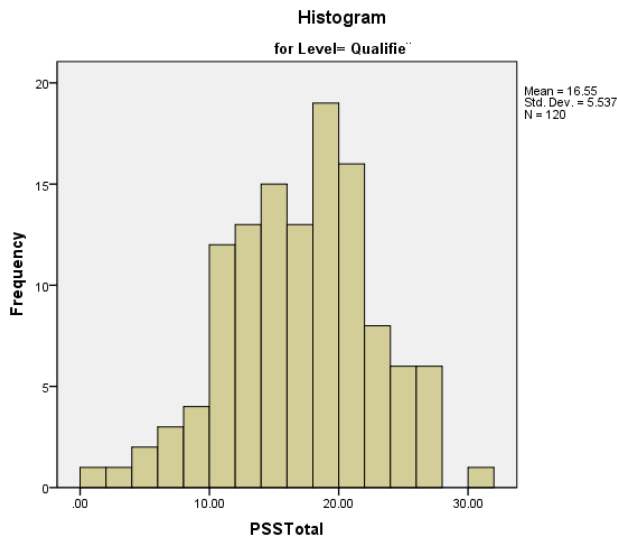
Fear of Giving Compassion
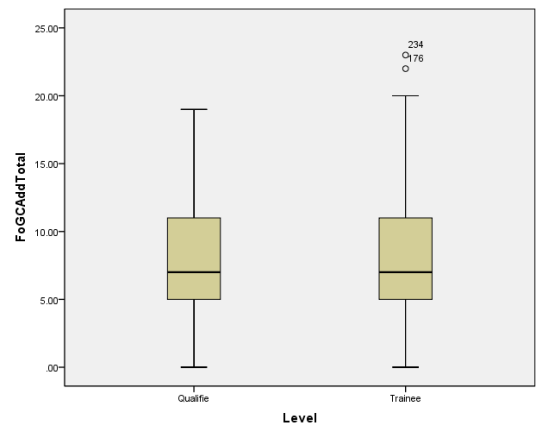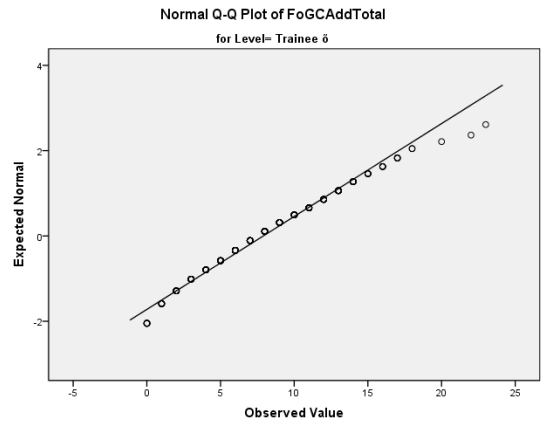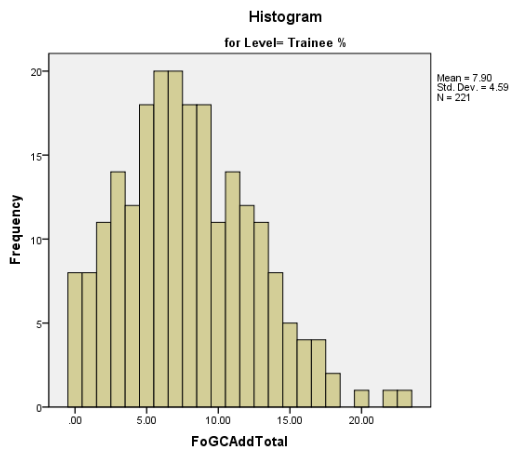
Trainees
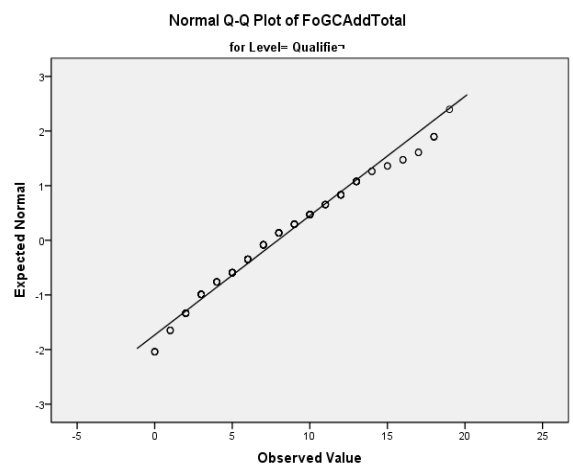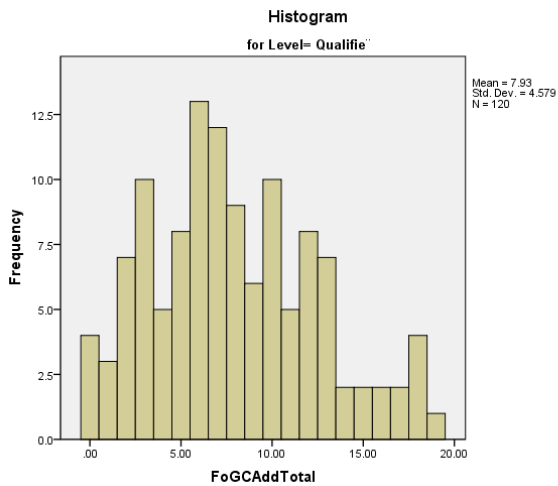
Qualified CP's

Fear of Receiving Compassion
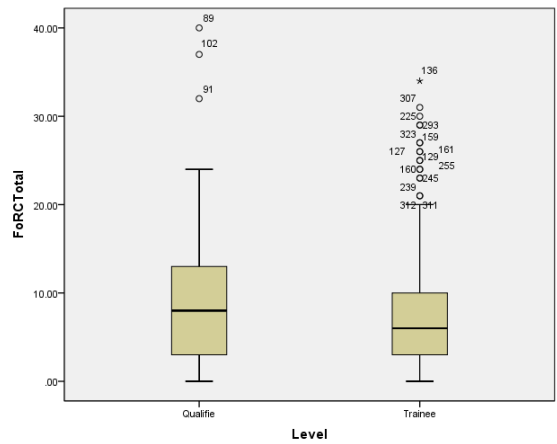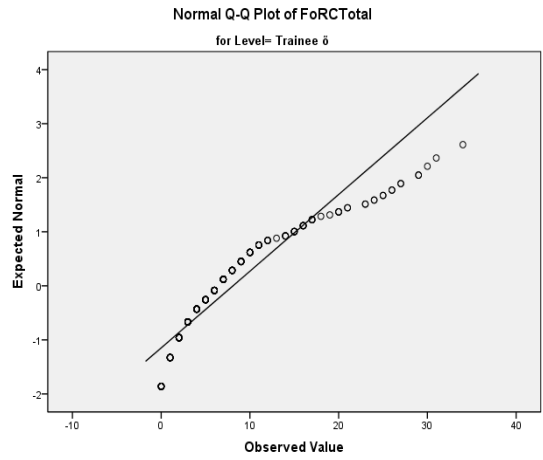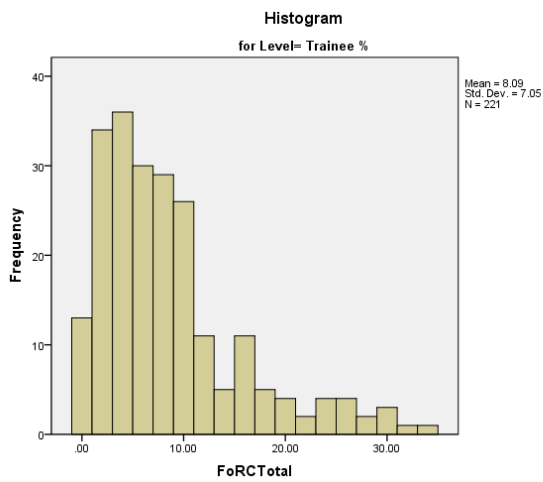
Trainees

Qualified CP's

Fear of self-compassion

Trainees

Histogram

for Level= Trainee %

Mean = 9.40
Std. Dev. = 8.255
N = 221

Normal Q-Q Plot of FoSCTotal

for Level= Trainee ŏ

Qualified CP's

Histogram

for Level= Qualifie¨

Mean = 8.26
Std. Dev. = 7.301
N = 120

Normal Q-Q Plot of FoSCTotal

for Level= Qualifie¬
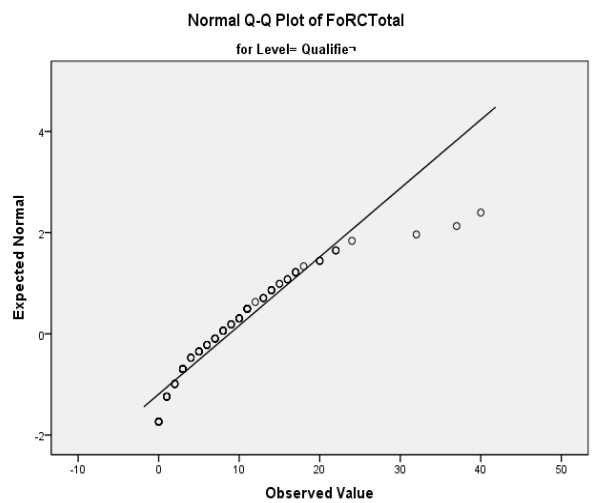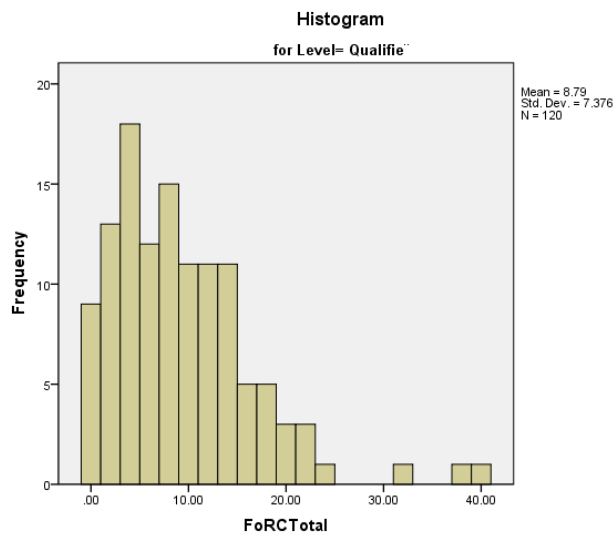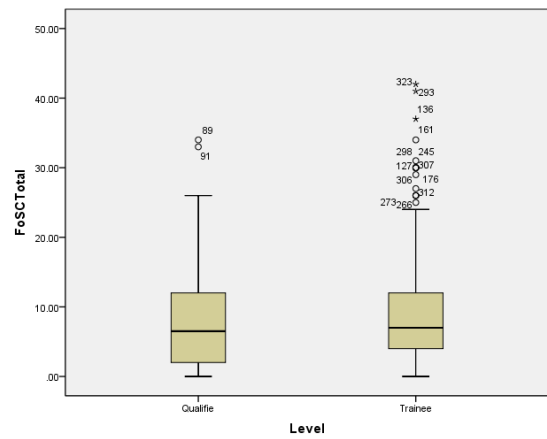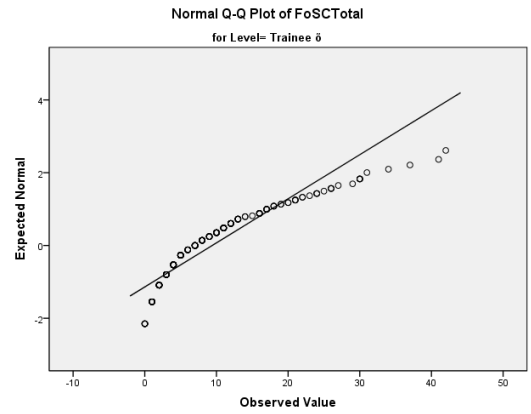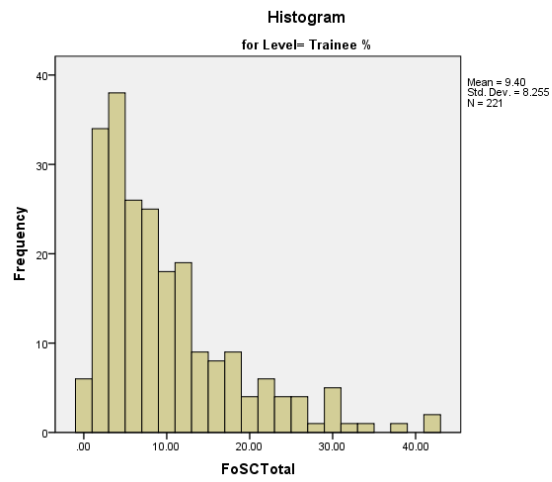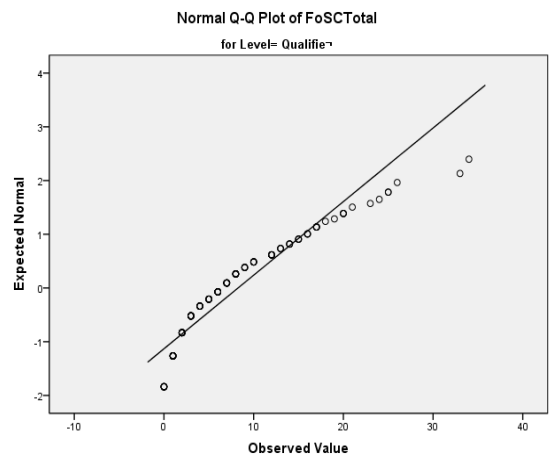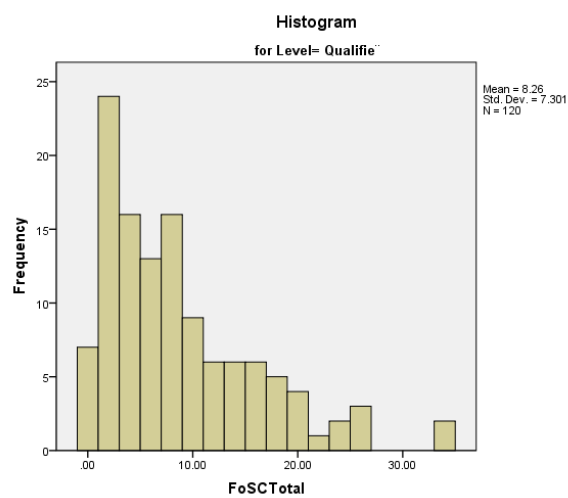
General Health Questionnaire- 12

Trainees
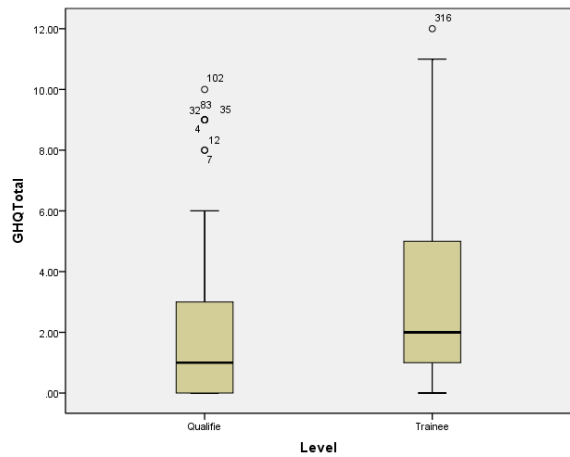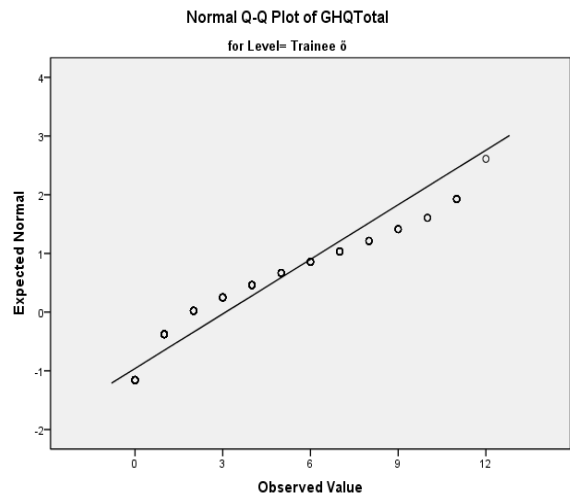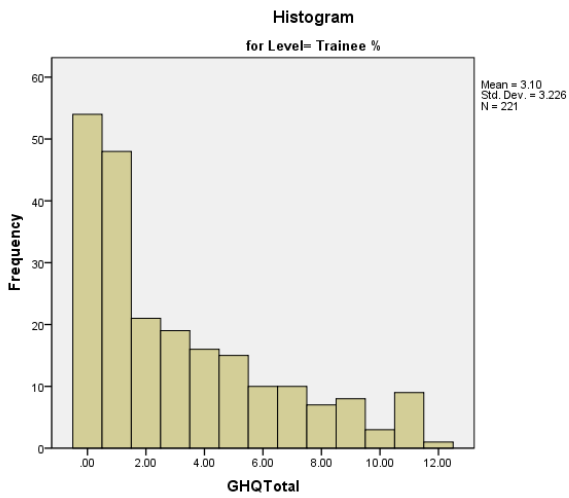
Qualified CP's
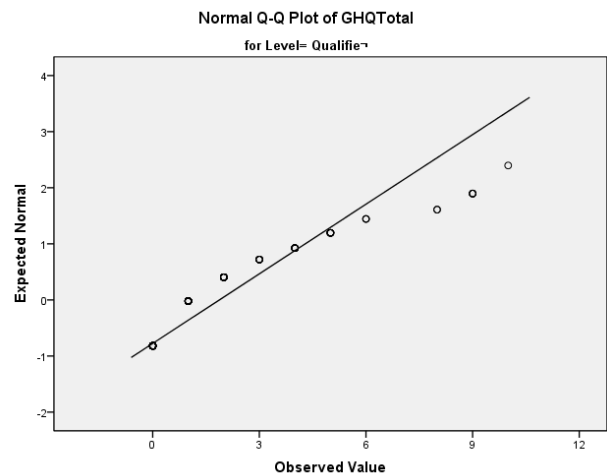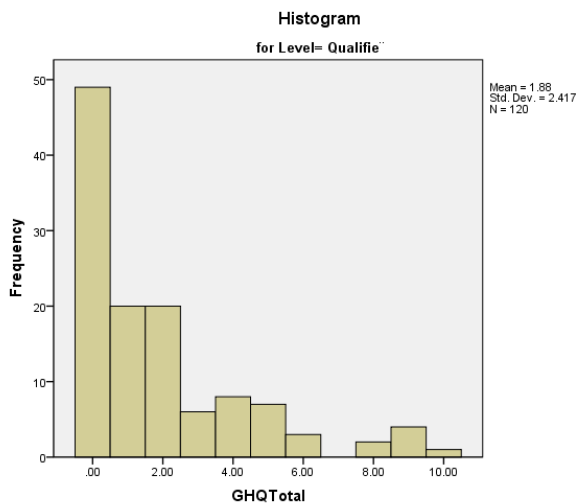
Social Connectedness Scale

Trainees

Histogram

for Level= Trainee %

Mean = 38.69
Std. Dev. = 8.361
N = 221

Normal Q-Q Plot of SoCS1Total

for Level= Trainee ö

Qualified CP's

Histogram

for Level= Qualifie¨

Mean = 38.09
Std. Dev. = 7.9
N = 120

Normal Q-Q Plot of SoCS1Total

for Level= Qualifie¬
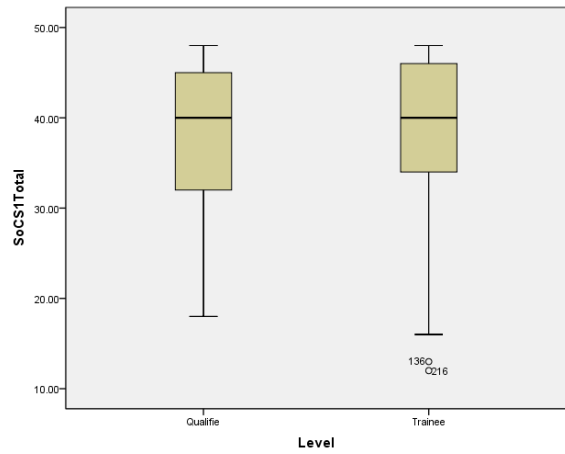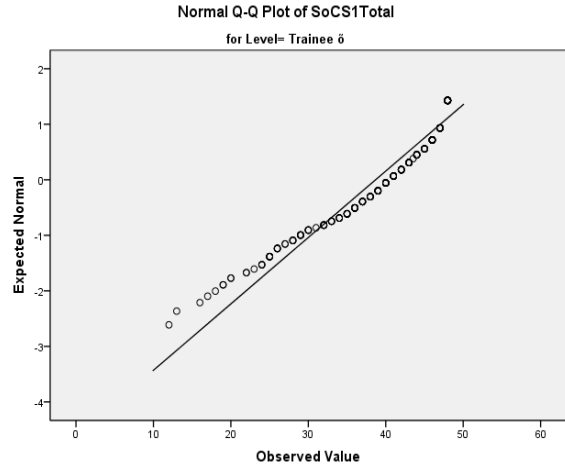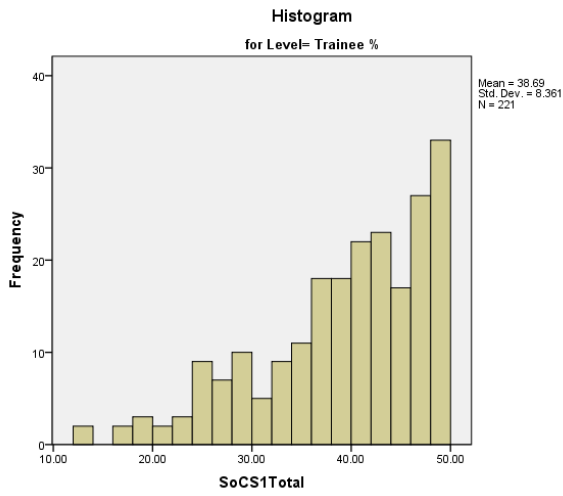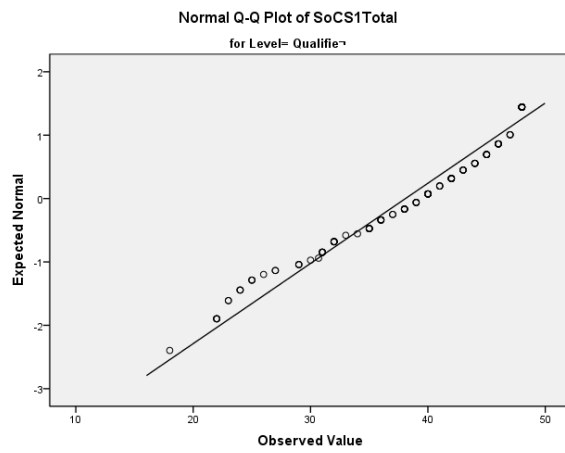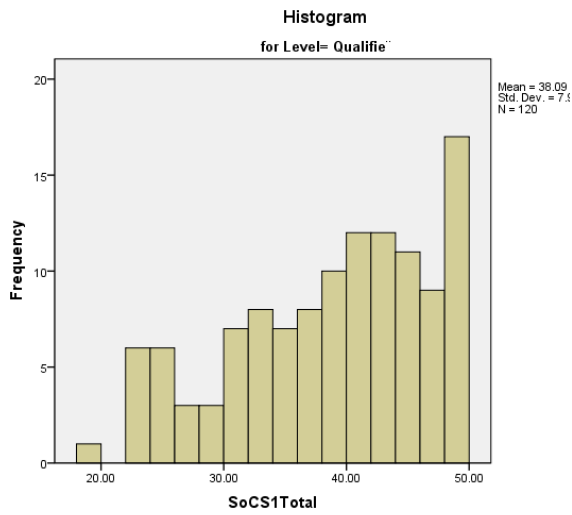
Age
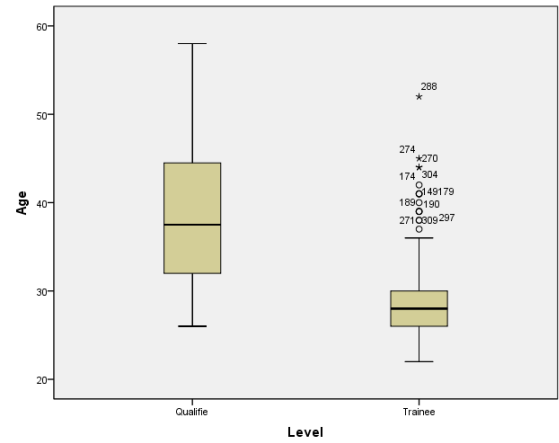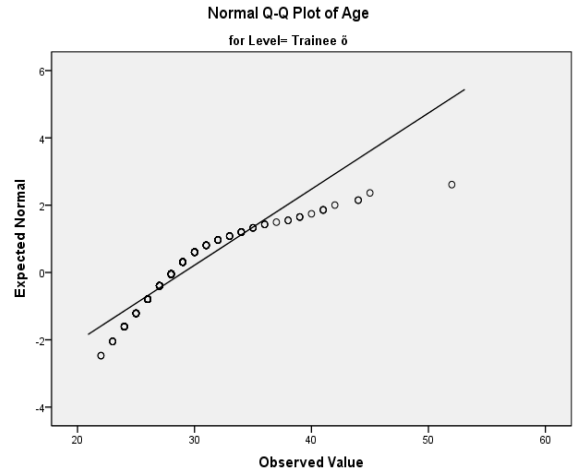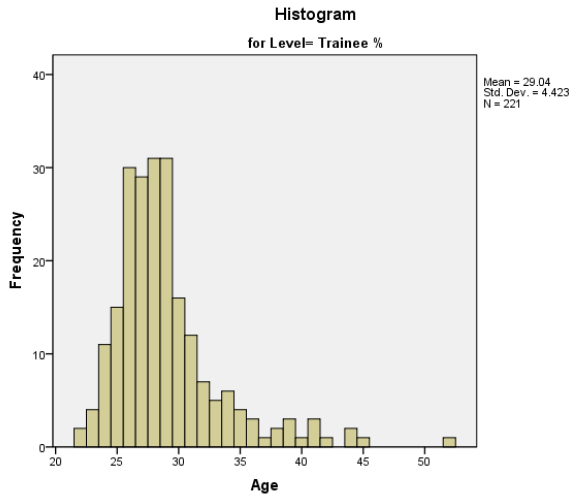
Trainees

Qualified CP's

Years of clinical experience

Trainees

Histogram

for Level= Trainee %

Mean = 4.73
Std. Dev. = 2.322
N = 221

Normal Q-Q Plot of YearsexpTOTAL

for Level= Trainee ö

Qualified CP's

Histogram

for Level= Qualifie¨

Mean = 14.15
Std. Dev. = 7.465
N = 120

Normal Q-Q Plot of YearsexpTOTAL

for Level= Qualifie¬
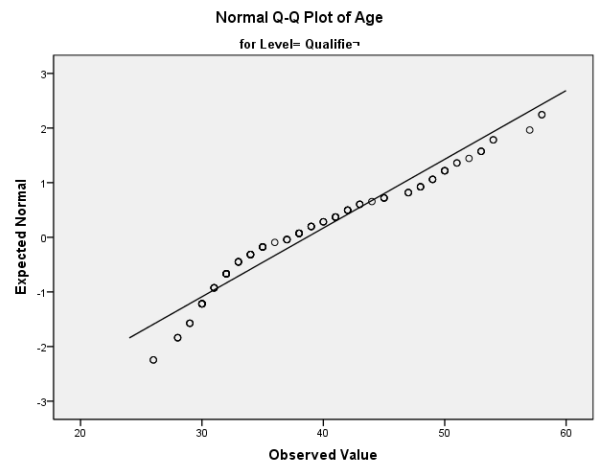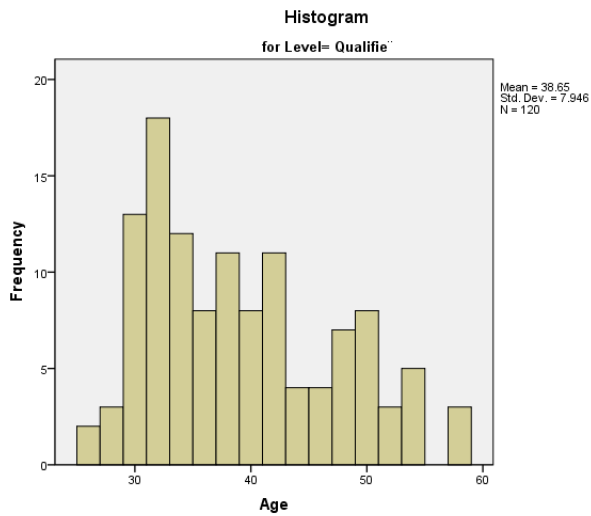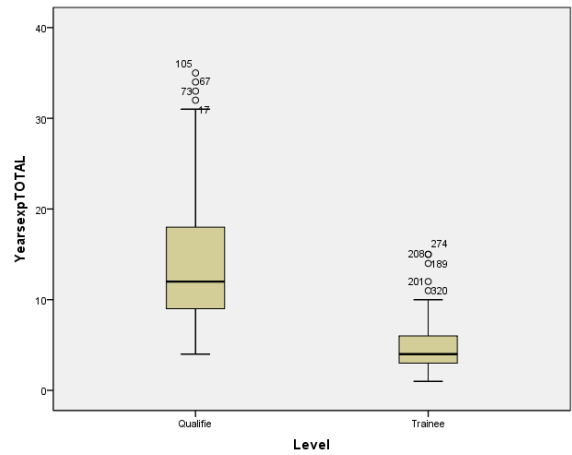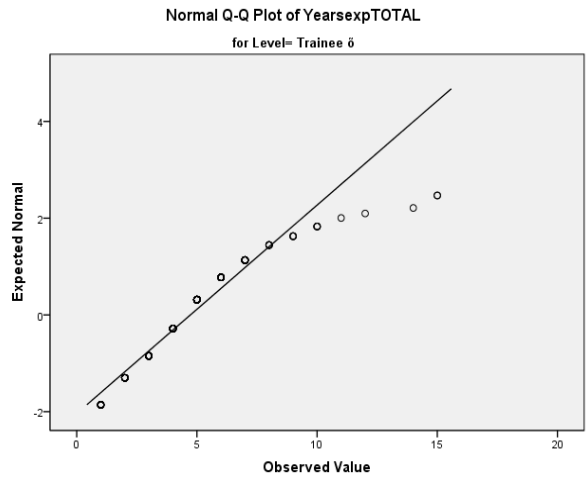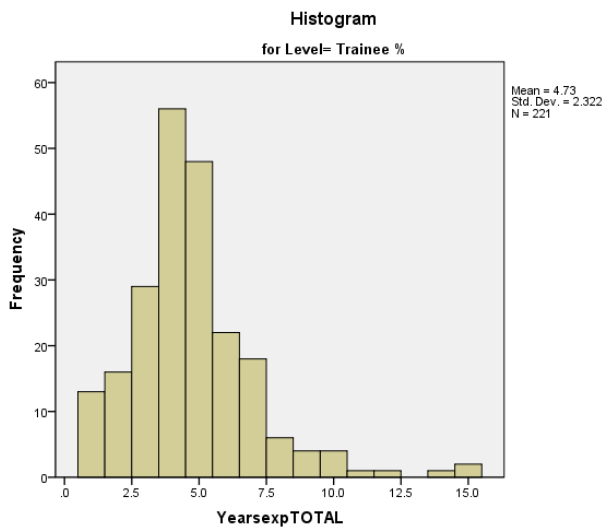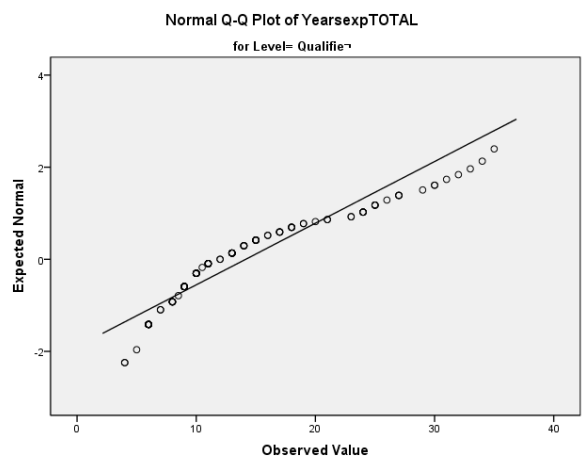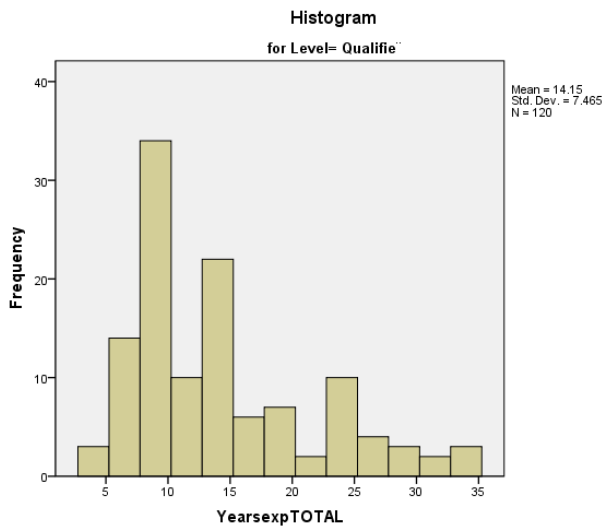
Appendix AH: Psychologist parametric checks; Homogeneity of variance

Table AH1. Homogeneity of variance checks between trainee and qualified CP's.

	Levene's test Sig.
Total SCS	.016*
Age	.000*
Years of clinical experience	.000*
PSS	.152
GHQ-12	.000*
FoGC	.930
FoRC	.573
FoSC	.321
SoCS-R	.767

Note. Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale-Revised.
* $p > 0.05$.

Appendix AI: Psychologist SCS Subscale parametric checks.

Table AI 1. Trainee Skewness and Kurtosis z-scores for SCS subscales.

* $p > 0.05$, [a] Based on Mean

	Mean (SD)	Skewness	Kurtosis	Shapiro-Wilks Sig.[a]
Total SCS	3.21 (.58)	1.69	0.92	0.39
Self-kindness	3.23 (.73)	-1.12	-0.27	0.02*
Self-Judgement	2.96 (.78)	0.80	-1.13	0.72
Common Humanity	3.41 (.81)	-1.16	-1.70	.003*
Isolation	2.87 (.85)	1.20	-1.86	.003*
Mindfulness	3.55 (.65)	-1.19	0.37	.001*
Over Identification	3.04 (.79)	1.40	-1.47	.005*

Table AI 2. Qualified CP Skewness and Kurtosis z-scores for SCS subscales.
* $p > 0.05$, [a] Based on Mean

	Mean (SD)	Skewness	Kurtosis	Shapiro-Wilks Sig.[a]
Total SCS	3.36 (.73)	-1.05	-.12	.338
Self-kindness	3.41 (.85)	-1.33	.11	.081
Self-Judgement	2.77 (.92)	.91	-.62	.131
Common Humanity	3.51 (.83)	1.09	-.32	.011*
Isolation	2.73 (.92)	-0.2	-1.65	.039*
Mindfulness	3.67 (.75)	-.65	-1.37	.015*
Over Identification	2.93 (.89)	0.73	-.65	.148

Trainee and Qualified CP Histograms, Q-Q plots and Box-plots for all subscales

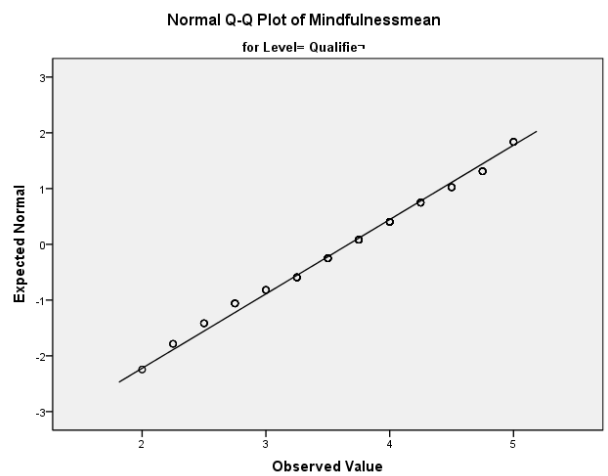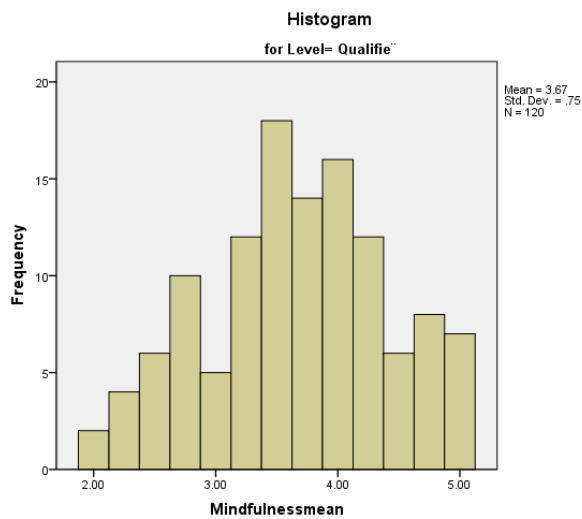Self-Kindness subscale

Trainees
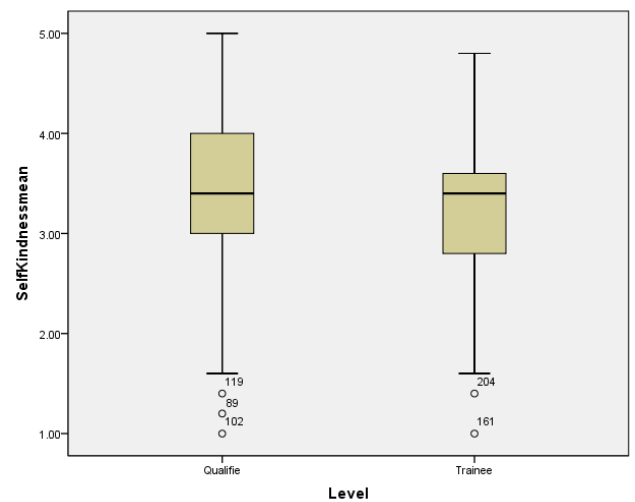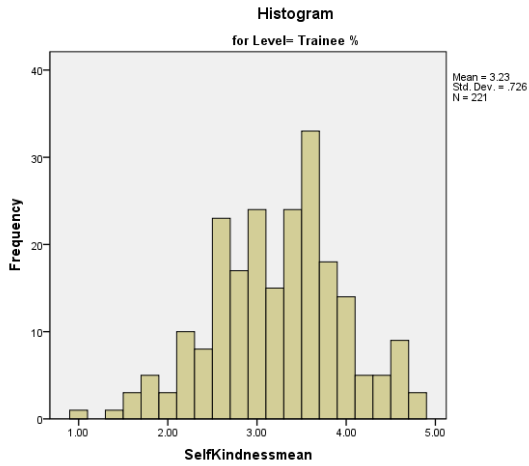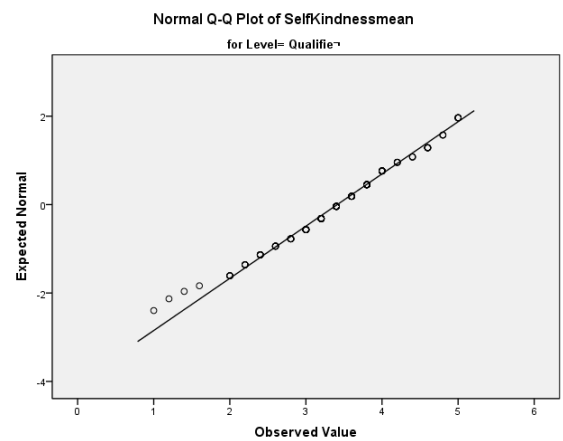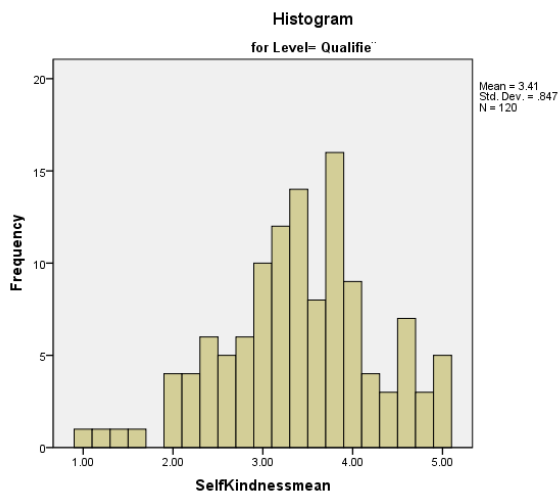
Qualified CP

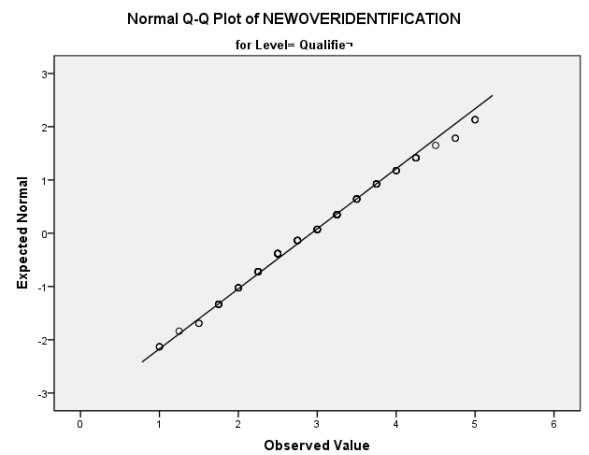## Self-judgement subscale

Trainees

Histogram

for Level= Trainee %

Mean = 2.96
Std. Dev. = .781
N = 221

Normal Q-Q Plot of NEWSELFJUDGEMENT

for Level= Trainee ö

Qualified CP

Histogram

for Level= Qualifie¨

Mean = 2.77
Std. Dev. = .919
N = 120

Normal Q-Q Plot of NEWSELFJUDGEMENT

for Level= Qualifie¬
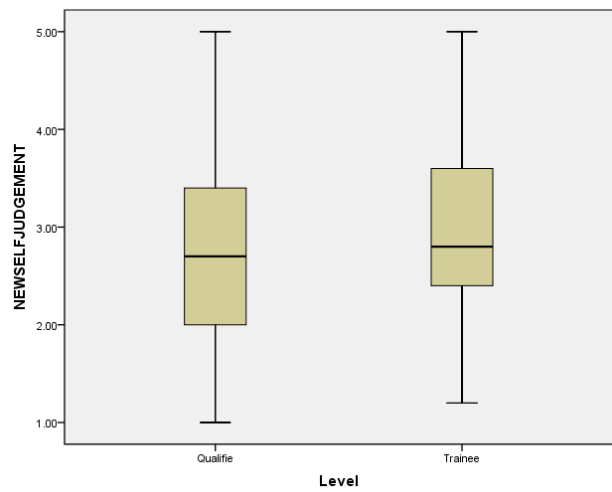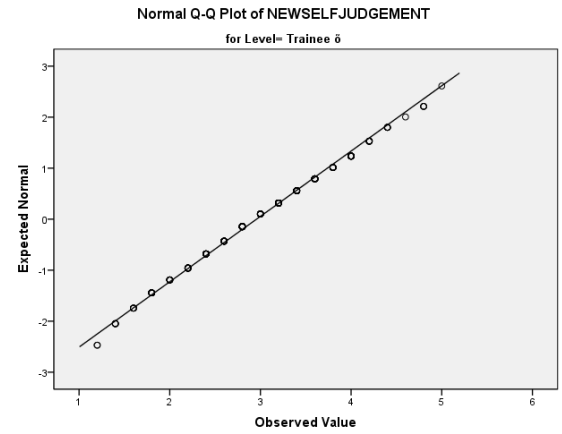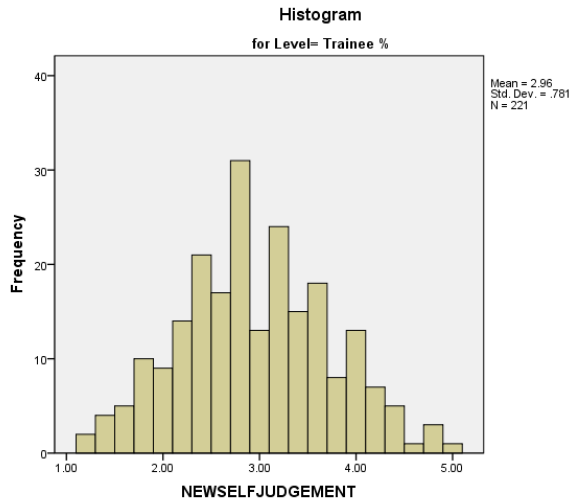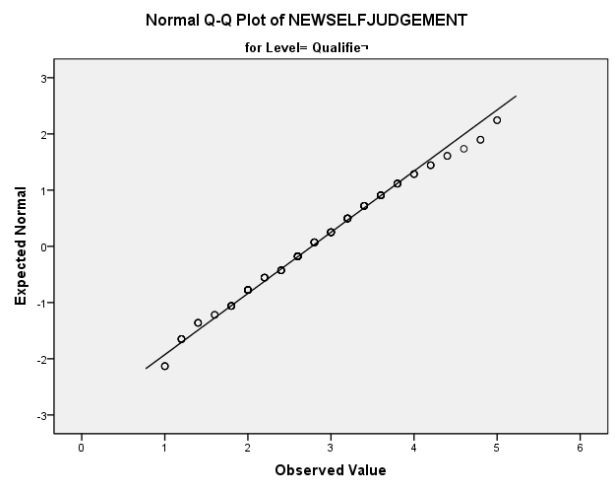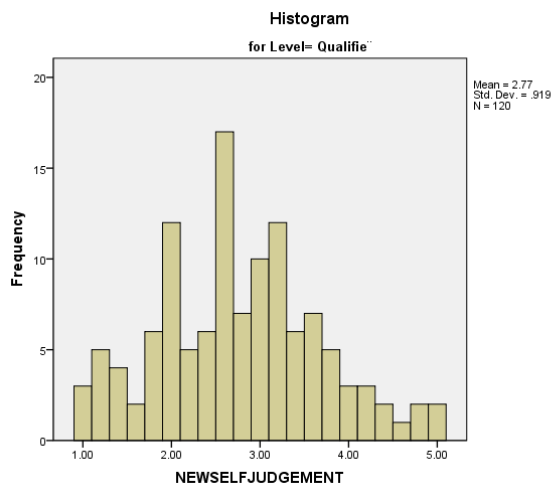
Common humanity subscale

Trainees

Histogram
for Level= Trainee %

Mean = 3.40
Std. Dev. = .812
N = 221

Normal Q-Q Plot of CommonHumanitymean
for Level= Trainee ö

Qualified CP

Histogram
for Level= Qualifie¨

Mean = 3.51
Std. Dev. = .832
N = 120

Normal Q-Q Plot of CommonHumanitymean
for Level= Qualifie¬
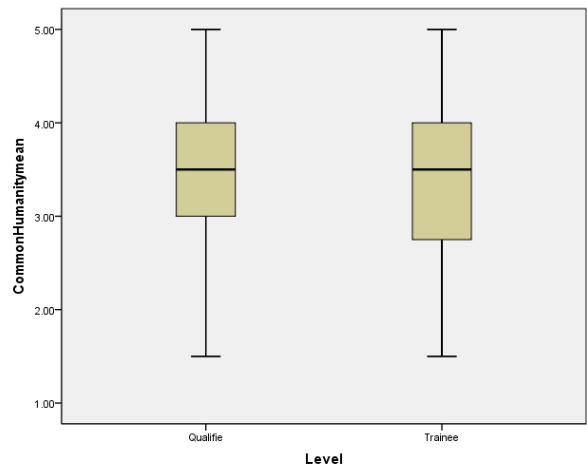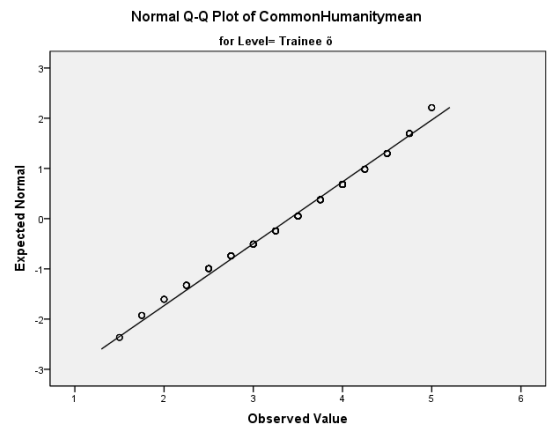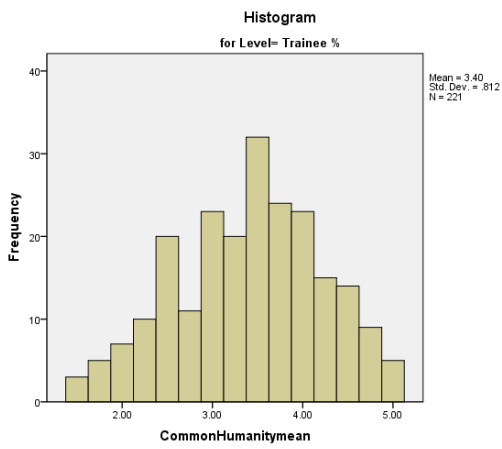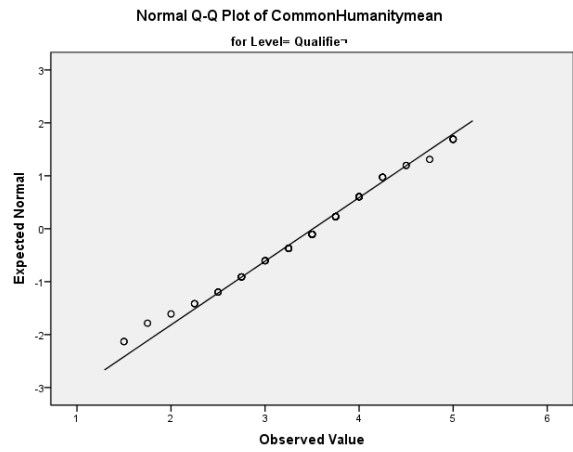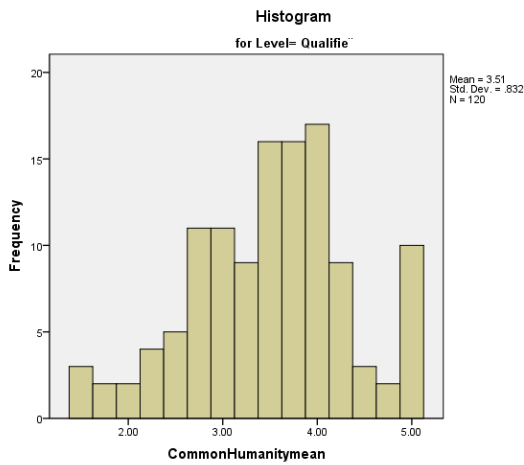
Isolation subscale
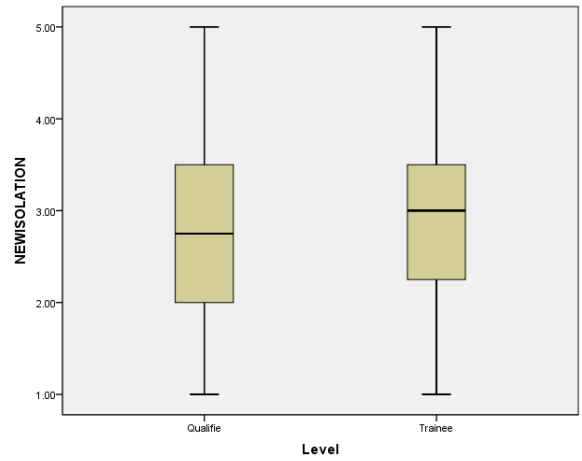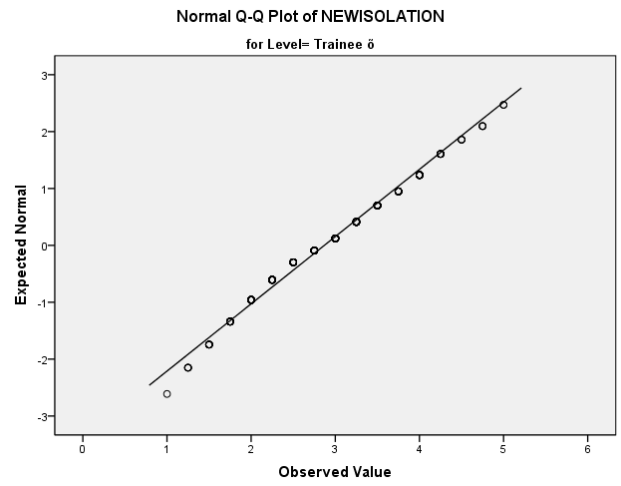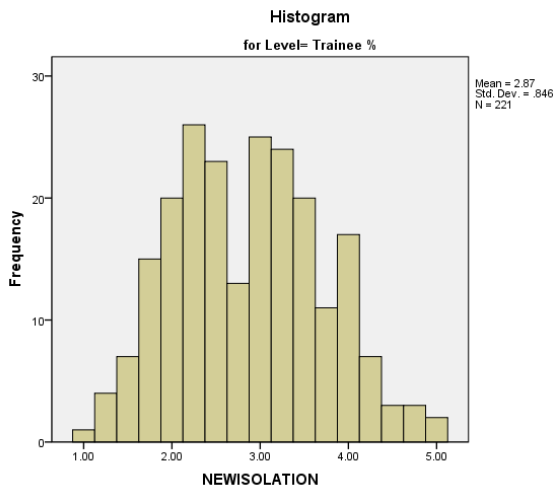
Trainees

Qualified CP

Mindfulness subscale

Trainees

Histogram

for Level= Trainee %

Mean = 3.55
Std. Dev. = .65
N = 221

Normal Q-Q Plot of Mindfulnessmean

for Level= Trainee ö

Qualified CP

Histogram

for Level= Qualifie¨

Mean = 3.67
Std. Dev. = .75
N = 120

Normal Q-Q Plot of Mindfulnessmean

for Level= Qualifie¬
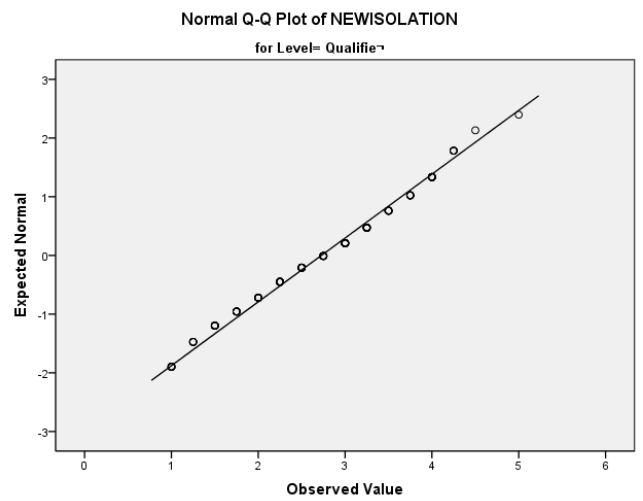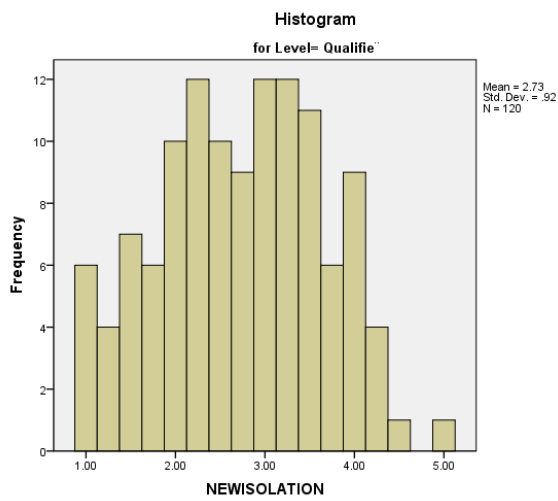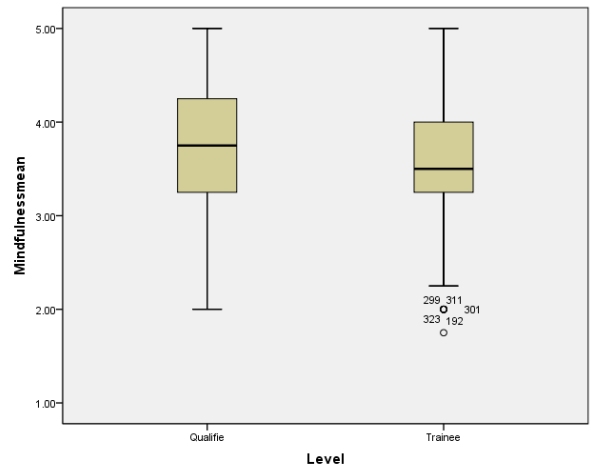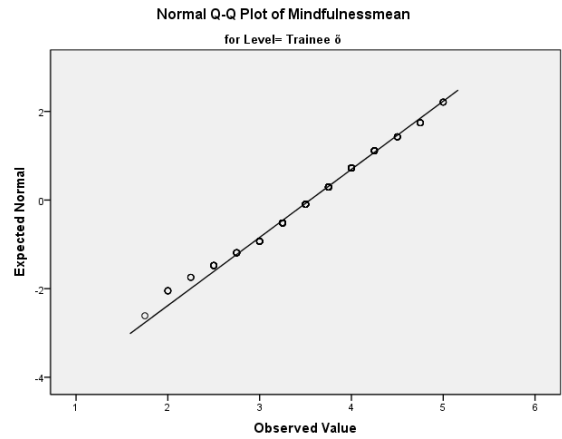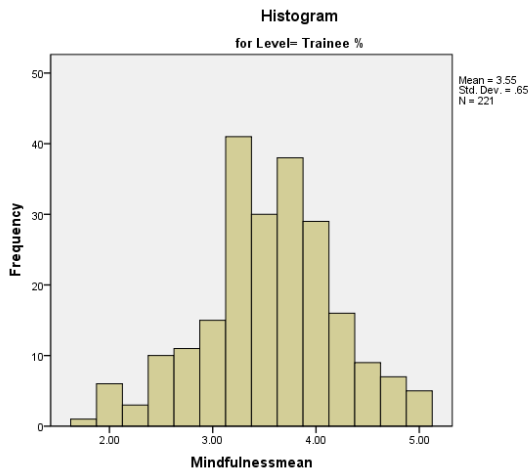
Over identification subscale

Trainees
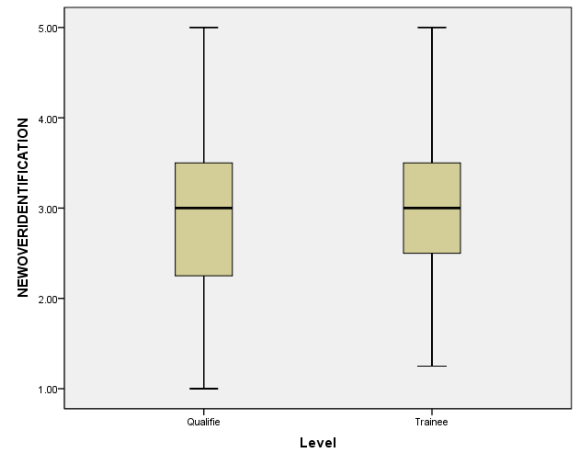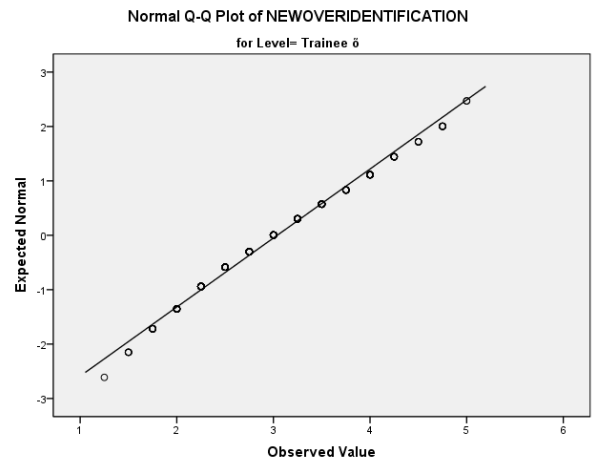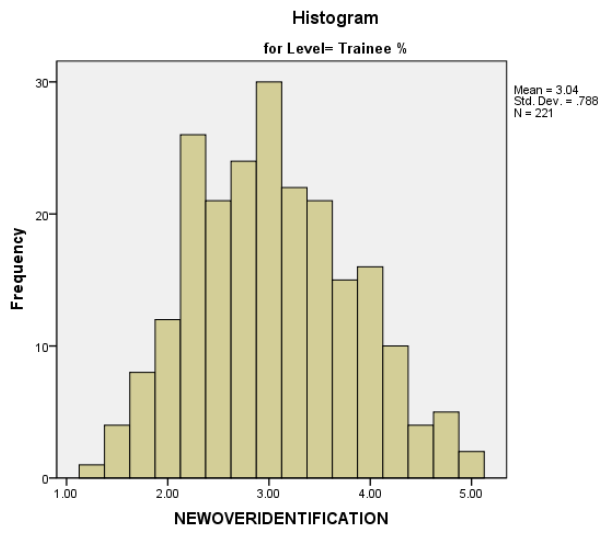
Qualified CP
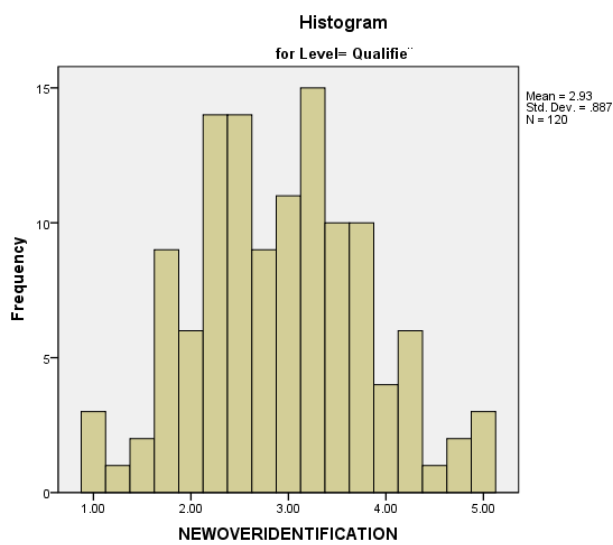
Test for homogeneity of variance

Table AI 3. Homogeneity of variance checks for SCS subscales.

	Levene's test Sig[a].
Self-kindness	.335
Self-Judgement	.073
Common Humanity	.801
Isolation	.285
Mindfulness	.095
Over Identification	.125

Note. [a] = Based on Mean.

Appendix AJ: Data transformations for all psychologist variables

Log10 transformation

Table AJ1. Trainees Log transformation results

	Skewness	Kurtosis	Shapiro-Wilks Sig.*
Total SCS	-3.93	.68	.000
Age	7.63	6.92	.000
Years of clinical experience	-2.20	2.35	.000
PSS	-2.85	1.48	.001
GHQ-12	.40[a]	-3.82[b]	.000
FoGC	-7.04	4.23	.000
FoRC	-2.56	-.45[a]	.000
FoSC	-1.5[a]	-1.00[a]	.000
SoCS-R	-9.70	8.59[b]	.000

Table AJ2. Qualified Log transformation results

|	Skewness	Kurtosis	Shapiro-Wilks Sig.*
Total SCS	-3.40	1.58	.000
Age	1.39[a]	2.13	.001
Years of clinical experience	1.02[a]	-1.54	.010
PSS	-8.67	15.2[b]	.000
GHQ-12	2.11	-2.30	.000
FoGC	-5.07[b]	3.25[b]	.000
FoRC	-2.92	-0.22[a]	.000
FoSC	-1.59[a]	1.28[a]	.005
SoCS-R	-4.28	0.37	.000

Note. Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale-Revised. [a] = Improved *z*-score, [b] = worse *z*-score . * $p > 0.05$.

Square root transformation

Table AJ3. Trainees square root transformation results

	Skewness	Kurtosis	Shapiro-Wilks Sig.*
Total SCS	-3.17[b]	.05	.001
Age	9.26	10.04	.000
Years of clinical experience	1.56[a]	3.56	.000
PSS	-0.07[a]	-1.14	.036
GHQ-12	0.5[a]	-3.26[b]	.000
FoGC	-4.13	2.08[b]	.000
FoRC	1.14[a]	0.02[a]	.002
FoSC	2.51	-0.15[a]	.001
SoCS-R	-7.52	3.79[b]	.000

Table AJ4. Qualified CP square root transformation results

	Skewness	Kurtosis	Shapiro-Wilks Sig.*
Total SCS	-2.61	0.85	.016
Age	2.02	-1.86	.000
Years of clinical experience	2.78	-1.01	.000
PSS	-4.21	4.12	.000
GHQ-12	1.95[a]	-2.14	.000
FoGC	-2.93[b]	1.40	.002
FoRC	-1.81[a]	0.23[a]	.050
FoSC	0.67[a]	-0.87[a]	.106
SoCS-R	-3.40	-0.66	.000

Note. Total SCS = Total Self-compassion Scale scores, PSS = Perceived Stress Scale, FoGC = Fear of Giving Compassion, FoRC = Fear of Receiving Compassion, FoSC = Fear of Self-compassion, GHQ-12 = General Health Questionnaire -12 item version, SoCS-R = Social Connectedness Scale-Revised.
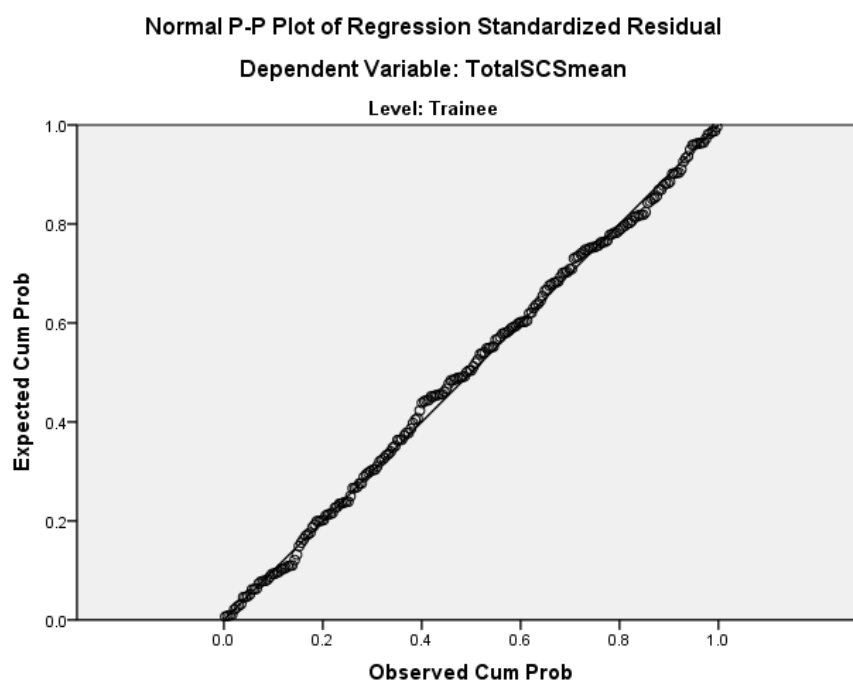[a] = Improved *z*-score, [b] = worse *z*-score .
* $p > 0.05$.

Appendix AK: Trainee clinical psychologist multiple regression parametric assumptions checks
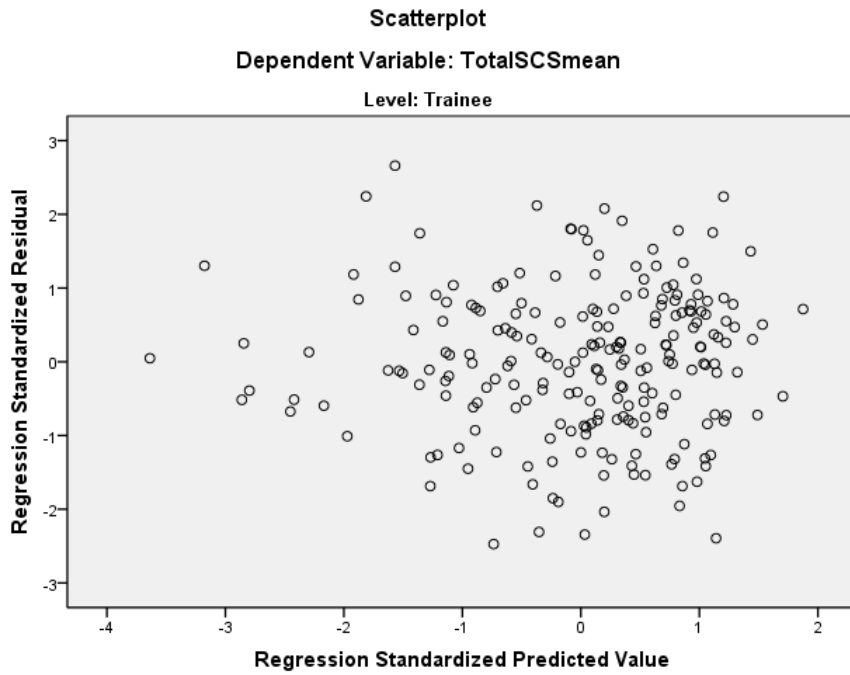
Histograms of residuals
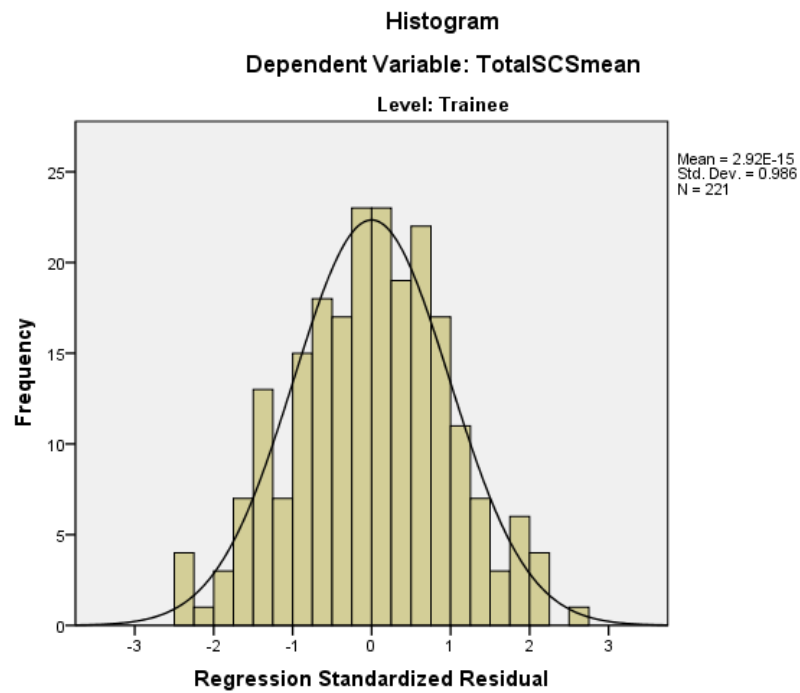
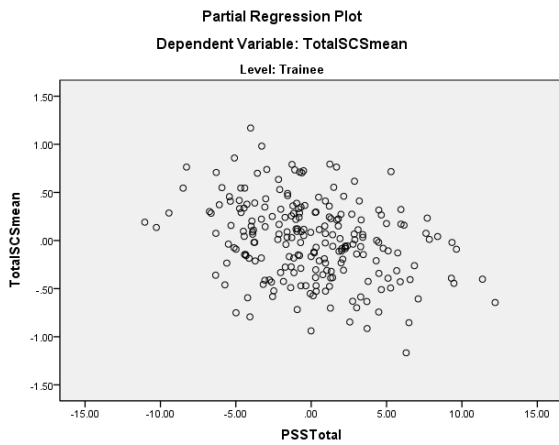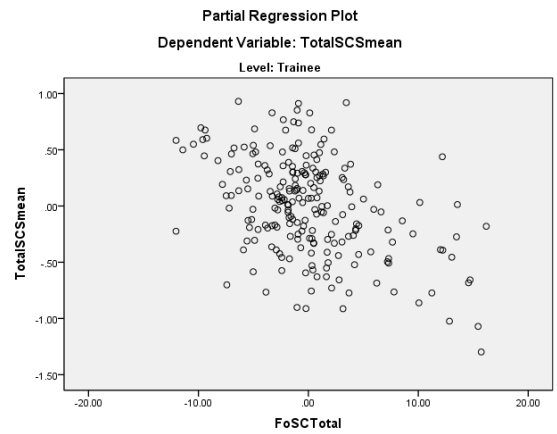Residual P-P plot

*ZRESID Vs *ZPRED Scatterplot

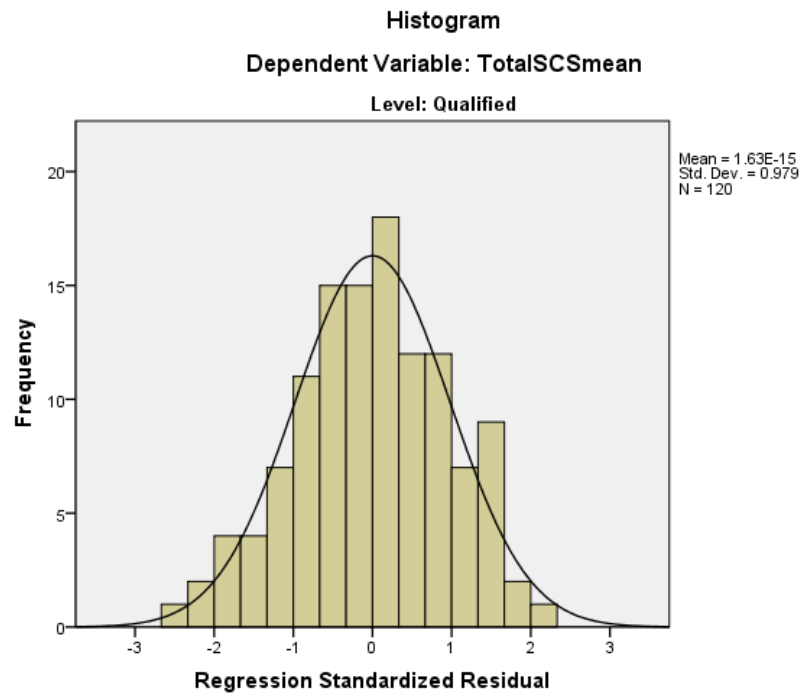Partial plot: PSS   Partial plot: FoSC
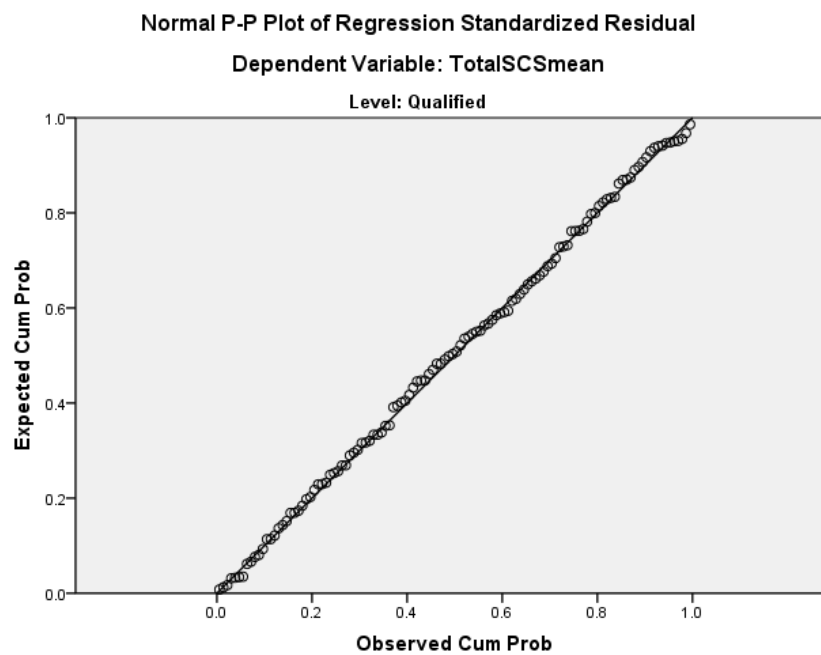
Appendix AL: Qualified clinical psychologist multiple regression parametric assumptions checks
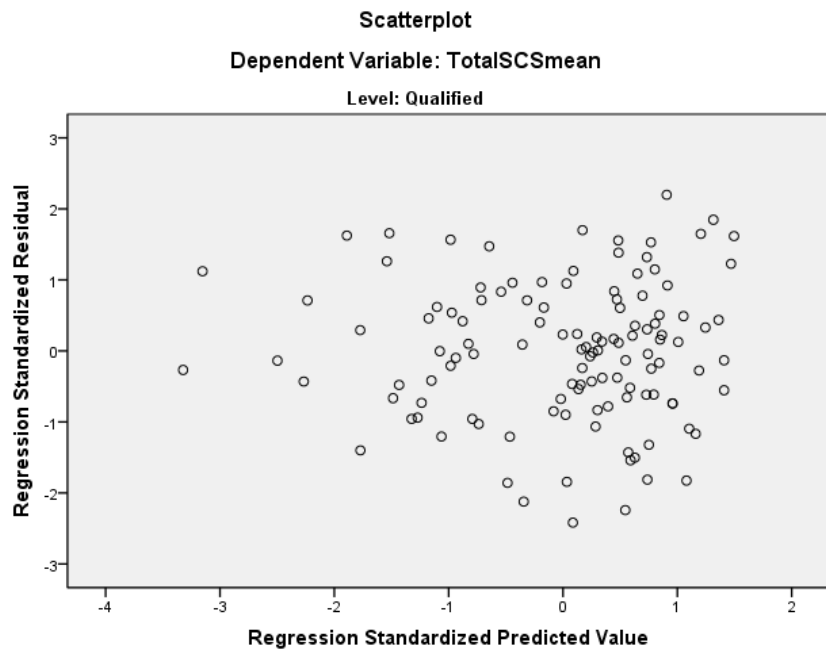
Histogram of residuals

P-P plot of residuals

*ZRESID vs *ZPRED Scatterplots
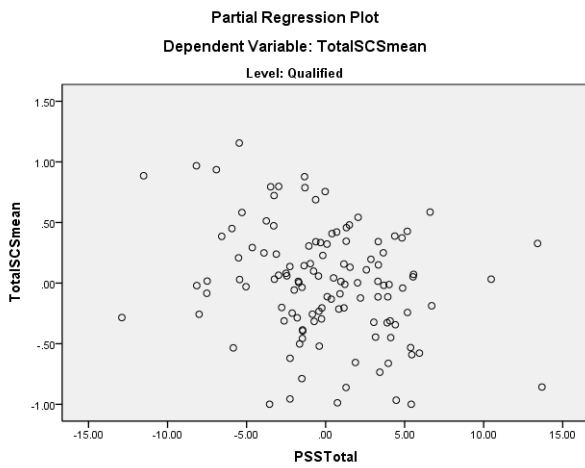

Partial plots

Partial plot: PSS   Partial plot: FoSC