Evaluating the use of Compassion Focused Therapy (CFT) by Psychologists within a Clinical and Health Psychology Setting

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1. Introduction

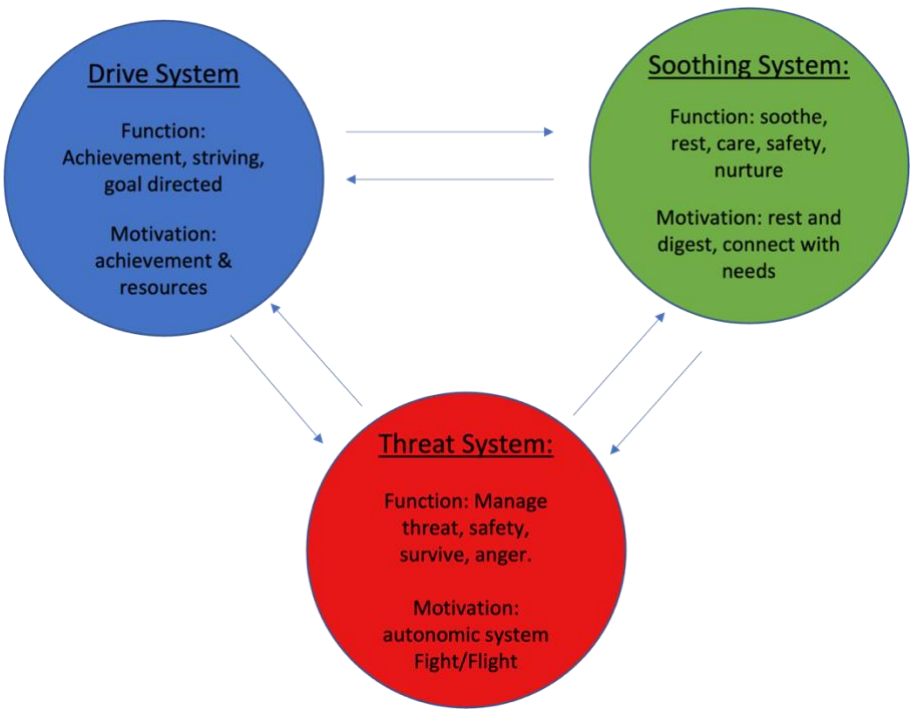
1.1.1 Premise of CFT

Compassion focused therapy (CFT) is a 'third-wave' model and intervention developed in 2000 by Gilbert (2009) with the underpinning of evolutionary, social, developmental approaches, Buddhist psychology, and neuroscience (Gooding et al., 2020), specifically for individuals with complex mental health difficulties (Gilbert, 2014). Gilbert (2009) observed the 'experience of suffering' in clients attending therapy, with high levels of shame and self-criticism, which impacted the individuals ability to attend to, experience and regulate emotions. The CFT model is therefore based on the functional aspects of emotion (Irons, 2022): how we consider threat and our defence strategies (threat system); our drive to seek resources and rewards (drive system); and the establishment of safety, rest, and contentment (soothing system). These three functions of emotion are known as the 'three-systems' or 'three-circles'[1] (Figure 1). In addition to the function of emotions, CFT also integrates the functional aspects of basic human motivational systems such as social status, connection (Gilbert, 2022), and seeking sexual partners, and physiological regulation (Maratos & Sheffield, 2020). CFT supports clients, using the three-circles model as its basis to formulate and understand a need to create a space to practice specific exercises in a therapy setting to increase self-compassion, which might include creating a sense of safety, by increasing a sense of worth through self-compassion and self-soothing skills (J. N. Kirby, & Gilbert, P., 2017). Intervention encapsulates elements utilised in other cognitive-behavioural therapies such as mindfulness (Eriksson et al., 2018; Tirch, 2010), acceptance, values and goals (Carvalho et al., 2020; J. N. Kirby, 2017).

[1] For the duration of this report, I will refer to this as only as 'three-circles' as it follows what has been identified in the data analysis.

Figure 1

Compassion Focused Therapy Model –Emotional Regulations Three Systems adapted from Gilbert (2009).



1.1.2 Literature and evidence base

Since its emergence as a therapy model over 20 years ago, CFT has been growing in popularity in clinical practice, with recent systematic reviews such as Millard et al. (2023), Craig et al. (2020), Cuppage et al. (2018) and Leaviss and Uttley (2015) highlighting the effectiveness of CFT in reducing clinical symptoms related to mental health and improved levels of self-compassion and self-reassurance, and reduced levels of self-criticism.

CFT has been used extensively in Clinical Health settings and has been shown to be beneficial in working with a wide range of health difficulties. Examples include, but are not limited to, HIV (Gibson et al., 2021), chronic pain (Gooding et al., 2020; Maratos & Sheffield, 2020), multiple sclerosis (Salimi, 2018), brain injury (Ashworth et al., 2015), type 2 diabetes (Bahadori, 2021), renal (Miller et al., 2017), cystic fibrosis (Kauser et al., 2022), and for clients with complex needs (Lucre & Clapton, 2021).

Whilst it appears that CFT has been well received by both psychologists and in clinical work with clients, research into the effectiveness of the intervention is relatively new (Craig et al., 2020), and there is little guidance from NICE (National Institute for Health and Care

Excellence) for recommending using CFT, as Cognitive Behavioural Therapy (CBT) still remains the 'gold standard' for many psychological interventions (David et al., 2018). Unlike CBT, no studies have been found to report the long-term effectiveness and benefits after finishing treatment (Millard et al., 2023).

Craig et al. (2020) also highlighted that there is no standardised method for the delivery of CFT, and there is little to no literature or guidance in training staff in the use and application of CFT. Despite this CFT has proven to be popular on clinical doctorate training courses, such as the University of Leeds, and numerous training courses are on offer through the British Psychological Society and other providers for continuous professional development in clinical practice.

1.2 Commissioning and Project Aims

1.2.1. The service

The Clinical and Health Department at Leeds Teaching Hospitals NHS Trust (LTHT) provides a range of services, delivered by Clinical Psychologists, Neuropsychologists and Counsellors to support both patients and staff of LTHT. The Department offers psychological support to adults with physical health conditions, and who are under the care of medical or surgical Consultant Doctors at LTHT. Staff within the Department cover the following areas of speciality: Cardiology; Cystic Fibrosis; Emergency, Major Trauma, Plastic, Reconstructive, Orthopaedic Surgery; HIV; Multi-Specialism; Neuropsychology; Oncology; Pain; Specialist Rehabilitation (prosthetics, orthotics, and wheelchairs); and Renal. The Department also offers staff support within LTHT, aiming to reduce psychological distress and enhance promotion of psychological wellbeing.

Clinical members of the team practice several therapy modalities, such as Acceptance and Commitment Therapy (ACT), CBT, Eye movement desensitization and reprocessing (EMDR) and trauma focused therapy. At a local level, CFT is increasingly being used by Clinical Psychologists within LTHT Department of Clinical & Health Psychology. The Department has

received CFT in-house training over recent years. There is also increasing evidence of the application of this model across a wide range of patient groups and ages reported by staff. To date there has been no formal overview which captures the wealth of experience in the use of CFT within LTHT Clinical & Health Department and across different patient groups.

1.2.1 Aims

This Service Evaluation Project (SEP) was commissioned by Dr Janette Moran (Lead Consultant Clinical Psychologist) and Dr Richard Hobbs (Senior Clinical Psychologist) of the Clinical and Health Psychology Department at Leeds Teaching Hospitals NHS Trust (LTHT). The aim of the SEP was to explore and learn of the different ways in which staff are using CFT across different patient groups and across their departments using a staff survey. The project takes a view to identify clinical and service development ideas, and potential departmental training needs.

In collaboration with the commissioners, the SEP aimed to achieve the following:

1) To identify the different ways in which CFT is used within clinical practice by psychologists in the department across the different patient groups worked with.
2) Identify which elements of CFT are most applicable in different Clinical Health contexts.
3) To learn which adaptations staff use, and what their preferred resources are.
4) To ascertain what the departmental training needs are.

2. Method

2.1 Design

This SEP used cross-sectional mixed methods design, gathering qualitative and quantitative data from a survey developed for this project. It was considered whether a focus group or interviews would be appropriate for this SEP, however it felt justifiable to use a survey which could reach greater numbers of potential participants and capture a more representative sample of data. The survey was designed collaboratively with the commissioners to meet the aims of the SEP. The survey was hosted and distributed using 'Online Surveys' for data collection. Online Surveys is a secure platform hosted by the University of Leeds, which allows for the design, distribution, and simple analysis of electronic surveys. The survey consists of 11 questions: list questions and free text questions.

2.2 Participants

All psychology staff (approximately n=41) working within Clinical and Health Psychology Department in LTHT were invited to participate. Potential participants will have been informed about this SEP during a CFT SIG (Special Interest Group) run by the Department, and all psychology staff across the Department received a study invitation via email from the researcher using the internal Department mailing list. To reach as many staff as possible, we encouraged staff to participate even if they do not use CFT in their practice. The study invitation email (Appendix A) included an Online Surveys link to the survey (Appendix D), containing the Participant Information Sheet (PIS) (Appendix B), and Consent form (Appendix C).

2.3 Data collection and procedure

Participants were invited to participate in this SEP using an email invitation (Appendix A) containing a link to Online Surveys. The Online Surveys link contained the PIS, consent form and survey. Participants were asked to read the PIS (Appendix B) on the first page of the Online Surveys link to aid their decision to participate. A mandatory consenting process was included within the link provided, whereby completing the electronic consent form (Appendix

C) provided implicit and implied consent to continue with the survey. Participants were informed their participation is completely voluntary and all information collected as part of the survey will be kept anonymous. The survey took up to 15 minutes to complete and was accessible for four weeks.

2.4 Credibility checks

Credibility checks were completed following Elo et al. (2014) recommendations for reviewing 'trustworthiness' of qualitative consent analysis: holding in mind *"credibility, dependability, conformability, transferability and authenticity"* of the data, from the point of data collection to results reported. The checklist recommended questions for the researcher to consider at all steps of analysis from collecting and preparing the data (1. preparation stage), to data analysis and interpretation (2. Organisation phase) and to reporting of the results and analysis (3. Reporting phase) (Appendix F). Once the researcher had completed data analysis, all qualitative themes and categories were reviewed by their academic supervisor, instead of the commissioners to reduce bias and any potential conflict of interest of findings, to enhance reliability of analysis.

2.5 Ethical considerations

Ethical approval was granted by the University of Leeds School of Medicine Research Ethics Committee (DClinREC 22-002) on 20/10/2022. The SEP was discussed with LTHT R&D department and did not require approval; however, the project was approved by the service manager (Appendix E).

2.6 Data analysis

This SEP used a qualitative and quantitative, cross-sectional design, with opportunistic sampling. Quantitative analysis included descriptive statistics, using frequencies of responses of staff as appropriate and to answer the research questions. Qualitative analysis will support

the quantitative data using free text answers, analysed using qualitative content analysis. Content analysis aims to deduct meaning from the content of the data, as well as counting frequencies of themes identified in the data (Krippendorf, 2004). This method felt appropriate by the researcher given the content of the data collected which was largely categorical and did not seem to fit into using a thematic analysis approach. It also seemed to better fit the aims of the SEP.

Survey data was analysed using the following process and steps outlined by Vears and Gillam (2022):

1. Read and familiarise self with data
2. First round coding, identify big-picture meaning units
3. Second-round coding – developing subcategories and fine-grained codes
4. Refining fine-grained sub-categories
5. Synthesis and interpretation of data

The researcher added in an additional step at step 5 by counting frequencies of themes as they appeared in the data for each sub-theme identified during analysis.

By using a multi-method analysis approach, the researcher is taking two epistemological approaches and combining to take a pragmatic stance, as the evidence suggests that this can assist in obtaining a richer understanding of the data collected (Foss & Ellefsen, 2002; Harrits, 2011). Therefore, a positivist approach is being taken for quantitative data, as data collected will be objective and measurable (Dieronitou, 2014); and interpretivist approach for qualitative data as it is considered that each participant's experience will be different (Hudson & Ozanne, 1988).

3. Results

3.1 Descriptive and quantitative Data

Twenty-four members of staff completed the survey. Staff were asked what their current roles were, however, to minimise identifying the participants based on their specific roles, they were

grouped into by their roles. Twelve participants were in senior psychologist roles (e.g., consultant, senior), ten were qualified psychologists, and two were assistant psychologists.

Demographic information, including information regarding specific Departments staff worked in was not collected to maximise anonymity. However, participants were asked broadly which area of the Clinical Health Departments they worked in: Medical n=8 (33.3%); Staff Support, n=2 (8.3%); Neuro n=7 (29.2%); and n=7 (29.2%) worked in Surgical, Rehab or Oncology Department.

3.1.1 Use of CFT and CFT training

Currently 91.3% (n=21) of respondents use CFT in clinical practice.

Internal training

CFT training was received by 70.8% (n=17) of staff whilst in post at LTHT. Of those who had internal training, fourteen had attended Mary Welford's 'Introductory three-day course', and five had attended the advanced CFT training by Mary Welford. Three participants indicated supervision and attending the specialist interest group (SIG) for CFT supported their in-post training.

External training

External training was accessed by 33% (n=8) whilst in post at LTHT. Of those, 25% (n=6) had accessed 1-2 external courses on introductory and advanced CFT training, and CFT skills training for physical health problems. Two participants had accessed between 5-7 external courses: which were advanced training on specific skill development (e.g. leadership and staff support, and specific courses for trauma focused CFT and role taking in CFT). 'The Compassionate Mind Foundation' (https://www.compassionatemind.co.uk/) was referenced several times as a popular training provider.

Twelve (50%) participants attended CFT training prior to working in LTHT. Five (20.8%) received teaching on introductory courses during Clinical Doctoral training. Six participants (25%) had attended either 1-or 3-day external introductory CFT courses. One participant indicated that they had not accessed external training, but had initiated self-

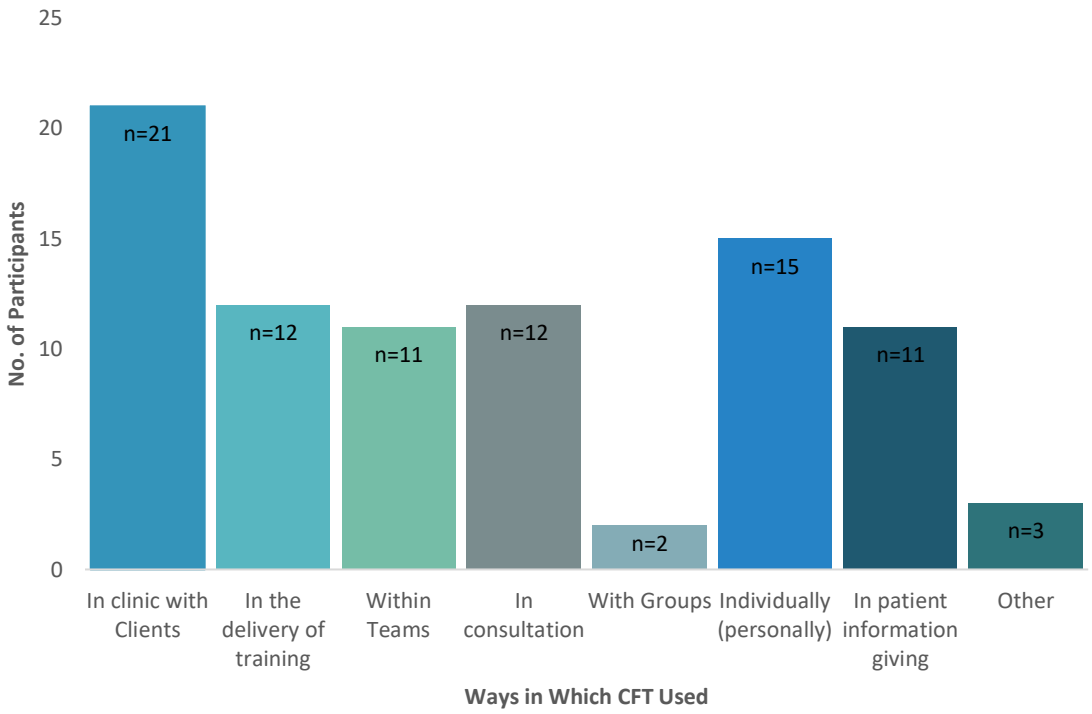
directed study using videos, handouts, and books. Specialist supervision and attending conferences were also referred to as accessing external training.

3.1.2 Application of CFT

Participants were asked of the different ways in which they might apply CFT in practice and were asked to select all that applied (figure 2). N=3 reported 'other': two reported using CFT: in meetings, research, and in the writing of reports; within supervision offered, in line management, and with trainees on placement within the Department. One participant did not apply CFT to their work.

Figure 2

Different Ways in Which Staff Apply CFT in Practice

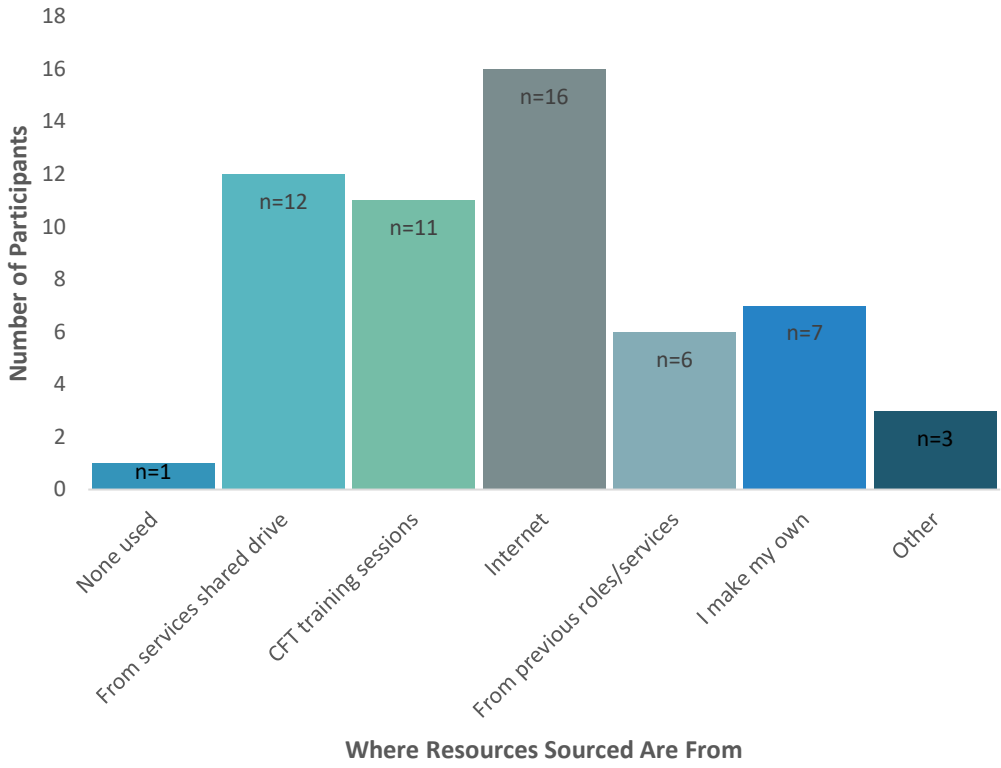


3.1.3 Resources used

Participants were asked if they used CFT resources, and if so where they were sourced from. See *figure 3* for details. Three participants (13.6%) selected other, specifying that resources were sourced from supervisors, from attending CFT SIG, and from resources shared within the Department.

Figure 3

Where do Staff Access CFT Resources?



3.1.4 Qualitative data

The survey contained several free text questions, which were analysed using summative and inductive approaches to content analysis. A summative approach initially condenses data collected by counting themes and words into categories and allows the researcher to draw conclusions and meaning from the categories identified (Zhang & Wildemuth, 2005). An inductive approach is well suited to text-based data as in this SEP data is approached by close reading to bring together similar pieces of text rather than searching for pre-determined coding items or themes from previous research or theories (Vears & Gillam, 2022).

Two categories were identified in the survey: 1) Use of CFT and 2) Support needs and barriers to using CFT. Category analysis is separated by survey questions: Category 1) how CFT is used by staff; which elements of CFT are used; and how it is adapted in practice; and Category 2) what support is needed to use CFT, including any CPD needs; and of barriers they may have encountered to using CFT. The frequencies of responses are listed below.

Figure 4
Summary of staff responses for Category 1 – Use of CFT

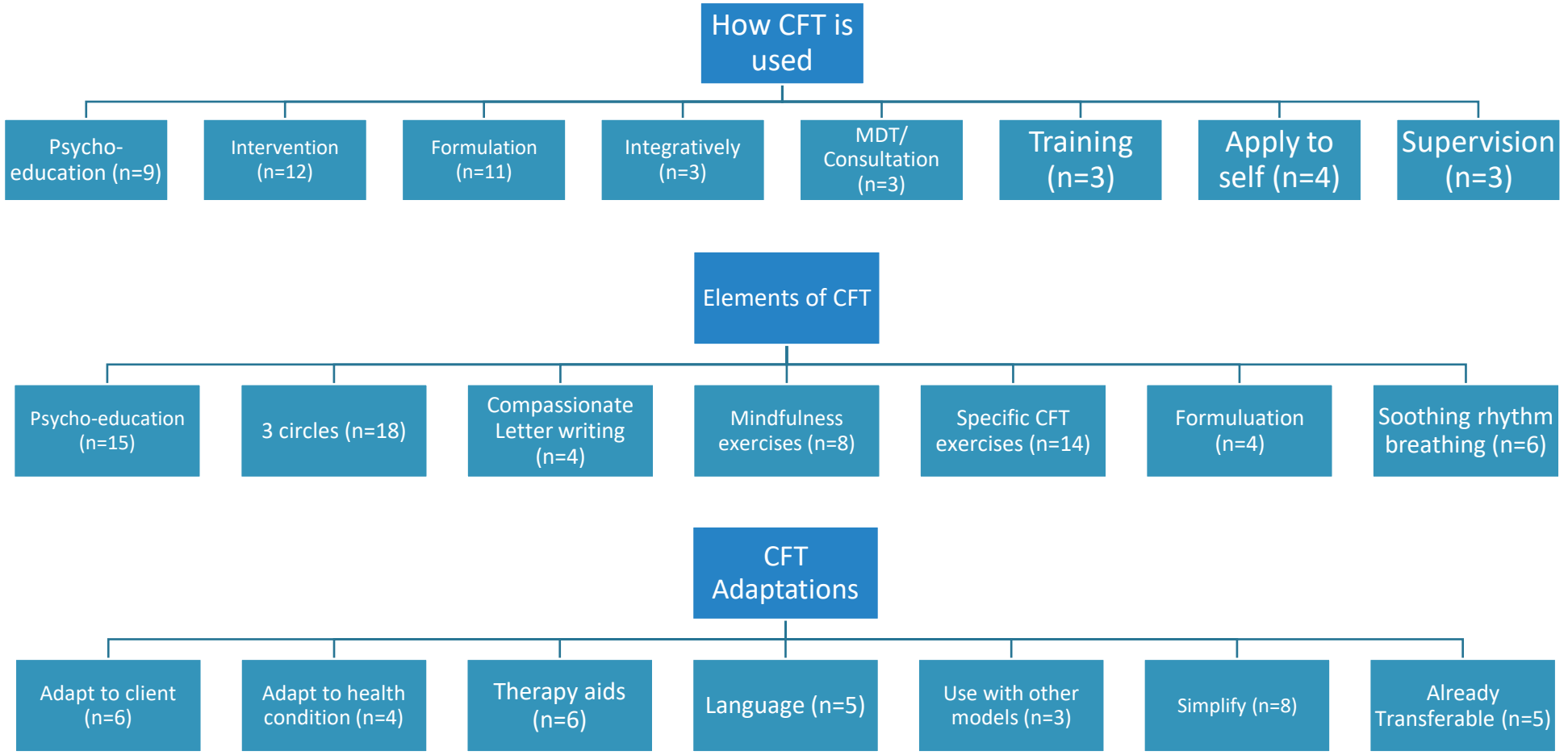
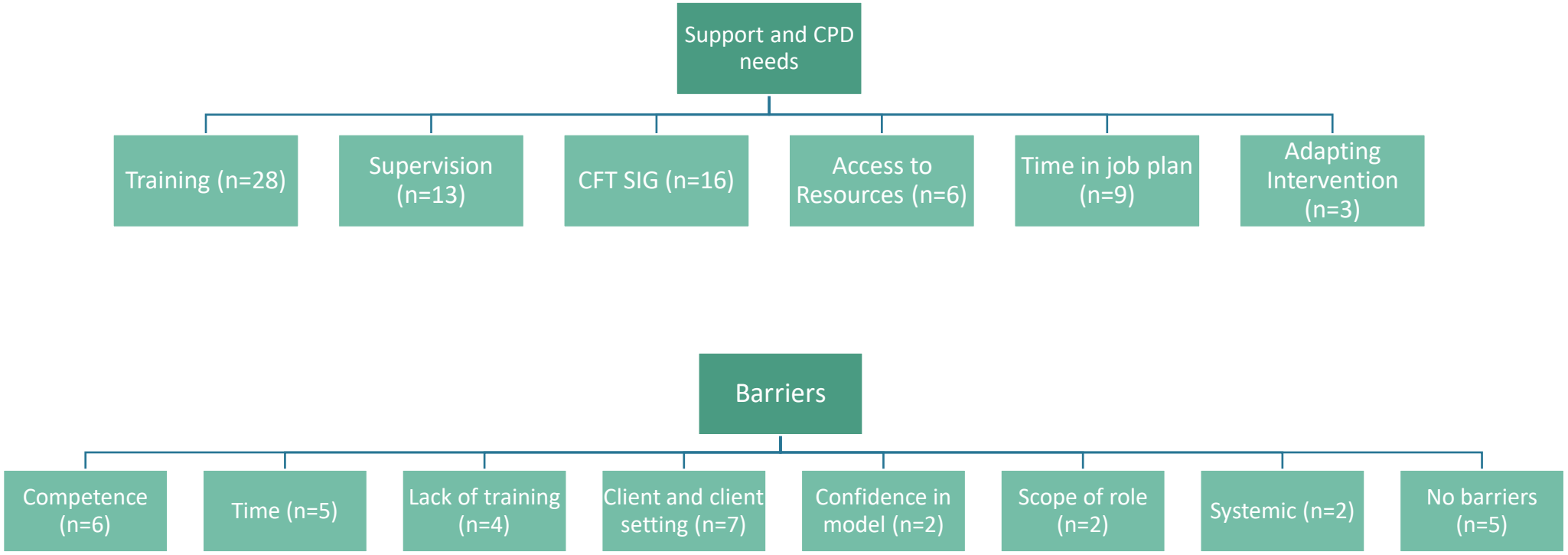


Figure 5

Summary of staff responses for Category 2 – Support and CPD needs and Barriers to use CFT



Category 1 - Use of CFT: How is CFT used (figure 4)

Sub-theme 1: *Psychoeducation (frequency = 9**)***

Nine staff shared using psychoeducation in their clinical work to *"promote the development of the soothing system*" and understand the "*tricky brain*". Psychoeducation was used to *"normalise emotional experiences… destigmatising what is an understandable reaction to very difficult and threatening medical events*". The three-circles were referenced six times as being used in the psychoeducation process.

Sub-theme 2: *Intervention (frequency = 12)*

Twelve staff responses used CFT as an intervention, which could either be used "*for shorter term brief work"* or for "*more in-depth work*" in one-to-one client work.

Sub-theme 3: *Formulation (frequency =11)*

Eleven responses considered formulation to be useful "*to formulate medical experiences and the impact of triggers to threat system".* One staff member highlighted formulation could be used to identify "fears and blocks to compassion". Formulation is used to *"support clients in developing strategies*" (interventions) to cope with threat.

Sub-theme 4: *Integratively (frequency =3)*

Three responders reported using CFT Integratively, for example "with ACT" and integrating *"systemic issues"* when using CFT. One respondent introduced CFT concepts as part of integrative therapy.

Sub-theme 5: *MDT/Consultation (frequency = 3)*

CFT was used to share ideas with staff and teams three times. Example responses used CFT "*to look at what could be done to bring balance and share ideas with staff supporting patients"* and to support staff in *"understanding the patient's experience".* In consultation, CFT

explained "*a client [attending] in threat, and how to support the client to access soothing in order to deliver a more efficient/helpful appointment".*

Sub-theme 6: *Training (frequency = 3)*

Three responses included reference to training, for example using CFT in "*training nursing teams"* and teaching the "*three-circles to understand anxiety and reactions*" to [illness].

Sub-theme 6: *Apply to self (frequency = 4)*

Four staff members applied CFT to their selves. For example, to "*apply principles in everyday life",* and *"to check in with self".* CFT interventions were used by staff, with one example *"to use strategies to notice large threat circles and self-critic".*

Sub-theme 7: *Supervision (frequency = 3)*

Three responders used CFT in supervision and line management using "*to help staff think about their own three-circles, and interactions with clients when threat is high".* CFT was also used "*for staff to consider self-care".*

<u>Category 1</u> - <u>Use of CFT</u>: Which elements of CFT are being used

See figure 4 for a summary of which elements of CFT are currently being used within the Department by staff.

Sub-theme 5: *Specific CFT exercises (frequency =14)*

Fourteen responses reported using specific CFT exercises. The following examples were listed as being used: *compassionate imagery; flows of compassion; role taking; compassionate breathing; compassionate thought challenging; three chairs; compassionate self/other; compassionate soothing; and metaphors e.g., "helpful vs critical teacher".*

<u>Category 1</u> – <u>Use of CFT:</u> CFT adaptions (figure 4)

Sub-category 1: *Adapt to client (frequency = 6)*

Six members of staff reported they adapt CFT depending on the client. Examples include "*using different techniques depending on the client"* and adapting for clients with *"cognitive and communication difficulties*". One participant reported *"adapt[ing] which exercises [were used] depending on how psychologically minded"* they felt the client was. CFT was also adapted for use with children.

Sub-category 2: *Adapt to health condition (frequency = 4)*

Four staff considered adapting the intervention to the health condition, with examples highlighting to *"think about what is appropriate for the health condition"* and the "*concerns the client is presenting with*" when delivering interventions.

Sub-category 3: *Therapy aids (frequency = 6)*

Six responses shared using "*videos or information sheets", "diagrams", "written information", "pictures vs words"*, and whiteboards when *"online"* to aid information giving.

Sub-category 4: *Language (frequency = 5)*

There were five responses listing items relating to use of language. Primarily examples given were to *"simplify language"* or "*tailor language used depending on interest/understanding of client".* One example specifically referred to tailoring the intervention and language for clients with "*limited English*".

Sub-category 5: *Use with other models (frequency = 3)*

Three responses shared using CFT with other models. For example "*using techniques from other models to tailor the intervention",* and using *"CFT alongside relational therapies such as CAT".*

Sub-category 6: *Simplify (frequency =8)*

Eight responses from staff revealed they simplified CFT with clients. For example, "*changing names of three-circles to make them easier to understand*", or "*just looked at threat and soothing".* Staff kept explanations "*very simple and layered with more information*", using *"pictures*" and "*diagrams".* With children staff had to find *"creative ways to explain and use three-circles".*

Sub-category 7: *Already transferrable (frequency = 5)*

Five responses shared that they felt that CFT required "*fewer adaptations*" and that it was "*extremely transferable"* between patient groups.

<u>Category 2</u> <u>– Support needs and barriers to use</u>: Support and CPD needs to use CFT (figure 5)

Sub-category 1**:** *Training (frequency = 28)*

Twenty-eight responses requested training. Requests included "*chair taking*", "*using CFT and ACT as an integrated approach*", "*working with barriers to compassion",* looking at *"process issues in CFT".* In house *"introduction"* training was referenced, with one respondent suggesting focus on *"the basics of the model, a 'how to do' assessment and therapy"* using CFT, as well as requests for regular *'refresher training"* to "*brush up on existing skills*", "*recap theory/practice*" and *"focus on specific skills with deliberate practice".*

Sub-category 2: *Supervision (frequency = 13)*

Thirteen responses highlighted supervision important to support and "*guide"* staff. Access to regular supervision provided a space to *"to reflect on how CFT can help each individual".* Peer supervision was mentioned twice as being helpful, where staff "*do not have time given existing commitments".*

Sub-category 3: *CFT SIG (frequency =16)*

Sixteen responses referenced the departmental CFT SIG. The SIG could be "*good for CPD",* and for using the space *"to hear how… people are using CFT in practice and discuss CFT ideas".* The SIG could provide opportunities to *"access learning with practical exercises and observe the way others deliver the model".* One response suggested *"using the SIG to present bite-size"* training updates from those who recently attended training events.

Sub-category 4: *Access to resources (frequency =6)*

Six members of staff referenced access to resources. Examples included requiring a *"departmental folder of useful online resources"* which could be "*watched in session*" or "*sent to clients after".* Resources requested were to be comprehensive, including "*video and audio*" and "*access to practical exercises*" for clinical work.

Sub-category 5: *Time in job plan (frequency =9)*

Nine staff felt that they needed allocated time in their job plan to attend SIG meetings, and to "*have more regular opportunities for case discussion as SIG time is limited".* Staff requested needing *"time in job plan to reflect and plan for sessions"*.

Sub-category 6: *Adapting intervention (frequency =3)*

Three members of staff requested training focusing on *"tailoring interventions to be consistent with CFT",* "*making psychoeducation more accessible"* and "*delivering CFT remotely*".

<u>Category 2</u> – <u>Support needs and barriers</u>: Barriers to using CFT (figure 5)

Sub-category 1: *Competence (frequency =6)*

Six members of staff reported that they "*lacked clinical competence"* and one response did not feel "supported in supervision". This included both a lack of "*confidence"* and *"skills barriers of how to use it beyond the three-circles, psych-ed, soothing and mindfulness exercises".*

Sub-category 2: *Time (frequency =5**)***

Time was referenced five times. Examples included "*not having enough time to plan sessions or read about it*", and that interventions were "*time-limited"* sometimes to *"four sessions"*. One example highlighted the "*fast pace of work meant limited time with patients if discharged quickly'.*

Sub-category 3: *Lack of training (frequency =4)*

Four responses indicated a lack of training as a barrier.

Sub-category 4: *Client and client setting (frequency =7)*

Client factors and the setting the client was in was mentioned seven times in the analysis. Examples included: clients "*not feeling they deserve compassion… mean that they struggle to engage in therapy", "client's ability to do higher level of reflection", "cognitive and language difficulties"* and that *"self-compassion is hardest for [clients] who are highly distressed*"*.* One example stated clients may not be "*at a stage where CFT meets their needs, and this may be later in their rehab journey",* and another sharing "*medical treatments or complications can impact regularity of sessions". "In-patient"* settings were also considered a barrier.

Sub-category 5: *Confidence in model (frequency =2)*

Two responses indicated a lack of confidence in the CFT model. For example, that it was not "a robust enough model to base a full intervention on", or that they found it "*difficult to personally use CFT skills when going through a difficult personal experience"* meaning they were not able to *"advocate skills to others"*.

Sub-category 6: *Scope of role (frequency =2)*

Two staff members felt that their current role did not provide them with scope to practice CFT.

Sub-category 7: *Systemic (frequency =2)*

Two responses indicated systemic factors, whereby "*systems aren't compassionate to staff"* and not having *"compassionate leaderships from the department"* were barriers to using CFT.

Sub-category 8: *No barriers (frequency =5)*

Five staff members reported there were no barriers to using CFT.

4. Discussion

The aim of this SEP was to evaluate the use of CFT within the Clinical and Health Department at LTHT. In the commissioning of this project, it was hoped that findings may contribute to service development and identify potential training needs across the Department. The key findings, strengths and limitations of this project are listed below, followed by recommendations for the project commissioners.

4.1 Use of CFT

The results of this SEP highlighted the different ways in which staff are currently using CFT within their clinical practice and roles. The findings seemed to fit with the wider evidence that CFT is used across various clinical health settings across different mental health difficulties, however the findings highlighted that there was variation how staff are using CFT, particularly in the elements of CFT being used in intervention with different client groups. In general staff referred to using CFT for "*adjustment to difficult emotional reactions to illness and treatment*" and to *"understand the threat of a physical health condition*" which fits with the literature for clinical health and disability (Stuntzner, 2017).

Staff were not asked if they were using CFT in a way that is recommended, for example whether they were following evidence-based treatment recommendations for adaptations to specific health conditions: e.g. treatment as outlined by Bahadori (2021) for clients with type 2

diabetes; acquired brain injury (Ashworth et al., 2015); or for the specific use of chair work to decrease self-criticism by increasing self-compassion and self-relating (Bell et al., 2021). However, it was found that more than half the staff who participated reported using only specific elements of CFT in their practice ('*psychoeducation*' and '*three circles'*), which may be reflective of the number of staff in receipt of introductory CFT training. It must be noted that the researcher was unable to find any literature to support the efficacy of only using just these two elements in clinical work. This may suggest that staff who report using CFT techniques may not be practising CFT in a universal and standardised manner that is efficacious in therapy (Craig et al., 2020).

How CFT was used, nonetheless, was supported by the wider evidence base for example: training, supervision and self-practice is integral in using CFT in practice with clients, staff and in teams (including MDT/consultation) (Gale et al., 2017; Welford & Langmead, 2015); training in applying CFT increases self-compassion in staff and reduces self-criticism, and improves the ability to be compassionate towards clients (Beaumont, 2016); and encouraging CFT self-practice and use of CFT in supervision reduced levels of stress in staff (Eriksson et al., 2018; Gale et al., 2017).

4.2. Support and CPD needs, Barriers to use CFT

Several consistent themes were identified in the analysis of staff responses, in particular *training* and *supervision,* to enable staff to competently deliver and overcome barriers to using CFT in their clinical practice.

Staff felt that accessing training would be beneficial for personal and professional development and this is echoed in the literature. Corrigan et al. (2022) found that supporting staff to learn CFT and offering appropriate supervision not only promoted confidence in model application, but also supported staff in increasing their own wellbeing, and improving their ability to respond to the emotional content of clinical work. Staff reported that 'fears and blocks' experienced by clients acted as a barrier to delivering CFT effectively. Supporting staff to learn how to formulate and understand fears and blocks is an important part of the

therapeutic process, and could help clients to open themselves to being compassionate and cultivating safety in therapy, thus improving outcomes (Steindl et al., 2022). Additionally, training offered to staff should be based on a range of teaching methods including reflective practice (Welford & Langmead, 2015), skills practice, role modelling, 'contemplative practice' (which involves self-practise of compassionate based interventions) (Beaumont et al., 2021), and reviewing staff learning over time improved confidence in model application (Sinclair et al., 2021).

Having access to regular supervision is an essential requirement of professional development (Bell et al., 2017), and staff highlighted that accessing a CFT practising supervisor or the CFT SIG, particularly when they had time in their job plan to attend was highly beneficial. Specific CFT Supervision has been shown to encourage staff to develop a 'compassionate internal supervisor', enhancing their understanding of compassion and its role in clinical practice and personally (Bell et al., 2017; Buttanshaw, 2020; Coaston, 2018).

4.3 Strengths

This SEP implemented a survey design with the commissioners which addressed the proposed aims as outlined in the introduction. A key strength of this SEP is that the project was novel in exploring the ways in which staff are using CFT, and in conducting a survey allowed for a greater number of respondents across the Department to participate regardless of whether they were using CFT in their work, and as a result was completed by half the Clinical and Health Department (n=24 out of a potential n=41).

Another strength of this SEP is that it provided an opportunity to complete an anonymous survey with free-text boxes, staff were provided with space to respond honestly about their needs from the Department. This SEP has provided scope for service development and highlighted gaps in supporting staff in using CFT.

4.4 Limitations

There were some limitations to this SEP. Whilst the range of staff that responded were broad, senior members of staff to assistant psychologists, it is unclear as to whether participants were representative across the Department, as only three members of staff shared they do not use CFT. Other staff who did not participate may have been reluctant to participate if they did not use CFT as they may have felt that they could not add value to the findings. However, may have been useful to gather further feedback by conducting a focus group with staff who did not use CFT. In addition, we cannot rule out if there was bias in the respondents in terms of those who regularly use and advocate for CFT and may have completed the survey to provide training requests.

This SEP would have benefited from piloting the survey to staff who regularly attend the CFT SIG to minimise repetition in questions and answers and highlight whether the SEP aims were feasibly being met by the survey questions, however due to time restraints this was not possible.

4.5 Conclusions

This SEP was designed to evaluate the use of CFT within the clinical and health Department at LTHT. The results address the proposed aims providing an overview in auditing the resources, adaptations, and methods in which staff use CFT. Staff indicated using CFT not just clinically with clients, but in supervision, teaching, consultation and in a personal context, using resources from the internet, shared with others in the Department and from training courses. Findings highlighted staff would benefit from training, and that a lack of training and a 'lack of time' acted as a barrier to using CFT. Whilst staff responses outlined several suggestions to improve their ability to deliver CFT, there may limits to what is feasible, such as funding and service demands. Table 1 outlines key recommendations following survey findings.

Table 1

Key recommendations to the commissioners of this SEP project evaluating the use of CFT in a clinical and health psychology setting

Recommendations

1) **All staff in the department to be offered 'Introductory' and 'Refresher' training.**
   Training could be sought through an external provider and offered internally – such as the 'introductory' training course previously delivered by Mary Welford. (Staff who accessed external training reported attending training delivered by Paul Gilbert, which would also be of benefit to staff as an alternative).
   However, should it not be feasible to offer training from an external provider to the department, consider offering in-house training by staff who have more recently attended training or feel competent in delivering training across the department. For any members of staff wanting to attend the training, allocations must be made in their work schedules for this CPD.

2) **CPD development through SIG attendance.**
   To address gaps in knowledge, a lack of confidence and skill competencies, SIG meetings should be used to allow space for experiential training to practice CFT skills. This would allow staff to refresh skills and consolidate learning from attending training. It may also support staff where supervision is not appropriate or meeting the demands for CPD.

3) **Time in work schedules.**
   Staff identified difficulties with time within their work schedules, meaning conflicts with attending SIG meetings, which were highlighted as being quite important to attend. Staff also felt that there was not enough time to prepare for CFT sessions – to address this, it may be useful to consider using SIG time to support staff in this.
   Consider offering alternative times for SIG meetings to encourage staff attendance.

4) **Updating the staff shared CFT resource folder**
   This may require auditing the current shared folder, and requesting staff to share all current resources they have to create one centralised base for resources. To minimise the impact on staff, consider delegating this task to an assistant psychologist, or trainee clinical psychologist. Review contents of the folder every 3-6 months.

4.6 Dissemination of results

The findings of SEP will be shared with the project commissioners, and findings were shared with the wider LTHT Clinical and Health Department during a CFT SIG on 14/05/2023.

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Appendix A- Research Advisement Email invitation

Dear colleagues,

My name is Chinar Arkuter-McKee, I am a Clinical Psychologist in training at The University of Leeds. I am contacting you because I am carrying out a service evaluation research project evaluating the use of Compassion Focused Therapy (CFT) within the Clinical and Health department at LTHT. This service evaluation project has been commissioned by Dr Janette Moran and Dr Richard Hobbs. Ethical approval for this service evaluation project has been approved by the School of Medicine Research Ethics Committee DClinPsych sub-REC (**DClinREC 22-002**).

I am contacting you to invite you to take part in a short online questionnaire which will take approximately 15 minutes to complete. We are interested in your experiences of using CFT within the clinical and health department and across different patient groups.

The survey is completely confidential and does not require you to disclose any identifiable information regarding yourselves or clients you have worked with.

In order to take part in the questionnaire you must:

- Be a psychologist or work in the psychology department within the clinical and health department at LTHT

It is not a requirement for you to use CFT in your current practice to participate in this service evaluation project. We are equally interested in why individuals do not opt to use CFT, and it can aid our understanding of potential barriers to using CFT within the context of your current practice.

If you are interested in taking part in the research, then please click on the link below which will take you to the online survey. You will first be presented with an information sheet which will provide you with more information about the study, so you can make a decision whether you want to take part. Participation in this service evaluation project is completely voluntary.

https://leeds.onlinesurveys.ac.uk/sep-use-of-cft

If you have any further questions, you can contact me via email umcamr@leeds.ac.uk
Thank you very much for taking time to read this.

Kind Regards,

Chinar Arkuter-McKee

Supervised by
Dr Janette Moran
Dr Richard Hobbs

Appendix B – Participant Information Sheet and Consent Form

Evaluating the use of Compassion Focused Therapy (CFT) by psychologists within a Clinical and Health Psychology Setting

Dear Colleague,

My name is Chinar Arkuter-McKee, and I am a Psychologist in Clinical Training at the University of Leeds.
I am inviting you to participate in a service evaluation project. This service evaluation project has been commissioned by Dr Janette Moran and Dr Richard Hobbs. Ethical approval for this service evaluation project has been sought by the School of Medicine Research Ethics Committee DClinPsych sub-REC (**DClinREC 22-002**).

Participating in the service evaluation project is entirely voluntary. Before you decide whether to take part, please read **this participant information** which tells you the purpose of the service evaluation project and what will happen to you if you take part.

Purpose of the service evaluation project
I am seeking to evaluate the use of Compassion Focused Therapy (CFT) within the Clinical and Health department. I am interested in learning of the different ways CFT is used within your clinical practice and across the different patient groups you work with. I would like to know of the elements of CFT that you find most applicable to your work context, of the adaptations you use, and any preferred resources that you may use in your work. I would also like to identify what you and your colleagues have found most applicable from CFT training they may have done, and of any potential training needs you may need.

Who can take part?
You must be a psychologist or work in the psychology department within the clinical and health department at LTHT, in a clinical facing role.
It is not a requirement for you to use CFT in your current practice to participate in this service evaluation project. I am equally interested in why individuals do not opt to use CFT, and it can provide some understanding of potential barriers to using CFT within the context of your current practice.

What would taking part involve?
For this service evaluation project, I am inviting you to complete a short survey based on your experience of using CFT within the clinical and health departments and across different patient groups. The link to complete the survey will be accessible on the next page.
I anticipate the survey taking you no longer than 15 minutes to complete.

Consent
Participating in this service evaluation project is completely voluntary. If you decide to participate in this service evaluation project, proceeding onto the survey will be taken as providing implicit consent.

What are the benefits of taking part?
Your participation in this service evaluation project would provide important information on the 'real world' applicability of using CFT in physical health and enhance clinical practice and within teams, with a view to identify clinical and service development ideas. Findings may also highlight potential department training needs which the Clinical and Health department is looking to commission. Therefore, an indirect incentive is that staff will access CFT training which would hopefully be more tailored to their needs. It would also inform the CFT SIG of areas that they can focus on to develop CFT in the department.

You will have an opportunity to share your experiences and contribute to the knowledge of how you use CFT across our departments.

My hope is that the findings from this service evaluation project will help the Clinical and Health department in collating a collection of resources to support our use of CFT with clients in physical health, identify ongoing CFT related support/supervision/ CPD, research and service development needs. The findings will also add to the wider literature on applying CFT within physical health settings.

What are the disadvantages to taking part?
The researchers have not identified any significant risk of taking part in this service evaluation project. However, in the unlikely event that you experience distress, or if you feel that you have any concerns about participating in this project, please approach the researcher Chinar Arkuter-McKee (contact details at the bottom of this document) so you can express your concerns privately.

What will happen if I wish to withdraw from the service evaluation project?
You may withdraw from this service evaluation at any time.
Should you decide to withdraw before submitting your survey response, please close the survey screen on your browser, and no participant data will be retained.
Once the survey has been completed and has been sent (by pressing the 'finish' button) you cannot withdraw your responses as the responses are anonymous and therefore cannot be traced to individual participants.
You will however be provided with a unique receipt identifier from Online Surveys upon completion of the survey. The unique receipt identifier will have a submission date and time. The receipt can be printed out or downloaded as a PDF by yourselves. The unique receipt number will match a Response ID on Online Surveys which the researcher (Chinar Arkuter-McKee) will have access to. This will allow the researcher to identify your responses for the purpose of withdrawing your data from the study up until analysis of the data should this be requested. You will need to email the researcher with your unique identifier receipt number should you wish to withdraw. You will not be allowed to withdraw from the study later than 31/10/2022, which is when the final analysis will be conducted.

Confidentiality
I will be maintaining your confidentiality as I will not be asking you questions that require you to disclose sensitive or personal data regarding yourselves or clients you have worked with. This includes not asking you to name the specific department you work in, and so we will ask you to select a category which is more general to the area and department that you currently work in.

Do not disclose any personal identifying data of patients you may have worked with previously, and if you are not able to do this, to anonymise your answers.

However, should you wish to withdraw from the service evaluation project by contacting the researcher with your unique Response ID, you will identify yourself to the researcher only who will be able to remove your data from the service evaluation project.

What will happen to my data?
All researchers involved in this study will follow Data Protection Act 2018 and to the University of Leeds Data Protection Policy. Data collected for this study will be stored in a personal storage area permitted for highly confidential data (m:drive and encrypted OneDrive permitted for use by University of Leeds).

All data collected for the purpose of the project will not contain any identifiable data and will be anonymised. All the information you provide will be given a unique identifier receipt purely for the purpose of withdrawal of data should you wish to withdraw from the service evaluation project. Your data will not be accessed by anyone outside of the research team and will only be accessible to the researcher and their supervisors.

The website we use (Online Surveys) to collect your outcome data is supported by a secure platform hosted by the University of Leeds, which is protected through university firewalls and security system throughout the duration of the study.

Any data collected may be used in academic publications, but all data will be non-identifiable. The data will be held by the University of Leeds for 3 years after the end of the project to allow time to refer back in the event of any questions arising from the write up of the service evaluation project or the event of writing up for publication.

What will happen to the results of the research study?
The researcher aims to disseminate the findings of this service evaluation project to the Clinical and Health department in departmental meeting and the CFT SIG. Findings will also be presented in a report and conference presentation at the University of Leeds in conjunction with course requirements.

Participants can request to be sent any publications or reports that result from this service evaluation project on request to the researcher and the commissioners of this project. Please note that you will not be identified in any publication or report.

Thank you for taking the time to read this participant information sheet.
Should you wish to continue and participate, please complete the survey on the next page.

Sincerely,
Chinar Arkuter-McKee
Clinical Psychologist in Training
University of Leeds

SEP Commissioners
Dr Janette Moran, *Lead Consultant Clinical Psychologist in Renal*
janettemoran@nhs.net
Dr Richard Hobbs, *Senior Clinical Psychologist in Oncology*
richard.hobbs1@nhs.net

Further information and contact details
Ethical approval has been given by the Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC ref number: DClinREC 22-002).

If you would like further information about this service evaluation project please contact the researcher Chinar Arkuter-McKee (Clinical Psychologist in Training) at University of Leeds (umcamr@leeds.ac.uk).

You may also contact the University of Leeds Data protection officer at dpo@leeds.ac.uk
For more information regarding your data, please review the following links to the University of Leeds privacy statement for participants involved in research:
https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf
https://dataprotection.leeds.ac.uk/wpcontent/uploads/sites/48/2020/08/My_data_and_research.pdf

Appendix C: Consent Form

Evaluating the use of Compassion Focused Therapy (CFT) by psychologists within a Clinical and Health Psychology Setting: Consent form

☐	I have read and understood the information sheet provided for this SEP.
☐	I have been given the opportunity to ask questions about the SEP and the answers have been satisfactory.
☐	I understand that my participation is voluntary.
☐	I understand that I may withdraw from this service evaluation project at any time without giving a reason.
☐	I understand that should I decide to withdraw my contribution to the service evaluation project survey, I will need to contact the researcher with my unique response ID provided at completion of the survey. In doing so, this will identify me to the researcher so that my data may be removed. I understand I have until the 30/11/2022 to request my data to be removed.
☐	I understand that any personally identifiable information will be removed from the survey responses and that I will not be identifiable in any future reports, publications, or presentations.
☐	I understand that the data collected will be securely stored on university approved secure systems and password protected. I am aware of what will happen to my data after the SEP is complete.

Date: _____

Thank you for agreeing to take part in this service evaluation project. Your contribution is very much appreciated.

Appendix D – Survey Use of Compassion Focused Therapy

1. **Which area/department of Clinical and Health at LTHT do you currently work in?**
   Please select from the following:
   - ☐ Medical
   - ☐ Staff Support
   - ☐ Neuro
   - ☐ Surgical, Rehab and Oncology

2. **What is your current role?**
   (answer box)_____

3. **Do you currently use CFT in your practice?**
   - ☐ No
   - ☐ Yes

4. **Have you received CFT training whilst in post at LTHT?**
   - ☐ No
   - ☐ Yes

If yes please document level of CFT training /courses attended AND whether this was provided "in house" or "external to the department"
(answer box)_____

5. **Had you received CFT training prior to working in LTHT?**
   - ☐ No
   - ☐ Yes

If yes please document level of CFT training /courses attended:
(answer box)_____

6. **In which of these areas do you use and apply CFT in practice?**

Please select all that apply.

a. in clinic with clients
b. in the delivery of training
c. within teams
d. in consultation
e. with groups
f. individually (personally)
g. In patient information giving
h. other (with text box to supply answer)

6.b. Please provide a brief explanation/description of how you use CFT in these areas?
With an answer box _____

7. **What elements of CFT do you use the most?**
   (answer box)_____

8. Do you use CFT resources and if so, where are they from?
For example, resources may be handouts, videos, or recommended reading.
Please select all that apply.

a. I do not use resources
b. From my services shared drive
c. Access resources from CFT training sessions
d. Search for/access resources on the internet
e. I have resources from previous roles/services
f. I make my own resources
g. Other (with text box to supply answer)

9. How do you adapt CFT to different client groups?
(answer box)_____

9. **What do you need to support you in using CFT?**
(answer box)_____

10. **What you feel your CPD needs are in using CFT?**
(Suggest CPD needed, or suggestions of how to deliver it easier?)
(answer box)_____

11. **Are there any inhibitors to using CFT in your role?**
(answer box)_____

Appendix E – R&D Approval Email

From: GOWING, Anne (LEEDS TEACHING HOSPITALS NHS TRUST) <anne.gowing@nhs.net>
Sent: 01 November 2022 09:56
To: Chinar Arkuter <umcamr@leeds.ac.uk>
Subject: RE: Service Evaluation Project

Dear Chinar,

Thank you for your email about your project.
I can confirm that this does not meet the definition of research within the NHS but would be considered a service evaluation. As such it would not require Health Research Authority (HRA) approval to go ahead here in LTHT and would not require local R&I Confirmation.
You may need to check with the local team that they are happy to participate within the study prior to you undertaking it.

I hope this is helpful.
Best wishes,
Anne

Anne Gowing
R&I Manager – Research Governance
Leeds Teaching Hospitals NHS Trust
E**:** anne.gowing@nhs.net

Research Goverance team email: leedsth-tr.researchgovernance@nhs.net
R&I Office email: ltht.researchoffice@nhs.net

From:MORRIS, Penny (LEEDS TEACHING HOSPITALS NHS TRUST) <penny.morris4@nhs.net>
Sent:19 October 2022 11:29
To:MORAN, Janette (LEEDS TEACHING HOSPITALS NHS TRUST) <janettemoran@nhs.net>
Cc:ARKUTER, Chinar (LEEDS TEACHING HOSPITALS NHS TRUST) <chinar.arkuter@nhs.net>
Subject:RE: SEP Ethics Manager Approval Query

To confirm that I am aware of Chinar's service evaluation project and can confirm that it has gone through the appropriate checks to proceed.

BW
Penny

My working days are Tuesday - Fridays

Dr Penny Morris
Head of Adult Medical Psychology
Lead Consultant Clinical Psychologist

Department of Clinical & Health Psychology
Fielding House, SJUH

Appendix F - Credibility Checklist

Table taken from Elo et al. (2014)
Checklist for Researchers Attempting to Improve the Trustworthiness of a Content Analysis Study.

Phase of the content analysis study	Questions to check
Preparation Phase	Data collection method How do I collect the most suitable data for my content analysis? Is this method the best available to answer the target research question? Should I use either descriptive or semi-structured questions? Self-awareness: what are my skills as a researcher? How do I pre-test my data collection method? Sampling strategy What is the best sampling method for my study? Who are the best informants for my study? What criteria should be used to select the participants? Is my sample appropriate? Is my data well saturated? Selecting the unit of analysis What is the unit of analysis? Is the unit of analysis too narrow or too broad?
Organisation Phase	Categorization and abstraction How should the concepts or categories be created? Is there still too many concepts? Is there any overlap between categories? Interpretation What is the degree of interpretation in the analysis? How do I ensure that the data accurately represent the information that the participants provided? Representativeness How to I check the trustworthiness of the analysis process? How do I check the representativeness of the data as a whole?
Reporting Phase	Reporting results Are the results reported systematically and logically? How are connections between the data and results reported? Is the content and structure of concepts presented in a clear and understandable way? Can the reader evaluate the transferability of the results (are the data, sampling method, and participants described in a detailed manner)? Are quotations used systematically? How well do the categories cover the data? Are there similarities within and differences between categories? Is scientific language used to convey the results? Reporting analysis process Is there a full description of the analysis process? Is the trustworthiness of the content analysis discussed based on some criteria?