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ORIGINAL ARTICLE

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"Sharing in people's pain is not an easy thing to do": Cognitive Behavioural Therapists' understandings of compassion in the workplace

Laurien E. Broadley[1] | Amy E. Burton[2] | Dipti K. Mistry[3]

[1]Hertfordshire Partnership University NHS Foundation Trust, Watford, UK

[2]Staffordshire Centre for Psychological Research, School of Health, Sciences and Wellbeing, Staffordshire University, Stoke-on-Trent, UK

[3]Nottinghamshire Healthcare NHS Foundation Trust, Leicester, UK

Correspondence
Dr Amy E. Burton, Staffordshire University Centre for Psychological Research, School of Health, Sciences and Wellbeing, Staffordshire University, Leek Road, Stoke-on-Trent ST4 2DF, UK.
Email: amy.burton@staffs.ac.uk

Abstract

Objectives: Compassion is central to the aim of improving patient care and staff well-being within healthcare systems. To inform service development, explorations of experiences and meanings of compassion are needed. This study explored cognitive behavioural therapists' understandings of compassion within their work environment.

Design: A qualitative study was conducted using semistructured interviews and interpretative phenomenological analysis (IPA).

Methods: Data were obtained from five practicing cognitive behavioural therapists.

Results: Two superordinate themes were developed, each with two subordinate themes. CBT therapists reported entering the profession with intrinsic motivation to care for others. They further developed an interest in compassion with exposure to clients and ongoing professional development in compassion-focused therapy (CFT). Compassionate work environments helped to facilitate compassionate practice; however, for many, workplaces were perceived to lack compassion. Challenges were encountered when negative workplace interactions left therapists feeling fatigued, distressed and demoralised. There was a desire for recognition and to be seen as more than a "work machine," the experience of which was a threat to retaining therapists within the profession.

Conclusions: Current recruitment and training processes are producing staff with skills and motivation to deliver compassionate care. However, lack of compassion within workplaces can be a barrier to actioning these skills and motivations. Research needs to focus on how to effectively implement and run systems that are compassionate for both staff and clients. To provide compassionate care, staff need work environments that show compassion to them. These findings provide some insights into and practical suggestions regarding how this can be achieved.

KEYWORDS
cognitive behavioural therapy, compassion, interpretative phenomenological analysis, qualitative research, self-compassion

Contributing authors: Laurien E. Broadley (laurien.broadley@nhs.net); Dipti K. Mistry (dipti.mistry@nottshc.nhs.uk).

1 | INTRODUCTION

In the quest to improve patient care and staff well-being, the concept of compassion features must be strong (Kirby & Gilbert, 2017; Lown, 2015). In the United States, former Medicare CEO Donald Berwick called for a "universal and compassionate" healthcare system (Berwick, 2020 p. 15), and in New Zealand, compassion is now enshrined in the Patient Bill of Rights (Paterson, 2011). In the UK, The Francis Report highlighted a lack of compassion as one of the key failings in the Mid-Staffordshire enquiry (Francis, 2013), and the UK National Health Service (NHS) People Plan 2020/21 states the organisation's aim to be "compassionate and inclusive" for all staff by 2024 (NHS England, 2020, p. 14).

Very little research has explored psychological therapists' perceptions and understandings of compassion. One qualitative study in the United States spoke to private-practice psychotherapists who had been nominated as compassionate by peers for their conceptualisations and uses of compassion with their clients and how they developed compassion within themselves. Compassion was defined as an innate skill, deeper than empathy, that could be facilitated through feeling a client's suffering, identifying with a client, involving the client in therapy, building strong relationships and understanding client dynamics. Barriers to compassion were perceived to be grounded in personal responses to the patient's personality, the patient's engagement with therapy and pathology (Vivino et al., 2009). The experience of delivering therapy in private practice within the United States is very different from therapy delivered within the NHS, and therefore, there is a need to explore therapist understandings of compassion in this context.

In the UK, cognitive behaviourial therapy (CBT) is one of the leading treatments for mental health difficulties. Cognitive behaviourial therapy is delivered in NHS Primary Care through the Improving Access to Psychological Therapies (IAPT) service. This service began in 2008 and provides National Institute of Health and Care Excellence (NICE)-recommended talking therapies, predominately CBT, throughout England for the treatment of depression and anxiety disorders. Services are delivered via a stepped care model of low- and high-intensity interventions. Low-intensity treatment includes guided self-help, computerised CBT and signposting. High-intensity therapeutic work is delivered by qualified CBT practitioners (Rizq, 2011). Whilst the IAPT programme has demonstrated significant successes, most notably in increasing access to talking therapies, with over a million people a year utilising services (Clark, 2019), it also faces significant challenges, particularly in terms of the waiting time between initial assessment and treatment and in staff retention. CBT therapists are strongly encouraged to be compassionate towards themselves to manage work-related stress (Wild, 2020), and the IAPT manual states that patients be provided with compassionate treatment and staff be managed in a compassionate way (The National Collaborating Centre for Mental Health, 2018).

As with many healthcare professionals, burnout is a risk to CBT therapists working in IAPT (Johnson et al., 2020; Singh et al., 2020). Burnout was first described in the literature by Freudenberger (1974) and has since been recognised in the ICD-11 as an occupational phenomenon resulting from poor management of chronic workplace stress (World Health Organization, 2019). The three dimensions of burnout are feelings of energy depletion or exhaustion, increased mental distancing or feelings of negativity or cynicism towards one's job, and reduced professional efficacy (World Health Organization, 2019). Working environment, including caseload (Thomas et al., 2014), levels of manager support (Hunsaker et al., 2015), and experiencing compassion fatigue (Thompson et al., 2014) have been illustrated to be important contributors to burnout in healthcare professionals. Burnout is also associated with high staff turnover and poorer patient care (Westwood et al., 2017). Fostering compassion within healthcare systems is argued to be an essential component in the prevention of burnout (Hofmeyer et al., 2020).

When addressing staff burnout, it is worth considering the literature that has explored the wider mental health in IAPT settings. Salient questions have been posed about the wider impact of the significant and rapid change in mental health provision over the last two decades, in particular, staff dynamics in the constant quest for additional resources, client expectations of the service, and whether the IAPT structures are equipped to acknowledge the enormous struggles of working in a field where there are significant limitations in treatment for complex disorders (Rizq, 2011). Furthermore, it has been argued that the structure of IAPT inadvertently inhibits the very compassion staff and clients are requesting by insisting on significant levels of staff monitoring and evaluation in the name of transparency and patient choice (Rizq, 2012).

With these considerations in mind, this study aimed to better understand the meanings and experiences of compassion in the work

Implications for practice and policy

- Compassionate work environments enabled cognitive behavioural therapists to have exposure to training and to extend professional development. These opportunities help them to become passionate about compassion and develop awareness of the value of self-compassion.
- Therapists need to feel recognised as more than just a "work machine" and to feel valued for the challenging and emotionally demanding service they provide.
- Compassionate management and leadership can help cognitive behavioural therapists feel supported to manage the demands of their role and role model what it means to deliver compassionate care.
- A lack of compassion within organisational cultures and approaches to staff management threaten the retention of cognitive behavioural therapists.

environment of IAPT CBT practitioners to develop recommendations for improving staff well-being and reducing burnout.

2 | METHODS

2.1 | Design

Inductive qualitative research using interpretative phenomenological analysis (IPA; Smith et al., 2009) was employed, which has its origins in phenomenology, hermeneutics and idiography (Smith, 1996) and recognises a double hermeneutic in which "the researcher is trying to make sense of the participant making sense of" the phenomenon under investigation (Smith et al., 2009, p. 187). IPA is deeply rooted in core CBT theory, which states that psychological distress is often generated not by what has happened to a patient but by how they interpret it (Beck et al., 1979) and is therefore well-suited to exploring perceptions and experiences of compassion in CBT practitioners.

2.2 | Ethical statement

This research was approved by the Staffordshire University psychology department ethics committee. All participants provided written informed consent.

2.3 | Participants

Interpretative phenomenological analysis is committed to a detailed examination of individual cases and therefore necessitates small samples (Smith & Osborn, 2015). Following sample size recommendations (Smith et al., 2009), five participants were recruited through advertisement in counselling and therapy agencies and The British Association for Behavioural and Cognitive Psychotherapies (BABCP). Participants were eligible if they were currently delivering CBT within IAPT. None were previously known to the interviewer. One participant was male and four were female, with an age range of 25–60 years.

2.4 | Data collection

Semistructured interviews were conducted using an interview schedule designed to explore the meanings and experiences of compassion for CBT practitioners within the IAPT workplace. Questions explored personal definitions of compassion, experiences of compassion in the workplace, experiences of self-compassion and the impact of compassion on the participants. Example questions include "Compassion is a commonly used word in healthcare, can you tell me what it means to you?" and "Can you tell me about your experiences of compassion in your work?" The schedule was used flexibly to enable discussions to be led by the participant and to probe areas of interest. The schedule was piloted with a colleague of the first author before being approved for participants.

Interviews were conducted remotely using Microsoft Teams. Participants were asked to ensure they had a quiet, private space in which they could talk openly and freely. Interviews lasted between 50 and 70 minutes and were audio-recorded and transcribed verbatim, with all identifying information removed.

2.5 | The interviewer and analysts

The interviewer and first author is a CBT practitioner with experience working in the NHS. The second author is a health psychologist and qualitative researcher with no experience of delivering CBT interventions. The third author is a trainee health psychologist, familiar with CBT and compassion-focused therapy.

2.6 | Analysis

Analysis was conducted following Smith et al.'s (2009) guidelines for IPA. Acknowledging the "double hermeneutic" (Smith et al., 2009, p. 3) in the IPA process, care was taken to explore prior assumptions of the first author through discussion with the second author and by adhering to a reflexive process, including keeping a diary of observations throughout the data collection and analysis. Immediately following each interview, the first author took notes on the interview content and her own emotional responses for examination during discussions with the second author.

Transcripts were read multiple times, and a chronological account of initial thoughts and observations was noted in the margin in the form of descriptive, linguistic and conceptual comments. Emergent themes were then developed through grouping and categorising initial notes within broader theme titles. Connections across themes were identified and recorded in a theme structure diagram for each case. This process was repeated for each transcript in turn, and comparison across cases was recorded within a final table of themes.

3 | RESULTS

Two superordinate themes were developed through data analysis, each with two underlying subordinate themes. The first theme, the qualities of a compassionate practitioner, illustrates how individuals with a desire to help others are drawn to the CBT profession, and how they go on to develop a passion for compassion through ongoing training and lived experience of delivering therapy. The second theme, the need for a compassionate work environment, highlights the importance of supervision and management for practitioner well-being and the need for therapists to be treated with compassion to ensure their continued desire to work in the profession. To contextualise the examples provided for each theme, a brief description of the participants is provided in Table 1.

3.1 | The qualities of a compassionate practitioner

Participants spoke about the skills and qualities required to be a compassionate therapist. All felt that the essential starting point was an intrinsic motivation to care for others. This motivation guided treatment decisions for clients and the evolving professional skill set.

3.2 | Motivation to care for others

Participants reported a desire to be of service to others and to alleviate distress. Charlie and Marissa, both of whom were recently qualified, explained:

> I think if you're going to kind of go into therapy, you have to have compassion and you have to be quite a caring person and I think they may be personality traits rather than skills [...] the human side of what I bring to my work is paramount…I think it's probably the most important part of being a therapist and if you have to try at that, you're not necessarily in the right field [...] if you're not willing to [have compassion for others] then perhaps it's not the best suited line of work.
>
> (Marissa)

Marissa stressed the importance of motivation to do this work and be "*naturally compassionate*." Here, Marissa seems to be suggesting that to have compassion for clients, a compassionate response needs to come easily and "naturally" to the therapist. The argument being made is that compassionate care requires an intuitive ability to respond to distress with care that comes without conscious thought. For those without a natural ability, Marissa suggests therapeutic work is not the right professional field.

Charlie also stated that:

> People that go into the caring profession want to give their best performance to help the public and to help people suffering with mental health.
>
> (Charlie)

This response again appears to argue that professionals are prepared to take their natural inclination to be of service to others and develop it further by "giving their best performance." Therapists are portrayed as committed, making an effort and putting time and energy into their work. Tasha and Phillipa's examples show the practical steps they took to achieve this.

Tasha expressed the importance of feeling that the professional skill set she used *"made a difference"* to clients, explaining how she left another healthcare discipline to become a CBT practitioner for this reason. She felt being a cognitive behavioural therapist enabled

TABLE 1 Participant characteristics and biographies

Pseudonym	Gender	Brief biographical details
Charlie	Male	A newly qualified CBT practitioner who was starting his first CBT role in an NHS Improving Access to Psychological Therapies (IAPT) team at the time of the interview. Charlie holds a counselling qualification and has previously worked in youth support. He is also a qualified psychological well-being practitioner (PWP). Currently working full time.
Elizabeth	Female	Qualified as a CBT practitioner when IAPT was launched in 2008/2009. Her original training was as a physical health nurse. She later completed a counselling degree before specialising in CBT. She has worked for her current NHS trust for over 20 years. Currently working full time.
Tasha	Female	Qualified as a CBT practitioner when the IAPT training was launched in 2008/2009. Her original training was in mental health nursing. She had worked for the NHS in a variety of roles for 35 years. Her last NHS role had been as a CBT practitioner in an eating disorders service. She holds a qualification in acceptance and commitment therapy (ACT). She had just retired before participating in this interview. She had taken a break and was now re-focusing on her private practice, something she had built up while working for the NHS.
Marissa	Female	Qualified as a CBT practitioner for just over a year at the time of this interview. She was working full time in an IAPT service and was planning to start her own private practice. She had previously worked as a PWP and in a personality disorders team. She is a qualified dialectical behavioural therapist (DBT). Currently working full time.
Philippa	Female	Originally trained as mental health nurse and then a counsellor over 20 years ago. She has worked in the NHS in a variety of roles, qualifying as a CBT practitioner when the IAPT programme was launched in 2008/2009. She also holds qualifications in ACT and eye movement desensitisation reprogramming (EMDR). At the time of the interview, she was suffering from physical ill health and considering taking early retirement. She also works in private practice.

her to show more compassion and make more of a difference to clients' lives.

Phillipa provided an example of her compassionate nature in practice, explaining how she had argued for additional treatment for a client where she felt it would make a difference:

> [the client] will get the compassion focused group because I've made sure she does…
>
> (Phillipa)

Phillipa regularly argued for more sessions or additional interventions for her clients and was often successful. Phillipa took the time and energy to put in additional work for her clients, often defending her point in meetings or completing additional written reports. It could be argued that this "going the extra mile" approach to secure the treatment she felt the client needed illustrates a passion and motivation for ensuring the most compassionate care for her clients.

3.3 | Becoming passionate about compassion

Once established in the profession, participants became increasingly interested in the compassionate approach. Compassion was viewed as a way of managing both the challenges of the professional role and issues in their personal lives. For Charlie and Marissa, training in compassion had been part of their postgraduate diploma in CBT. For Phillipa, Tasha and Elizabeth, compassion was not part of their original CBT qualification, but all had done their own research and received subsequent continuing professional development (CPD).

Elizabeth explained her motivation for seeking further training in compassion postqualification:

> We didn't do a huge amount of compassion work in our degree… it was never really talked about, being compassionate or the compassionate mind by Paul Gilbert… There was nothing said about it….so compassion is something I just think you pick it up as you go along and read yourself in your own time… so I think it's been very interesting with Chris Irons as well…..and doing the Compassionate Mind Days [training].
>
> (Elizabeth)

All participants mentioned Paul Gilbert, the founder of compassion-focused therapy (Gilbert, 2009), by name. This may suggest that participants received compassion from the work of Paul Gilbert, something they felt they could both use in their personal lives and deliver to clients.

As Tasha highlighted:

> Paul Gilbert was the keynote [at an event] and he was just an <u>amazing</u>… and I just found the theory of it tremendous […] I was going through some difficult times myself in my personal life and I thought, "you know actually…compassion yeah, self-compassion."
>
> (Tasha)

Tasha's account illustrated her passion for the topic and motivation to apply this both to clients and to herself. Similarly, Elizabeth expressed her realisation about what compassionate practice meant for her:

> It was a complete revelation really to think you could be kind to yourself as well as other people … you know, as soon as somebody said, "what about yourself?" it was like "my god! … yes…why can't you be kind to yourself as well as others?" […] you want to actually tell everyone about compassion… I think the more you can be compassionate about yourself the more you can flourish as well […] so I define it as … having the permission, having permission, giving ourselves permission to be kind to ourselves.
>
> (Elizabeth)

Elizabeth seemed almost evangelical in her enthusiasm for compassion. She went on to talk about how she has been recommending Paul Gilbert's book, "The Compassionate Mind" (Gilbert, 2009), to both clients and family members in the hope that they would also benefit. Elizabeth recommended something which had benefited her to others, perhaps showing her ability to acknowledge her own needs and how these helped her to connect with the needs of others.

Phillipa also explained her enthusiasm for this book:

> I read [The Compassionate Mind] twice – [laughter] – […] I found it really, really interesting and since then I've done lots of compassion training and done workshops and I run a compassion group.
>
> (Phillipa)

Phillipa's interest in compassion led her to further her knowledge of compassion through reading, workshops and delivering training to clients via her group. She explained that learning about compassion helped her acknowledge her motivation to help others whilst balancing this with the resources she has:

> Compassion [is] about actually saying "yes I can do this and I want to grow and help and support but I'm going to have to say no" […] And I think that is getting the balance … being aware of your limitations and what you can do and you can't do because actually you won't achieve it or you'll just, as you say, burnout, just overdo your drive system.
>
> (Phillipa)

All had heard about compassion and compassion-focussed therapy through work, had attended additional training in it and had attempted to implement some of the concepts into their professional practice. Phillipa, Tasha and Elizabeth's personal experiences demonstrate how they also integrated the concepts of compassion into their personal lives with positive outcomes. This demonstrates both their commitment to the compassionate approach and how the positive influence extended beyond the consulting room. These responses seem to show a "practice what you preach mentality," perhaps demonstrating their integrity by using the tools they are recommending to clients in their own lives. Skills in self-compassion appeared to have enabled them to be more compassionate practitioners and offered some protection from burnout by providing the clinicians with something they needed. This ability to show compassion to themselves is perhaps what drives their ability to show compassion to their clients as well.

3.4 | The need for a compassionate work environment

Participants highlighted the workplace influences on the delivery of compassionate practice and therapist well-being across two key areas: through the presence (and absence) of compassion within interpersonal workplace relationships and within expectations of the service and broader workplace culture.

3.4.1 | The presence and absence of compassion

Compassionate workplace interactions left the participants feeling confident, contained and "*held*" (Elizabeth) in their emotional well-being and professional abilities. Being involved in situations where there was an absence of compassion produced the opposite: fatigue, psychological distress, demoralisation and symptoms of physical ill health.

Charlie described what it felt like to receive compassion when discussing an interaction with a supervisor:

> When you were in the room with him you felt as if nothing else existed … it was almost as though he was there with you…in your pain or whatever was going on for you and he was absolutely present and on the same side as you … it was a very powerful experience.
>
> (Charlie)

In this example, we can see how having a supervisor who models compassion can help the theoretical concept be made real. Here, Charlie defined compassion as a feeling that someone is "present" with you, they listen, feel and understand your pain. When asked whether this led him to feel more confident in his work, he replied: "*Yeah, absolutely … very much so…*"

Charlie's experience of someone else being present in the face of his emotional pain appeared to enable him to understand what this looks like from the perspective of a client. This may illustrate the value of compassionate supervision for both treatment delivery and professional growth and well-being. This supervisory relationship would also suggest that compassionate skills can be developed beyond an initial interest or motivation essential when joining the profession, as discussed in the first theme.

There were also accounts of experiences reflecting a lack of compassion within the workplace. For example, in direct contrast to Charlie's experience, Marissa described a recent incident which left her feeling "*very, very, very distressed.*" Marissa explained how she had tried to manage a client she perceived as exceptionally verbally aggressive and outlined her perception of the response she received from her senior team:

> it almost felt like there was a bit of splitting going on because I was told one thing like, you know, "you've done the right thing, it sounds like you managed it well, you did this you did that and, you know, I wouldn't have done anything any different…" but then on the other hand saying to the patient that they were assured I would be spoken to … which would suggest that I have done something wrong.
>
> (Marissa)

Marissa spoke with shock and confusion, which illustrated how unnerved she was by this event. This was twofold: there was the impact of the verbal assault by the client and the impact of the service's response. Marissa felt, as an experienced mental health practitioner, that she had a good understanding of emotional dysregulation and had been trained in how to manage it sensitively and professionally. Unfortunately, she felt none of her skills had worked in this situation. This had left her professional confidence shaken. However, her account suggests her perception of the response of the senior team compounded this and left her feeling unsupported. Marissa perhaps would have benefited from a space to process this situation and to learn and reflect—a place like that provided by Charlie's supervisor. This may have given her the time and space to acknowledge the difficult feelings she experienced and explore how to manage similar situations in future. This, in turn, may have built her confidence. Marissa used her own skills to try and process the incident constructively, skills she had learned in her CBT training, but she did not feel supported or encouraged to do this; in fact, she appears to have felt negatively judged by her service:

> My service, it doesn't always feel very compassionate to staff, almost like there's a culture of, you know, you can't look after yourself; it's a little bit selfish.
>
> (Marissa)

It could be argued that Marissa experienced the response of her service as a barrier to processing the experience. As a result, Marissa was contemplating how much longer she wished to remain employed in her role, suggesting that she felt the job was not sustainable in the long term without a nonjudgemental space to process, perhaps in the form of appropriate clinical supervision. It could be argued that she was not given the space to acknowledge her humanity in the face of extreme distress.

Similarly, Phillipa discussed issues with her workplace relationships:

> It's not a very compassionate environment to work in … I'm not, I mean, I can only speak from my experience and my manager is under investigation for bullying at the moment, so … [slight chuckle].
>
> (Phillipa)

Phillipa's slight chuckle at the end of this revelation may be her way of reflecting on the irony of working in a system which is supposed to provide "care," yet her manager was under investigation for bullying. This comment seems to highlight the discrepancy between the ideal and reality. Towards the end of the interview, Phillipa said:

> I'm not planning on working for much longer to be quite honest with you because getting this, whatever I've got, this inflammatory disorder auto immune thing, then that, I think that's probably part of stress.
>
> (Phillipa)

Having outlined the struggle to provide a compassionate service for her clients, Phillipa appeared to be acknowledging the toll this was taking on her physical well-being. For both Marissa and Phillipa, it seems that the impact of the perception of working in an environment they felt was uncompassionate made delivering compassion to clients much more challenging and led them to question their desire to remain in their roles.

3.4.2 | More than just a "work machine"

The above examples illustrate the potential for feeling dehumanised within the work environment. Participants articulated some recommendations for making a work environment more compassionate, first by acknowledging the challenges of being a CBT practitioner.

Being a CBT practitioner was viewed as a role that can be rewarding, emotionally painful, psychologically distressing and extremely tiring. Charlie reflected on the challenge of this by acknowledging how hard it could be to face someone else's pain:

> I think perhaps for the difficulty sharing in people's pain is not an easy thing to do… you will often come back drained…
>
> (Charlie)

Elizabeth echoed this:

> It's tiring… the work that we do is tiring… (Elizabeth)

These short acknowledgements highlight some of the challenges of being a CBT practitioner and the risks of compassion fatigue. The CBT practitioner needs to hold and contain the client's distress whilst providing a framework for understanding difficulties and offering a tailored treatment programme. These are complex tasks that can only be achieved within a workplace that supports staff.

This was discussed further when Charlie stated that staff "*are not just a work machine*" and need to be "valued" and "appreciated" for the difficult and demanding job they do:

> What is really important is to show them [the staff] that value, to show them that appreciation for their job and that helps therapists to manage the difficulty of it and be better therapists for their clients.
>
> (Charlie)

He went on to explain how his service provided this for him:

> One of the things [my supervisor] will often say at the end of supervision is "thank you so much for the work you've done this week and we are really grateful and really appreciative" and that's just one line, and, but it gives you a very different feel […] I look forward to him saying that, almost it's a validation that I have worked hard, that I've contributed and that my work is valued, and I think in some ways that's, in many ways it's basic decency but it's also, it goes so much more than that.
>
> (Charlie)

This example related to a different supervisor to the one Charlie discussed earlier, illustrating experience of compassionate supervision from multiple sources. Charlie's service provided confirmation that his efforts were worthwhile and that his work was needed and appreciated, not just by his clients but by his employer: his individual worth as a clinician felt honoured and respected. These supervisors acted as role models on how to provide clinician support in a way that increases the supervisee's confidence and builds their professional skills. Finally, Charlie commented on how compassionate values needed to permeate throughout the whole organisation:

> Services can embody that value by giving therapists time to really speak to other colleagues and not create that pressure that you have to be seeing clients 24 / 7 and that you can have a work life balance, take holiday, and that's a real value that permeates throughout the organisation.
>
> (Charlie)

While Charlie seemed to be working within a compassionate work environment, the other therapists described experiences illustrating a lack of compassion within the workplace culture. For example, Tasha explained that she believed staff views and opinions needed to be "listened to and heard":

> You've got to make compassion by hearing others, so I would think about maybe hearing the thoughts and feelings of the staff group already, and maybe, and be truly open to hearing that and listening.
>
> (Tasha)

Tasha's account of the need to be "truly open" suggests she had experienced being asked for her opinion and feeling it was not listened to. She went on to say it must not be a "*tick box exercise*" and must be authentic. Comparably, Phillipa accounted for this lack of listening through her perception that management is often prevented from listening by the pressures of the job:

> [Managers] just seem to be very distracted a lot of the time…[by] stuff that they've got in their heads I guess… […] "are they going to get told off?" … "are they going to be punished?…" "are they going to get something wrong?"… because I think there's too much expectation a lot of the time within the NHS to achieve this, this, this and more, more, more, more and yet you cannot do that."
>
> (Phillipa)

Here, Phillipa places responsibility not on individual managers, but on the pressure of the NHS system within which the service is based. This account highlights a perception of demands too great for the system and unrealistic expectations of what can be achieved with the given resources. Phillipa argued that this prevented people from acting compassionately to colleagues or to clients. Similarly, Marissa explained that she believes the organisation needs to show staff the same compassionate behaviour that therapists are being asked to show clients:

> If someone was able to just listen to you and I guess use the skills that we use with patients that would feel very supportive even, even, if they said at the end of it, "you know, actually I hear what you're saying and I know that you're asking me for this I think that would be a great idea but we can't do it,", just to have that validation and that understanding, that in itself would go a long way.
>
> (Marissa)

This ties in with Elizabeth's belief that the delivery of compassion needs time:

> Compassion needs time, energy and reflection … to reduce the workload.. … make it more manageable… so then, yes, you'd be able to give more compassion to patients […] so I think, less clients, smaller caseloads obviously … more time to reflect, more time to give.
>
> (Elizabeth)

These examples reflect the different ways the participants felt compassion can be demonstrated within the culture of a healthcare system. While individual managers play a role, how the wider system deals with resource allocation and caseload management is equally important. In the participants' experiences and recommendations, there appears to be a significant juxtaposition between the need to comply with IAPT bureaucracy, the "tick boxes," and the need to show compassion and care towards clients, one system leaving little, if any, space for the other.

4 | DISCUSSION

This paper presents a novel exploration of CBT practitioners' experiences and perceptions of compassion within the UK IAPT healthcare service. Participants perceived themselves as motivated to provide compassionate care, with evolving passion for compassion and self-compassion. They also demonstrated how compassionate care is influenced by therapists' experiences of receiving, or not receiving, compassion. This was through both individual interpersonal relationships with managers and supervisors, and the broader workplace expectations, culture and environment.

Participants appeared to be drawn to the profession by their own innate desire and motivation to be of service to others, which can readily be related to compassion satisfaction (Hooper et al., 2010), a pleasure and satisfying feeling that comes from helping others. These accounts confirm that many CBT practitioners enter the profession with the motivation and capacity to be compassionate towards others (Simpson et al., 2020) and mirror the accounts of the US psychotherapists in previous research, who saw compassion as innate (Vivino et al., 2009). This motivation for compassion is something that, it is argued, is essential for clinical and psychotherapeutic work (Gilbert & Leahy, 2007). The participants perceived that CBT practitioners enter the profession with compassion (Shea & Lionis, 2014), as is expected to underpin healthcare policy and practice (Spandler & Stickley, 2011). This suggests that the profession is successful in attracting and recruiting the appropriate candidates.

Furthermore, the participants described becoming increasingly passionate about compassion through their training and working lives. The accounts highlighted work-based opportunities for CPD relating to compassion and their own personal motivations to seek out resources and learn more about the concept. Again, as in previous research, the participants recognised that the skill of compassion could be further developed and improved (Vivino et al., 2009). This is promising as policy directives and staff training schemes (e.g., compassion in practice e-learning programme) published by the Department of Health (2012) recommend that the 6 C's of compassionate care (Care, Compassion, Courage, Commitment, Communication and Competence) are enacted. Furthermore, course design and CPD programmes are recognising the importance and efficacy of compassionate care and are incorporating it into their staff development (West & Chowla, 2017). The NHS People Plan 2020/21 (NHS England, 2020) explicitly states its intention to create a culture of compassion within the organisation, which is both sustainable and inclusive, through acknowledging the challenges faced, and by promoting staff well-being through compassionate leadership. These accounts suggest that the opportunity to learn more about compassion and further development of compassionate organisations are wanted and needed by CBT practitioners. Evaluation of the effectiveness of these initiatives will be essential to ensure that such training and initiatives have the intended impact.

However, some participants felt that they did not currently work in a compassionate environment, and this had important implications for staff confidence, well-being and, ultimately, whether some wanted to remain in the profession. This appears consistent with existing understandings that staff working in conditions and organisations where there is an overactivation of the threat and drive emotion regulation systems and underactivation of the soothing (affiliative) system are at increased risk of stress, burnout and reduced capacity for compassion to self and others (Gilbert, 2009; Henshall et al., 2018). Charlie's two examples of receiving compassionate supervision and the positive influence of this on his own work illustrate best practice for how compassionate workplace cultures can be facilitated. Charlie's descriptions echo what Paul Gilbert (Gilbert, 2017a) describes as the “compassionate competencies of the clinician” (Gilbert, 2017b, p. 214) within clinician–client interactions; however, these accounts also illustrate how these elements are just as important within staff interactions. High-quality supervision, where staff feel safe to express themselves openly, has been associated with lower staff burnout (Johnson et al., 2020); therefore, compassionate supervision is central to the ethos of a compassionate organisation, which enables staff to feel safe and provide support to colleagues (Cole-King & Gilbert, 2011). These findings illustrate that, at present, not all IAPT CBT professionals are experiencing the quality of supervision needed to protect against the risk of compassion fatigue.

Participants' experiences of supervision and management within the workplace that were perceived to be lacking compassion, such as those expressed by Marissa, could have negative impacts. This is something Gilbert (2017b) argues is a significant block to compassionate practice and can discourage staff from seeking help. A lack of resources (e.g., inadequate supervision) has been associated with an activation of the threat system (Cole-King & Gilbert, 2011). This results in staff not seeking support due to the fear they will be judged and criticised, with significant impacts on the ability to provide quality care and, therefore, patient outcomes. It can be argued that these experiences contribute to burnout and compassion fatigue. These are characterised by emotional and physical exhaustion, resulting in a reduced ability to empathise or feel compassion for others, impairing the quality of services provided to clients (Singh et al., 2020). These findings support Singh et al.'s (2020) assertion that resources must be put in place to mitigate the impact on therapists of dealing with difficult client interactions, but also illustrate that the same considerations are needed for interactions with other staff members and supervisors.

Participants also highlighted the value of supervision and training for the development of self-compassion, a factor shown to protect against burnout (Gilbert & Choden, 2015; Mills et al., 2015). It is proposed that self-compassion may reduce the experience of a range of barriers to compassion (Dev et al., 2018) and is therefore an important trait to facilitate. Compassion-focused staff support groups have the potential to help healthcare staff members develop an awareness of compassion and a healthy balance between self-sacrifice, compassion and self-care. These groups can help staff to recognise and regulate emotions and distress and cultivate empathic concern and motivation to engage with and alleviate distress in self and colleagues (Drobinska et al., 2022). The combination of well-being days and compassion-focused therapy training for clinical staff has also been proposed as an effective approach to facilitating ongoing compassion-focused staff support (Lucre & Clapton, 2021). Alternatively, mindfulness-based interventions have been shown to increase self-compassion (Wasson et al., 2020) and have the potential to reduce stress in healthcare professionals (Burton et al., 2016).

Work environments were also highlighted as a challenge for IAPT CBT practitioners. The participants expressed a need to be seen as more “than just a work machine” and highlighted burnout symptoms within their experiences. One cause of this perception was high caseloads resulting in an overactivation of the drive system (Gilbert, 2009), already known to be a significant predictive factor of staff burnout and compassion fatigue (Johnson et al., 2020; Singh et al., 2020). Where prevalent, this burnout can lead to good therapists leaving the profession, further exacerbating pressures on existing staff. For example, Phillipa was about to retire from the NHS and move into private practice, Tasha had retired from the NHS and Marissa was considering leaving her service for another. Services that do not provide appropriate compassionate support for their motivated, well-trained staff are at risk of losing them.

The accounts highlighted how, to ensure compassionate patient care, space is needed within workloads to enable discussion of clinical practice with others and to minimise opportunities for compassion fatigue. The advancing complexity of clients within IAPT services (Cairns, 2014) adds to the high caseload challenges already discussed and reinforces the need for organisational change to better support IAPT practitioners. High levels of practitioner satisfaction with work environments and organisational leadership result in greater patient satisfaction (West & Chowla, 2017), illustrating the value of change for both patients and practitioners. The participants' accounts support the argument that a reduced workload for CBT practitioners within IAPT is needed, and cost implications may be offset by reduced burnout and fatigue in staff members (Westwood et al., 2017). Further work to test this hypothesis is urgently needed.

Participants highlighted that work satisfaction can be bolstered by effective management support that models compassionate behaviour. It is difficult for healthcare professionals to provide adequate support for their clients if they are not receiving compassion themselves (Sue et al., 2016). Beyond clarifying the existing evidence linking increased supervision hours to reduced levels of burnout (Westwood et al., 2017), the participants' accounts illustrate how high-quality supervision facilitates the perception of a compassionate workplace, as already discussed. There is a clear link in the participants' accounts between staff well-being and well-run organisations with a culture of compassion and positive patient experience. This is supported by evidence illustrating that highly compassionate organisations result in more positive and caring stories by staff, whereas in low-compassion organisations, such stories are difficult to recall and there are increased examples of poor management and staff stress (Simpson et al., 2020). By having a compassionate organisation, compassionate leadership offers a clear vision, ensuring direction, alignment of values and a commitment to prioritising high-quality care, with staff showing high levels of engagement and a strong sense of shared purpose, values and common humanity, which appear to be influential in creating compassionate healthcare cultures (de Zulueta, 2021).

The accounts of the participants echo several scholars who have advocated that compassion is essential in the provision of effective healthcare systems (Basran et al., 2019; Cameron, 2017; Crawford et al., 2014; Parsons et al., 2019). However, they also show how the best intentions can be undermined by a range of variables, including resource allocation, leadership culture, disputes on how to effectively manage targets and the politics of healthcare funding. Some argue that the decline in compassion seen in recent years is due to the move towards a market-based, technology-focused, bureaucratised approach to health care in both the USA and the UK (Jefferey, 2016). Rizq (2012) argues that the highly regulated and standardised structure of IAPT, with its continual pressure to meet targets, creates an environment where the difficulties and complexities of the role cannot be acknowledged. It could be argued that this structure generated the negative experiences Marissa and Phillipa experienced. Since the publication of The Francis Report in 2013 (Francis, 2013), there has been increasing concern that the market-based approach has not produced the levels of care desired, and there are recent calls for systems to be refocused on a care-based approach (Simpson et al., 2020). Phillipa's views about senior managers concur with this. As she outlined, she believes they are too distracted by the fear of "being punished" for not reaching targets to focus on compassionate care. The literature supports the participants' views that to provide the compassionate care that patients ask for (Sinclair et al., 2018), the healthcare system needs to move away from the prioritisation of bureaucracy.

It is important to reflect upon the impact of COVID-19 on CBT practitioners. At the time these data were collected, all participants had either paused their practice or moved it online. In July 2020, when the interviews were conducted, the idea that providing services online was going to become long term was not in the general consciousness. This makes Wiljer et al.'s (2019) work on defining compassion in a digital age timely. Although written before COVID-19, it acknowledges that digital healthcare delivery is becoming a greater reality, which provides both significant opportunities and pitfalls. Of particular concern is the impact digital technologies could have on the ability to demonstrate and provide compassionate treatment. They argue that digital health care represents a "transformational shift" (Wiljer et al., 2019, p. 2) in the context, process and way care is delivered and will have a significant impact on the therapeutic relationship. As staff and clients have gone through a rapid, unanticipated transition in working practice (an activation of the threat and drive systems with changes in ways of working and concerns about the virus), the importance of compassionate care, and systems to support staff in delivering this, is more relevant than ever. Which forms this support takes and how it is effectively delivered is an area of further research. The data from this study highlight that the facilitation of staff well-being must be a priority and could ensure better outcomes for all.

4.1 | Limitations

The recruitment of participants was self-selective; therefore, only those with an interest in the topic and the time to complete an interview participated. Three of the five participants had actively sought out additional training in compassion-focused therapy (CFT) and had positive experiences of it. It must be acknowledged that CBT therapists who may have had negative experiences of CFT training might have been unlikely to volunteer to participate. The first author and interviewer is a practicing CBT therapist and therefore may be subject to preconceived ideas and unconscious bias regarding participants' answers. This was managed using the IPA structure and reflexive process (Smith et al., 2009), combined with regular interrogation of developing themes with the second author.

5 | CONCLUSIONS

Current recruitment and training processes are producing staff with the skills and motivation to deliver compassionate care. However, lack of compassion to staff within workplaces can be a barrier to actioning these skills, ensuring motivation and retaining therapists. Evaluation of strategies to effectively implement and run compassionate systems for both therapists and patients is needed. A starting point for these interventions includes enhanced compassion training for healthcare management staff to facilitate the role modelling of compassionate behaviours, to help staff feel valued and to facilitate therapist self-compassion.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions. Participants did not explicitly consent to data being held in a public repository.

ETHICS STATEMENT

This research was approved by the Staffordshire University Psychology Research Ethics Committee.

PATIENT CONSENT STATEMENT

All participants were CBT practitioners and provided written informed consent.

ORCID

Amy E. Burton https://orcid.org/0000-0002-3698-0712
Dipti K. Mistry https://orcid.org/0000-0002-7766-2067

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AUTHOR BIOGRAPHIES

Laurien E. Broadley is a senior cognitive behavioural therapist at Hertfordshire Partnership University NHS Foundation Trust. She has been practising psychotherapy since 2003, originally qualifying as a drama therapist and working extensively with complex presentations in forensic and psychiatric intensive care settings. She qualified as a cognitive behavioural therapist in 2016 and has delivered treatment for a multitude of presentations in IAPT for the last six years.

Dr Amy E. Burton is a health and care professions–registered health psychologist and senior lecturer in qualitative psychological research methods at Staffordshire University.

Dipti K. Mistry is a trainee health psychologist, completing the professional doctorate at Staffordshire University, and is employed in Nottinghamshire Healthcare NHS Foundation Trust.

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