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Compassion in mental health: a literature review

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Compassion in mental health: a literature review

Abstract

***Purpose**:* To systematically review the current literature on compassion in mental health from a historical, service user and carer (SUAC)/academic researcher perspective with respect to the current paradigm/biomedical model.

***Methodology*:** Searches were conducted in CIANHL Complete, Academic Search Complete, British Education Index, ERIC, MEDLINE, PsycArticles, Scorpus, Proquest Central using a simplified PRISM approach.

***Findings*:** In the UK, the SUAC-movement facilitated the adoption of more compassionate mental health in statutory services. Across the world, compassion-based approaches may be viewed as beneficial, especially to those experiencing a biomedical model 'treatment'. Healthcare workers, suffering burnout and fatigue during neoliberal economics, benefit from compassion training, both in their practice and personally. Randomised control trials (RCTs) demonstrate compassion-type interventions are effective, given sufficient intervention timing, duration, and design methodology. Psychology creates outcome measures of adequacies and deficiencies in compassion, demonstrating their importance statistically, with reservations. The effective protection of mental health by self-compassion in both SUACs and health care professionals is evident. It is clear from qualitative research that SUACs prefer compassionate mental health. It also makes a large difference to mental health in general populations. Implications for practice and suggestions for future research are given, including a necessity to fund RCTs comparing compassionate mental health interventions with the biomedical model. Unless statutory mental health services adopt this emerging evidence base, medics and their SUACs will continue to rely on pharmaceuticals.

Originality/value: This is the first integrated literature review of compassion in mental health from a historical, SUAC/academic researcher viewpoint using all research methodologies.

Keywords: compassion, self-compassion, mental health, biomedical model, service users and carers

Paper type: Literature review

Introduction

Compassion in mental health care is widely recognised as a necessity for those delivering and receiving support due to troubled lives. However, service users and carers (SUACs), their families, friends and healthcare professional allies are unhappy that compassion may be disappearing in statutory healthcare systems internationally, possibly due to the current paradigm of using a biomedical model of professionally, detached healthcare workers and neoliberal economics.

Compassion across all healthcare disciplines needs to be distinguished from compassion in mental health within these disciplines. Clearly, a notion of compassion is embedded in an early evidence base, arising from spirituality - that compassion is an act of doing something to alleviate troubles in contrast to empathy, sympathy and feeling something for the person in trouble.

Compassion may be directed towards others or oneself. The evidence base for self-compassion is increasingly being defined as including kindness to oneself, being non-judgemental of oneself, common humanity rather than isolation and mindfulness rather than over-identification. It is having kind and warm attitudes toward oneself when one encounters difficulties, failures, or suffering (Neff, 2003).

In psychology, compassion fatigue, compassion stress, compassion satisfaction and secondary posttraumatic stress disorder were first recognised by Figley (1995) as those facets of caring for service users which may appear in mental health professionals. Psychologists have designed many questionnaire measures which include Likert scales that are standardised to define and distinguish these lexicons resulting in a multitude of semi-quantitative, multivariate analysed published studies of outcomes.

The paradigm of a biomedical model of mental health is becoming more widely questioned by mental health professionals and service users and carers, most recently in an alternative - power, threat, meaning framework (PTMF; Johnstone and Boyle, 2018). There are no biological aberrations linked to psychiatric diagnoses (for example, in a physical scenario: comparing insulin deficiency in diabetes). Neither are there currently simple biomarkers in human genomes that suggest psychiatric diagnoses or biomedical body parts being involved (Johnstone and

Boyle, 2018). People experience troubles, not biology, and troubles lead to mental distress (Johnstone, 2019).

There is gathering momentum from SUAC organisations and their health and social care professional allies for another route to wellbeing, for example, Compassionate Mental Heath (2020), Mad in America (Whitaker, 2010), Mad Studies (Menzies *et al.,* 2013; Russo and Sweeny, 2016; Spandler and Poursanidou, 2019). The notion of human compassion holds an enormous evidence base; this review is confined to those studies which include mental health affecting students, populations, SUACs and healthcare professionals where compassion is measured by a defined methodology.

Methodology

A simplified PRISM approach was employed: an initial literature search used the search terms “compassionate mental health” together in CIANHL Complete, Academic Search Complete, ERIC, MEDLINE, PsycArticles, Scorpus, Proquest Central with no restrictions and produced 17 relevant articles.

These databases were revisited using broader literature search terms: “compassion” AND “mental health” which generated >7,600 hits; thus these terms were filtered to be included in title only, adding: AND NOT “young adult” OR “young person” OR adolescent OR juvenile OR child* across all whole articles; there were 53 further relevant articles. Reference list and citation searches produced a further 41 articles.

Inclusion and exclusion criteria/ quality assessment

Case studies and studies with fewer than nine participants were excluded. During the first search, six were omitted as the search-phrase was used with no definition. During the second, eight were omitted because of sampling methodology and drop-out rates.

Findings

A historical perspective is presented, initially in the UK, also including some of the drivers for change: poor quality care resulting in new policy, education and outcomes in practice; then internationally, and where possible, information with greater reliability is presented first (randomised control trials- RCTs,), next semi-quantitative (psychology

generated Likert scales outcome measures), and lastly qualitative evidence.

UK origins and early works

Brown *et al.* (2014) cite Valera (1992) as maybe a recent starting point for compassion philosophy. Certainly, grassroot activists were evident during 2005, when Paul Farmer, then of the Mental Health Alliance, was cited by Parish (2005) as campaigning about deficiency of compassionate mental health in statutory mental health services.

Gilbert first published his ideas on teaching compassion (Gilbert and Procter, 2006), later developing this into a compassion-based psychotherapy (Gilbert, 2010). This is still widely practised as compassion focused therapy (CFT) by trained psychologists, sometimes within NHS Trusts. Gilbert (2010) went on to describe the relationships between different forms of compassion and fear in undergraduate psychology plus forensic science students (N=222) and therapists (N=53) because in therapy he discovered some clients were not able to respond to CFT. Fear of compassion for self was linked to fear of compassion from others; thus, difficulties with therapeutic interventions and the therapeutic relationship were explainable.

UK increasing momentum – compassion in mental health care

SUACs, grassroots activists, third sector organisations and healthcare professional allies are all able to influence policy and practice encouraging compassionate mental health. The Blair legacy for mental health reform of statutory services was discussed by Allen (2007); he cited a Mental Health Network of the NHS Confederation document: Time and Trouble: towards proper and compassionate mental health care (2007). During this time, the King's Fund ran a series of workshops the findings of which were published (Firth-Cozens and Cornwell, 2009) about compassionate care in acute settings (not necessarily mental health).

Shea and Lionis (2010) cite a 2009 Department of Health NHS Constitution report including a call for compassionate action, now updated with six mentions in the 2015 NHS Constitution. The Oxford Handbook of Compassion Science (2017) contains a Shea and Lionis chapter (2017: pp 457-474) calling for compassion in healthcare.

A further Department of Health (2012) Chief Nursing Officer's consultation document was published by The King's Fund (2012) on the

six C's including 'developing a culture of compassionate healthcare'. While in 2014, Dewar *et al*. (2014) clarified misconceptions about compassionate care in a discussion article, including citing the atrocities of Winterbourne View and the South Staffordshire NHS Trust debacle. For nursing, their findings should:

"…be used across policy, practice and education to raise awareness of beliefs and values that underpin the meaning of compassionate care.

…provide a foundation on which to establish a shared vision for compassionate caring in health and social care that has relevance to the realities of practice." Dewar *et al.* (2014: pp. 1739).

UK education to undergraduates and mental health professional in compassion

From 2010, Shea and Lionis, take up the gauntlet for teaching compassionate healthcare, providing a historic overview and application in rural settings across the world (Shea and Lionis, 2010).

The Scottish Leadership in Compassionate Care Programme, (Adamson and Dewar, 2015) further described how action research in practice was used to educate a group of 37 third year undergraduate nursing students through stories and reflections, at least benefitting the 16 who posted feedback about their increased compassionate care. They all thought that the knowledge, skills and confidence gained would result in a development of compassionate relationship centred care within future practice (Adamson and Dewar, 2015).

Further, education of clinicians and trainees weak in compassion is outlined in a model that benefits clinicians, patients, trainees and institutions through four steps – detached care, detached empathy, affective empathy and compassionated care (Post *et al.,* 2014). It also suggests future development of a compassion scale and that 'detachment' is not to be idealised.

For social work students (n=87) self-compassion, assessed via a simplified, 12 question, five-point Likert scale, significantly inversely affected stress, anxiety and depression in multiple regression analysis (Kotera, et al., 2019). Thus, these authors recommend further education in self-compassion during social work undergraduate and postgraduate study in Higher Education, and research to assess its impact.

UK outcome comparisons in practice

SUACs

A consideration of the relationship between a "recovery model" and compassionate care by Spandler and Stickley (2011) including service user perspectives and current policy, concluded that compassionate acceptance of the uniqueness of 'recovery' for all those with troubles is necessary together with compassionate relationships and contexts to foster hope, a central tenet of recovery.

Five focus groups of SUACs (n=30) were consulted regarding their views on compassion during mental health care (Lloyd and Carson, 2011). Three themes emerged: universality, diversity and recovery. Possible means to measure compassion was by comparing staff as: presence with absence; collaboration with oppression and persistence with resistance (Lloyd and Carson, 2011).

The only third sector organisation represented is MIND (McAndrew et al., 2017). From a small sample of mental health services users (n=12) themes established from individual interviews: mindful of the gap; easing like Sunday morning; magic moments; love is in the air; lighting-up a future and changing the status quod. These themes demonstrated that SUACs preferred MIND counselling to statutory services with respect the means of delivery of compassionate mental health.

Within an NHS setting, Cogan et al. (2017) implemented a "mindful path to compassion" intervention to an adult group (n=20). These researchers demonstrated significantly improved outcome measures and qualitative feedback had high levels of satisfaction experienced by those people, assessed to hold several clinically associated troubles.

Military veterans (n=10) associated with Scottish mental health clinics believed that compassion is an important quality of peer support workers, particularly in the persistence in gaining veterans' engagement (Weir et al. 2019)

Mental health professionals' delivery of compassion

Language used in interviews of acute mental healthcare staff (n=20) demonstrated a use of "production-line", task orientated ideas rather than those of compassion, especially as interview questions were centred around compassion; language used included: time pressures, care processes, and organizational tensions undermining best practice Crawford *et al.* (2013).

While Barron *et al. (*2017) suggested that even following policy and scandal reports, it continued to be difficult for a small number (n=9) of experienced community psychiatric nurses in Scotland to always deliver compassionate mental health with the pressures of NHS task-orientated systems. They recommended supervision, mindfulness, and self-compassion as solutions, together with further consideration of what compassion means in practice in the workplace.

A review of 32 articles which described compassion fatigue within a range of mental health professionals suggested such factors as trauma history of mental health professionals and empathy were ameliorated by certain behavioural and cognitive coping styles and mindfulness (Turgoose and Maddox, 2017).

Towey-Swift and Whittington (2019) using questionnaires and a number of Likert scale measures with professionally qualified staff (n=217; response rate = 61%) within community mental health teams of three NHS Trusts demonstrated that compassion fatigue and compassion satisfaction were statistically significantly linked to workload as a professional quality of life indicator. Workload is unlikely to be significantly reduced within the NHS, however, approaches aiming to streamline workload burden, together with interventions targeting perceived reward and values need to be considered by managers and further studied.

Donald et al. (2019) demonstrated a training course developed to convey compassion-based care with hospital mental health staff, during times of economic pressure, was transformative according to a qualitative study of participant's views (n=12).

Development of Compassionate Mental Health across the world

There is also the notion of compassion stress in healthcare professionals, particularly in social workers, first identified by Figley (1995) and readdressed by Radey and Figley (2007). The model they created suggested increasing positive effect by keeping a positive attitude to people, increasing resources to manage stress and increasing self-care by finding inspiration and happiness in life.

Randomised Control Trials (RCTs)

Systematic reviews and meta-analyses of RCTs in relation to compassion delivering-type interventions demonstrated that compassion and self-compassion highly significantly increased. While fear of self-

compassion, psychopathology, for example, anxiety, depression, and stress decreased, often also highly significantly (MacBeth and Gumley 2012, Kirby et al. 2017, Ferrari et al. 2019; Lombas, 2019). Where measured, such changes were maintained even after 6 months.

Not included in the above was a RCT of Compassion Focused Therapy (CFT) resulted in a sustained transformation in 3, 9 and 12-month follow-ups in an adult population (n=120) in the Netherlands, compared with those remaining on a waiting list (n=122; Sommers-Spijkerman et al., 2018). Thus, CFT as guided self-help showed promise as a public mental health strategy for enhancing well-being and reducing psychological distress.

In addition, a RCT of mainly mental health social workers (n=63), in USA, demonstrated that guided imagery versus taking a break, reduced compassion fatigue through increased sleep quality and decreased anxiety (Kiley et al., 2018).

Most recently, Kirby and Gilbert (2019) critiqued Wilson et al. (2019) meta-analysis of the efficacy of self-compassion type therapies, suggesting their inclusion criteria were not critical enough.

Psychology measures of aspects of compassion in mental health – both SUACs and healthcare workers

Rossi et al. (2012) provided quantitative evidence from a questionnaire (n=250; 84% response rate) of Italian community mental healthcare professionals in Verona, of compassion satisfaction – lacking due to psychological distress and compassion fatigue more in social workers and psychiatrists based on five-point Likert scales. Compassion fatigue was higher in women, those with all those of longer service year by year and those with adverse life events in the previous year (Rossi, et al., 2012).

Ray et al. (203) extended these findings to Canadian frontline mental healthcare staff (n=169) to include six areas of work (workload, control, reward, community, values and fairness); higher levels of compassion satisfaction, lower levels of compassion fatigue, and higher overall degree of fit in the six areas of work life reduced burnout (Ray, et al., 2013).

Some mental health counsellors in USA suffer compassion fatigue; this was predicted by working conditions, mindfulness, use of coping strategies and compassion satisfaction through a significant 31% of variance in multiple regression analysis (n= 213; Thompson et al., 2014).

More recently in the South African Cape, Abrahams and Gevers (2017), cited compassion fatigue by providers of mental health services negatively affecting the work of their staff. They recommend debriefing, support, understanding the need for self-care, as staff are reported to become protective, detached and distress-intolerant of cases of rape.

While surveying general nurses (n=235), a study in Taiwan, Chu (2017), found they self-assessed as moderate for compassion, interpersonal relationship quality and job performance over-all, on a six-point Likert scale. Providing compassion was significantly positively correlated with interpersonal relationship quality, job performance and mental health. Thus, Chu (2017; 464) concluded that nurses who often provided compassion to suffering colleagues have enhanced job performance and improved mental health. Creating high-quality interpersonal relationships in the workplace can effectively strengthen the positive benefits of providing compassion for both job performance and mental health.

A large Italian survey (n=400; response rate 87%), including psychiatrists, psychiatrists in training, psychologists, social workers, psychiatric nurses, educators, rehabilitation therapists, and healthcare support workers, across three similar areas. Interacting factors, including compassion fatigue and satisfaction were analysed with multiple regression statistics from a 30 question, five-item Likert scale Italian Life Scale questionnaire (Cetrano et al., 2017). Ergonomic problems (especially time pressures) and impact of work on life predicted: higher levels of compassion fatigue; perceived quality of meetings; need of training. Compassion satisfaction was affected by future job insecurities.

Samios (2018) demonstrated, for a combination of mental health social workers, psychologist and counsellors in rural western Australia (n=69), compassion satisfaction partially mediated the relationship between mindfulness and depression, and fully mediated the relationships between mindfulness and the positive indicators of adjustment (i.e., positive affect and life satisfaction). The outcome of this study supported the incorporation of mindfulness-based strategies into rural mental health professionals' self-care.

La Mott and Martin (2019) demonstrated that for USA licenced mental healthcare providers (individuals; n=371), there were greater negative compassion outcomes of those that suffered adverse childhood experiences (ACE) compare with those who did not have such a history. Because self-care and compassion satisfaction were significantly statistically linked, it was suggested that training in self-care is necessary for those experiencing ACE.

Varghese (2020) demonstrated from American Psychiatric Nurses Association active nurses (n=xxx), that those with high levels of positive attributes of self-compassion had higher perceived levels of caring efficacy and those with high levels of negative attributes of self-compassion had lower perceived levels of caring efficacy. Therefore, a knowledge of the association between attributes of self-compassion and perceived caring efficacy will provide nurses with improved awareness of the need to be compassionate to the self and its relationship to effectiveness of care provided, potentially leading to positive health outcomes in clients. There was no significant ameliorating effect, for example, length in role, nurse patient ratio and perceived level of caring efficacy.

In those individuals with mental distress (n=13), a CFT intervention compared with controls (n=7) resulted in significantly increased self-compassion, and reduced depression, anxiety, stress and rumination (Frostadottir and Dorjee, 2019).

In inpatient units, a mindfulness self-compassion (MSC) intervention on those people suffering mental distress, without acute psychosis (n=139) was compared with a control of progressive muscle relaxation. Self-compassion significantly increased as did happiness with MSC as assessed five weeks later; mental health increased similarly in both study groups (Gaiswinkler et al (2019).

Qualitative evidence for SUACs

Academics in the USA (Iwasaki and Byrd, 2010), used focus groups to demonstrate that urban American Indians (n=25) believed that Indian doctors gave greater compassionate mental health care recognising their cultural identities.

More recently, Horsfall et al. (2018) consulted people with mental distress (n=24) during a year of study of their recovery. These researchers were able to identify a fourth theme, of having a

compassionate service provision, provided by those people with lived experience.

Self-compassion in all populations

Ying (2009) in USA social work students (n=65) demonstrated that a negative component of self-compassion: over-identification, directly and indirectly (as mediated by decreased coherence, ie. competence) affected depressive symptom level.

In the Netherlands, Trompetter et al. (2017) demonstrated, for university student recruited public (n=349), self-compassion is significantly linked to positive mental health and inversely to psychopathology. It was speculated that self-compassion is a resilience mechanism and adaptive emotion regulation strategy.

Self-compassion in older Korean adults was statistically demonstrated to reduce depression, sleep disturbance and increase health related quality of life (Kim and Ho, 2018).

Self-compassion was further studied in USA college students (n=500; Berryhill et al., 2018). Positive communication within families was related to higher levels of self-compassion, and that higher levels of self-compassion were related to lower levels of depression and anxiety. Positive communication and self-compassion mediated the relationship between cohesive flexible family functioning and anxiety and depression (Berryhill et al., 2018).

Emotional regulation may be a means of accepting self-compassion if individuals learn to be present with their distress, reducing the need for maladaptive strategies. This finding was from an Australian review of five selected articles (Inwood and Ferrari, 2018). Explicitly cultivating self-compassion may be a beneficial treatment target for many mental health disorders.

A Turkish study of questionnaires generated from a general population, also involving researchers from the Netherlands (Yakin et al., 2019; n=296) demonstrated that when early years emotional needs are not met then self-compassion and negative emotion regulation represent complementary concepts, each playing a unique role in different aspects of mental health.

Potentially morally injurious experiences were ameliorated by the level of self-compassion in USA military veterans (n=203) as assessed by a

questionnaire (Forkus, et al., 2019). These authors suggested that research needs to be carried out on benefits of using self-compassion as a clinical intervention for PTSD, self-harm, and depression symptoms.

Discussion

While much literature is present about compassion in mental health, this may be the first recent synthesis across all healthcare professions that includes RCTs, semi-quantitative questionnaire outcome measures and qualitative reports from interview and focus group thematic analyses; space precludes discussion of the merits and limitations of each.

Taken together this literature demonstrates the human psyche has difficulty fitting into neoliberal economies of more recent times. Although there are no studies which explicitly make such comparisons. Neither are there studies, yet published, in which RCTs compare a biomedical model implementation of diagnoses and pathology with any other compassion-based therapies. The only evidence are qualitative studies of the service user voice (Lloyd and Carlson, 211; Cogan 2017; McAndrew et al., 2017). However, there is a RCT in progress as part of a UK Open Dialogue (OD), ODESSI initiative, where networks of people around a person in trouble are supported by mental health professionals using an equal power platform (Razzaque and Stockmann, 2016). Compassion, while part of an OD philosophy, is not explicitly a measured outcome. In recovery philosophy, peer support workers also use compassion as part of their toolbox (Horsfall et al. 2019; Weir et al, 2019), seeking trouble peoples' strengths, however, there are no published RCTs of the use of compassion by peer support workers.

Self-compassion is also emerging in the literature as an important means of gaining resilience against experiencing troubles (Trompetter et al., 2017).

The evidence to date mostly relies on differences between an intervention, and leaving people on waiting lists; outcomes from questionnaires using numbers generated from maybe imprecise Likert scales to infer causality, though maybe overly relying on statistical significances, and thematic analysis of troubled peoples' views, be they mental healthcare staff, SUACs and people drawn from general populations. Given these limitations what is clear is that the human psyche needs to be provided with compassion: by work colleagues, and organisational systems of statutory care. Then SUACs, their families,

friends and professional allies will experience the compassion they need to facilitate recovery. Across the world there is growing impetus, and funds being made available to study compassion science and disseminate gains in wellbeing of all through implementing compassionate mental health.

Implications for practice

Self-compassion and care will dispel troubles within our circle of control. For things we cannot control, then statutory mental health services need to ensure their staff undergo mandatory training in all aspects of compassionate mental health, including self-compassion, regular assessments of their personal compassion indicators together with supervision. It is clear from the current evidence base that whole mental health systems will benefit. SUACs need to have compassionate mental health care made available as alternatives to biomedical pharmacology.

Future directions

Until funding is made available by such organisations as, for example, in UK, NIMHR to undertake RCTs around the efficacy of compassionate mental health approaches compared with a biomedical model, then it will remain under-represented in any meaningful way in the literature.

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