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### **Accessible Summary**

- Compassion is described as a sensitivity to suffering in oneself and others, with an intent to alleviate and prevent it (Gilbert, 2009). A population within healthcare that has limited research on compassionate care is that of learning disabilities.
- The current study aimed to explore the experiences of compassion of professionals within learning disability services. Attention was given to the flow of compassion between professionals and service users, as well as the growth of compassion, over time.
- The findings suggested that compassion is difficult to foster in learning disability services that also value time-pressured, target-driven outputs. More needs to be done to support services to encourage compassion in care, for example by considering candidates' compassion at recruitment and through supportive supervision and group reflection, for both people with learning disabilities and the healthcare professionals employed.

Keywords: Compassion, Learning Disability, Compassionate Care, Compassionate Growth.

## Abstract

**Background** Compassion is one of six core principles that the NHS means to promote within healthcare. Research concerning compassion within learning disability services is scarce, therefore the current study aimed to explore the experiences of compassion of professionals within learning disability services.

**Materials and Methods** Twelve professionals from learning disability services completed a quantitative measure of professional quality of life and answered a series of qualitative questions regarding their experiences of compassion, in either an online survey or interview.

**Results** Narrative analysis was used to interpret participants' experiences of compassion. Three chapters were generated based on thematic and linguistic connections. In chapter one, participants explored their compassionate identities. In chapter two, participants detailed the flow of compassion, experienced interpersonally and intrapersonally. In chapter three, participants described their compassionate growth, owing to significant life events over time.

**Conclusions** Recommendations for improving compassionate care have been made, including encouraging self-compassion for professionals through training screening for compassion during recruitment and including people with learning disabilities on interview panels.

## Background

Compassion is described as a sensitivity to suffering in oneself and others, with an intent to alleviate and prevent (Gilbert, 2009). Compassion is a dynamic construct that can be experienced as a flow (Gilbert, 2014); interpersonally between the self to others, and intrapersonally from the self to the self as self-compassion. Compassion can grow over time in response to cultural, social and psychological life events (Parry, 2017). Following a significant life event, particularly one which involves some degree of personal suffering and adversity (Vollhardt, 2009), an individual may engage in reflection and sense-making to better

understand what they have experienced (Lilius et al., 2008). This reflection can reshape an individual's understandings of what it means to be compassionate, with themselves and to others, and develops their compassionate approach for the future.

### **Review of Literature**

Compassion is cited in the healthcare literature as a fundamental characteristic of quality care by patients, families and professionals (Sinclair et al., 2016). In the United Kingdom (UK), the National Health Service (NHS) recognises compassion as one of six key values that are integral to creating a culture where patients come first (Department of Health, 2015). The NHS has implemented nationwide strategies to deliver high quality, compassionate care (CC; Department of Health, 2012) in response to the changing landscape of the healthcare system. As in many countries, in the UK people are living longer, and therefore healthcare services must coordinate support for a greater number of people (Department of Health, 2012). Healthcare professionals (HCPs) working within the NHS are encouraged to respond with humanity and kindness to patients' pain, distress, anxiety or need, and search for things to do to give comfort and relieve suffering (Department of Health, 2015).

Although healthcare policy and patient need agree on the significance of CC, it cannot be assumed that all services can implement it autonomously. Turgoose and Maddox (2017) found time pressures, staff shortages and heavy workloads within healthcare created a culture that valued target-driven outputs, at the expense of person-centred compassionate practice. Furthermore, significant work-related stress, secondary trauma and burnout exist within healthcare services which impair CC and impact the quality of life of HCPs (Sprang, Clark & Whitt-Woosley, 2007; Glasberg, Eriksson, & Norberg, 2007; Meadors, Lamson, Swanson, White, & Sira, 2010; Montero-Marin et al., 2016). It is the responsibility of the

healthcare system to promote a culture that fosters compassion for all (Department of Health, 2015), therefore empirical research which identifies shortcomings in CC, should be an important consideration for healthcare services.

In response to the growing evidence base that demonstrates the benefits of employing a compassionate framework in practice, research regarding patient experiences has increased over the last eight years (Sinclair et al., 2016). However, to date relatively little attention has been paid to practitioner experiences, with only one study exploring HCPs understandings of compassion in healthcare; a new clinically informed model to guide practice was generated from HCPs personal perspectives and experiences of compassion (Sinclair et al., 2018). Participants conceptualised compassion and identified the knowledge, skills, behaviours and qualities that underpin CC to create a practitioner-informed framework. However, the sample recruited within this study was based in Canada, which whilst sharing a professional respect for the relevance of compassion, is not a cohort that adheres to the specific standards of care followed by the NHS. Further research is required to explore the transferability of the model across cultures, as well as to address compassion within specific populations in healthcare.

One population marginalised in the compassion literature is individuals with learning disabilities. The paucity of research in this population means an understanding of their unique experiences and needs is limited. The limited literature that does exist indicates that HCPs recognise CC for people with learning disabilities as a tautology (Horsburgh & Ross, 2013); in that care without compassion is not care at all. A better understanding of HCPs experiences of compassion within learning disabilities services is fundamental; as the people they support require and desire CC (Dodevska & Vassos, 2013), and the impact of work-related stress and

burnout for HCPs is significant within this area of healthcare (Søndenaa, Whittington, Lauvrud & Nonstad, 2015; Devereux et al., 2009).

### **Research Question**

The current study aimed to explore HCPs' understandings and experiences of compassion within learning disability services. Attention was given to the flow of compassion between professionals and service users, as well as the growth of compassion, over time.

### **Materials and Methods**

#### **Design**

The current study employed a mixed-methods design, which involved collating and analysing quantitative data to understand professional quality of life, and qualitative findings to explore experiences of compassion. Narrative analysis techniques were used to interpret participants' experiences of compassion. Narrative theory posits that the stories people tell and the way they are told offer insight into their lived experiences and self-identity (O'Reilly & Kiyimba, 2015). Within narrative analysis, the focus is on what is said by participants in their stories or narratives, to identify thematic connections or 'chapters' across the cohort (O'Reilly & Kiyimba, 2015), to provide an overarching cohesive story of experience. It is a useful methodology when there are a suitably small number of participants to offer a rich ideographic account, and where the focus of enquiry is between the self and culture (Weatherhead, 2011).

To ensure inclusive platforms for participation, professionals could either attend a face-to-face interview or complete a web-based survey that used the same interview schedules, both options facilitating the opportunity to tell their narratives in their own words (O'Reilly &

Kiyimba, 2015). Quantitative data was collected using a self-report measure, The Professional Quality of Life Scale (ProQoL; Stamm, 2009).

### **Ethical Considerations**

The current study was approved by the ethics committee of Manchester Metropolitan University and the NHS Research and Development panel of Salford Royal NHS Foundation Trust.

### **Participants**

A selected sample of HCPs were recruited from care providers working alongside the NHS within the North West of England, that offered a range of residential and day centre support services for adults with learning disabilities. Twelve participants were recruited in accordance with existing literature that states six to 12 narratives are a suitable number to reach a point of theoretical generalisability for future research to build upon (Guest, Bunce & Johnson, 2006). Participants (M = 1, F = 11) were aged from 25 – 64, nine were employed full-time and three worked part-time, and the sample was made up of eight support workers and four managers. Participants had completed the relevant professional qualifications for their roles that were required by their services; two participants had completed qualifications at a secondary-school level, two had completed undergraduate qualifications, six had completed vocational qualifications and two had completed undergraduate qualifications.

The inclusion criteria for the current study were to be working in a provider service, within the North West of England, supporting people with learning disabilities. Informed consent was appropriately obtained from all participants.

### **Recruitment**

Research information was disseminated through organisations via suitable gatekeepers. For participants who agreed to an interview, the researcher attended their place

of work and interviews were audio-recorded using a digital audio-recording device. For participants who chose to complete the online survey, a link was included in the study information to provide participants with the opportunity to complete the survey without needing to provide identifying information to the researcher. The Compassionate Mind Foundation contributed a £50 voucher prize to encourage participation, therefore participants who chose to enter the prize draw were required to provide an email address. The researcher destroyed this information once data was collected and a winner was selected randomly.

### **Data Collection Procedures**

Data collection was conducted from June until August in 2018. For participants who chose to complete face-to-face interviews, the researcher began by reiterating the study information and provided participants with the opportunity to ask questions before consent was obtained. Following this, audio recording began. Participants first completed the demographics questionnaire, and were then given version five of the Professional Quality of Life Scale (ProQOL) (Stamm, 2009) to complete. The ProQOL is a 30-item self-report measure of the positive and negative effects of helping others who experience suffering and trauma. Respondents are instructed to rate each item on a scale from one to five based on how frequently said item was experienced in the previous 30 days. Example items include, “I feel worn out because of my work as a helper”, and “I get satisfaction from being able to help people”. It has been in use since 1995 (Stamm, 2009), and previous research has used the measure to explore the quality of life experiences of HCPs (Newell & MacNeil, 2011; Sprang, Clark & Whitt-Woosley, 2007). Subsequently, participants answered four narrative questions exploring their personal reflective accounts pertaining to their understandings and experiences of compassion. Occasional prompts were used to encourage expansion and



produce detailed narratives (Riessman, 2008). Eight of the twelve participants completed face-to-face interviews, which ranged in length from 16 – 44 minutes ( $M = 30$ ,  $SD = 19$ ). On completion of the interviews, audio recording was stopped and debrief information was given to the participants in a word document, which included contact information for the lead researcher. Participants were also given a second opportunity to ask questions.

For the other four participants who completed the online survey, it was accessed using a cloud-based software program Qualtrics. Study information was included at the beginning of the survey, followed by the online version of the consent form. The demographics questionnaire, ProQOL and compassion questions were then presented to participants, and debrief information was provided following completion of the survey. The word count for online responses ranged in length from 112 - 430 words ( $M = 271$ ,  $SD = 224$ ).

### **Data Analysis Procedures**

Audio-recordings of interviews were transcribed verbatim and responses to the online surveys were downloaded to create twelve individual transcripts. Quantitative data regarding participants' professional quality of life was summarised and scored according to instructions outlined in the ProQOL (Stamm, 2009) measure manual. Qualitative data regarding participants' experiences of compassion was collected from transcripts and a narrative analytic framework was developed and used to interpret participants' experiences of compassion. The current study adopted a combination of narrative approaches outlined by Weatherhead (2011). Riessman's (1993) steps to narrative analysis were used to establish familiarity with the transcripts, identify segments of narration and note content. Consideration of features to explore within narratives, outlined by Cossley (2000) and Weatherhead (2011) were made, which included references to key events, life chapters, significant people and personal ideology. Furthermore, the use of narrative constructs,

outlined by Burck (2005), were considered, which included story-telling techniques such as reflections, giving accounts and positioning. Once thematic summaries were made for each transcript the researcher identified the thematic and linguistic connections across all transcripts to generate chapters.

To increase the rigour of the current findings (Yardley, 2008), the content of one transcript was reviewed by a co-author, to compare with the lead researcher's analysis. No new themes arose which were not already incorporated in the researcher's interpretations. The data that support the findings of this study are available from the corresponding author upon reasonable request.

### **Results and Discussion**

#### **The Professional Quality of Life Scale**

The ProQOL (Stamm, 2009) has three subscales. The Compassion Satisfaction scale captures pleasure derived from helping others through work. The Burnout scale reflects feelings of hopelessness and difficulties in managing work-related stress. The Secondary Traumatic Stress scale denotes work-related, secondary exposure to traumatic events. Compared with normative data (Stamm, 2009), participants' mean scores fell within the average range for all three subscales; the Compassion Satisfaction scale ( $M = 41.08$ ,  $SD = 7.47$ ), the Burnout scale ( $M = 23.08$ ,  $SD = 3.03$ ), and the Secondary Traumatic Stress scale ( $M = 24.67$ ,  $SD = 5.91$ ). These scores suggest that participants' levels of burnout and secondary traumatic stress are comparative to the general population. The mean scores on the Compassion Satisfaction and Burnout subscales reflect those from previous explorations of professional quality of life (Newell & MacNeil, 2011; Sprang, Clark & Whitt-Woosley, 2007). However, the sample in the current study scored higher, on average, on the Secondary Traumatic Stress scale compared with previous samples (Sprang, Clark & Whitt-Woosley,

2007), which may be explained by the differing healthcare services that participants were recruited from.

### **Compassion Questions**

Narrative analysis yielded three chapters, re-narrating the collective narratives of the participants.

#### **Chapter One: Compassionate Identity - “It underpins everything that you do”**

##### **(Participant 05)**

In this chapter, participants explored their compassionate identities by describing their personal understandings of compassion, and its significance within learning disability services.

Most participants identified features of compassion that they frequently use in learning disability services. Empathy was noted as a prominent feature of compassion, as Participant 04 explained that CC should expand upon a sympathetic approach to include, “an understanding of how that person is, (...) to take the individual as a whole; the likes, the interests, and just make sure that we know what makes them happy”. Participants also reflected on the importance of compassionate communication in care, to include the way in which something is said, “listen to the tone of the voice, it’s from that that you pick up the way that people are” (Participant 05), and how it is expressed, “sometimes you just don’t need words, a hand on the shoulder is just to let the people know that actually you’re not on your own” (Participant 01). Quality time to spend reflecting with others was also identified by participants as a key component of CC, “people have brews with people, and have sit downs and chat, and start slowing things down” (Participant 09). The features of compassion identified by participants reflect those described in Gilbert’s (2014) definition of compassion. However, participants expand on Gilbert’s (2014) conceptualisation of compassion by

reiterating the importance of establishing a deep understanding of the people they support with the use of several strategies of communication.

Many participants acknowledged the compassionate nature of their working role, and stipulated that compassion is a prerequisite to supporting people with learning disabilities:

I think it underpins everything that you do, working in a health and social care setting.

It underlies the respect that you have for people, the dignity that you want to uphold for people, the respect for their rights, as human beings.

(Participant 05)

Several participants discussed the prospect of training to develop CC for professionals, but all concluded training would be problematic as they understood compassion to be an instinctual trait which, like love, would be difficult to teach, “you can throw training at people, but in my experience that doesn’t change the way that they are as a person” (Participant 05). Participants’ conclusions are significant for the implementation of existing training courses designed to enhance compassionate care, for example Compassionate Mind Training for emerging HCPs (Beaumont & Martin, 2016). For training to be successful it may be worth first addressing the assumptions trainees have about the legitimacy of teaching compassion.

Reflection during questioning provided participants with the opportunity to identify connections between their approach to CC and their personal values, “I have very strong values, it’s something that I’ve wanted to bring into this work, and that I see for my role working for the people we support,” (Participant 04). Positioning (Burck, 2005) was used by participants to establish how their own worldviews can influence their CC approaches. Participant 03’s understanding of compassion was closely linked with their perceptions of what it meant to be human; they gave an account of a time when using touch to support a

person with learning disabilities who was in distress felt like appropriate CC, even though it conflicted with the safeguarding regulations advised by the service because, “at some point we’re still human beings”. A third of participants detailed how their understandings of CC stemmed from their desire to do their very best for people with learning disabilities who are experiencing distress, “if you’re not compassionate for the service users at difficult times (...) I don’t really think the job is for that person” (Participant 11). The drive to relieve suffering over time which was experienced by participants mirrors Gilbert’s (2014) definition of compassion, and clinically contextualises principles of compassionate growth (Parry, 2017).

### **Chapter Two: Compassionate Flow - “If they’ve had a good day, I’ve had a good day” (Participant 07)**

In this chapter, participants detailed the intrapersonal and interpersonal flow of compassion.

All participants discussed their understandings of self-compassion, and the ways in which they experience the intrapersonal flow of compassion. Participant 05 noted that self-compassion involves turning the personal attention we afford others inward, “sometimes you need time to sort of slow down and have some self-reflection”. This practice is a useful technique to coordinate reflective conversations with other members of the healthcare team, to relieve stress, as Participant 05 described, it is helpful to have “an organization that has an approachable management team, (...) that’s always got an open door, (...) is always kind of receptive to staff needing to go and speak to them”. Participant 01 stressed the importance of self-compassion when supporting others, “you have to have compassion really for yourself before you can have compassion for other people”.

Although most participants acknowledged the importance of self-compassion, many described the professional and personal barriers that impaired their ability to be self-compassionate:

If you're busy, you just don't think about yourself at all. Well, I'm fit, I'm walking and breathing, I'm fine. You know, I might have a bad back, but I'm fine. So, you go in, you crack on, and my back is ten times worse. You've forgotten that person that you are, from going through the door to coming back out.

(Participant 08)

Several participants commented on their ability to “mentally shut off” (Participant 07) from their own needs, as a means of prioritizing their work load. Participant 08 equated their management of working responsibilities with their responsibilities at home. They specified that their role as a parent meant they sought to meet the needs of others, both personally and professionally, in favour of addressing their own, “it's a parent thing, (...) it's just an automatic response to things”. Participants' considerations of the significance of self-compassion in healthcare are significant as they imply self-compassion is not a regular practice for learning disability professionals. Existing literature indicates that an absence of self-compassion in learning disability HCPs plays a role in explaining subsequent burnout (Montero-Marin et al., 2016). Participants' narratives confirm previous findings and distinguish opportunities for intervention, namely by providing timely moments of reflection with other professionals, to foster self-compassion.

Participants also reflected on the interpersonal nature of compassion. Several participants described how the nature of their working environment fostered strong connections between professionals and the people they supported, “we are in a 24-hour care environment and we are with the service users a lot, plus their families, so being there as

support is vital, compassion is very important” (Participant 11). A third of participants described the happiness they experience after observing the positive affects their CC has for people with learning disabilities, “If they’ve had a good day, I’ve had a good day” (Participant 07). Whilst others reflected on how their work with people who have experienced trauma has had a significant impact on them, personally and professionally; a quarter of participants explained they had taken traumatic experiences home with them, “I supported someone for about five years, who passed away, and I cried my eyes out, I mean you’re not supposed to form that relationship, but when he passed away it broke me” (Participant 03). The emotional experiences participants described reflect the interpersonal flow of compassion, as outlined by Gilbert (2014). Participants’ narratives capture the non-linear, interpersonal nature of compassion, and they identify both positive and negative compassion experiences associated with supporting people with learning disabilities.. Existing research confirms compassionate HCPs experience secondary traumatisation after listening to people’s stories (Meadors, Lamson, Swanson, White & Sira, 2010; Sprang, Craig & Clark, 2011), and these narratives further explain the higher scores on the Secondary Traumatic Stress Scale of the ProQOL.

Finally, for many participants their services featured in their narratives, with their barriers that impaired the flow of compassion:

There are procedures that we have to go through, (...) and sometimes I think that as a human being, I think they’re inappropriate and not compassionate. (...) Are we just making it worse? By being official? Is that showing compassion? (...) It’s difficult drawing that line between being a human being and a manager basically.

(Participant 03)

Participants used Burck’s (2005) narrative construct of positioning to explore how their own values concerning compassion conflicted with the procedures valued by their services.

The pressures of time, short-staffing and a lack of resources, were noted by many of the participants, “barriers (to compassion) can be restrictions within the service, for example, time constraints, reduction in staffing levels, and poor training opportunities” (Participant 10). These left many participants feeling stretched when required to provide CC to people with learning disabilities, “it’s like a measuring jug. You can’t give 10 people, fighting over 100mls of juice, enough each, when that’s all you’ve got. So, you’re limited.” (Participant 08). For participants in managerial positions, the difficulty meeting expectations of managing a service, whilst also providing support to colleagues experiencing distress, was noted, “sometimes it is difficult in my role, I have to supervise staff and I have to take some interest, but I have to separate myself, (...) and I suppose it could have been a conflict for myself, it’s hard to balance at times” (Participant 04). The challenges to the flow of compassion described by participants reflect previous research that found healthcare organisations can impede the momentum of CC (Tierney, Seers, Reeve & Tutton, 2017), by valuing a target-driven approach instead of one informed by compassion (Turgoose & Maddox, 2017).

### **Chapter Three: Compassionate Growth - “An understanding, a way of life” (Participant 01)**

Participants described and reflected on life events that have changed their perceptions of compassion over time, with attention to significant cultural, social and psychological experiences that have contributed to compassionate growth. This chapter is the most sequential of the three, as participants journey through their experiences of compassion in relation to temporality:

It’s one of those that you grow, it grows, it grows on you, you learn a bit more, (...) you become more compassionate as you get older, because of your life experiences, (...) as



you grow up, you learn to love more, (...) you learn to love properly, (...) you care, but the compassion comes later.

(Participant 08)

A third of participants described how their understandings of compassion have developed with time; from believing compassion to be “people who cry a lot, but don’t do a lot about it” (Participant 01) to something “much stronger”, “an understanding, a way of life” (Participant 01). Participant 07 captured their compassionate growth using metaphor, “it’s the same old saying of (...) when you speak to somebody in a wheelchair, you tend to talk to the carer and not to the person, and that has changed”. This narrative technique not only represents personal changes in perspective, but also the systemic changes in healthcare that have occurred over the last 35 years for people with learning disabilities (Department of Health, 2001).

Finally, participants described cultural, social and psychological events that have prompted compassionate growth. A third of participants described how the experience of aging enhanced their desire to better understand people with learning disabilities, “I think when you see what other people go through, their experiences of life, how it affects them, I used to feel sorry for people, but now I think it’s a different feeling” (Participant 07). Significant life events, like a change in working role and responsibility, shaped several participants’ understandings of compassion within their learning disability services, “for 15 years I was a support worker, and when you work alongside a member of staff you can sometimes think “you’re selfish”. Now as a manager, you get a better idea of exactly what’s wrong with them” (Participant 03). Reflection on personal experiences of suffering deepened participants’ compassion for others and themselves. Participant 01’s experiences of secondary trauma earlier on in their career reshaped their compassionate approach, “looking

back (...) their (people supported) histories were so traumatic, I remember thinking it's really weighing me down, (...) you've got to have compassion for yourself, that's something that I've learnt, definitely". Participant 10 explained how the care received by their mother at the end of her life has informed their own approach when supporting others:

Knowing people loved and respected her was the most important thing. A kind word, a hug, someone listening without judgement, giving her time. This has had a profound effect on me and my work practices.

(Participant 10)

Experiences of suffering also provided participants with opportunities to reflect on how the people they support could handle similar events, "you don't understand until you've had experiences yourself, you come in and reflect on somebody here who's gone through the same thing, (...) and you start to question what else can I do for that person?" (Participant 09). Participants' accounts of compassionate growth reflect existing literature that suggests personal suffering enhances one's motivation to help others (Vollhardt, 2009), especially for those who participate in the delivery of compassion (Lillius et al., 2008). Their narratives clinically contextualise Parry's (2017) outline of the development of compassionate growth, specifically demonstrating the significance of experiencing adversity and learning from experience.

### **Concluding Discussion**

Participants' narratives explored the dynamic nature of compassion within learning disability services, with reference to their own compassionate identities, and experiences of compassionate flow and compassionate growth over time. Whilst some findings echoed those from existing literature, the current study has also contextualised assumptions that were based on theoretical and conceptual work, with a clinically relevant sample of working HCPs.

Furthermore, there were findings expressed in participants' narratives that are not captured in previous relevant studies. For example, the practice of self-compassion was not valued by all participants, which has potential implications for the effectiveness of professional compassion training. Additionally, several narratives and the ProQOL scores suggested that learning disability HCPs may be experiencing significant secondary trauma which they are managing with their own compassionate coping strategies established autonomously.

There are several limitations in the current study that future research should consider addressing. The sample represented HCPs from several learning disability services within the North West of England, thus further research is required to explore the transferability of these findings across a greater breadth of learning disability services within the UK, and within other healthcare populations. With regards to the analysis, narratives were not presented to participants for review after the researcher had established thematic and linguistic summaries, due to time constraints. Therefore this study did not undertake a triangulation stage, although the findings of this study could inform larger scale research in this area in the future. This is also true of the quantitative findings from this study; the researcher acknowledges that data from 12 participants cannot be used to determine significant conclusions regarding professional quality of life, so it was instead used in this study to contextualise participants narratives. Future research could build upon this design with a statistically significant sample size to establish reliable findings regarding professional quality of life. Finally, the sample recruited included only one male HCP; therefore, the findings are vulnerable to gender bias. Gender bias is evident in healthcare workers (Apostolides, 2017); however, the current study remains somewhat limited considering statistics outlined by charities and governing bodies which estimate that males represent 25% of support roles within the adult social care workforce (Skills For Care, 2017).

The findings have several clinical implications and recommendations for individual learning disability HCPs and for services. Participants' narratives imply that the pressures of working responsibilities can prevent self-compassion, as well as aggravate burnout and secondary trauma. Therefore, HCPs must be made aware of the benefits of self-compassion and its status as a protective factor against the undesirable impacts of work within learning disabilities (Glasberg, Eriksson & Norberg, 2007). Future research could explore effective methods for relaying information about the importance of self-compassion to HCPs, with reference to how to practice it. Systemically, the findings suggest compassion is difficult to foster in learning disability services that also value time-pressured, target-driven outputs. Therefore, more needs to be done to support healthcare services to incorporate compassion into practice, such as through supportive supervision and group reflexive spaces. This should also be a consideration for other healthcare professionals and services away from learning disabilities – given that the healthcare system within the UK is forced to consider time-pressures and target-driven outputs (Turgoose & Maddox, 2017). Practical recommendations based on the narratives in the current study include exploring the compassionate attitudes of candidates during the recruitment stage of employment. Asking questions pertaining to compassion in applications and interviews would establish the significance of CC, as well as evaluate interviewees' compassion values.

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