Exploring Shame and Compassion in Student Nurses

Abstract

The Nursing and Midwifery Council (NMC) considers compassion essential to good nursing practice. In order to maintain standards of practice, student nurses in the UK are formally assessed on their proficiency in delivering care that is compassionate. Research suggests that these assessments might promote artificial displays of compassionate behaviour, termed 'submissive compassion', rather than cultivate genuine cultures of compassion as intended. It is hypothesised that submissive compassion is not only bad for nursing practice but also for the mental health of nurses.

In order to test this hypothesis a cross-sectional study was designed which gathered quantitative data from 650 student nurses on measures to do with shame, compassion and negative affect. Statistical analysis explored how these variables influenced one another; the findings suggest that feelings of shame to do with students' caring role were predictive of increased submissive compassion and increased negative affect. The relationship between these variables was stronger in the current sample than in a previously reported sample of students from other professions. The potential implications of these findings are discussed in relation to future research into compassion in the NHS.

Introduction

National Health Service context

The National Health Service (NHS) categorises compassion as one of six values it aims to instil in the care that it provides. This values statement commits NHS staff to providing care that is more than just the execution of clinical tasks: it reiterates the importance of interpersonal skills which are considered essential to patients' subjective experience of care (Luff & Thomas, 2000; Schantz, 2007). Nursing has always been considered a more holistic practice than medicine because of its attention to these aspects of care which go beyond the objective treatment of illnesses. It is on the basis of this distinction that the nursing profession remains distinct from medicine in both training and in practice, though some might argue that this distinction has more to do with differences in sex than practice (Baumgart, 1999; Triggle, 2019).

The modern nurse's role has seen increased medicalisation. Financial constraints have seemingly necessitated that nurses take on multiple and more specialist roles within the care setting (Coombes, 2008); the rise of nurse practitioner and nurse prescriber roles are perhaps evidence of this. Medical specialisation has created opportunities for nurses' continual professional development and has facilitated fairer pay on the basis of clinical experience. Some though argue that increased medicalisation has been detrimental to nurses' characteristic holism (Darbyshire & McKenna, 2013). For example, Robert Francis (2013) attributed the failures in care that occurred in Mid-Staffordshire NHS Trust in part to a lack of compassion amongst staff. Compassion was subsequently revitalised as part of the NHS' '6Cs' vision for nursing, midwifery and care staff (Cummings & Bennet, 2012).

‘Action area 3’ of the NMC’s new vision called for ‘indicators’ of compassion to be developed that could be used to identify insufficiently compassionate nurses and prevent them from entering into the profession, presumably in the hope that this would distil more compassionate care into hospitals. The indicators of compassion that were developed can be found in ‘annexe 3’ of the Standards for Pre-Registration Nursing Education (NMC, 2010), an example of which is presented in Table 1. The standards outline examples of compassionate behaviour and order them by the level of competence they are thought to indicate. The standards were intended to regulate the quality of those interpersonal aspects of nursing care that were thought to have gone neglected compared to the rising standards of medical practice.

Bradshaw (2009) suggests that attempts to regulate compassion in the same way that other medical competencies are assessed have unwittingly espoused a teleological view of compassion that she criticises as reductionist. This is because, Bradshaw argues, such regulatory practices privilege the assessment of actions over intentions, ignoring the moral dimensions of compassion as described by more traditional nursing theories (Bradshaw, 2011). Bradshaw warns that without equal attention paid to both aspects of compassion then nurses risk becoming merely actors performing displays of compassion to their patients.

It could be argued that by formalising the cultivation of compassion in nurse training the NMC has incentivised compassion as a professional behaviour. One incentive for student nurses to demonstrate compassion is career progression, something that is associated with financial gain. These financial incentives attach an extrinsic value to the demonstration of compassion for student nurses, broadening the scope of student nurses’ reasons to behave compassionately to include avoiding

Table 1. Criteria 5 of the 'Care, compassion and communication' essential skills cluster for pre-registration nursing education.

5. People can trust the newly registered graduate nurse to engage with them in a warm, sensitive and compassionate way.		
First progression point	Second progression point	Entry to the register
1. Is attentive and acts with kindness and sensitivity.		6. Anticipates how people might feel in a given situation and responds with kindness and empathy to provide physical and emotional comfort.
2. Takes into account people's physical and emotional responses when engaging with them.		7. Makes appropriate use of touch.
3. Interacts with the person in a manner that is interpreted as warm, sensitive, kind and compassionate, making appropriate use of touch.		8. Listens to, watches for, and responds to verbal and non-verbal cues.
4. Provides person centred care that addresses both physical and emotional needs and preferences.		9. Engages with people in the planning and provision of care that recognises personalised needs and provides practical and emotional support.
5. Evaluates ways in which own interactions affect relationships to ensure that they do not impact inappropriately on others.		10. Has insight into own values and how these may impact on interactions with others.
		11. Recognises circumstances that trigger personal negative responses and takes action to prevent this compromising care.
		12. Recognises and acts autonomously to respond to own emotional discomfort or distress in self and others.

course failure and seeking financial gain. This approach to cultivating compassion endows compassion with a commodity value within healthcare settings. It would seem that student nurses can now choose how compassionate they would like to be depending on how much they would like the rewards, or fear the penalties, associated with doing so.

Compassion

The decision to incentivise compassion following the events in Mid-Staffordshire reflects a perception that these failures in care had something to do with nurses lacking compassion. This is a perspective that gained legitimacy in the so called 'compassion deficit debate' (Stenhouse, Ion, Roxburgh, Devitt & Smith, 2016) but which sits at a micro level of analysis that has been criticised by social psychologists as superficial (Paley, 2014). This is because it draws attention onto the individual rather than addressing systemic issues such as understaffing and poor leadership, which Robert Francis also reported on. Some would argue that these systemic issues are a more productive area for intervention as they focus on creating environments that facilitate compassion rather than trying to get rid of one or two 'bad apples'.

The idea that environments can facilitate or hinder compassion draws on Paul Gilbert's (2005) research. Gilbert defines compassion as being aware of suffering in others while also feeling motivated to prevent and alleviate it. Gilbert views compassion as not one thing but a motivation, something out of which compassionate behaviour might arise but on which its definition is not dependent. Gilbert uses an evolutionary perspective when he conceptualises compassion as part of a pro-social mentality innate to humans developed over time to facilitate group

survival. Gilbert sees compassion and a pro-social mentality as only one of a number of mentalities, all motivating different kinds of behaviours. These different mentalities enable humans to adapt their behaviour to meet the changing pressures of their environment. Gilbert believes that pro-social mentalities will get superseded by non-social mentalities if an environment becomes more threatening in nature, inclining an individual towards behaviour that prioritises their own needs over others'. As such, Gilbert believes that threatening or competitive environments are inimical to compassion. Put simply, we will struggle to imagine the needs of others if we are made to feel too distracted by our own. The potential for such a process to occur in a modern healthcare setting has already been evidenced (Henshall, 2015).

While Gilbert draws attention to the overarching importance of one's current environment to compassion, Wang (2005) integrates neurological and psychodynamic literature to explain how a person's early environment might affect their capacity for compassion in adulthood. Evidence suggests that certain brain areas are responsible for facilitating compassion and that these brain areas are larger in individuals who have had more secure early attachment experiences (Damasio, 2003; MacLean, 1985). The extent to which an individual is resilient to stress might also reduce their subjective experience of threat and increase the likelihood of them remaining calm and compassionate in otherwise stressful situations (Henry & Wang, 1998; Wood, Saltzberg & Goldsamt, 1990). While these studies highlight the potential for individual differences in a person's capacity for compassion they all concede that, under certain circumstances, anyone might struggle to be compassionate. This challenges the notion that individual characteristics are the best predictor of compassionate behaviour and questions whether individual assessments are the most productive way to cultivate compassion in the NHS. Berwick (2013)

has argued that “Good people can fail to meet patients’ needs when their working conditions do not provide them with the conditions for success”.

It is not unreasonable for the NHS to want to hire nurses who are able to remain compassionate in stressful situations. Assessments of compassion might go some way in helping to identify those student nurses with a predisposition to do so and there is some evidence to suggest that these characteristics can be cultivated later in life by practicing meditation (Davidson et al., 2003; Davidson & Lutz, 2008) or self-compassion (Neff, 2003). At their root however these practices only mediate an individual’s experience of threat, meaning there is no evidence that compassion can be taught per se. So while there is some literature to support individual assessments of compassion, a number of authors warn of the pitfalls of this approach and the need for systemic change. It is possible that assessing students on their ability to act compassionately is not only ineffective but counterproductive as it creates an atmosphere of threat (of course failure) and competition (for financial gain) that can hinder rather than cultivate compassion.

Submissive compassion

The idea that environments might affect someone’s tendency to be compassionate gains support from studies on motivation more widely. Deci and Ryan (2000) saw how the imposition of extrinsic rewards on tasks requiring creativity hampered participant’s performance. The pair concluded that extrinsic rewards are more effective in motivating rote tasks. Pence (1983) argues that compassion cannot be taught as it is not a replicable sequence of actions but is a creative process, requiring an individual to imagine another’s needs, to put oneself in another person’s shoes so to speak. Similarly, Bateman and Fonagy (2004), in their understanding of

borderline personality disorder, warn of the potential for threat-based attachment insecurities to hinder an individual's capacity to reflect on the mental states of others.

Competition or threat might hinder someone being compassionate but they do not stop a person from acting compassionately. If compassionate behaviour can be separated out from compassionate intent then, as Bradshaw (2009) warns, it creates a potential for people to behave in ways that appear compassionate but lack any caring motivations. This is what Catarino, Gilbert, McEwan and Baião (2014) call 'submissive compassion'. Catarino et. al. distinguish submissive compassion from genuine demonstrations of compassion as they state that submissive compassion arises from fears of rejection and desires for acceptance rather than the desire to alleviate suffering. They use the descriptive 'submissive' in respect to Gilbert's (2000) social rank theory of shame. This supposes that shame functions to regulate behaviour in groups by motivating submissive behaviour in those who fear rejection. Student nurses might fear being rejected by the nursing profession if they do not behave compassionately enough. Feelings of shame might then motivate student nurses to behave compassionately for submissive reasons. Catarino et. al. distinguish this from genuine compassion because the behaviour is interested primarily in avoiding rejection.

Catarino et. al. (2014) created a measure for submissive compassion and studied whether 'caring shame', the fear of not being caring enough, might increase the chance that students behave submissively compassionate. They found that caring shame was predictive of submissive compassion, supporting their hypothesis that shame plays an important role in motivating submissive displays of compassion. Shame is thought to contribute to the experience of depression (Cheung et al., 2004)

and Catarino et al. found that individuals who scored highly for caring shame and submissive compassion also scored highly on measures of stress, anxiety and depression. It is possible that work environments that promote submissive compassion are also harmful to staff's mental health. Catarino et al. also found that submissive compassion was not correlated with scores on a measure of genuine compassion, supporting their hypothesis that submissive compassion is not the same as genuine compassion.

Rationale

The NHS is trying to cultivate compassion amongst its staff. Research suggests that one of the ways it is training student nurses to be more compassionate might be counterproductive. Instead of cultivating compassion, efforts to assess students on their ability to be compassionate might induce feelings of shame and promote artificial displays of compassion. Submissive compassion is described unfavourably by its authors as it is not considered conducive to high quality care, like genuine compassion, and might also be detrimental to staff's mental health.

There is currently no evidence to prove that student nurses provide care to patients with submissive compassion. Catarino et al. (2014) note the potential relevance of research into submissive compassion to the nursing profession; this study aims to research submissive compassion in a population of student nurses. Eight research questions were formulated to explore submissive compassion's relationship with caring shame, genuine compassion, stress, anxiety and depression in a sample of student nurses. The results of the study might help to inform research into how best to cultivate compassion in the NHS. Ultimately, this study aims to support the NHS

to continue providing high quality nursing care in a manner that is safe and sustainable.

Research Questions

Submissive compassion and caring shame are not concepts that have been explored in a population of student nurses before. In order to investigate whether student nurses experience submissive compassion and caring shame the following research questions were formulated:

1. What are student nurses' levels of submissive compassion and caring shame?

2. How do levels of submissive compassion and caring shame differ between a sample of student nurses and a generic student sample?

It is hypothesised that student nurses will report submissive compassion and caring shame to a greater extent than a generic student sample reported.

Submissive compassion is thought to be different from genuine compassion but there is little evidence to support this distinction empirically. To investigate whether submissive compassion is different from genuine compassion the following research question was formulated:

3. To what extent is genuine compassion predictive of submissive compassion?

Levels of genuine compassion were not predictive of submissive compassion in Catarino et. al.'s (2014) study and it is hypothesised that the two will not be predictive of each other in this study.

Caring shame was predictive of submissive compassion in Catarino et al.'s (2014) study. In order to investigate the relationship between caring shame and submissive compassion amongst the sample of student nurses in this study the following research question was formulated:

4. To what extent is caring shame predictive of submissive compassion?

It is hypothesised that caring shame will be predictive of submissive compassion in the sample of student nurses.

Catarino et al. (2014) found that reports of caring shame and submissive compassion were associated with increased reports of stress, anxiety and depression. It will be interesting to see whether this relationship is replicated amongst a sample of student nurses. In order to investigate this the following research questions were formulated:

5. To what extent can levels of depression be predicted by levels of caring shame and levels of submissive compassion?

6. To what extent can levels of anxiety be predicted by levels of caring shame and levels of submissive compassion?

7. To what extent can levels of stress be predicted by levels of caring shame and levels of submissive compassion?

It is possible that environments that incline individuals to behaving submissively compassionate might also be harmful to individuals' mental health. In order to investigate this the following research questions were formulated:

8. Do nurses from different year groups report significantly different levels of submissive compassion and caring shame?

It is hypothesised that student nurses in year three will report higher levels of caring shame and submissive compassion than student nurses in year one.

Method

Participants

662 student nurses were recruited from one higher education pre-registration nursing course in the UK. This pre-registration nursing course was approved by the NMC, meaning that it met the standards of proficiency set out by the NMC for its approved programmes (2010). 12 participants were removed prior to analysis for leaving questionnaires incomplete. The remaining 650 student nurses represented all three years across all four nursing specialities (adult, child, learning disability, mental health).

Design

A cross-sectional design was implemented in line with the study's exploratory nature. Quantitative data was collected from five self-report questionnaires which student nurses completed consecutively and in one sitting following the end of one of their lectures.

Measures

Measures were presented to participants on paper, each measure occupying one page. Participants' demographics were sourced from questions on a cover page that asked participants if they were willing to provide their age, gender, year group and speciality (see Appendix A). All measures were self-report measures. Measures were

ordered so that two measures involving a similar theme were not carried out one after another. This was to reduce the chance that priming effects would influence their answering. The measures used in this study were the same as those used in Catarino et. al.'s study (2014).

Submissive Compassion Scale (Catarino et. al., 2014)

The Submissive Compassion Scale measured the extent to which participants feel they are inclined to act compassionately out of the fear of rejection or the desire for acceptance. Items are summed to produce a total out of 40 with higher scores indicating a greater propensity to act with submissive compassion. Catarino et. al. reported that the measure had face validity but did not report any other validity statistics. The measure was also reported as having good reliability, returning a Cronbach's Alpha of .89 when tested in a generic student population of 157 students.

Marlowe-Crowne Social Desirability Scale – Short Form (Reynolds, 1982)

The Marlowe-Crowne Social Desirability Scale – Short Form measured whether participants were inclined to answering in a socially desirable manner. This scale was included as a weighting variable on Catarino et al.'s (2014) recommendation as they noticed the potential for participants to not want to lie about behaving compassionately out of self-interest. The short form was preferred to the original 33 item scale (Crowne & Marlowe, 1960) because the student nurses' lecturers could only provide a limited window of time for the students to fill out the questionnaires. Items in the scale that participants are judged to have answered in a socially desirable manner are summed to produce a total out of 13 with higher scores indicating a greater propensity for socially desirable answering. 0-3 constitutes a low score, 3-8 constitutes an average score, and 8-13 constitutes a high score. In a sample

of 608 undergraduate students the short form produced a product moment correlation coefficient of .76 in comparison with the original 33 item form (Reynolds, 1982). More recently, in a sample of 633 undergraduates, the short form was found to have moderate internal consistency, the same as other short forms available, returning a Cronbach's Alpha value of .66, and did not demonstrate gender bias (Loo & Loewen, 2004).

Caring Shame Scale (Martin, Gilbert, McEwan & Irons, 2006)

The Caring Shame Scale was used to measure the extent to which participants experienced shame for fear of not being caring enough. Originally designed for carers of people with dementia, the wording of some statements were changed in order to better apply to student nurses: "relative" was changed to "patients" in items 4, 5 and 6. Items in the scale are summed to produce a total out of 24 with higher scores indicating greater caring shame. The measure is reported to have good face validity and good internal consistency. When tested on 70 carers of people with dementia it produced a Cronbach's Alpha of .87.

Compassionate Love Scale (Sprecher & Fehr, 2005)

The Compassionate Love Scale was used to measure participants' perceptions of how compassionate they are. Items in the scale are averaged to produce a total score out of 7 with higher scores indicating greater compassion. The measure is reported to have good convergent validity with other measures of compassion (Strauss et. al., 2016) and high internal consistency (Sprecher & Fehr, 2005). When tested on 700 university students the measure produced a Cronbach's Alpha of .95.

Depression, Anxiety and Stress Scale – 21 (DASS-21) (Lovibond & Lovibond, 1995)

The DASS-21 was used to measure participants' levels of stress, anxiety and depression. Items in the scale are summed and then doubled to produce a total out of 42 for each construct, with higher scores indicating higher levels of stress, anxiety or depression. The DASS-21 provides threshold descriptors based off normative data that classify scores as normal, mild, moderate, severe or extremely severe. The DASS-21 is reported to have adequate construct validity and a cleaner latent structure than the 42 item DASS. When tested on 1794 adults from the general population the depression scale returned a Cronbach's Alpha of .88, the anxiety scale .82, the stress scale .90, and the total scale .93 (Henry & Crawford, 2005).

Procedure

The researcher contacted the Director of the University's pre-registration nursing programme in summer 2016 to seek their approval to carry out the study within their student nurse population. The researcher hoped to carry out the study between September 2017 and January 2018. Information was provided to the Director that explained the purpose of the study and that the study would require 20-30 minutes of students' time for data collection. Trials had been carried out that estimated the amount of time it would take for students to complete all of the forms. Information sheets were made available to students electronically (see Appendix B). Approval for the study was granted by a local ethics committee in July 2017, the certificate for which can be found in Appendix C. Individual members of staff from each three years of the nursing course were contacted in summer 2017 in order to identify which lectures the researcher could attend to carry out the study. Data was collected on three separate occasions between November and December 2017, collecting data from a different year group on each occasion. Consent to participate was explained as assumed if student nurses began to answer questionnaires. All participants

completed paper questionnaires and the researcher inputted data into IBM SPSS Statistics version 24.0 (IBM Corp., 2016) for Windows.

Power Analysis

A power analysis calculation using G*Power version 3.1.3 (Faul, Erdfelder, Buchner & Lang, 2009) was performed to find the sample size necessary to carry out a regression analysis on whether caring shame was predictive of submissive compassion. The calculation was based on a requirement of 80% power and a 5% significance level. Using the effect sizes produced by Catarino et. al. (2014) when running the same analysis, a power calculation showed that 100 participants would need to be recruited in order to detect a small effect size of 0.08. At least 100 participants would therefore be sought as there were no ethical or logistical issues in recruiting more than this.

Data Analysis Procedures

Data were analysed using IBM SPSS Statistics version 24.0 (SPSS) (IBM Corp., 2016) for Windows. Crosstabulations and descriptive statistics were used to summarise the demographic data. Exploratory analysis was used to produce means and standard deviations for participants' total scores on measures. Pearson's correlations were calculated between all measures.

The developers of each measure did not provide guidance on what to do in the case of missing data and therefore participants who missed at least one question from a measure were excluded from any relevant analysis. On this basis sample sizes included in the analyses across the measures ranged from 618 to 645. Scores on all measures were designed to correlate positively with the trait they were measuring, however the Marlowe-Crowne Social Desirability Scale was reverse scored for the

purpose of analysis and therefore higher scores indicated a lower tendency for socially desirable answering. While thresholds were available to categorise participants' scores on measures of negative affect, this variable was treated as continuous for increased statistical power.

A significance level of 5% was used for all statistical tests. A summary independent samples t-test was used to analyse the difference between participants' average total scores for submissive compassion and caring shame and associated scores produced by the sample in Catarino et al's study (2014). This comparison was carried out in response to the study's second research question. Simple linear regression analysis was used to analyse the nature of the relationships outlined in research questions 3 to 7.

Finally, in response to research question 8, two univariate analyses of variances (ANOVA) were conducted in order to analyse whether year group had a significant effect on levels of caring shame and submissive compassion. Four independent variables (age, gender, speciality, year group) were inputted for each dependent variable (caring shame, submissive compassion). Age was analysed as a continuous variable whereas gender had two levels (male, female), speciality had four levels (adult, mental health, learning disability, child) and year group had three levels (year 1, year 2, year 3). All analyses that included submissive compassion as either an independent or a dependent variable also included the Marlowe-Crowne Social Desirability Scale - Short Form as a weighting variable, such that participants who were deemed less likely to answer in a socially desirable manner were provided with more weight in the analysis.

Regression analyses and ANOVAs were screened for normality according to the normality, skewness and kurtosis of their residuals. The summary independent samples t-test was not computed from a full data set and therefore could not be screened for normality. All distributions were judged to be substantially non-normal and therefore requiring adjustment according to the parameters set out by Kim (2013) for sample sizes larger than 300. Bootstrapping was subsequently employed to correct for these non-normal distributions in the subsequent analyses. Figures 1 to 7 in Appendix G display histograms of the data distributions for participants' total scores on each variable.

Results

Demographic Characteristics

A summary of participants' demographic characteristics can be found in Table 2. Participants were unevenly distributed between the three years with the fewest participants (22%) from year 3. The majority of participants identified as female (93%) which is in line with national gender statistics for the nursing profession in the absence of statistics for the student population (NMC, 2017). One person identified as gender fluid but was excluded from analyses of gender as a single participant could not be analysed statistically as a group.

The majority of participants specialised in adult nursing which is also normal for the profession. Participants' average age was 26.96 (SD=7.75) and ages ranged from 18 to 59. A one-way analysis of variance confirmed that the age of participants did not vary significantly between year groups ($F(2,640)=1.210$, $p=.299$), indicating that any

Table 2. Demographic statistics according to year group, gender and speciality (LD, Learning Disability; MH, Mental Health). The means and standard deviations for participants' ages are also reported.

	Year 1 N=256 (39%)	**Year 2 N=251 (39%)**	**Year 3 N=143 (22%)**	**Total N=650**
Age				
(mean, SD)	26.40 (8.23)	27.20 (7.24)	27.56 (7.70)	26.96 (7.75)
Gender				
Female	240 (94%)	229 (91%)	132 (92%)	601 (93%)
Male	16 (6%)	20 (9%)	11 (8%)	47 (7%)
Speciality				
Adult	194 (76%)	204 (82%)	115 (80%)	513 (79%)
LD	9 (4%)	13 (5%)	11 (8%)	33 (5%)
MH	24 (9%)	7 (3%)	7 (5%)	38 (6%)
Child	29 (11%)	26 (10%)	10 (7%)	65 (10%)

Table 3. Descriptive statistics, reporting the means and standard deviations for each measure. N is the number of participants that completed each measure.

Measure	**Mean**	**SD**	**N**
Compassionate Love Scale (Min. 0, Max. 7)	5.12	0.91	618
Caring Shame Scale (Min. 0, Max. 24)	18.16	4.93	645
Submissive Compassion Scale (Min. 0, Max. 40)	25.13	9.20	641
Depression (Min. 0, Max. 42)	13.00	11.11	642
Anxiety (Min. 0, Max. 42)	13.62	10.89	642
Stress (Min. 0, Max. 42)	18.60	11.00	644
Marlowe-Crowne Social Desirability Scale – Short Form (Min. 0, Max. 13)	5.07	2.59	618

Table 4. Correlation matrix reporting Pearson's correlations with associated significance levels.

	Compassion	**Submissive Compassion**	**Caring Shame**	**Depression**	**Anxiety**	**Stress**	**Social Desirability**
Compassion							
Submissive Compassion	.126 .002						
Caring Shame	.236 .001	.517 .001					
Depression	.026 .527	.301 .001	.255 .001				
Anxiety	.052 .201	.325 .001	.266 .001	.716 .001			
Stress	.033 .422	.328 .001	.300 .001	.763 .001	.769 .001		
Social Desirability	-.260 .001	.191 .001	.150 .001	.256 .001	.202 .001	.295 .001	

analysis of year group would not be confounded by differences in age. Out of the total sample, seven people did not record their age, two people did not record their gender and one person did not record their speciality.

Descriptive and Correlation Statistics

Means and standard deviations for participants' scores on all measures can be found in Table 3. Table 4 presents a correlation matrix for the 21 correlations that were carried out between all measures. All 21 correlations were significant at the .01 level, apart from the correlations between compassion and measures of negative affect. Further descriptive statistics, reporting participants' mean scores on measures according to year group, speciality and gender can be found in Tables 1, 2 and 3 in Appendices D, E and F respectively. Table 4 in Appendix H shows the Cronbach's Alpha statistics for each measure as produced by this study's sample.

Comparative Analyses

Research Questions 1 & 2

Research questions one and two asked what student nurses' levels of caring shame and submissive compassion would be and whether they would differ significantly from those the generic student sample in Catarino et al.'s (2014) study. In accordance with the hypothesis for research question two, a summary independent samples t-test indicated that the average levels of submissive compassion ($M=25.133$, $SD=9.201$, $N=641$) and caring shame ($M=18.158$, $SD=4.932$, $N=645$) were significantly higher in this study than the average levels of submissive compassion ($M=18.760$, $SD=8.520$, $N=157$, $t(796)=7.889$, $p<.001$, 95% confidence intervals (4.789, 7.956)) and caring shame ($M=9.820$, $SD=5.440$, $N=157$,

$t(800)=18.610$, $p<.001$, 95% confidence intervals (7.460, 9.216)) in Catarino et al's study.

Research Questions 3 & 4

The outputs to linear regressions for research questions three and four can be found in Table 5. Higher levels of compassion were found to be significantly predictive of higher levels of submissive compassion, despite returning a small r-squared value. This finding provided evidence to contradict the hypothesis to research question three, that genuine compassion would not be predictive of submissive compassion. This finding contrasts with Catarino et al.'s (2014) finding which was interpreted to support submissive compassion's theoretical distinction from genuine compassion and the discriminant validity of their Submissive Compassion Scale.

Higher levels of caring shame were significantly predictive of higher levels of submissive compassion, the beta-coefficient suggesting that participants' scores on both measures fluctuated in close tandem. This finding was in accordance with the hypothesis to research question four and Catarino et al.'s (2014) similar finding.

Research Questions 5, 6 & 7

Tables 6, 7 and 8 report the outputs of linear regressions for research questions six, seven and eight which asked whether caring shame and submissive compassion were predictive of depression, anxiety and stress. Higher levels of caring shame and submissive compassion were significantly were found to significantly predict higher levels of depression, anxiety and stress. Small r-squared values suggested that many other variables were involved in explaining differences in negative affect. Caring shame and submissive compassion accounted for a greater amount of variance in student nurses' negative affect than students in Catarino et al.'s (2014) study

Table 5. Output of two simple linear regressions with compassion and caring shame as predictor variables and submissive compassion as dependent variable. Reported are the r-squared value, beta-coefficient, t-value, level of significance and 95% confidence intervals.

	r^2	β	t	p	CI	
					-	+
Compassion	.022	1.434	3.569	.003	0.515	2.271
Caring Shame	.325	1.057	16.750	.001	0.904	1.211

Table 6. Output of two simple linear regressions with caring shame and submissive compassion as predictor variables and depression as dependent variable. Reported are the r-squared value, beta-coefficient, t-value, level of significance and 95% confidence intervals.

	r^2	β	t	p	CI	
					-	+
Caring Shame	.068	0.590	6.784	.001	0.436	0.745
Submissive Compassion	.096	0.399	7.834	.001	0.302	0.506

Table 7. Output of two simple linear regressions with caring shame and submissive compassion as predictor variables and anxiety as dependent variable. Reported are the r-squared value, beta-coefficient, t-value, level of significance and 95% confidence intervals.

	r^2	β	t	p	CI	
					-	+
Caring Shame	.075	0.606	7.165	.001	0.441	0.769
Submissive Compassion	.115	0.424	8.685	.001	0.320	0.525

Table 8. Output of two simple linear regressions with caring shame and submissive compassion as predictor variables and stress as dependent variable. Reported are the r-squared value, beta-coefficient, t-value, level of significance and 95% confidence intervals.

	r^2	β	t	p	CI	
					-	+
Caring Shame	.094	0.684	8.104	.001	0.525	0.837
Submissive Compassion	.123	0.432	9.222	.001	0.331	0.532

Research Question 8

Research question eight asked whether levels of caring shame and submissive compassion would significantly differ between year groups. Levels did not significantly differ between year groups, providing evidence to contradict research question eight's hypothesis. Age was the only demographic variable to have a significantly effect on levels of caring shame and submissive compassion. The main effect for age on submissive compassion yielded an F ratio of $F(1,586)=47.097$, $p<.001$ and a beta coefficient of -.332 with 95% confidence intervals (-.444, -.227). The main effect for age on caring shame yielded an F ratio of $F(1,594)=23.053$, $p<.001$ and a beta coefficient of -.128 with 95% confidence intervals (-.188, -.074). Social desirability was used to weight all regressions that included submissive compassion as either a predictor or a dependent variable. Participants reported an average tendency for socially desirable answering ($m=5.07$, $SD=2.59$). When the Social desirability was used to weight all regressions that included submissive compassion as either a predictor or a dependent variable. Participants reported an average tendency for socially desirable answering ($m=5.07$, $SD=2.59$). When the same regressions were run without controlling for social desirability, results did not differ to any meaningful degree.

Discussion

Summary

This study found that student nurses reported higher levels of caring shame and submissive compassion than students from a generic student sample (Catarino et al., 2014), suggesting that student nurses are more vulnerable to these experiences than students from other professions. Since higher levels of depression, anxiety and stress

were associated with caring shame and submissive compassion, this also highlights a unique risk factor for student nurses' mental health. This study did not provide evidence to suggest that student nurses were more vulnerable to caring shame and submissive compassion as a result of time spent in training. Genuine compassion was predictive of submissive compassion meaning that no evidence was found to support Catarino et al.'s supposition that these are distinct phenomena.

Research Questions 1 & 2

Research questions one and two asked what student nurses' levels of submissive compassion and caring shame were and how these levels differed from those reported by a generic student sample (Catarino et. al., 2014). The finding that student nurses reported higher levels of caring shame and submissive compassion was in agreement with the hypothesis. This is not surprising considering the larger amount of time student nurses spend in caring roles. Research suggests that caring shame and submissive compassion are symptomatic of environments that are not conducive to the cultivation of compassion (Gilbert, 2014; Henshall, 2015).

Research Questions 3

Research question three asked whether genuine compassion was predictive of submissive compassion. Despite a small effect size, genuine compassion was significantly predictive of submissive compassion which was in disagreement with the study's hypothesis and did not support Catarino et al.'s (2014) assertion that the two were distinct phenomena. The implication of this finding might be that Catarino et al.'s measure of submissive compassion is not sensitive enough to detect the distinction, or that submissive compassion is not as different from genuine compassion as Catarino et al. initially thought. Further research will need to be

carried out to provide a definitive answer. One other possibility is that the lack of distinction in this study does not contradict Catarino et al.'s theoretical distinction but suggests that student nurses have more difficulty separating out their motivations for care. As student nurses spend more time in caring roles their reasons for care might be more complex and less distinct than those experienced by other students.

Research Question 4

Research question four asked whether caring shame was predictive of submissive compassion. Caring shame was found to be highly predictive of submissive compassion which was in agreement with this study's hypothesis and supported Catarino et al.'s (2014) findings. Caring shame was more significantly predictive of submissive compassion for student nurses ($\beta=1.040$, $p<.001$) than the generic student sample ($\beta=.554$, $p<.001$). The implication of this finding is that submissive compassion does not appear occur in isolation but is the product of feelings of shame for being judged as not being caring enough, something that is more relevant to student nurses than students of other professions.

Research questions 5, 6 & 7

Research questions five, six and seven asked to what extent depression, anxiety and depression could be predicted by caring shame and submissive compassion. Depression, anxiety and stress are considered functional responses to shame according to social rank theory and all have the potential to lead to poor mental health (Gilbert, 2000; Gilbert & Allan, 1998). Caring shame was significantly predictive of depression, anxiety and stress and accounted for a greater amount of variance in reports of depression, anxiety and stress than in Catarino et al.'s (2014)

study. The implication of this is that environments that incline students to experience caring shame might also contribute to higher levels of depression, anxiety and stress.

Submissive compassion was also significantly predictive of depression, anxiety and stress. Submissive compassion is thought to be a response to caring shame in the same way that depression, anxiety and stress are and so it is curious that it was also predictive of negative affect rather than simply correlated with these states. It is possible that submissive compassion contributes to depression, anxiety and stress in isolation because of the ‘emotional labour’ (Hochschild, 1983) that it entails. Emotional labour describes when someone is required to change how they feel or appear to be feeling as part of their job, ‘service with a smile’ so to speak. Emotional labour has been shown to negatively affect people’s mental health in the human services (Bakker & Heuven, 2006; Morris & Feldman, 1996). Hochschild describes emotional labour as an effortful process that can induce experiences of ‘alienation’, affecting a person’s sense of self and purpose and limiting the satisfaction they derive from their work (Pines, 2000).

Research question 8

Research question eight asked whether student nurses from different year groups would reporting different levels of caring shame and submissive compassion. Caring shame and submissive compassion did not differ significantly between year groups, perhaps meaning that one’s environment does not have a cumulative effect on the extent to which someone experiences caring shame or submissive compassion. This analysis did not control for confounding variables such as shame proneness, or the extent to which students were self-critical of how compassionate they were (Tangney, Wagner, & Gramzow, 1992). Further research is required to determine

how environment interacts with experiences of caring shame and submissive compassion.

Limitations

This study and the reliability of its findings benefited from its large sample size and controlling for socially desirable answering. All of the measures that were used in this study were self-report measures meaning that there was still the potential for bias not controlled for. Measures of compassion are thought to lack generalisability, especially between the genders (Seppälä, 2014). This study was exploratory in nature because submissive compassion is a relatively new area of research but future research might wish to include controlled interventions that investigate the causal processes between caring shame, submissive compassion, depression, anxiety and stress. The reliability of future studies would benefit from further empirical validation of the Submissive Compassion Scale (Catarino et al., 2014) and the inclusion of other control variables such as shame proneness (Tangney et al., 1992).

The rationale for this study was to support the NHS to continue to provide high quality nursing care in a manner that is safe and sustainable. There is a risk that cultures of caring shame and submissive compassion that arise in training might carry over into the profession (Randle, 2003). Future research might implement a longitudinal design to compare levels of caring shame and submissive compassion pre- and post-qualification. It might also be useful to replicate the current study within samples of qualified nurses working in different areas of the NHS with the intention of reviewing how efforts to cultivate compassion have affected the nursing profession over the past eight years. This study only recruited nurses from one

university, there is the potential for different universities to assess student nurses differently on compassion, affecting the generalisability of the findings.

Conclusion

This study found evidence to suggest that student nurses are vulnerable to experiencing shame for fear of not being caring enough and that this might predispose them to behaving compassionately through self-interest rather than the interests of their patients. Submissive compassion is considered an undesirable outcome for the NHS and its efforts to cultivate genuine compassion; it might also contribute to poor mental health amongst NHS staff. It is hypothesised that caring shame and submissive compassion derive from threatening environments. While this study did not find evidence to suggest a causal connection between these things and student nurses' experience of caring shame, submissive compassion, depression, anxiety and stress it is hypothesised that genuine compassion will be constrained by any work practice that endorses competition and fear. Compassion is explicitly valued by the NHS, but while the NHS continues to fight for survival in an economically threatening environment then compassion might stand in direct competition with more fundamental interests of cost-saving and efficiency. Further research is needed to clarify how work environments are affecting compassion and the delivery of care in the NHS.

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Appendix A. Demographics sheet

Demographics Sheet

This study is interested in the information that you can provide that is relevant to your unique experience of nursing education, therefore we ask that you provide us with some information about yourself that we can use in our analysis.

There is some research to suggest that people of different ages and genders might experience shame and compassion differently, and therefore we ask that you provide your age and gender if you feel comfortable doing so.

We also think that it would be interesting to see whether people have different experiences of the course dependent on what year they are in and what client group they are specialising in.

Please use the space below to provide as much information as you feel comfortable.

Age	Gender
Year Group 1 2 3	Nursing Speciality Child Learning Disability Adult Mental Health

Appendix B. Participant information sheet

Participant Information Sheet

Title of the study: Exploring Shame and Compassion in Student Nurses

I would like to invite you to take part in a study that is interested in you as a student nurse and your experience of pre-registration nursing education.

What is the purpose of the study?

The purpose of this study is to support student nurses and the profession in which they hope to work in the future.

This study is interested in how the current context of the NHS might be impacting student nurses as it attempts to cultivate more of a culture of compassion in the nursing profession. The NHS believes that it will be able to deliver a higher standard of care if it can ensure that the nurses it recruits are compassionate in nature. Therefore, student nurses are assessed for the compassion they can provide patients as well as their technical skills.

This approach by the NHS has not been evaluated before. We wish to explore how student nurses experience compassion and how they care for others. We also would like to understand how this might relate to their psychological well-being. We hope this study will help understand how best to provide nurse training in the future and give the best care for patients.

Why have I been invited?

You have been invited because you are student nurse who is currently studying a pre-registration nursing degree.

This study believes that you have valuable information to provide that is relevant to the future of the nursing profession. It finds value in the information that you can provide that might be reflective of your unique experience of nursing education: whether you are in your first or final year, or whether you specialise in one area of nursing rather than another.

Do I have to take part?

No, it is entirely your decision to participate in this study, and the decision you make will not affect your position on the course, nor your ability to be involved in research in the future.

What will happen if I decide to take part?

If you decide to take part in the study then, at the end of one of your lectures, you will be asked to stay behind, provide a small amount of information about yourself, and then answer five questionnaires that will involve questions about caring, compassion and your current mental health.

This study is interested in the information that you provide in these questionnaires because they will give some indication of whether the way in which student nurses are being assessed for compassion is changing the way they think about care and affecting their mental health.

What are the possible disadvantages and risks of taking part?

There are no expected risks involved in participating in this study; however, it will involve giving up between 20-30 minutes of your time.

What are the possible benefits of taking part?

By sharing your information, your involvement in this study could contribute to positive changes in the ways that nurses are educated in the future, something that will have a knock on effect to the profession. In this way, you will be helping to shape the future of your profession. You may help to promote better care for patients and improved wellbeing for nurses.

What will happen if I decide I no longer wish to take part?

The questionnaires that you will be asked to fill out are all anonymous, meaning that you will not have to give your name alongside the answers you give. You may choose to stop participating at any point through the study; however it will not be possible to find your data to remove it at a later date.

What if there is a problem?

If there is a problem during the study then you may ask for help from the researcher or choose to stop participating. In this situation, the researcher would ask that they still have access to the information you provided up to that point.

If after the study you wish to have your data removed from the study then you are entitled to do so, yet you must keep a note of the number that is on your questionnaire.

Will my taking part in this study be kept confidential?

There are very strict rules around keeping the information you provide both safe and confidential. The researcher will not pass on any of the information you provide, nor try to change it in any way.

What will happen to the results of the study?

The results of this study will be written up as part of the researcher's doctoral thesis, and will then be made available to read as part of a scientific journal. The results may also be presented at conferences.

As a result of their publication, the results of the study could be used to inform improvements in nursing training – improvements that would have patient care and nurses' well-being in mind.

Who is organising and funding the research?

This study is being organised and funded by The University of Hull as part of the research carried out by the doctorate course in clinical psychology. It is also being supported by members of the nursing programmes.

Who has reviewed the study?

This study has been reviewed by the School of Health and Social Work's ethics committee, to make sure that it adheres to the proper guidelines and is safe for you to participate in.

Further information and contact details

If you would like further information about the nature of this study, what will be involved in it, or the subject area surrounding it, please use the following contact details:

Sean Malkin

Clinical Psychology Doctorate Programme

School of Health and Social Work - Aire Building

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Appendix C. Confirmation of ethical approval

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PRIVATE AND CONFIDENTIAL
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Via email

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Research Ethics Committee

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E: E.Walker@hull.ac.uk

REF 278

6th July 2017

Dear Sean

REF 278 - Exploring shame and compassion in student nurses

Thank you for your responses to the points raised by the School of Health and Social Work Research Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of subsequent amendments to your study.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, SHSW Research Ethics Committee

Cc file

Appendix D. Descriptive statistics according to year group

Table 1. Descriptive statistics reporting means and (standard deviations) for participants' scores on each measure according to their year group.

Measure	Year 1	Year 2	Year 3
Compassionate Love Scale (Min. 0, Max. 7)	5.20 (0.83)	5.01 (0.93)	5.13 (0.98)
Caring Shame Scale (Min. 0, Max. 24)	18.30 (4.57)	18.08 (5.40)	18.06 (4.75)
Submissive Compassion Scale (Min. 0, Max. 40)	25.82 (9.25)	25.14 (9.32)	23.80 (8.85)
Depression (Min. 0, Max. 42)	12.65 (10.97)	13.14 (11.47)	13.34 (10.82)
Anxiety (Min. 0, Max. 42)	14.33 (10.99)	13.05 (11.00)	13.06 (10.26)
Stress (Min. 0, Max. 42)	18.20 (10.40)	18.58 (11.59)	19.19 (10.83)
Marlowe-Crowne Social Desirability Scale – Short Form (Min. 0, Max. 13)	5.14 (2.63)	5.24 (2.53)	4.58 (2.60)

Appendix E. Descriptive statistics according to speciality

Table 2. Descriptive statistics reporting means and (standard deviations) for participants' scores on each measure according to their speciality (adult, learning disability, mental health, child).

Measure	Adult	LD	MH	Child
Compassionate Love Scale (Min. 0, Max. 7)	5.11 (0.92)	5.16 (0.84)	5.19 (1.06)	5.08 (0.81)
Caring Shame Scale (Min. 0, Max. 24)	18.20 (5.07)	17.66 (4.16)	17.37 (5.13)	18.56 (4.04)
Submissive Compassion Scale (Min. 0, Max. 40)	25.35 (9.19)	22.36 (9.08)	21.45 (10.20)	26.82 (8.12)
Depression (Min. 0, Max. 42)	13.43 (11.27)	10.55 (11.37)	11.78 (9.19)	11.51 (10.69)
Anxiety (Min. 0, Max. 42)	13.85 (10.77)	12.48 (11.80)	13.63 (11.49)	11.68 (10.46)
Stress (Min. 0, Max. 42)	18.87 (11.00)	16.90 (10.26)	19.00 (10.52)	16.74 (11.22)
Marlowe-Crowne Social Desirability Scale – Short Form (Min. 0, Max. 13)	5.08 (2.66)	4.74 (2.28)	5.53 (2.44)	4.79 (2.25)

Appendix F. Descriptive statistics according to gender

Table 3. Descriptive statistics reporting means and (standard deviations) for participants' scores on each measure according to their gender.

Measure	Male	Female
Compassionate Love Scale (Min. 0, Max. 7)	4.67 (1.33)	5.14 (0.86)
Caring Shame Scale (Min. 0, Max. 24)	16.76 (4.19)	18.27 (4.98)
Submissive Compassion Scale (Min. 0, Max. 40)	22.36 (9.08)	25.33 (9.19)
Depression (Min. 0, Max. 42)	12.68 (11.99)	13.01 (11.05)
Anxiety (Min. 0, Max. 42)	10.78 (9.83)	13.77 (10.89)
Stress (Min. 0, Max. 42)	16.09 (12.56)	18.76 (10.81)
Marlowe-Crowne Social Desirability Scale – Short Form (Min. 0, Max. 13)	4.93 (3.25)	5.07 (2.54)

Appendix G. Data distributions

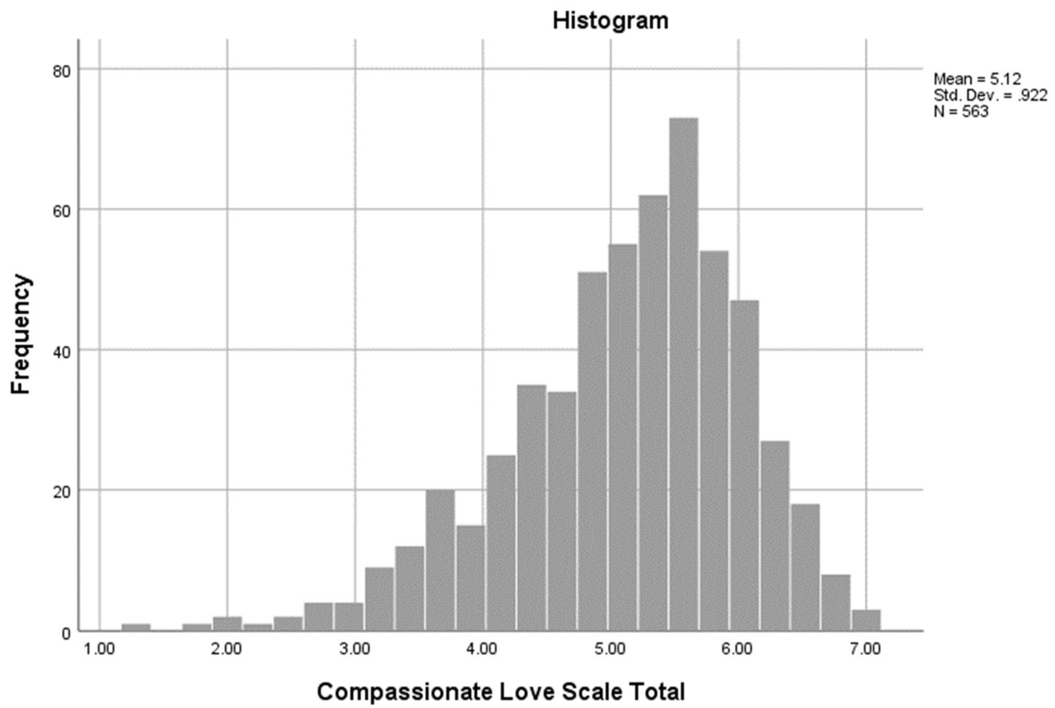

Figure 1. A histogram of participants' scores on the Compassionate Love Scale.

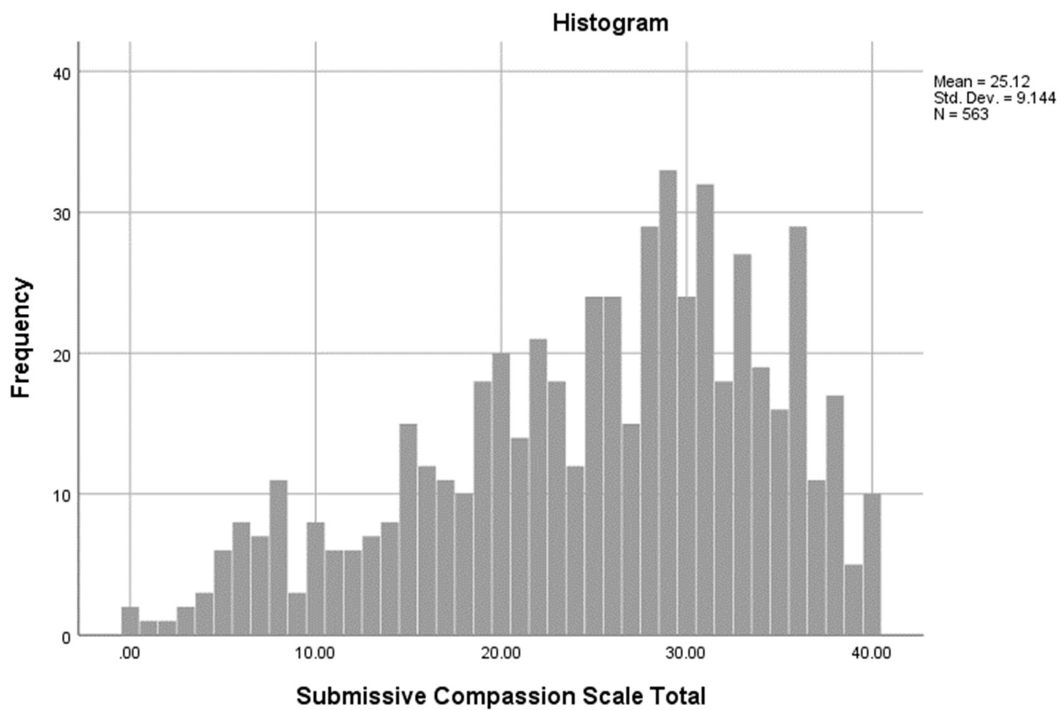

Figure 2. A histogram of participants' scores on the Submissive Compassion Scale.

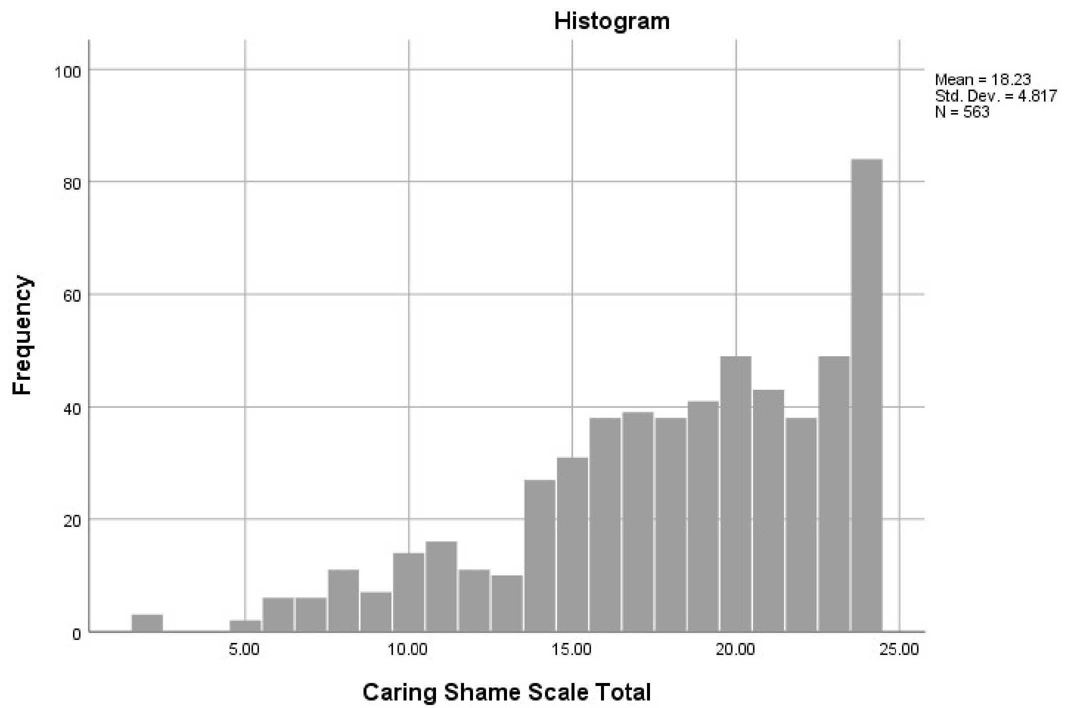

Figure 3. A histogram of participants’ scores on the Caring Shame Scale.

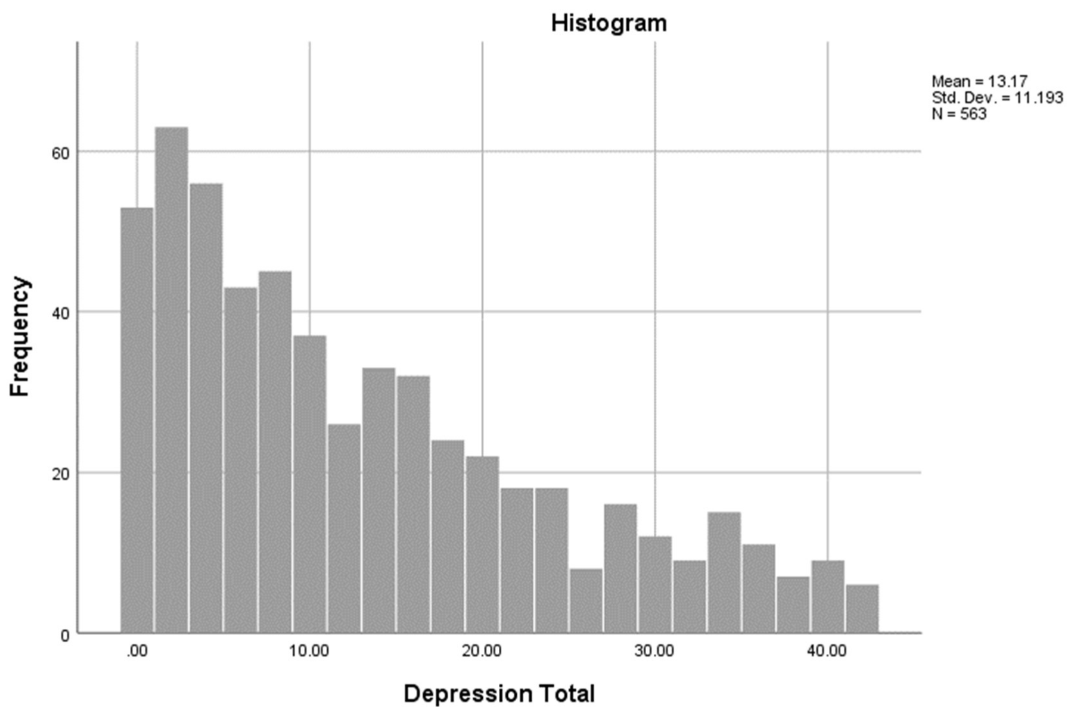

Figure 4. A histogram of participants’ scores on the Depression subscale of the DASS-21.

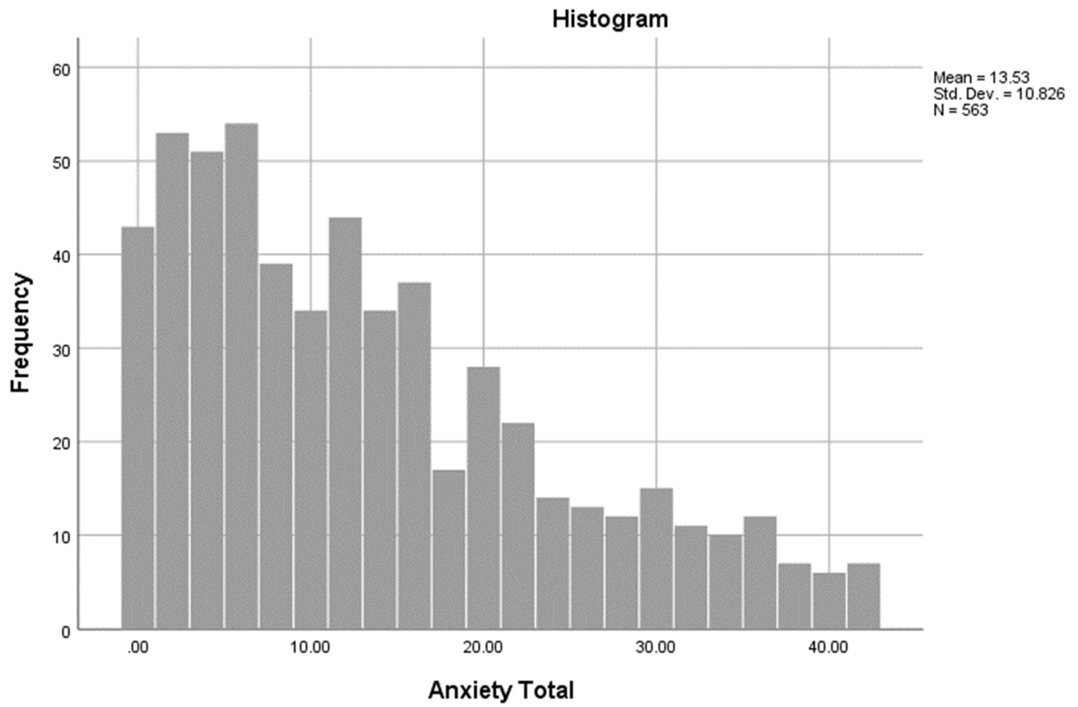

Figure 5. A histogram of participants' scores on the Anxiety subscale of the DASS-21.

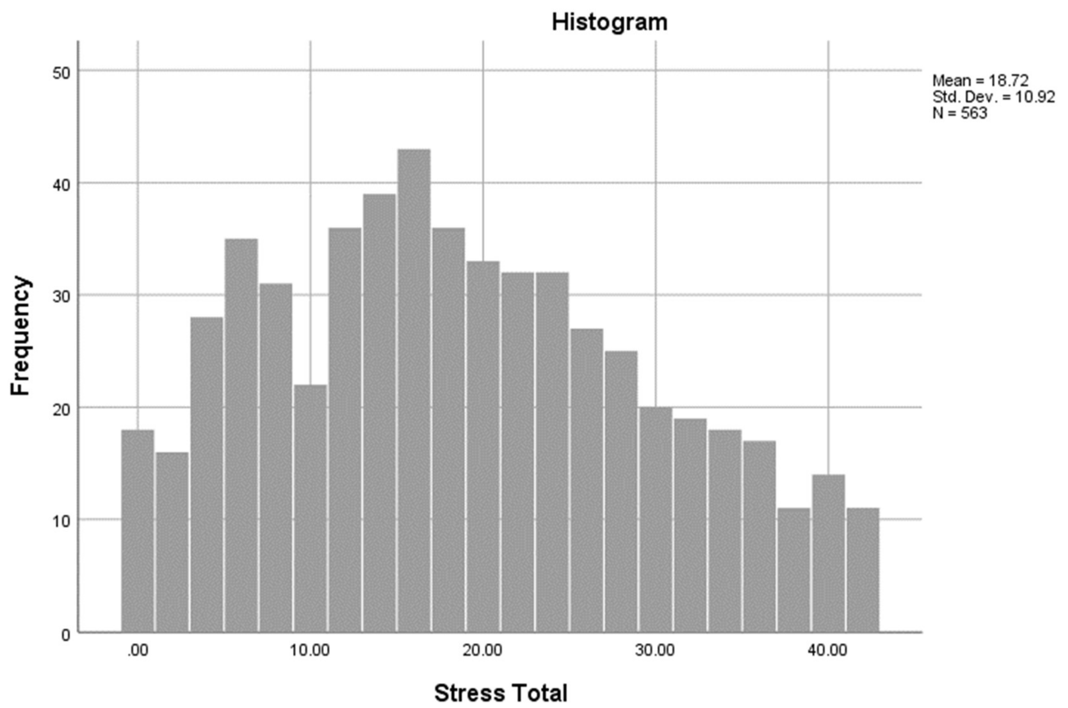

Figure 6. A histogram of participants' scores on the Stress subscale of the DASS-21.

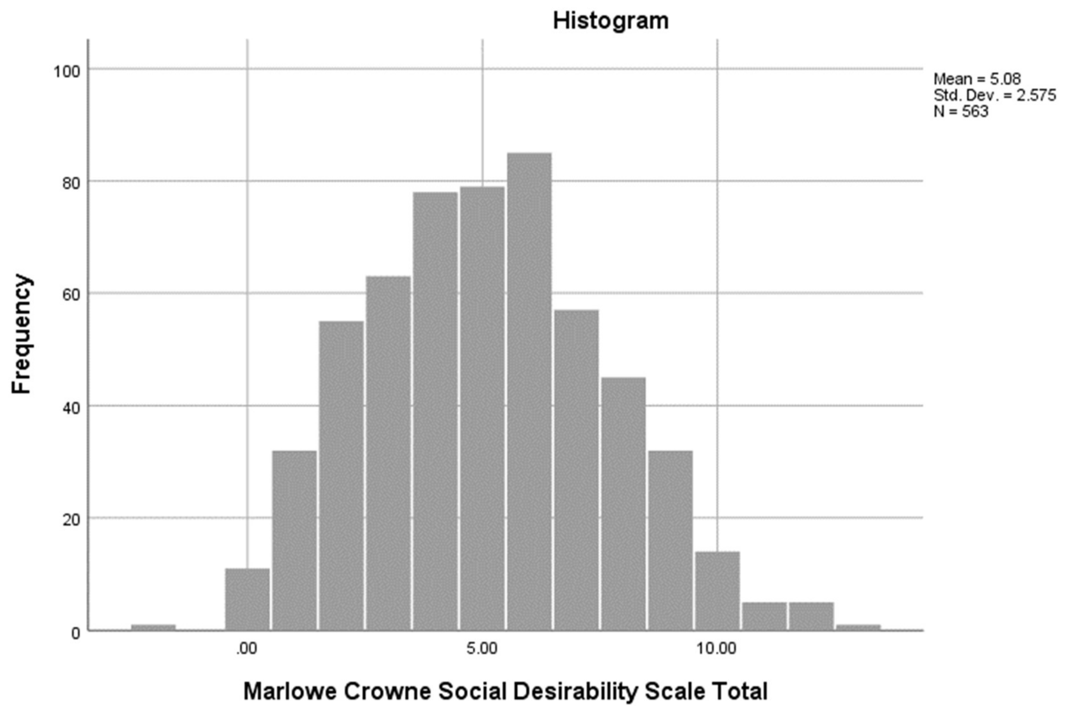

Figure 7. A histogram of participants' scores on the Marlowe Crowne Social Desirability Scale.

Appendix H. Cronbach's Alpha statistics

Table 4. Cronbach's Alpha statistics for measures as produced by N number of participants who completed the measure within this study's sample.

Measure	**α**	**N**
Compassionate Love Scale	.928	618
Caring Shame Scale	.817	645
Submissive Compassion Scale	.897	641
Depression	.888	642
Anxiety	.842	642
Stress	.844	644
Marlowe-Crowne Social Desirability Scale – Short Form	.584	618