The Compassion Focused Caregiver Protocol: A Pilot Investigation

Eli Cwinn and Katarina Guillen
Western University

ABSTRACT

The current paper reports on a pilot investigation of a novel Compassion Focused Therapy protocol for parents and caregivers of young people with mental health difficulties. Results suggest improvements in parental burnout, self-criticism, and self-reassurance as well as improvements in child mental health.

Keywords: Compassion-Focused Therapy, parenting, youth mental health, parental burnout, process-based therapy

RÉSUMÉ

Le présent article décrit les résultats d'un projet pilote portant sur un nouveau protocole de Thérapie Fondée sur la Compassion (TFC) pour les parents et les soignants de jeunes avec des problèmes de santé mentale. Les résultats font état d'améliorations quant à l'épuisement parental, à l'autocritique et l'autocompassion, de même que des améliorations concernant la santé mentale de l'enfant.

Mots clés : Thérapie Fondée sur la Compassion, parentalité, santé mentale des jeunes, épuisement parental, thérapie basée sur les processus

Compassion Focused Therapy (CFT) is a form of Cognitive Behavior Therapy that targets shame and criticism, emotion regulation, and interpersonal dynamics. CFT is an effective intervention for several internalizing and externalizing mental health difficulties (Kirby & Gilbert, 2017) but there has been limited research exploring its efficacy with children and adolescents. Parents and caregivers are important determinants of

Eli Cwinn, Faculty of Education, Centre for School Mental Health, Western University, London, Ontario; Katarina Guillen, Faculty of Education, Centre for School Mental Health, Western University, London, Ontario.

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Correspondence for this article should be addressed to Eli Cwinn, Faculty of Education, Western University, 1137 Western Road, Room 1154, London, ON, Canada, N6G 1G7. Email: ecwinn2@uwo.ca

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the mental health of young people. As such, there has been growing interest in examining the role of CFT for caregivers with the hopes of improving both caregiver well-being and child mental health (Kirby & Gilbert, 2017). To date, no research on CFT for caregivers has included evidence-based parenting practices (EBPPs) into the treatment protocols. Rather, CFT for caregivers has involved traditional CFT for caregiver burnout, self-criticism, and stress. The current paper introduces a pilot investigation of a the CFT Caregiver Protocol, a novel intervention that incorporates both EBPPs and traditional CFT exercises designed to support caregivers who are raising young people with mental health difficulties.

In the CFT Caregiver Protocol, parents and caregivers learn CFT-consistent parenting practices related to meeting emotional needs, scaffolding, supporting behavioural change, and reducing self-criticism as well as other forms of criticism. Using deliberate self-practice, caregivers practice these skills with themselves so that they work through their own self-criticism, begin to meet their own emotional needs, and begin to scaffold and change unhelpful behaviour in their own life. They then learn and practice the use of these skills with their children. The intervention occurs over six, two-hour sessions and the intervention comprises psychoeducation on self-criticism and self-compassion, training and practice with emotion coaching, and training on behaviour change and practice scaffolding behaviour hierarchies for different mental health difficulties. Participants also practice guided imagery, shifting from self-criticism to compassionate self-correction and self-support, and relaxation training. Experiential role-play, and home-practice are used to help shape and generalize the use of skills to other environments.

The authors assume that at least five processes may be related to treatment gains. First, through deliberate self-practice and self-reflection, caregivers develop greater fluency and depth of knowledge with the caregiving skills. Second, by embracing a caregiving mentality and allowing compassion to flow in and out, caregivers will develop more flexibility in their interpersonal and intrapersonal style and caregiving habits. Third, parents will learn and use evidence-based caregiving skills with their children. Fourth, shifting the ways caregivers relate to themselves, coupled with beneficial changes in their child's behaviour and mental health difficulties, will contribute to reduced burnout, feelings of inadequacy, and psychological distress among caregivers. We suggest that the dual processes of increased parental effectiveness, combined with increased compassion, will contribute to a virtuous cycle of improvement. Finally, caregivers will reduce their sense of isolation and inadequacy through peer support within the group. While a fulsome evaluation of these mechanisms is outside the scope of this paper, the authors included the theory of change here for the sake of promoting future research on this topic.

Nonetheless, changes in caregiver burnout, self-criticism, and self-compassion, coupled with changes in child mental health difficulties, may provide indirect supporting evidence for some of the aforementioned mechanisms because these outcomes are intrinsically linked to the processes described above. The present study presents pilot data on the effectiveness of the Compassion Focused Caregiver Protocol delivered in a virtual, community-based mental health setting. This study examines the effects of the program on caregiver burnout, self-criticism (inadequacy), and self-reassurance. It also examines the effects on parent-reported mental health difficulties of the children they care for.

METHODS

Design

The CFT Caregiver Protocol was delivered on three occasions throughout 2021 in a community mental health clinic in London, Ontario. The program was delivered virtually and at no cost to clients. Clients completed pre- and post-questionnaires as part of Continuous Quality Improvement within the clinic. After receiving approval from the research ethics board at Western University and internal approval at the clinic, participants were asked for permission to have their data used for research purposes. Over the course of 2021, 37 participants completed the program. Of those, 18 consented to research participation.

Participants

Participants ($n = 18$) unanimously endorsed cisgender and heterosexual identities. Caregivers ranged in age from 36–60. Approximately, 44.4% of caregivers report that they are currently struggling with their own diagnosed mental health difficulty. Child mental health difficulties at pre-test were severe (approximately two standard deviations higher than what was observed in other clinical settings). Children ranged in age from 7–19. Participants were 75% Caucasian and were predominantly rearing their child with the support of another caregiver. See Table 1 (next page) for details.

Measures

Sociodemographic Survey. The Sociodemographic Survey includes questions pertaining to ethnicity, gender, sexuality, family composition, personal mental health, and age.

Parental Burnout. The Parental Burnout Scale is a 22-item self-report measure asking participants to rate how often they have feelings and experiences of parental burnout from 0 (never) to 6 (every day). This scale demonstrates good internal consistency (Cronbach's alphas ranging from 0.87–0.96) and validity (Roskam et al., 2017).

Forms of Self-Criticism/Attacking and Self-Reassuring Scale. The Self-Criticism/Attacking and Self-Reassuring Scale is a 21-item self-report measure asking participants to rate their tendency to engage in self-attacking or self-reassuring behaviour on a scale of 0 (not at all like me) to 4. The scale demonstrates good internal consistency with a Cronbach's alpha of .92 (Gilbert et al., 2004). The Inadequate-Self and Self-Reassurance subscales were used to measure self-criticism and self-reassurance in the present study.

Behaviour and Feeling Survey. The Behaviour and Feelings Survey (BFS) is a 12-item self-report measure asking participants to rate how problematic certain behaviours in their child were over the course of the past week on a scale from 0 (not a problem) to 4 (a very big problem). The scale demonstrates good internal consistency (Cronbach's alpha = .87) and convergent validity with established mental health screeners (Weisz et al., 2019). Although the BFS is not normed, in clinical samples, caregiver ratings demonstrate a mean of approximately 19 and a standard deviation of 9–10 depending on the sample (Weisz et al., 2019).

Table 1

Sample Characteristics

Characteristic		Frequency/Mean
Child Mental Health Difficulties at pre-test (BFS)		M(SD) = 37.33 (11.32)
Age of child with mental health difficulty	7–9	3
	11–13	8
	14–16	5
	17–19	2
Number of Children in the household	1	5
	2	7
	3	4
	4	2
Age of caregiver	36–40	3
	41–45	4
	46–50	1
	51–55	3
	56–60	4
Caregiver current and active mental health diagnosis from a medical professional	Yes	8
	No	10
Currently co-parenting with spouse/partner	Yes	12
	No	6
Ethnicity of caregiver	Caucasian	13
	East Asian	1
	South Asian/Middle Eastern/Arab	2
	Indigenous	1
	Black Canadian/Afro-Caribbean/African	1

RESULTS

A series of paired-sample *t*-tests were run to investigate pre-post changes in the outcome measures (See Table 2). Results indicate a significant decrease in parental burnout ($t(17) = 3.05$, $p<.01$) and self-criticism ($t(17) = 2.31$, $p<.05$) and child mental health difficulties ($t(17) = 2.72$, $p<.05$) with moderate effect sizes ($d = .72$, $d = .56$ and $d = .64$ respectively). Results also indicate a significant increase in parent self-reassurance ($t(17) = -2.27$), $p<.05$) with a medium effect size ($d = .83$).

Table 2

Paired Sample *t*-Tests and Effect Size for Outcome Measures

Outcome	Paired Difference Mean and *SD*	*T* (*df* = 17 for all variables)	Effect Size (*d*)
Burnout	9.83(13.69)	3.05**	.72
Self-criticism	2.76 (4.93)	2.31*	.56
Self-reassurance	-2.11 (3.93)	-2.27*	.54
Child mental health difficulties	3.11 (4.86)	2.72*	.64

Note. * indicates $p<.05$; ** indicates $p<.01$

DISCUSSION

This paper investigated a novel CFT protocol for caregivers of young people with mental health difficulties. The protocol is unique in that it includes both elements of traditional CFT for caregivers and training in evidence-based parenting practices. Moreover, the protocol is unique in that it asks caregivers to learn and practice the parenting practices on themselves as a form of deliberate self-practice before using them with their children.

The results of the current study suggest that the CFT Caregiver Protocol is effective at supporting both caregiver well-being and child and adolescent mental health difficulties. These results suggest that future programs targeting CFT for caregivers should also include evidence-based parenting practices in their curricula. It also suggests that parents may benefit from the deliberate self-practice approach to building coping skills with themselves and then transmitting those to their child.

The current study was limited by its small sample size. While the clients attending the program are typical of those in a regular clinical setting (e.g., many caregivers have their own mental health difficulties, children are rated as having significant and high levels of difficulty, wide age range of caregivers and children), the sample was primarily Caucasian, heterosexual, and comprised cisgender persons living in two-parent households. Future research should explore the effects of the CFT Caregiver Protocol with other demographic samples. Future research should also examine the proposed mechanisms of change described above. Nonetheless, the results of the current study are promising and suggest that the CFT Caregiver

Protocol may be an efficient and effective method to support both caregivers and children struggling with mental health difficulties.

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