

Does Compassion-Focused Therapy Training for Health Care Educators and Providers Increase Self-Compassion and Reduce Self-Persecution and Self-Criticism?

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Introduction: There is a growing body of evidence within the health care community suggesting that developing feelings of compassion can profoundly affect physical and psychological health. This is an important area of work, and initial research with nonprofessional groups has found that practicing compassion through a variety of experiential practices and meditations can lead to higher levels of compassion for others, sensitivity to suffering, motivation to help, and altruism. This study examines outcome measures after a 3-day introductory workshop on compassion-focused therapy provided to health care providers and educators. The aim of the research is to explore whether the training would increase self-compassion and reduce self-criticism and self-persecution.

Methods: A total of 28 participants who were classified into three groups “nurses and midwives,” “counselors/psychotherapists,” and “other health care providers” completed the Self-Compassion Scale and Functions of Self-Criticizing and Self-Attacking Scale before and after training.

Results: Results reveal an overall statistically significant increase in self-compassion and statistically significant reduction in self-critical judgment after training. There was no statistically significant reduction in self-persecution or self-correction scores after training.

Discussion: Developing self-compassion and compassionately responding to our own “self-critic” may lead the way forward in the development of more compassionate care among health care professionals. Training people in compassion-based exercises may bring changes in levels of self-compassion and self-critical judgment. The findings are exciting in that they suggest the potential benefits of training health care providers and educators in compassion-focused practices.

Keywords: workplace learning, profession-other, human factors, self-compassion, compassion-focused therapy, health care educator and provider, compassionate mind training

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Compassion is one of the essential tools that health care workers need to work effectively with the individuals they treat.¹ Compassion has been defined in various ways, but a common definition is that it involves “a basic kindness, with a deep awareness of the suffering of oneself and of living things, coupled with a wish and effort to relieve it.”^{2(xiii)} Compassion may involve a variety of attributes (eg, empathy,

distress tolerance, being nonjudgmental, and sympathy) and links to motivational systems associated to caring for and being cared for.³ Recently, there has been much debate about compassion in health and social care⁴⁻⁷ and after recent scandals within the National Health Service, much of the literature has focused on the blocks, deficits, and lack of compassion in health and social care settings.

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Blocks to Compassionate Health Care

Recently, factors that may negatively affect health and social care professionals' compassionate capacity have been explored. These include a variety of factors linked to the working environment, such as high workload, time demands, and paperwork.^{7,8} Research has also suggested that within this context, various intrapersonal factors may also block compassionate care, including experiences of vicarious trauma, compassion fatigue, stress, and burnout.^{1,9} We now know, for example, that at the beginning of their careers, nurses are often motivated to provide high quality, patient-centered, and evidenced-based care. However, Maben et al.¹⁰ found that just 2 years after starting their nursing career, many reported feelings of frustration, and exhibited evidence of burnout. This in turn, led to disillusionment, role changes, and in some cases staff opting to leave the profession. Similarly, Bjerknes and Bjørk¹¹ found that newly

qualified nurses tended to enter the nursing profession with empathy for their patients and enthusiasm toward the organization and their new role. However, once ensconced into their new role they often found themselves faced with organizational and professional obstacles that hindered their performance.

Can We Cultivate More Compassionate Health Care?

At present, there is a growing body of evidence within the health care community that suggests that developing feelings of compassion can have a profound impact on mental health^{12,13} and has also been shown to increase immune system effectiveness,^{14,15} lower blood pressure and cortisol release,¹⁶ and improve general psychological well-being.¹⁷ There have been a variety of studies that have looked at cultivating more compassionate “organizations”¹⁸ while other researchers have focused on how we could train and cultivate compassion as individuals. This is an important area of work, and initial research with nonprofessional groups has found that practicing compassion through a variety of experiential practices and meditations can lead to higher levels of compassion for others, sensitivity to and motivation to help suffering, and altruism.^{19–21}

Researchers have also been interested in how self-compassion, and cultivating compassion for oneself, may have an important impact on our ability to be compassionate toward others. Gustin and Wagner²² found that the cultivation of self-compassion in clinical nursing teachers improved the compassion they exhibited to other people. Heffernan et al.²³ discovered a positive correlation between emotional intelligence and self-compassion, with both factors leading to increased compassion for others among a sample of nurses.

Another related area of recent study has been the exploration of factors associated with lower levels of self-compassion. One emerging factor that seems to play an important role in this aspect is self-criticism. For example, self-criticism has been found to be strongly related to lower levels of self-compassion,²⁴ and that practicing compassion is associated with a reduction in self-criticism.¹³ Moreover, being critical with ourselves has been found to be associated with a variety of negative correlates, including higher levels of stress and symptoms of mental illness.²⁵ Gilbert et al.²⁴ suggest that individuals may criticize themselves because they have thoughts of inadequacy, inferiority, disgust, and/or hatred toward themselves. The functions of self-criticism include correcting or improving oneself, to hurt or punish oneself, to prevent future mistakes, to maintain a certain standard, or to elicit sympathy from others.²⁴

Given the results of this research, it seems helpful to consider whether compassion—and self-compassion—can be trained or cultivated in staff. This research is relevant to our study because self-attacking tends to be activated when individuals think that they have failed in a particular task. An alternative and psychologically healthier response could perhaps be taught. For example, another response to failure could be to learn to self-support or develop compassion for one’s pain and suffering.^{24,26}

Compassion-Focused Therapy and Self-Compassion

Self-compassion has its roots in Buddhist teachings but during the recent years it has been linked to psychological well-being. This has led to an increase in research exploring the benefits of cultivating compassion.^{3,15,27–32} Compassionate mind training (CMT) and compassion-focused therapy (CFT) were specifi-

cally developed by Professor Paul Gilbert with and for individuals who experience self-criticism and shame. The model offers an evolutionary and neuroscience-based approach that explores how the evolution of affiliative emotions can regulate threat processing. Key principles of CFT are to motivate individuals to care for their well-being, to become sensitive to personal needs and distress, and to extend warmth and understanding toward themselves.³ CFT involves developing key compassionate attributes and the skills of compassion.² Compassionate attributes include:

1. Developing a caring motivation and wish to alleviate distress (care for well-being)
2. Learning to recognize our own and other people’s distress (sensitivity to distress)
3. Being emotionally moved by feelings of distress (sympathy)
4. Using the compassionate mind to tolerate difficult emotions by moving toward suffering rather than avoid suffering (distress tolerance)
5. Seeing the world through the eyes of another and learning to understand why we feel the way we do (empathy)
6. Individuals are taught techniques that aim to help them become more aware of and let go of self-attacking and self-criticism (nonjudgmental attitude).

Individuals are encouraged to reflect on the key attributes of compassion and practice the skills needed to develop them. For example, skill training includes learning to direct attention in a compassionate way, behave, think, reason, and respond to emotions in a compassionate way and use imagery to cultivate a compassionate mind. Individuals are taught to use self-soothing actions, adaptive coping strategies, courage, and acts of kindness.^{24,33,34} Research within therapeutic practice demonstrates that developing compassion for oneself and others can be beneficial for individuals experiencing chronic mental health problems,^{29,35} psychosis,^{36–38} trauma,^{27,39–41} and eating disorders.⁴² The study by Gilbert³ entails a comprehensive overview of the origins and nature of CFT.

Rationale for This Study

Increasing self-compassion and reducing self-criticism and self-persecution may protect health care professionals (HCPs) from compassion fatigue and burnout,^{1,43–45} in addition to improving physical and psychological health.^{12–17} Given the current pressures within health care settings, the literature highlighting frequent reductions in compassionate care as professionals move through their careers, and research emphasizing the important role played by self-compassion and self-criticism, this study was designed to measure whether attendance at a training course in CFT (as part of a Continuing Professional Development [CPD] programme) may increase levels of self-compassion of the attendees while lowering their self-reported self-criticism.

CPD is essential for those working within health care professions because it helps ensure that professional standards of care are maintained. Keeping up to date with health care developments and therapeutic approaches helps practitioners acquire new skills, reflect on practice, and remain a competent practitioner. CPD can help the clinician to identify and challenge their own assumptions and reflect on their own needs as HCPs.⁴⁶ For these reasons, we introduced CFT as a CPD event to the staff team.

To the best of our knowledge, this is the first study to investigate the outcome of a brief 3-day introduction to CFT on HCPs' level of self-criticism and self-compassion.

METHODOLOGY

Participants

Participants were HCPs working at a university in the United Kingdom. Forty-four people attended the workshop and 28 completed pre and postquestionnaires were obtained. The sample consisted of 11 nurses and midwives, 10 therapists (counselors and cognitive behavioral psychotherapists) and seven HCPs. The HCPs included smoking cessation workers, health care improvement practitioners and lecturers in health care.

Data Collection

Data were collected before the start of the workshop, at the end of training and at a follow-up focus group 1 month later.

Quantitative Element

Two measures were given to participants before and after training.

Self-Compassion Scale–Short Form (SCS-SF). The SCS-SF is a 12-item questionnaire.⁴⁷ The scale consists of six subscales (self-kindness, self-judgment, mindfulness, common humanity, isolation, and overidentification) and examines how individuals act toward themselves while experiencing difficulties. Recent research suggests that the scale measures two separate factors, self-compassion and self-critical judgment,⁴⁸ we therefore collapsed items to give a measure of two subscales. Self-compassion scores were calculated by collating data from the self-kindness, common humanity, and mindfulness subscales. Self-critical judgment scores were calculated by collating data from the subscales isolation, self-judgment and overidentification.⁴⁸ This scale has a near perfect correlation with the long-scale questionnaire when examining total scores.⁴⁷

Functions of Self-Criticizing and Self-Attacking Scale (FSCS). This scale measures the functions of self-criticism.²⁴ This scale examines why people think they self-criticize and self-attack. Factor analysis suggests two very different functions for being self-critical, which are as follows:

1. To try and improve oneself and to stop oneself from making mistakes. Questions include “to make sure I keep my standards up” and “to stop me being lazy.”
2. The other involves expressing anger and wanting to harm oneself. Questions include “to destroy a part of me” and “to harm part of myself.”

This is a 21-item scale measuring both of these factors. The responses are given on a 5-point scale (ranging from 0 = not at all like me, to 4 = extremely like me). Cronbach alphas were 0.92 for correcting and persecuting, respectively. Statistical analyses used SPSS release 20 for Windows (IBM SPSS, Chicago, IL).

Qualitative Element

Participants were given the opportunity when completing posttraining questionnaires, to answer the following questions:

1. What have you found most useful from the 3-day training course?
2. Will you use any of the interventions with your students or clients or patients?

Participants were informed that they would be invited at a later date to attend a focus group to discuss the workshop. The results collected through the focus group will be examined in a second article.

Procedure and Study Design

Participants were offered a place on a 3-day workshop titled “An Introduction to Compassion Focused Therapy.” Training was provided by one of us (C.I.), a board member of the Compassionate Mind Foundation (www.compassionatemind.co.uk) and an experienced trainer and practitioner in CFT. The workshop has been developed for attendees to use in their clinical practice, although as part of the workshop, attendees are encouraged to consider the model in relation to themselves and their students.

Overview of the Workshop

Participants were introduced to core theoretical elements of CFT, including the evolved nature of our minds; how our sense of self is created through an interaction between our genes and our social experiences; and our emotion regulation systems (threat, drive, and soothing); and the nature of shame, self-criticism and compassion. Participants also explored the evolution, definition, and qualities of compassion, along with the practice of a variety of experiential exercises designed to cultivate different aspects of compassion (TABLE 1).

Ethical approval was given by the College Research Governance and Ethics Committee.

RESULTS

Following participation in the 3-day training changes between premeasures and postmeasures across occupation groups were assessed by a series of 2 (time: pre versus post: within) \times 3 (occupation: nurses and midwives versus therapists versus HCPs: between) mixed analysis of variance (ANOVA). Each subscale was analyzed independently.

Multivariate ANOVA was not appropriate. To use multivariate ANOVA, dependent variables are required to be conceptually related and moderately correlated. Specifically, Maxwell⁴⁹ recommends that correlations should be in the range of 0.3 to 0.7. Consideration of dependent variable intercorrelations revealed that correlations between self-critical judgment and self-correction, $r = 0.29$, $df = 26$, $P = .07$; self-compassion and self-correction, $r = -0.20$, $df = 26$, $P = .15$, failed to reach the required level. Additionally, Levene's test for equality of variance revealed nonhomogeneity of between-group variance for pre and posttraining intervention measures of self-correction before, $F = 4.28$, $df = 2, 25$, $P = .025$; after, $F = 3.80$, $df = 2, 24$, $P = .036$. Given these data limitations, an ANOVA was performed on each dependent variable (SCS: self-critical judgment and self-compassion; FSCS: self-correction and self-persecution). Means (M) and standard deviations (SD) are shown in TABLE 2.

It was predicted that posttraining scores on SCS and FSCS subscales would improve compared to the pretraining scores.

TABLE 1.
Some of the Experiential Exercises That Were Examined and Practiced in the 3-day Workshop

Mindfulness and focused attention	Mindfulness: learning how to pay attention in the present moment without judging or criticizing
Soothing rhythm breathing	Teaching breathing methods that have been found to be associated with heart rate variability, positive health outcomes and facilitation of frontal cortex activity
Compassion-focused imagery	Use of imagery to help manage life's struggles (imagining the compassionate self-dealing with a problem)
Creating a safe place	Creating a place in the mind that provides a feeling of safety and calm
Compassion as a flow	Compassion can flow in three ways, from others to us, from us to other people and from and to ourselves
Developing the compassionate self	Using method acting and imagery techniques to create and develop a compassionate ideal self which may be used to direct compassion to others, and to oneself
Developing our ideal compassionate other	Using imagery techniques, participants create an image of an ideal compassionate other, and learn to experience compassion from this image
Using compassionate self to explore and relate to different parts of ourselves (multiself)	Participants explore different emotional parts of themselves (eg, angry, anxious, sad) to a recent distressing incident, and then use their compassionate mind to relate to these different parts, and the incident itself
Using compassion to engage with self-criticism	From the developed compassionate part of self, participants direct compassion (eg, empathy, distress tolerance, care) to their self-critical parts
Compassionate Letter writing	Compassionate letter writing helps to engage with difficulties and problems by focusing on being kind, supportive, and nurturing, as opposed to being self-critical

To reduce the probability of type I errors, posthoc interaction comparisons were restricted to pretraining versus posttraining differences by using related t tests on each level/occupation type. Application of Bonferroni corrections for multiple comparisons produced an alpha level of 0.017. Information about effect sizes accompanies statistical analysis and is indicated by partial eta-squared (η_p^2) within ANOVA and Cohen's *d* when t tests were calculated. A partial eta-squared value of between 0.01 and 0.06 reflects a small effect size, 0.06 to 0.13 represents a medium effect size, and a value of 0.14 or higher indicates a large effect.⁵⁰ Cohen's⁵¹ *d* classifies effect sizes as small (0.2), medium (0.5), and large (0.8) when interpreting the effect of an intervention.

Self-Compassion Scale

Self-Critical Judgment

A significant main effect was observed for time, $F(1, 25) = 19.48, P < .001, \eta_p^2 = 0.44$. Posttraining ($M = 15.61, SD = 4.57$) self-critical judgment scores were lower than pretraining ($M = 18.11, SD = 5.09$) scores. The occupation main effect was significant, $F(2, 25) = 18.00, P < .001, \eta_p^2 = 0.59$. These main effects were qualified by the significant time \times occupation interaction, $F(2, 25) = 3.96, P = .032, \eta_p^2 = 0.24$.

Simple main effect analysis revealed differences between pre and posttraining ratings for therapists ($M = 13.60, SD = 3.17$ versus $M = 11.40, SD = 3.20$), $t = 3.60, df = 9, P = .006, d = 0.69$, and HCPs ($M = 23.43, SD = 4.20$ versus $M = 18.00, SD = 2.45$), $t = 2.52, df = 6, P = .046, d = 1.92$. Self-critical judgment for therapists and HCPs reduced after training. The HCP score after applying the Bonferroni correction was above the corrected level of significance. However, scores suggested a trend toward improvement as indicated by the large effect size.⁵⁰ Pre and posttraining scores for nurses and midwives did not differ significantly ($M = 18.81, SD = 3.13$ versus $M = 17.91, SD = 4.01$), $t = 1.34, df = 10, P = .211, d = 0.25$.

Self-Compassion

A significant main effect was observed for time, $F(1, 25) = 15.76, P = .001, \eta_p^2 = 0.39$. Posttraining ($M = 20.75, SD = 3.21$) self-compassion scores were higher than their pretraining ($M = 18.36, SD = 4.44$) scores. No main effect was found for occupation, $F(2, 25) = 0.71, P = .501, \eta_p^2 = 0.05$. The time \times occupation interaction was not significant, $F(2, 25) = 1.90, P = .170, \eta_p^2 = 0.13$.

TABLE 2.
Pre and Posttraining Occupation Mean and Standard Deviations on the SCS and FSCS

Scale	Occupation										Overall (n=28)					
	Nurses and Midwives (n = 11)				Therapists (n = 10)				HCP (n = 7)				Pre		Post	
	Pre		Post		Pre		Post		Pre		Post		M	SD	M	SD
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
SCS																
Self-Judgement	18.81	3.13	17.91	4.01	13.60	3.17	11.40	3.20	23.43	4.20	18.00	2.45	18.11	5.09	15.61	4.57
Self-Compassion	19.27	4.83	20.46	3.39	19.00	3.77	21.30	3.62	16.00	5.16	20.43	2.57	18.36	4.44	20.75	3.21
FSCS																
Self-Persecution	4.73	4.63	7.00	5.06	3.50	5.70	2.40	4.17	11.14	7.93	8.29	4.99	5.89	6.52	5.68	5.22
Self-Correction	24.64	13.13	23.45	13.25	15.70	9.32	13.70	6.73	26.86	4.45	28.71	7.02	22.00	11.00	21.29	11.34

FSCS indicates Functions of Self-Criticizing and Self-Attacking Scale; SCS, Self-Compassion Scale.

Functions of Self-Criticizing and Self-Attacking Scale

Self-Correction

No significant main effect was observed for time, $F(1, 25) = 0.10, P = .756, \eta_p^2 = 0.00$. Posttraining ($M = 21.29, SD = 11.34$) and pretraining ($M = 22.00, SD = 11.00$) scores did not differ. The occupation main effect was significant, $F(2, 25) = 4.58, P = .020, \eta_p^2 = 0.27$. Posthoc comparisons using independent Bonferroni corrected independent t tests found HCP ($M = 27.79, SD = 3.63$) self-correction scores to be higher than those of therapists, ($M = 14.70, SD = 7.10$), $t = 4.45, df = 15, P < .001, d = 2.34$. Differences between nurses and midwives ($M = 24.05, SD = 12.95$) and HCPs ($M = 27.79, SD = 3.63$), $t = -0.90, df = 12.31, P = .38, d = 0.38$ and nurses and midwives ($M = 24.05, SD = 12.95$), and therapists ($M = 14.70, SD = 7.10$), $t = 2.08, df = 15.79, P = .055, d = 0.93$ were not significant. While significance testing indicated no significant difference between the nurses and midwives versus therapist groups, a large effect size was present. This suggested that a significant difference would be observable with a relatively modest increase in sample size. The time \times occupation interaction was not significant, $F(2, 25) = 0.61, P = .550, \eta_p^2 = 0.05$.

Self-Persecution

No significant main effect was observed for time, $F(1, 25) = 0.33, P = .570, \eta_p^2 = 0.01$. Posttraining ($M = 5.68, SD = 5.22$) and pretraining ($M = 5.89, SD = 6.52$) scores did not differ. The occupation main effect was significant, $F(2, 25) = 4.19, P = .027, \eta_p^2 = 0.25$. Posthoc comparisons using independent Bonferroni corrected t tests found that HCPs ($M = 15.29, SD = 9.19$) had higher self-persecution scores than therapists ($M = 4.70, SD = 7.66$), $t = -2.59, df = 15, P = .021, d = 1.38$. However, this difference was above the Bonferroni corrected significance level. Differences between nurses and midwives ($M = 8.23, SD = 6.26$) and HCPs ($M = 15.29, SD = 9.19$), $t = -1.95, df = 16, P = .069, d = 1.00$ and nurses and midwives ($M = 8.23, SD = 6.26$) and therapists ($M = 4.70, SD = 7.66$), $t = 1.16, df = 19, P = .260, d = 0.53$ were not significant. Consideration of the observed effect sizes revealed large effect sizes⁵⁰ for the HCPs versus therapists and nurses and midwives versus HCPs comparisons indicated that modest increases in sample size would produce significant differences. The time \times occupation interaction was not significant, $F(2, 25) = 2.43, P = .109, \eta_p^2 = 0.16$.

An introductory, 3-day CFT training workshop had beneficial effects on SCS ratings. Compared with the pretraining ratings, the posttraining ratings for self-critical judgment decreased for therapists and HCPs and self-compassion ratings increased.

The workshop had no statistical significant effect on FSCS subscales (self-correction and self-persecution).

DISCUSSION

There is an increasing focus within health care about the importance of compassionate care, and an awareness of blocks or inhibitors to this. This study looked at whether, as part of a training workshop, teaching health care and academic professionals about CFT, there may be associated increases in participant's levels of self-compassion, and reductions in levels of self-criticism. Self-compassion scores increased posttraining in all groups and self-critical judgment (as measured using a composite of item scores on the SCS) reduced posttraining in all groups.

Our finding that in the total sample there were pre to post CFT training changes in the scores on the SCS suggests that training people in compassion-based exercises may bring about changes in their self-reported levels of compassion and judgment, even when this is in the context of training in an approach for one's clients/work. This supports other research that has found that training in compassion-based experiential exercises may bring changes in levels of self-reported compassion.⁵² Given that this was a brief training programme, and that the experiential exercises that participants engaged with were part of a broader programme of learning, these findings are exciting in that they suggest the potential benefits of training health care staff in compassion.

Although we found very small reductions in two specific forms of self-criticism—self-correction and self-persecution—these did not reach statistical significance. It is interesting that while we identified statistical significance in changes in self-compassion, this did not translate to changes in self-criticism. There may be a number of reasons for this; this was a preliminary study with a small sample size, with statistical analysis suggesting that a significant difference may be observed on self-correction and self-persecution scores with a relatively modest increase in sample size. However, it may be that affecting change in levels of self-criticism may take longer than was given in this study. Moreover, given that the introductory workshop taught participants compassion-based exercises, it spent longer teaching participants about the theory and practice of CFT. Given this, it may not be surprising that levels of self-criticism did not reduce.

Although sample size numbers were small, there seemed to be some interdisciplinary variation in change scores. Looking at the three different professional groups, we found an interesting pattern of change pre to posttraining. On the two subscales of the SCS, all groups showed an increase in scores linked to self-compassion, and a reduction in items measuring self-critical judgement. Interestingly, the "other HCPs" group also showed a small (nonsignificant) increase in self-criticism (self-correction) scores. One explanation which was discussed in the training itself is that we may have multiple ways of relating to ourselves (eg, self-critically, self-compassionately) and therefore it may be easy, in the early stages of exposure to this work, to tone up one's capacity for self-compassion, but this does not mean that our level of self-criticism reduces accordingly. This study did not set out to test the impact of changes in levels of self-compassion on self-criticism (ie, in a linear, causal manner), but it may be interesting in the future to see whether change in one, or both, is salient in facilitating change in other related processes (eg, stress, burnout, compassion fatigue, depression, and so forth).

Although it is difficult to make clear inferences because of low numbers in each professional subgroup, the different patterns of average scores across the measures in each group is intriguing. Self-persecution scores increased posttraining in the nurses and midwives group only. For some people, practicing compassion exercises can bring them in contact with their self-criticism and personal distress in a way that may, in the short term, increase their self-reported scores as they become more aware of something that previously they were disconnected from. Counselors and psychotherapists seem to have lower levels of self-criticism and higher self-compassion, whereas the "other HCPs" group had the highest pretraining levels of self-criticism and lowest pretraining level of self-compassion. It is unclear whether these

findings are an accurate reflection of interprofessional differences, but if they are, these may link to a variety of factors, including the content/nature of differences in professional training; the nature of professionals' day-to-day job stress; or the level of support/supervision provided. It may be helpful for future studies to explore these findings in greater detail, and if replicated, investigate further what might account for such differences.

Training was only conducted for a 3-day period and the results suggest that this may not be enough time to instigate change in self-criticism and self-persecution for all participants.

LIMITATIONS

There are a number of limitations to the study. First, this was a small study which used only two questionnaires. Second, the training took place on the university campus, which meant participants may have been distracted by students and work commitments during break times. Moreover, some staff had to leave sections of the workshop to deal with work-related issues. Third, although we took measures of self-compassion, we did not record if participants' level of "other" compassion increased, or if participants' ability to experience support and compassion from others changed after training. Fourth, although the workshop includes many compassion-based exercises, it also includes participants having to engage (potentially) difficult memories, emotions, and thoughts, including working directly with recognizing the nature and function of their own self-criticism. Actively engaging in experiential exercises that linked to shame memories and self-criticism may have reduced the potential for some participants to benefit from the compassion exercises themselves. One participant disclosed on the posttraining questionnaires "I will practice the exercises (CFT) myself when I notice shame. . . I didn't realize I had such feelings until I started to reflect over the 3 days." Another commented, "The training was a reminder of the nature and role of shame in maintaining distress and a reminder about the importance of self-compassion."

Despite the limitations, participants reported that the model was easy to understand. Participants reported that they valued the experience of coming together as a staff group to discuss the CFT model and to examine interventions that could potentially help them develop compassion for themselves and others.

FURTHER RESEARCH

Future studies would benefit from larger sample sizes, and not only might this be helpful to detect overall effects on attendance at compassion training but it would also elucidate whether there are interdisciplinary differences between levels of self-criticism and self-compassion. We would also be keen to explore whether any potential benefits gained from attendance at similar trainings are maintained, and whether continued practice of compassion-focused exercises is linked to this.

There is growing evidence that compassion-based approaches can positively affect clinical and student populations. It is essential that HCPs deliver compassionate care especially because research suggests that there is an increase in compassion fatigue and burnout.^{1,45} With research suggesting that more HCPs want to leave their profession because of stress-related issues⁵³ policy makers and organizational factors should be examined in further research. Interestingly, one participant

commented after training that the training helped them feel valued by the organization, "the training helped me to feel valued by the organization and has been academically satisfying. I want to know more and study more about this topic." With another participant reflecting, "the techniques will empower me and help me to relate and be with others. Getting a chance to spend time with colleagues and getting to know them was beneficial."

SUMMARY AND CONCLUSIONS

This study provides some initial data on the impact on health professional's level of self-compassion and self-criticism after a 3-day introductory CFT training course. Results suggest some intriguing findings, and trends in places toward pre to post increases in self-compassion, and reductions in self-criticism. Given the difficulties that health professionals face in their jobs, and the potentially deleterious impact of self-criticism on their ability to maintain compassionate care for others, it may be that training staff on having compassion for their own suffering may be helpful in developing greater self-care and emotional resilience. It is therefore essential that health care educators and providers explore these concepts in more depth.

CPD helps to ensure effective patient and student care. Education regarding the impact that self-compassion and self-criticism plays within health care populations may help HCPs be "kinder to themselves" in times of distress, which in turn may help them foster compassionate environments. Nursing, midwifery, and psychotherapy professions have evolved during the past 30 years, cultivating a compassionate mind and compassionate working environments may lead the way forward in the development of more compassionate care among HCPs.^{5,7,18}

Lessons for Practice

- Training health care professionals in compassion-based exercises may bring changes in levels of self-compassion and self-critical judgment.
- Cultivating compassion for oneself may have an impact on our ability to be compassionate to others.
- Practicing compassion may be associated with a reduction in self-criticism.
- Self-attacking tends to be activated when individuals think that they have failed in a particular task. An alternative response could be taught by learning to self-support and develop compassion for one's pain and distress.
- Developing a compassionate mind by responding to our own "self-critic" may lead to more compassionate care among health care professionals.

REFERENCES

1. Figley CR. Compassion fatigue: psychotherapists' chronic lack of self-care. *Psychotherapy Pract.* 2002;58:1433-1441.
2. Gilbert P. *The Compassionate Mind*. London, United Kingdom: Constable; 2009.
3. Gilbert P. The origins and nature of compassion focused therapy. *Br J Clin Psychol.* 2014;53:6-41.

4. Brown B, Crawford P, Gilbert P, et al. Practical compassions: repertoires of practice and compassion talk in acute mental healthcare. *Sociol Health Illn.* 2014;36:383–399. doi: 10.1111/1467-9566.12065.
5. Care Quality Commission. *The State of Health Care and Adult Social Care in England.* London, United Kingdom: Stationery Office; 2011.
6. Crawford P, Gilbert P, Gilbert J, et al. The language of compassion. *Taiwan Int English Specif Purposes J.* 2011;3:1–16.
7. Crawford P, Brown B, Kvangarsnes M, et al. The design of compassionate care. *J Clin Nurs.* 2014;23:3589–3599. doi: 10.1111/jocn.12632.
8. Francis R. *Independent Inquiry into Care provided by Mid Staffordshire NHS Foundation Trust, January 2005–March 2009.* Vol. 1. London, United Kingdom: The Stationery Office; 2010.
9. Sharkey S, Sharples A. The impact of work-related stress of mental health teams following team-based learning on clinical risk management. *J Psychiatr Ment Health Nurs.* 2003;10:73–81.
10. Maben J, Cornwell J, Sweeney K. In praise of compassion. *J Res Nurs.* 2010;15:9–13.
11. Bjercknes MS, Bjørk IT. Entry into nursing: an ethnographic study of newly qualified nurses taking on the nursing role in a hospital setting. *Nurs Res Pract.* 2012;6:90348. doi: 10.1155/2012/690348.
12. Beaumont E, Hollins Martin CJ. A narrative review exploring the effectiveness of compassion-focused therapy. *Counselling Psychol Rev.* 2015;30:21–32.
13. Leaviss J, Uttley L. Psychotherapeutic benefits of compassion-focused therapy: an early systematic review. *Psychol Med.* 2015;45:927–945. doi: 10.1017/S0033291714002141.
14. Klimecki O, Leiberg S, Lamm C, et al. Functional neural plasticity and associated changes in positive affect after compassion training. *Cereb Cortex.* 2012 Jun 1:bhs142. doi: 10.1093/cercor/bhs142.
15. Lutz A, Brefczynski-Lewis J, Johnstone T, et al. Regulation of the neural circuitry of emotion by compassion meditation: effects of meditative expertise. *PLoS One.* 2008;3:e1897. doi: 10.1371/journal.pone.0001897.
16. Cosley BJ, McCoy SK, Saslow LR, et al. Is compassion for others stress buffering? Consequences of compassion and social support for physiological reactivity to stress. *J Exp Soc Psychol.* 2010;46:816–823.
17. Neff K, Germer C. A pilot study and randomized controlled trial of the mindful self-compassion program. *J Clin Psychol.* 2013;69:28–44.
18. Dutton JE, Workman KM, Hardin AE. Compassion at work. *Ann Rev Organizational Psychol Organizational Behav.* 2014;1:277–304. doi: 10.1146/annurev-orgpsych-031413-091221.
19. Breines JG, Chen S. Self-compassion increases self-improvement motivation. *Pers Soc Psychol.* 2012;38:1133–1143. doi: 10.1177/0146167212445599.
20. Condon P, Desbordes G, Miller WB, et al. Meditation increases compassionate responses to suffering. *Psychol Sci.* 2013;24:2125–2127.
21. Wallmark E, Safarzadeh K, Daukantaitė D, et al. Promoting altruism through meditation: an 8-week randomized controlled pilot study. *Mindfulness.* 2013;4:223–234.
22. Gustin LW, Wagner L. The butterfly effect of caring—clinical nursing teachers' understanding of self-compassion as a source to compassionate care. *Scand J Caring Sci.* 2012;27:175–183.
23. Heffernan M, Quinn MT, McNulty R, et al. Self compassion and emotional intelligence in nurses. *Int J Nurs Pract.* 2010;16:366–373.
24. Gilbert P, Clarke M, Hemel S, et al. Criticizing and reassuring oneself: an exploration of forms, style and reasons in female students. *Br J Clin Psychol.* 2004;43:31–35.
25. Kannan D, Levitt H. A review of client self-criticism in psychotherapy. *J Psychother Integr.* 2013;23:166–178. doi: 10.1037/a0032355.
26. Kohut H. *The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders.* Chicago, IL: University of Chicago Press; 1971.
27. Beaumont E, Galpin A, Jenkins P. Being kinder to myself: a prospective comparative study, exploring posttrauma therapy outcome measures, for two groups of clients, receiving either Cognitive Behaviour Therapy or Cognitive Behaviour Therapy and Compassionate Mind Training. *Couns Psychol Rev.* 2012;27:31–43.
28. Germer CK, Siegel RD, eds. *Wisdom and Compassion in Psychotherapy: Deepening Mindfulness in Clinical Practice.* Guilford, CT: Guilford Press; 2012.
29. Gilbert P, Procter S. Compassionate mind training for people with high shame and self-criticism: overview and pilot study of a group therapy approach. *Clin Psychol Psychother.* 2006;13:353–379.
30. Leary MR, Tate EB, Adams CE, et al. Self-compassion and reactions to unpleasant self-relevant events: the implications of treating oneself kindly. *J Pers Soc Psychol.* 2007;92:887–904.
31. Neff KD, Hsieh Y, Dejitterat K. Self-compassion, achievement goals, and coping with academic failure. *Self Identity.* 2005;4:263–287.
32. Neff KD, Vonk R. Self-compassion versus global self-esteem: two different ways of relating to oneself. *J Pers.* 2009;77:23.
33. Gilbert P, Baldwin MW, Irons C, et al. Self-criticism and self-warmth: an imagery study exploring their relation to depression. *J Cogn Psychother.* 2006;20:183–200.
34. Neff KD, Kirkpatrick KL, Rude S. Accepting the human condition: self-compassion and its links to adaptive psychological functioning. *J Pers.* 2007;41:139–154.
35. Judge L, Cleghorn A, McEwan K, et al. An exploration of group-based compassion focused therapy for a heterogeneous range of clients presenting to a community mental health team. *Int J Cogn Ther.* 2012; 5:420–429. doi: 10.1521/ijct.2012.5.4.420.
36. Braehler C, Gumley A, Harper J, et al. Exploring change processes in compassion focused therapy in psychosis: results of a feasibility randomized controlled trial. *Br J Clin Psychol.* 2012;52:199–214. doi: 10.1111/bjc.12009.
37. Laithwaite H, O'Hanlon M, Collins P, et al. Recovery after psychosis (rap): a compassion focused programme for individuals residing in high security settings. *Behav Cogn Psychother.* 2009;37:511.
38. Mayhew S, Gilbert P. Compassionate mind training with people who hear malevolent voices. A case series report. *Clin Psychol Psychother.* 2008;15: 113–138.
39. Ashworth FM, Gracey F, Gilbert P. Compassion focused therapy after traumatic brain injury: theoretical foundations and a case illustration. *Brain Impairment.* 2012;12:128–139. doi: 10.1375/brim.12.2.128.
40. Beaumont E, Hollins Martin CJ. Using compassionate mind training as a resource in EMDR: a case study. *J EMDR Pract Res.* 2013;7:186–199.
41. Bowyer L, Wallis J, Lee D. Developing a compassionate mind to enhance trauma-focused CBT with an Adolescent female: a case study. *Behav Cogn Psychother.* 2014;42:248–254.
42. Gale C, Gilbert P, Read N, et al. An evaluation of the impact of introducing compassion focused therapy to a standard treatment programme for people with eating disorders. *Clin Psychol Psychother.* 2014;21:1–12. doi: 10.1002/cpp.1806.
43. Beaumont E, Durkin M, Hollins Martin CJ, et al. Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in trainee counsellors and trainee cognitive behavioural psychotherapists: a quantitative survey. *Couns Psychother Res.* 2016;16:15–23.
44. Beaumont E, Durkin M, Hollins Martin CJ, et al. Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: a quantitative survey. *Midwifery.* 2015. doi: 10.1016/j.midw. 2015.11.002.
45. Figley CR. *Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview. Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized.* New York, NY: Brunner/Maze; 1995.
46. Bager-Charleson S. *Reflective Practice in Counselling and Psychotherapy.* Exeter, United Kingdom: LearningMatters; 2010.
47. Raes F, Pommier E, Neff K, et al. Construction and factorial validation of a short form of the Self-Compassion Scale. *Clin Psychol Psychother.* 2011; 18:250–255.
48. López A, Sanderman R, Smink A, et al. A reconsideration of the self-compassion scale's total score: self-compassion versus self-criticism. *PLoS One.* 2015;10:e0132940.
49. Maxwell S. When to Use MANOVA and significant MANOVAs and insignificant ANOVAs or vice versa. *J Consum Psychol.* 2001;10:29–30.
50. Cohen J. *Statistical Power Analysis for the Social Sciences.* Hillsdale, NJ: Laurence Erlbaum; 1988.
51. Cohen J. *Statistical Power Analysis for the Behavioral Sciences.* Cambridge, MA: Academic Press; 2013.
52. Barnard LK, Curry JF. Self-compassion: conceptualizations, correlates, & interventions. *Rev Gen Psychol.* 2011;15:289.
53. MacKusick CI, Minick P. Why are nurses leaving? Findings from an initial qualitative study on nursing attrition. *Medsurg Nurs.* 2010;19: 335–340.