

CFT Training for Healthcare Educators and Providers

Does Compassion Focused Therapy Training for Healthcare Educators and Providers increase self-compassion, and reduce self-persecution and self-criticism?

Introduction

Compassion is one of the essential tools that healthcare workers need in order to work effectively with the individuals that 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 (e.g. empathy, distress tolerance, non-judgement 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 following recent scandals within the NHS, much of the literature has focused on the blocks, deficits and lack of compassion in health and social care settings.

Blocks to Compassionate Healthcare

Recently, factors that may negatively impact on health and social care professional's 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 two 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 Bjork¹¹ found that newly qualified nurses tended to enter into the nursing profession with empathy for their patients and enthusiasm for the organisation and their new role. However, once ensconced into their new role they often found themselves faced with organisational and professional obstacles that hindered their performance.

Can we cultivate more compassionate healthcare?

At present there is a growing body of evidence within the healthcare community which 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 release¹⁶ and improve general psychological well-being.¹⁷ There have been a variety of studies that have looked at cultivating more compassionate 'organisations'¹⁸ whilst other researchers have focused on how we may train and cultivate compassion as individuals. This is an important area of work, and initial research with non-professional 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 upon our ability to be compassionate towards 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 here 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 oneself has been found to be associated with a variety of negative correlates, including higher levels of stress and mental health symptoms.²⁵ Gilbert et al.²⁴ suggest that individuals may criticise themselves because they feel inadequate, inferior, disgusted and/or hate themselves. The functions of self-criticism include to correct or improve 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 feel 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}

Compassionate Focused Therapy and Self-Compassion

Self-compassion has its roots in Buddhist teachings but over 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 specifically developed with and for individuals who experience self-criticism and shame by Professor Paul Gilbert. 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 wellbeing, to become sensitive to personal needs and distress, and to extend warmth and understanding towards themselves.³ CFT involves developing key compassionate attributes and the skills of compassion.² Compassionate attributes include;

- developing a caring motivation and wish to alleviate distress (care for well-being)
- learning to recognise our own and other people's distress (sensitivity to distress)
- being emotionally moved by feelings of distress (sympathy)
- using the compassionate mind to tolerate difficult emotions by moving toward suffering rather than avoid suffering (distress tolerance)
- seeing the world through the eyes of another and learning to understand why we feel the way we do (empathy)
- individuals are taught techniques that aim to help them become more aware of and let go of self-attacking and self-criticism (non-judgement)

Individuals are encouraged to reflect on the key attributes of compassion and practice the skills needed to develop them. For example, skills 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 employ 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 suffering with *chronic mental health problems*,^{29, 35} *psychosis*,^{36, 37, 38} *trauma*,^{27, 39-41} and *eating disorders*.⁴² See Gilbert (2014)³ for 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 healthcare professionals from compassion fatigue and burnout,^{1,43-45} in addition to improving physical and psychological health.¹²⁻¹⁷ Given the current pressures within healthcare settings, the literature highlighting frequent reductions in compassionate care as professionals move through their careers, and research emphasising 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 CPD programme) may increase attendees levels of self-compassion, whilst lowering their self-reported self-criticism.

Continuing Professional Development (CPD) is essential for those working within healthcare professions because it helps ensure that professional standards of care are maintained. Keeping up to date with healthcare 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 healthcare professionals.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 on healthcare professional's level of self-criticism and self-compassion following a brief, three day introduction to Compassion Focused Therapy.

Methodology

Participants

Participants were healthcare professionals working at a University in the United Kingdom. Forty-four people attended the workshop and twenty-eight completed pre and post-questionnaires were obtained. The sample consisted of eleven nurses/midwives, ten therapists (counsellors and cognitive behavioural psychotherapists) and seven healthcare professionals (HCPs). The healthcare professionals included smoking cessation workers, healthcare improvement practitioners and lecturers in healthcare.

Data Collection

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

Quantitative element

Two measures were given to participant's pre and post-training.

*The Self-Compassion Scale - Short form (SCS-SF).*⁴⁷

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

*The Functions of Self-Criticising/Attacking Scale (FSCS).*²⁴

This scale measures the functions of self-criticism. This scale examines why people think they self-criticise and self-attack. Factor analysis suggests two very different functions for being self-critical which are:-

- (1) To try and improve the self and to stop the self 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 the self. 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, USA).

Qualitative element

Participants were given the opportunity when completing post-training questionnaires, to answer the following questions:

- What have you found most useful from the three day training course?
- Will you use any of the interventions with your students/clients/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 via the focus group will be examined in a second paper.

Procedure and study design

Participants were offered a place on a three 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 (see Table 1).

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

Please insert Table 1 here

Results

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

MANOVA was not appropriate. In order to use MANOVA dependent variables are required to be conceptually related and moderately correlated. Specifically, Maxwell⁴⁹ recommends that correlations should be in the range .3 to .7. Consideration of dependent variable inter-correlations revealed that correlations between self-critical judgement and self-correction, $r = .29$, $df = 26$, $p = .07$; self-compassion and self-correction, $r = -.20$, $df = 26$, $p = .15$) failed to reach the required level. Additionally,

Levene's test for equality of variance revealed non-homogeneity of between-group variance for pre and post-training intervention measures of self-correction pre, $F = 4.28$, $df = 2, 25$, $p = .025$; post, $F = 3.80$, $df = 2, 24$, $p = .036$. Given these data limitations, an ANOVA was performed on each dependent variable (Self-Compassion Scale, SCS: self-critical judgement and self-compassion; Functions of Self-Criticising/Attacking Scale, FSCS: self-correction and self-persecution). Means (M) and standard deviations (SD) appear in Table 2.

Please insert Table 2 here

It was predicted that scores on SCS and FSCS subscales would improve post (vs. pre) training.

To reduce the probability of type I errors, post-hoc interaction comparisons were restricted to pre vs. post-training differences via the use of related t-tests on each level/occupation type. Application of Bonferroni corrections for multiple comparisons produced an alpha level of .017. Information about effect sizes accompanies statistical analysis and is indicated by partial eta squared (ηp^2) within ANOVA and Cohen's d when t-tests were calculated. A partial eta-squared value of between .01 and .06 reflects a small effect size, .06-.13 represents a medium effect size, and a value of .14 or higher indicates a large effect.⁵⁰ Cohen's d classifies effect sizes as small (0.2), medium (0.5) and large (0.8) when interpreting the effect of an intervention.⁵¹

Self-Compassion Scale (SCS)

Self-Critical Judgement

A significant main effect was observed for time, $F(1, 25) = 19.48, p < .001, \eta^2 = .44$. Post-training ($M = 15.61, SD = 4.57$) self-critical judgement scores were lower than pre-training ($M = 18.11, SD = 5.09$) scores. The occupation main effect was significant, $F(2, 25) = 18.00, p < .001, \eta^2 = .59$. These main effects were qualified by the significant time x occupation interaction, $F(2, 25) = 3.96, p = .032, \eta^2 = .24$.

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

Self-Compassion

A significant main effect was observed for time, $F(1, 25) = 15.76, p = .001, \eta^2 = .39$. Post-training ($M = 20.75, SD = 3.21$) self-compassion scores were higher than pre-training ($M = 18.36, SD = 4.44$) scores. No main effect was found for occupation, $F(2, 25) = .71, p = .501, \eta^2 = .05$. The time x occupation interaction was not significant, $F(2, 25) = 1.90, p = .170, \eta^2 = .13$.

Functions of Self-Criticising/Attacking Scale (FSCS)

Self-Correction

No significant main effect was observed for time, $F(1, 25) = .10, p = .756, \eta p^2 = .00$. Post-training ($M = 21.29, SD = 11.34$) and pre-training ($M = 22.00, SD = 11.00$) scores did not differ. The occupation main effect was significant, $F(2, 25) = 4.58, p = .020, \eta p^2 = .27$. Post-hoc comparisons using independent Bonferroni corrected independent t-tests found HCPs ($M = 27.79, SD = 3.63$) self-correction scores to be higher than therapists, ($M = 14.70, SD = 7.10$), $t = 4.45, df = 15, p < .001, d = 2.34$. Differences between nurses/midwives ($M = 24.05, SD = 12.95$) and HCPs ($M = 27.79, SD = 3.63$), $t = -.90, df = 12.31, p = .38, d = 0.38$ and nurses/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. Whilst significance testing indicated no significant difference between the nurses/midwives vs. 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 x occupation interaction was not significant, $F(2, 25) = .61, p = .550, \eta p^2 = .05$.

Self-Persecution

No significant main effect was observed for time, $F(1, 25) = .33, p = .570, \eta p^2 = .01$. Post-training ($M = 5.68, SD = 5.22$) and pre-training ($M = 5.89, SD = 6.52$) scores did not differ. The occupation main effect was significant, $F(2, 25) = 4.19, p = .027, \eta p^2 = .25$. Post-hoc 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/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/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 vs, therapists and nurses/midwives vs. HCPs comparisons indicated that modest increases in sample size would produce significant differences. The time x occupation interaction was not significant, $F(2, 25) = 2.43$, $p = .109$, $\eta^2 = .16$.

Conclusion

An introductory, three day CFT training workshop had beneficial effects on Self-Compassion Scale (SCS) ratings. Relative to pre-training ratings, post-training ratings for self-critical judgement decreased within therapists and HCPs and self-compassion ratings increased.

The workshop had no statistical significant effect on functions of Self-Criticising/Attacking Scale (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 healthcare and academic professionals about Compassion Focused Therapy, there may be associated increases in participant's levels of self-compassion, and reductions in levels of self-criticism. Self-compassion scores increased post-training in all groups and self-critical judgement (as measured using a composite of item scores on the SCS) reduced post-training 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 judgement, 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 healthcare 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 whilst 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 on 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 appeared to be some interdisciplinary variation in change scores. Looking at the three different professional groups, we found an interesting pattern of change pre-to-post-training. On the two subscales of the self-compassion scale, all groups showed an increase in scores linked to self-compassion, and a reduction in items measuring self-critical judgement. Interestingly, the 'other healthcare professionals' group also showed a small (non-significant) 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 (e.g. 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 (i.e. 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 (e.g. stress, burnout, compassion fatigue, depression and so forth).

Although it is difficult to make clear inferences due to low numbers in each professional subgroup, the different patterns of average scores across the measures in each group is intriguing. Self-persecution scores increased post-training in the nurses/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. Counsellors and psychotherapists appear to have lower levels of self-criticism and higher self-compassion, whereas the ‘other healthcare professionals’ group had the highest levels of self-criticism and lowest level of self-compassion pre-training. It is unclear whether these findings are an accurate reflection of inter-professional 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 over a three 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 utilised 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, whilst 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 altered post-training. Fourth, whilst the workshop includes many compassion based exercises, it also includes participants having to engage (potentially) difficult memories, emotions and thoughts, including working directly with recognising the nature and function of their own self-criticism. Actively engaging in experiential exercises which 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 post-training questionnaires *"I will practice the exercises (CFT) myself when I notice shame....I didn't realise 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 this may be helpful to detect overall effects upon attendance at compassion training, but 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 are linked to this.

There is growing evidence that compassion based approaches can have a positive impact on clinical and student populations. It is essential that healthcare professionals deliver compassionate care especially as research suggests that there is an increase in compassion fatigue and burnout.^{1,45} With research suggesting that more healthcare professionals want to leave their profession because of stress related issues⁵³ policy makers and organisational factors should be examined in further research. Interestingly, one participant commented post-training that the training helped them feel valued by the organisation, *“the training helped me to feel valued by the organisation and it 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. Having chance to spend time with colleagues and get 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 following a three day, introductory Compassion Focused

Therapy training course. Results suggest some intriguing findings, and trends in places towards pre to post increases in self-compassion, and reductions in self-criticism. Given the difficulties that health professional's 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 in compassion for themselves may be helpful in developing greater self-care and emotional resilience. It is therefore essential that healthcare 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 healthcare populations may help healthcare professionals be 'kinder to themselves' in times of suffering, which in turn may help them foster compassionate environments. Nursing, midwifery and psychotherapy professions have evolved over the past 30 years, cultivating a compassionate mind and compassionate working environments may lead the way forward in the development of more compassionate care amongst healthcare professionals.^{5,7,18}

Lessons for Practice

- Training healthcare professionals in compassion based exercises may bring changes in levels of self-compassion and self-critical judgement.
- Cultivating compassion for oneself, may have an important impact upon 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 feel 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 suffering.
- Developing a compassionate mind by responding to our own 'self-critic' may lead the way forward in the development of more compassionate care amongst healthcare professionals.

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Table 1: Some of the experiential exercises that were examined and practiced in the 3 day workshop

Compassionate Mind Experiential Exercises	
<i>Mindfulness and focused attention</i>	Mindfulness – learning how to pay attention in the present moment without judging or criticising.
<i>Soothing Rhythm Breathing</i>	Teaching breathing methods that have been found to be associated with heart rate variability, positive health outcomes and facilitation of frontal cortex activity
<i>Compassion Focused Imagery</i>	Use of imagery to help manage life's struggles (imagining the compassionate self dealing with a problem)
<i>Creating a Safe Place</i>	Creating a place in the mind that provides a feeling of safety and calm
<i>Compassion as a flow</i>	Compassion can flow in three ways, from others to us, from us to other people and from and to ourselves.
<i>Developing the Compassionate Self</i>	Using method acting and imagery techniques to create and develop a compassionate ideal self which may be used to develop compassion to others, and to oneself.
<i>Developing our Ideal Compassionate Other</i>	Using imagery techniques, participants create an image of an ideal compassionate other, and learn to experience compassion towards themselves from this image.
<i>Using compassionate self to explore and relate to different parts of ourselves (multi-self)</i>	Participants explore different emotional parts of themselves (e.g. angry, anxious, sad) to a recent distressing incident, and then use their

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<i>Using compassion to engage with self-criticism</i>	compassionate mind to relate to these different parts, and the incident itself From the developed compassionate part of self, participants direct compassion (e.g. empathy, distress tolerance, care) to their self-critical parts
<i>Compassionate Letter Writing</i>	Compassionate letter writing helps to engage with difficulties and problems by focusing on being kind, supportive and nurturing as opposed to being self-critical.

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Table 2: Pre and post-training occupation mean and standard deviations on the Self-Compassion Scale (SCS) and the Functions of Self-Criticising/Attacking Scale (FSCS).

Scale	Occupation															
	Nurses/Midwives (n = 11)				Therapists (n = 10)				HCP (n = 7)				Overall (n = 28)			
	Pre		Post		Pre		Post		Pre		Post		Pre		Post	
	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