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Invitation to Self-Compassion: Reshaping Burden of Care in the Light of Self-Compassion Training Given to Relatives of Patients Hospitalised in Palliative Care

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ABSTRACT

Aim: This study was conducted to investigate the effects of self-compassion training given to the relatives of patients hospitalised in the palliative care unit on the care burden and self-compassion of patient relatives.

Method: The study is a randomised, controlled experimental study in pretest-posttest design. The study was conducted between February 2024 and June 2024 with the relatives of the patients who received care and treatment in the palliative care unit of a hospital in eastern Turkey. The study was completed with 30 patient relatives in the intervention group and 32 patient relatives in the control group. The patient relatives in the intervention group received 40–50 min of self-compassion training for 8 weeks. No intervention was given to the control group. Personal Information Form, Self-Compassion Scale, and Caregiver Burden Scale were used to collect the data.

Results: While there was no significant difference in the total mean scores of the caregiver burden scale and self-compassion scale of the intervention group before the intervention compared to the control group ($p > 0.05$), a significant difference was found after the intervention ($p < 0.05$). When the regression coefficients were analysed, it was found that self-compassion training negatively affected the total mean score of the caregiver burden scale and explained 55% of its variance, while it positively affected the total mean score of the self-compassion scale and explained 55% of its variance.

Conclusion: This study shows that self-compassion training given to the relatives of patients hospitalised in the palliative care unit is effective in terms of reducing the burden of care and increasing their self-compassion. Relatives of patients who received self-compassion training experienced a decrease in their care burden and an increase in their self-compassion. These findings emphasise the importance of self-compassion training in supporting the relatives of patients in palliative care.

1 | Introduction

According to the definition made by the Ministry of Health, palliative care units are units that focus on early diagnosis, prevention or elimination of physical, psycho-social, and spiritual problems, especially pain management, with the aim of improving the quality of life of individuals who have life-threatening diseases. These units are affiliated to the Ministry of Health in our country and they are units where not only physical examinations (such as examinations, analyses) but also rehabilitation and follow-up of patients in psycho-social dimensions are carried out.

In addition to the patients hospitalised in these units, the families who spend time with the patients and care for them should also be addressed. Families of patients hospitalised in these units are individuals who try to cope with high levels of stress and anxiety as they see their relatives' severe symptoms and try to adapt to the caregiver role [1]. Tripodoro et al. [2] identified the needs of family members as a result of their study on family members who are the hospital attendants of palliative care patients. These needs include the need to protect their physical health, to be able to spare time for themselves by getting away from the patient they care for, to make plans for the future, to receive psycho-social support, to be in constant communication with healthcare professionals and social services, and to provide financial support [2]. Of these needs, psycho-social support has recently begun to be integrated into medical health sciences. It is not possible to achieve physical health with biological interventions alone. The aim of psycho-social support studies is to reduce physical and emotional pain, to facilitate return to pre-disease life, to provide counselling about the reactions that can be given in the face of the event, to strengthen coping strategies, to direct to the right coping methods, and to mobilise environmental support systems that can be used (UNICEF & AÇSHB 2019). Therefore, it is wrong to define psycho-social support as a counselling service provided in psychiatric diseases or as a therapy model that forces the patient to talk [3].

Psycho-social support activities, which have examples of application in different fields, have positive effects especially on caregivers. Therefore, the presence of psycho-social support in palliative care is an important dimension [4, 5]. In this context, the concept of self-compassion, which has an important place in psycho-social support studies, is a subject that has recently been frequently addressed in research with positive psychology. It is also referred to as self-understanding and self-sensitivity in the literature. Compassion is categorised according to the source from which it is directed or received: the feeling of compassion directed from oneself to others, the feeling of compassion received from others, and the feeling of compassion directed directly to the self. The flow of compassion directed to the self was first conceptualised as self-compassion by Neff, [6, 7]. It means showing compassion and understanding to oneself as one shows compassion and understanding to others, accepting one's own suffering, and being accepting towards oneself without being judgemental [6, 7]. Individuals with self-compassion recognise that their difficulties, flaws and shortcomings are normal and that everyone can experience these situations due to the characteristics of being human. Individuals are usually less compassionate towards themselves than they are towards others. However, individuals with self-compassion are as understanding, forgiving and loving towards themselves as they are towards other people [8].

Research indicates that self-compassion training enhances psychological resilience, which enables caregivers to better cope with the demands of caregiving [9, 10]. Additionally, self-compassion training has been shown to reduce stress, anxiety, and depression among caregivers by fostering a more positive self-image and promoting emotional regulation [11]. A longitudinal study examining the relationship between self-compassion, mindfulness, and caregiver stress found that higher levels of self-compassion were associated with lower levels of caregiver stress and depressive symptoms [12]. This suggests that self-compassion training may serve as a protective factor against the adverse psychological effects of caregiving.

In the light of this information, palliative care is an approach that aims to increase the quality of life of individuals with life-threatening diseases, focusing on early diagnosis and treatment of physical, psychosocial, and spiritual problems. In this process, it is of great importance to support not only patients but also their family members who care for them (Ministry of Health 2021). In Türkiye, relatives of patients receiving palliative care generally cope with high levels of stress and anxiety, which increase the burden of care. In the current literature, it is seen that psychosocial support interventions aimed at reducing the burden of care for relatives of patients are limited and that studies examining the effects of self-compassion training in particular are lacking.

In this respect, the purpose of this study is to examine the effects of self-compassion training given to relatives of patients in the palliative care unit on the care burden and self-compassion levels of these individuals. In this way, it is aimed to contribute to meeting the psychosocial support needs of patients' relatives and to increase the quality of palliative care services.

1.1 | Research Hypotheses

Hypothesis 0. *Self-compassion training given to the relatives of patients hospitalised in the palliative unit has no effect on the burden of care and self-compassion levels of patient relatives.*

Hypothesis 1. *Self-compassion training given to the relatives of patients hospitalised in the palliative unit has effects on the burden of care and self-compassion levels of patient relatives.*

2 | Method

2.1 | Study Design

Pretest-posttest randomised controlled experimental design.

2.2 | Population of Research and Sample Selection

The universe of the study consisted of 67 relatives of patients who were caring for patients receiving care and treatment in the palliative care unit of a hospital in eastern Turkey between February 2024 and June 2024. A priori power analysis was performed using the G-Power 3.1. 9.4 program to determine the sample size in the study. For the a priori power analysis, since there were no similar studies on the subject, when the effect size was taken into account according to Cohen's t test in independent groups in the effect size table as 0.8 [13], the confidence interval was 95% [14], the significance level was 0.05 [14], and the power was 0.90 [15], the minimum number of relatives to

be included in the study was 56: 28 for the intervention group and 28 for the control group. Sixty-seven relatives of patients were reached between the dates specified in the study. Since two of the patient relatives did not meet the research criteria (being over 18 years of age, Being the primary relative responsible for the care of the patient hospitalised in the palliative care unit, Not having participated in self-compassion training before, Not having any obstacles to communicate, Not having any physical illness or psychiatric disorder, Not taking any medication and other psychotropic drugs) and one did not want to participate in the research, a total of 64 patient relatives, 32 in the intervention group and 32 in the control group, constituted the sample of the study. However, during the research process, two relatives of the patient in the intervention group could not continue the training due to illness and could not participate in the post-test and were removed from the study. As a result, the study was completed with 30 patient relatives in the intervention group and 32 relatives in the control group who volunteered to participate in the study and constituted the sample group of the study.

2.3 | Randomisation

The study process started with explaining the research plan to the patient relatives. All patient relatives who met the research criteria and voluntarily agreed to participate were informed. Participants were grouped into two as intervention and control groups by lot method [16]. The study process started with explaining the research plan to the patient relatives. All patient relatives who met the research criteria and voluntarily agreed to participate were informed. Participants were grouped into two as intervention and control groups by lot method. There was no blinding between the control and experimental groups. The analyses of the study were conducted by a different person than the researchers, solely to prevent bias. The person conducting the analysis was not given any information about the experimental and control groups. The research process was based on CONSORT 2010 guidelines (Figure 1: CONSORT Flow Diagram) and the research registration number required for randomised controlled trials (NCT06339723) was obtained from ClinicalTrials.gov.

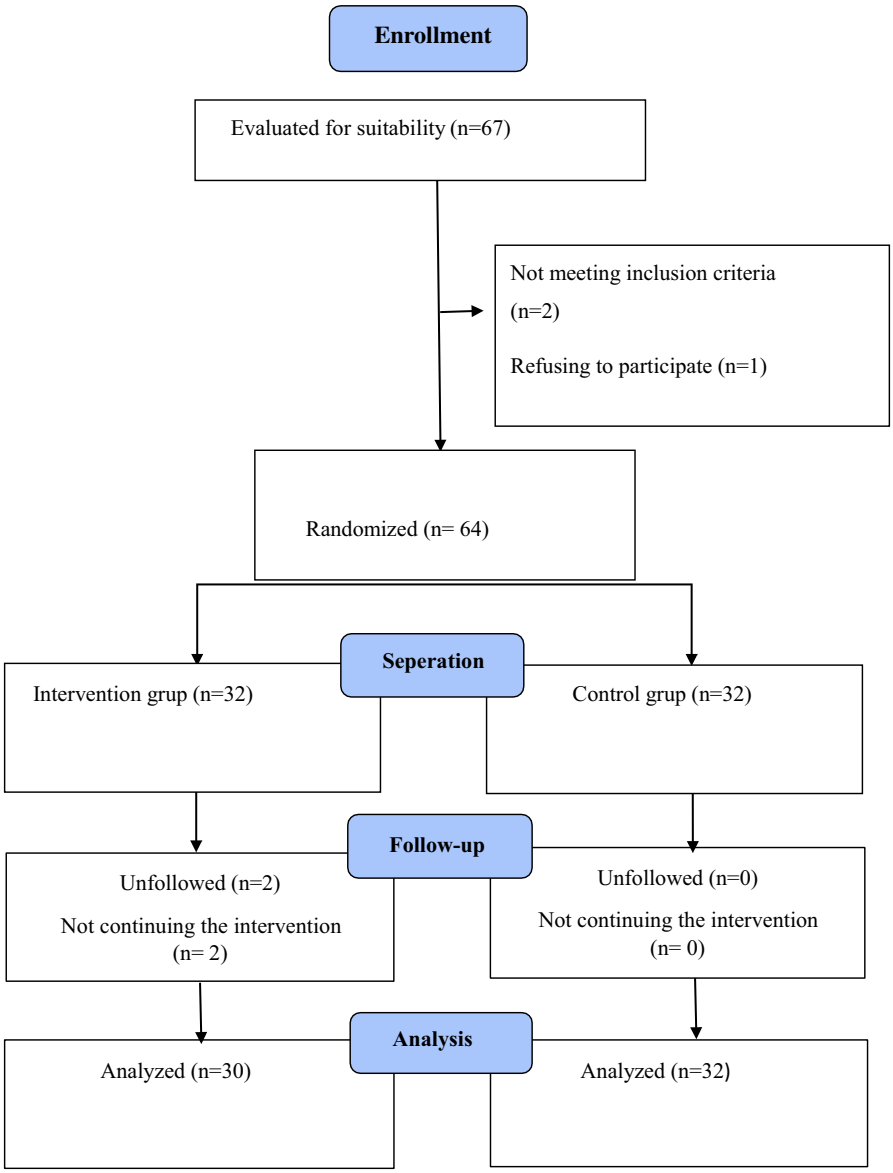

FIGURE 1 | Consort Diagram.

2.4 | Data Collection Tools

2.4.1 | Personal Information Form

This form, prepared by the researchers, consists of 19 questions, including sociodemographic information of patient relatives, such as age, gender, marital status, etc.

2.4.2 | Self-Compassion Scale

In order to measure the self-compassion levels of adults, the Self-Compassion Scale (SSC) was developed by Neff, [6, 7] and adapted into Turkish by Deniz, Kesici, and Sümer [17]. The Turkish adaptation of the SSC consists of 24 items. Adult individuals indicate the extent to which each item is appropriate for them by marking one of the following options: almost never (1), rarely (2), occasionally (3), often (4), and almost always (5). Eleven items in the SSC are scored reversely. Following the re-scoring of items that need to be scored reversely, the responses given by the participants to the scale items are collected and the scores that can be obtained from the scale vary between 24 and 120. Higher scores obtained from the scale indicate greater self-compassion, while lower scores suggest reduced self-compassion levels. The Cronbach alpha value of the scale reported by Deniz et al. [17] is 0.89. In this study, the pretest-posttest Cronbach's Alpha values of the Self-Compassion scale were found to be between 0.89 and 0.95.

2.4.3 | Caregiver Burden Scale

The Caregiver Burden Scale was originally developed by Zarit, Reever, and Bach-Peterson in 1980 to assess the stress experienced by caregivers of individuals requiring care, particularly older adults. The Turkish validity and reliability study was conducted by İnci and Erdem [18]. The scale consists of 22 items evaluating the impact of caregiving on various aspects of the caregiver's life, particularly in social and emotional domains. It can be completed either by the caregiver or through researcher administration. Responses are rated on a 5-point Likert scale ranging from 0 (never) to 4 (almost always), with total scores ranging from 0 to 88. Higher scores indicate greater levels of caregiver burden and distress [18]. The scale's Cronbach's alpha reliability coefficient was calculated as 0.95. In this study, the pretest and posttest Cronbach's alpha values for the Caregiver Burden Scale were found to be between 0.87 and 0.90, demonstrating strong internal consistency.

2.5 | Data Collection

The interventions were carried out face-to-face with the relatives of patients hospitalised in the Palliative Care Unit after obtaining the necessary permissions, in a way that would not disrupt the routine schedules of the unit such as treatment-follow-up, by meeting with the relatives of the patients in the activity room in the unit where the relatives of the patients in the unit can gather and spend time and not be away from the patients. There are palliative care 1 and palliative care 2 units in the institution where the study was conducted. Which unit would be the control group and which unit would be the intervention group was determined at the beginning of the study by drawing lots by someone independent from the research. As a result of the lottery, Palliative Care 1 unit became the intervention group and Palliative Care 2 unit became the control group. Thus, the risk of transmission was prevented by preventing interaction between groups.

In this study, data were collected using a personal information form, self-compassion scale, and caregiver burden scale. The data were collected at the beginning of the study (pre-test) and at the final stage after the completion of the educational intervention (post-test).

2.6 | Experimental Process

Self-compassion, an adaptation of the Mindfulness-Based Stress Reduction (MBSR) program developed by Kabat-Zinn (1990), was applied to the intervention group. The sessions of the program were created by using Neff and Germer's [19] Mindfulness-Based Self-Compassion program and Neff's [20] exercises to increase self-compassion, combined with psycho-education activities [20]. Before the Self-Compassion Development Program was prepared, the relevant literature was reviewed and the programs prepared to develop self-compassion were examined [19, 21]. In this context, the concepts and techniques of the cognitive-behavioural approach were utilised. Neff and Germer [19] argued that self-compassion is a teachable skill and that it will improve overall quality of life.

In this sense, the self-compassion training given to the relatives of patients hospitalised in the palliative care unit is a psycho-education program that aims to examine the effects on the care burden and self-compassion of patient relatives. Psycho-education programs are educational, cognitive, developmental-oriented programs prepared in line with a predetermined purpose, and these programs aim to develop a certain skill in individuals [22]. The self-compassion program developed aims to teach what self-compassion means and what it does, and tries to enable participants to include self-compassion in their own lives through various activities and exercises. The program was prepared by taking into account the basic components of self-compassion, which are the concepts of self-kindness, mindfulness, and a sense of common humanity, and aims to develop self-compassion through both the practices in the sessions and the homework assignments.

In this study, an 8-week 40–50-min mindfulness-based self-compassion program was conducted for patient relatives. The program consisted of 8 sessions, each focusing on a specific topic [19, 21, 22]. The content of the sessions is planned as follows:

Session 1: Introducing the concept of self-compassion.

Session 2: Awareness of strengths and weaknesses and self-recognition.

Session 3: Self-compassion and related concepts (self-kindness, self-understanding etc.) and the development of self-compassion.

Session 4: Self-compassion meditations and homework.

Session 5: Feedbacks and mindfulness.

Session 6: Breathing exercises and body scanning.

Session 7: Awareness of destructive self-criticism.

Session 8: Completion of the sessions within the scope of the general objectives of the program with group evaluation and closing.

The self-compassion training applied in the study was applied by the researcher who has a training certificate on the subject. In each session, the first 15–20 min were allocated to presentations on self-compassion, while the remaining 25–30 min were allocated to meditation practices and experience sharing. Throughout the sessions, different topics related to self-compassion (mindfulness concept, breathing exercise, autopilot concept, self-knowledge, etc.) were focused on.

The needs of the program were determined, national and international researches were reviewed, and the objectives were formed in line with the data collected. Each session was planned in line with the determined outcomes, and at the end of the sessions, the researcher noted whether the objectives were achieved or not (if not, why not). In this respect, the plan of the next sessions was structured.

PowerPoint, topic-oriented video screenings and interactive narration techniques were used as presentation techniques. Participants were given homework assignments (body scanning, breathing exercise, mindful eating, etc.) according to the themes covered each week, and feedback on these assignments was listened to one-to-one at the end of each session.

After the training program was completed, the questionnaire forms were redistributed to the participants in the intervention group, and they were asked to respond to the forms. At the end of the program, post-tests were also collected from the patient relatives in the control group, and a self-compassion program was also applied to the control group in line with the equality principle of the research.

2.7 | Data Analysis

The data obtained in the study were analysed by using the SPSS (Statistical Package for Social Sciences) 23.0 programme. Numbers, percentages, mean, and standard deviation were used to analyse the data. Chi-square analysis was used to compare the demographic characteristics between the intervention and control groups (categorical measurements). In the examination of normality distribution of the data, it was found that skewness and kurtosis values were within the range of +2 and −2 values. Histogram graphs were also analysed, and it was found that the measurements showed normal distribution. Independent samples t test was used for intergroup comparison of intervention and control groups, and dependent samples t test was used for intra-group comparison. Regression analysis was conducted to measure the relationship between quantitative variables. P values less than 0.05 were considered statistically significant in all analyses.

2.8 | Ethical Considerations

In order to conduct the study, the necessary administrative permissions (number: 2024/03–19) were received from the Ethics Committee and the relevant institutions before starting the study. In the Measures section confirming that permissions were obtained from the original authors of the scales used, ensuring adherence to ethical research practices. Before starting to collect the research data; the participants were informed about the research and their questions about the research were answered, 'Informed Consent Principle' was fulfilled by taking care to comply with the 'Confidentiality and Protection of Confidentiality Principle' by obtaining the consent of the participants.

3 | Results

The results of the Chi-square analysis in Table 1 show that the control and intervention groups were homogenous in terms of descriptive characteristics.

When the intra-group comparison of the intervention and control groups was analysed, a significant difference was found in the mean total scores of the Caregiver Burden Scale and Self-Compassion Scale of the participants in the intervention group after the intervention ($p < 0.05$). In the control group, no significant difference was found in the pre-intervention Caregiver Burden Scale total mean score after the intervention ($p > 0.05$). When the intergroup comparison of the patients in the intervention and control groups was analysed, it was found that while there was no significant difference in the mean total scores of the Burden of Care Scale and Self-Compassion Scale before the intervention ($p > 0.05$), there was a significant difference after the intervention compared to the control group ($p < 0.05$) (Table 2).

Table 3 shows the regression analysis results regarding the effect of self-compassion training on "Caregiver Burden Scale" and "Self-Compassion Scale". It was determined that the two models were statistically significant ($p < 0.05$). When the regression coefficients were analysed, it was determined that self-compassion training negatively affected the total mean score of the Caregiver Burden Scale ($\beta = -0.744$, $p = 0.001$) and explained 55% of its variance, while it positively affected the total mean score of the Self-compassion Scale ($\beta = 0.752$, $p = 0.001$) and explained 55% of its variance.

4 | Discussion

The results of the study in which we examined the effects of self-compassion training given to the relatives of patients hospitalised in the palliative care unit on the care burden and self-compassion of the patient relatives were examined in line with the literature.

It was found that the intervention and control groups did not show a statistically significant difference in terms of care burden and self-compassion levels at baseline ($p > 0.05$). Thus, it is thought that the observed effects can be attributed to the training intervention

TABLE 1 | Distribution and comparison of the findings related to the descriptive characteristics of the participants in the intervention and control groups ($n = 60$).

	Groups				
	Intervention		Control		
Variables	***n***	**%**	***n***	**(%)**	**Test value and significance**
Gender					
Female	19	63.3	21	65.6	$x^2 = 0.036$ $p = 0.851$
Male	11	36.7	11	34.4	
Marital status					
Married	18	60.0	18	56.3	$x^2 = 0.089$ $p = 0.765$
Single	12	40.0	14	43.7	
The status of having children					
Yes	23	76.7	23	71.9	$x^2 = 0.186$ $p = 0.667$
No	7	23.3	9	28.1	
Educational status					
Literate	1	3.3	1	3.1	$x^2 = 0.038$ $p = 0.998$
Primary	4	13.3	4	12.5	
Secondary	6	20.0	7	21.9	
High school	19	63.4	20	62.5	
Employment status					
Employed	13	43.3	13	40.6	$x^2 = 0.047$ $p = 0.829$
Unemployed	17	56.7	19	59.4	
Income status					
Income<expense	28	93.3	30	93.8	$x^2 = 0.004$ $p = 0.669$
Income = expense	2	6.7	3	6.2	
The status of quitting your job due to care giving					
Yes	11	36.7	12	37.5	$x^2 = 0.005$ $p = 0.946$
No	19	63.3	20	62.5	
Your closeness to the patient you care for					
Mother	11	36.7	13	40.6	$x^2 = 0.102$ $p = 0.999$
Father	9	30.0	9	28.1	
Brother	2	6.6	2	6.3	
Spouse	6	20.0	6	18.7	
Mother-in-law	2	6.7	2	6.3	
The status of having someone to help with the care					
Yes	20	66.7	22	68.8	$x^2 = 0.031$ $p = 0.861$
No	10	33.3	10	31.2	
Overall assessment of your health					
Poor	2	6.7	2	6.3	$x^2 = 0.019$ $p = 0.991$
Moderate	23	76.7	25	78.1	
Good	5	16.6	5	15.6	
Status of having a chronic disease					

(Continues)

TABLE 1 | (Continued)

Variables	Groups				Test value and significance
	Intervention		Control		
	n	%	*n*	(%)	
Yes	24	80.0	26	81.3	$x^2=0.016$ $p=0.901$
No	6	20.0	6	18.7	
The status of caring for your own health					
Yes	20	66.7	22	68.8	$x^2=0.031$ $p=0.861$
No	10	33.3	11	31.2	
The status of participating in social activities					
Yes	2	6.7	2	6.3	$x^2=0.004$ $p=0.947$
No	28	93.3	30	93.7	
Continuous variables	X ± SD		X ± SD		
Age	42.93	12.84	41.68	13.35	$t=0.374$; $p=0.710$
Duration of care giving	3.56	2.94	3.78	3.23	$t=-0.273$; $p=0.786$

Note: $p<0.05$ was considered statistically significant.
Abbreviation: x^2, Pearson chi-square test.

and are purified from the effects of other variables. This method supports the reliability and validity of the study results.

After the 'Mindfulness (MBSR)-based self-compassion training', the mean caregiver burden scale score of the intervention group decreased significantly compared to the control group. In other words, it was found that the distress experienced by the patient relatives in the intervention group regarding the burden of care decreased significantly after the training ($p<0.001$). Although no study evaluating the effects of self-compassion on the burden of care was found in the literature, [6, 7] concluded that there was a negative relationship between self-compassion and depression, rumination and anxiety, and a positive relationship between life satisfaction, self-acceptance and self-esteem, and that a high level of self-compassion increased psychological well-being. In this regard, the findings of the study are in line with the literature. The purpose of self-compassion practices is not to avoid pain, but to accept pain with compassion and to support oneself with kindness [23]. Therefore, mindfulness-based self-compassion training applied to the relatives of patients in long-term care units such as palliative care is considered to increase the psychological health and reduce the burden of care by increasing the awareness of patient relatives, who are accepted as hidden patients, in the care process by supporting them with kindness and accepting them with compassion.

The mean self-compassion scale score of the intervention group increased significantly compared to the control group after the 'Mindfulness (MBSR) based self-compassion training', the effectiveness of which was tested in the study and applied to the relatives of the patients. In other words, it was determined that the compassion shown by the patient relatives to themselves increased ($p<0.001$). When the literature was examined, it was concluded that awareness programs for self-compassion in different sample groups had a significant positive effect on the level of self-compassion and that individuals with increased self-compassion at the end of the program developed a deeper understanding, accepting and loving attitude towards themselves, increased their ability to cope with stress and improved their emotional well-being [4, 21, 23–29]. Fusco [24] investigated the effects of self-compassion intervention program on self-compassion, self-criticism and stress. According to the findings of the study, at the end of the program, it was observed that there was a decrease in the stress levels and self-criticism of the students in the intervention group and an increase in self-compassion levels. According to the results of the research conducted by Yela et al. [29], an increase was observed in the self-compassion, mindfulness and psychological well-being scores of individuals who participated in the program for self-compassion practices. Sarıcaoğlu & Arslan, [30] also tested the effectiveness of Mindfulness-Based Self-Compassion Program on the self-compassion levels of university students [30]. According to the results of this study, while there was an increase in the self-compassion levels of the students who were included in the program, there was no significant change in the self-compassion levels of the students who did not receive experimental treatment. Karakasidou & Stalikas [26] prepared a self-compassion psychoeducation program to teach how to be more self-compassionate in challenging situations and tested the effectiveness of the program. As a result of the study, the program was found to be effective in increasing students' self-compassion levels. In studies conducted both abroad and in Turkey, it was found that self-compassion was negatively correlated with depression [31, 32], rumination and anxiety [6, 7], negative emotions [33], and stress [34]; while it was found to be positively correlated with psychological well-being [6, 7], positive emotions [33], subjective well-being [34], and subjective happiness [35]. When the literature on self-compassion is examined, these findings of the study are in line with the findings of other experimental studies [21, 23–25, 28, 29], which concluded that self-compassion levels of individuals increased after self-compassion intervention programs. In this respect, it is thought that the mindful awareness (MBSR) based self-compassion training applied to patient relatives increases the awareness of

TABLE 2 | Intragroup and intergroup comparison of caregiver burden and self-compassion scale total scores of participants in the intervention and control groups.

	Groups		
	Intervention	Control	
	X ± SD	X ± SD	Intergroup t^x/p
Caregiver burden scale			
Before intervention	49.30 ± 15.50	53.31 ± 8.95	$t = -1.258$, $p = 0.213$
After intervention	34.00 ± 10.28	55.68 ± 9.48	$t = -8.638$, $\mathbf{p = 0.001}$*
Intragroup t^y/p	$t = 9.842$, $\mathbf{p = 0.001}$*	$t = -1.589$, $p = 0.122$	
Self-compassion scale			
Before intervention	52.86 ± 17.09	54.03 ± 18.02	$t = -0.261$ $p = 0.795$
After intervention	84.03 ± 8.05	53.43 ± 17.25	$t = 8.846$, $\mathbf{p = 0.001}$*
Intragroup t^y/p	$t = -11.511$ $\mathbf{p = 0.001}$*	$t = 0.411$, $p = 0.684$	

Abbreviations: SD, standard deviation; *t*/*p*, significance test; *x*, independent groups *t* test; X, mean; *y*, dependent groups *t* test.
*$p < 0.05$ considered statistically significant.

TABLE 3 | Regression analysis results regarding the effect of self-compassion training on caregiver burden and self-compassion scale total scores.

								95% CI	
Dependent variable	**Model**	**Variables**	***B***	**S.Error**	***β***	***t***	***p***	**Lower**	**Upper**
Caregiver burden scale	1	Fixed	55.687	1.747		31.884	**0.001***	52.194	59.181
		Self-compassion training	−21.687	2.511	−0.744	−8.638	**0.001***	−26.710	−16.665
			$R = 0.744$, $R^2 = 0.554$, $F_{(1.60)} = 74.608$, $\mathbf{p = 0.001}$*						
Self-compassion scale	1	Fixed	53.438	2.406		22.212	**0.001***	48.625	58.250
		Self-compassion training	30.596	3.459	0.752	8.846	**0.001***	23.678	37.514
			$R = 0.752$, $R^2 = 0.559$, $F_{(1.60)} = 78.258$, $\mathbf{p = 0.001}$*						

Note: *β, standard beta; $p < 0.05$ considered statistically significant.

the patient relatives, increases their psychological health and increases their self-compassion by supporting them with kindness in the care process.

Another significant finding in the study was that the mean score of the caregiver burden scale in the intervention group decreased significantly after the 'self-compassion training, which is an adaptation of the Mindfulness-Based Stress Reduction (MBSR) program' in intra-group analyses, while an increase occurred in the control group ($p < 0.001$). This suggests that the patient relatives who did not receive any intervention worsened in terms of burden of care as time passed.

In this context, with this study, it is thought that examining the effect of self-compassion training given to the relatives of patients hospitalised in the palliative care unit on the care burden and self-compassion of patient relatives in terms of both increasing the quality of life by evaluating the caregivers and increasing the quality of care for the patient being cared for will make a significant contribution to the literature.

5 | Conclusion

This study shows that self-compassion training plays a very effective role in reducing the burden of care and increasing the self-compassion of patient relatives. It shows that self-compassion training can significantly improve the psychosocial well-being of the relatives of patients in the palliative unit and alleviate the burden of care.

These results emphasise the importance of self-compassion training for the relatives of patients hospitalised in palliative care. It is thought that more widespread implementation of such training programs in different sample groups in health institutions would be an important step to support the well-being of patient relatives.

While the findings are promising, certain limitations should be acknowledged. The study's confined to a single hospital in eastern Turkey, which may limit the generalisability of the results. Future research with larger, more diverse populations

and extended follow-up periods is recommended to validate and expand upon these findings. To effectively support patient relatives in palliative care settings, it is crucial to integrate self-compassion training into the broader framework of caregiver support programmes. This integration can be achieved by increasing the number of certified health workers trained in self-compassion and palliative care. Incorporating self-compassion training into the education and professional development of healthcare providers can enhance their ability to deliver compassionate care, thereby indirectly benefiting patient relatives.

In conclusion, integrating self-compassion training into caregiver support initiatives and enhancing the education of healthcare professionals in this area are essential steps towards improving the well-being of patient relatives in palliative care settings.

5.1 | Strengths and Limitations of the Study

Strengths of the study can be listed as follows: the study was conducted in a palliative care unit where the patient relatives accompany the patient for a long time; the self-compassion training applied in the study was applied by the researcher who has a training certificate on the subject; the study is a randomised controlled study; and short self-compassion training was also applied to the control group at the end of the study. The limitation of the study is that it was conducted in the palliative unit of a single hospital in the east of Turkey.

5.2 | Clinical Implications

This study reveals the positive effects of self-compassion training given to the relatives of patients in a palliative care unit on their care burden and self-compassion levels. Self-compassion training can help patient relatives maintain their physical and psychological health by reducing the burden of care, and this can improve the quality of life of both relatives and patients. The training increases the self-compassion levels of patient relatives and strengthens their coping with stress and emotional resilience, thus enabling them to display a more balanced and positive attitude in the care process. The study emphasises the importance of supporting patient relatives in palliative care and shows that interventions such as self-compassion training contribute to making them feel more supported and valued. The findings suggest that self-compassion training should become a standard practice in palliative care units and that such programmes can be implemented by health personnel and provide emotional and psychological support to patient relatives. In conclusion, self-compassion training is effective in reducing the burden of care and increasing the level of self-compassion in patient relatives and can make significant contributions to the development of strategies in clinical practice.

Author Contributions

Study design: Y.E., G.B.T., N.K., E.B. Data collection: N.K., Y.E. Data analysis: G.B.T. Study supervision: Y.E., G.B.T., N.K. Manuscript writing: Y.E., G.B.T., N.K., E.B. Critical revisions for important intellectual content: Y.E., G.B.T., N.K., E.B.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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