The effects of Compassionate Mind Training on student psychotherapists

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Word Count 5797

Abstract

Purpose: This study examines pre and post outcome measures following a course of Compassionate Mind Training (CMT). Participants were students enrolled on a Post Graduate Diploma in Cognitive Behavioural Psychotherapy (CBP). The aim of the research was to explore whether the training would increase self-compassion, compassion for others and dispositional empathy. **Method:** Twenty-one participants who had enrolled on the CBP programme took part in the study. Data were collected using the Self-Compassion Scale, Interpersonal Reactivity Index and the Compassion for Others Scale. **Findings:** Results reveal an overall statistically significant increase in self-compassion scores and statistically significant reduction in self-critical judgement scores post training. There was no statistically significant difference post training on the Interpersonal Reactivity Index or the Compassion for Others Scale. **Research limitations/implications**: CMT training may help students develop healthy coping strategies, which they can use to balance their affect regulation systems when faced with organisational, placement, client, academic and personal demands. Further research using a larger sample size is needed to examine whether cultivating compassion whilst on training can help students build resilience and provide a barrier against empathic distress fatigue, compassion fatigue, and burnout. **Practical Implications:** Incorporating CMT into psychotherapy training may bring changes in student levels of self-compassion and self-critical judgement. **Originality/value of the paper:** This inaugural study examines whether incorporating CMT into a CBP programme impacts on students levels of compassion, dispositional empathy and self-critical judgement. The findings from this preliminary study suggest the potential benefits of training students in compassion focused practices.

Keywords: self-compassion, compassionate mind training, compassion focused therapy, cognitive behavioural psychotherapy, education

Introduction

Counselling and psychotherapy students face a number of client, organisational, academic, placement, supervision and personal demands whilst on training (Beaumont, 2016; Beaumont & Hollins Martin, 2016). Without adequate self-care students may experience emotional distress that can be both physically and psychologically challenging. According to Porter (1995), self-care serves three main functions, to protect the therapist by reducing occupational hazards such as burnout, to enhance therapy by modelling healthy behaviour, and to protect clients by reducing risks of ethical violations. Self-care and self-reflection is an ethical imperative for psychological practitioners (Barnett, Baker, Elman & Schoener, 2007) and helps the individual remain emotionally fit for purpose (Harris, 2007).

Incorporating interventions into psychotherapy training that assist the flow of compassion may help students care for their own well-being. The practice of self-care has been found to promote psychological and physical health and improve well-being (Williams-Nickelson, 2001), increase capacity for empathic understanding and lower levels of anxiety and depression (Schure, Christopher & Christopher, 2008).

This study intends to examine whether incorporating Compassionate Mind Training (CMT) into a psychotherapy training programme increases self-compassion, compassion for others, dispositional empathy and reduces self-critical judgement in a sample of student Cognitive Behavioural Psychotherapists (CBP's).

Psychotherapy Training Demands

Students undergoing psychotherapy training may be more vulnerable to symptoms of stress and burnout (Beaumont, 2016; Beaumont & Hollins Martin, 2016; Boellinghaus, Jones & Hutton, 2013; Rønnestad & Skovholt, 2003) because they may work in settings that are emotionally and physically draining, with clients that experience high

levels of distress (De Stefano, Atkins, Noble & Heath, 2012). Students enrolled on counselling and psychotherapy courses face idiosyncratic demands whilst training. For example, they may work with clients presenting with suicidal thoughts or work with clients who self-harm, which can present professional challenges (Reeves, Bowl, Wheeler & Guthrie, 2004; Reeves & Dryden, 2008). Students may also experience anxiety especially because they may need to react quickly to ethical and legal issues relating to confidentiality and client disclosure (De Stefano et al., 2012; Moore & Cooper, 1996). This in turn may lead to self-critical judgement and students may feel overwhelmed, fearful or incompetent (Reeves & Mintz, 2001; Wheeler, Bowl & Reeves, 2004). It is therefore essential that therapists strive to provide quality care for clients, whilst at the same time, take care of themselves (Beaumont & Hollins Martin, 2016; Bell, Dixon & Kolts, 2016).

Rønnestad and Skovholt (2003) carried out a longitudinal study looking at the development of 100 counsellors and therapists and propose that counsellors and therapists move through six phases; the lay helper, the beginning student, the advanced student, the novice professional, the experienced professional, and the senior professional. Rønnestad and Skovholt (2003) suggest that students initially question their personal characteristics and abilities, whilst gaining an awareness that in reality the practice and the theory of psychotherapy pose different obstacles. During the early stages in student development, direct or subtle criticism (actual or perceived), or negative feedback from clients, could impact negatively on morale, prompting self-criticism.   During training, students were only expected to function at a basic professional level of competence, however, many had higher aspirations for themselves, reporting that they felt pressure to perform perfectly. Trying to become the 'perfect practitioner' can result in a more anxious psychotherapeutic approach and

an excessive and misunderstood sense of responsibility toward clients (Jacobsson, Lindgren & Hau, 2012). Jacobsson et al. (2012) echo this view and found in a sample of student psychotherapists, that experiencing anxiety was a phenomenon of the education process and part of each student's journey toward development of their individual psychotherapeutic identity.

Rønnestad and Skovholt (2003) suggest that for some students, psychotherapy supervision experiences also had particular significance. During the advanced student phase, students felt that they were supposed to master professional tasks with a greater level of competence. Supervision conflicts peaked during this stage of training with students reporting increased tension and constant self-evaluation, which suggests that although supervision may be rewarding for many students, for others it may exacerbate anxiety and self-criticism. Liddle (1986) reinforces this idea suggesting that whilst supervision intends to be supportive, it can incite self-criticism due to a fear of negative evaluation by supervisors, feelings of shame or embarrassment and/or impression management. Fears relating to incompetence can lead to non-disclosure during supervision with trainees endeavoring to conceal their perceived flaws. Practising interventions, which encourage self-acceptance, self-compassion, and self-reflection, could help students gain more value and support from clinical supervision and psychotherapy training. Bennett-Levy, Thwaites, Haarhoff and Perry (2015) suggest that self-practice enhances the therapeutic relationship because it provides students with an understanding regarding the process of therapy.

Beaumont, Durkin, Hollins Martin and Carson (2016) found in a sample (n=54) of student cognitive behavioural therapists and student counsellors that higher levels of self-compassion was correlated with lower levels of compassion fatigue and burnout. Higher self-judgement scores however, correlated positively with symptoms

of burnout, compassion fatigue and reduced psychological well-being. Beaumont, Durkin, Hollins Martin and Carson (2016) suggest that students may benefit from using psychological interventions that increase levels of self-compassion.

Compassion fatigue is a form of burnout affecting individuals working in the caregiving professions (Joinson, 1992; Figley, 1995), who as a result of their role bear witness to the suffering of others. Klimecki and Singer (2012) hold a similar view, they use the term empathic distress fatigue, which is a consequence of listening to the trauma stories of clients. Empathic distress fatigue occurs as a result of emotional, psychological, spiritual, physical and occupational exhaustion and according to Klimecki and Singer (2012), is the cause of compassion fatigue and burnout.

Klimecki and Singer (2012) propose that the neural pathways linked with compassion can be activated to enhance well-being by using techniques that aim to increase compassion, empathy, and altruistic behaviour. This idea is reinforced by Beaumont (2016), who suggests that cultivating compassion may help students build resilience, develop compassion for their own suffering, and may help protect them from the symptoms associated with empathic distress fatigue, secondary trauma, compassion fatigue and burnout.

Gilbert (2005) suggests that self-compassion helps individuals feel calm, cared for and connected. Developing self-compassion and responding to the *"bully within, by being kinder to oneself"* (Beaumont, Galpin & Jenkins, 2012, p.42), in times of suffering may help students on their journey to become CBP's. Cultivating self-compassion may act as a remedy to self-criticism (Beaumont, 2016) and is necessary for self-care. Therefore examining educational interventions, which aim to cultivate compassion and promote self-care is worthy of exploration.

Cultivating compassion

The growing body of literature in relation to self-compassion appears to indicate that it may serve as a barrier against psychological distress (Beaumont, 2016; Beaumont & Hollins Martin, 2016; Dorian & Killebew, 2014, Gilbert, 2005, Neff & McGehee, 2010). Furthermore, cultivating self-compassion may help CBP's develop the skills and psychological resources needed in order to develop empathy and compassion for others, a crucial foundation in psychotherapy training (Dorian & Killebrew, 2014, Hick & Bien, 2008).

Neff (2003a) suggests that self-compassion can be viewed as having the ability and the desire to treat ourselves with kindness, to be open to our own suffering, and be non-judgmental in relation to our own inadequacies. Neff (2003a) proposes that there is a link between self-compassion and psychological well-being, with high levels of self-compassion being associated with happiness, conscientiousness, life satisfaction, social connectedness and optimism. In addition, high levels of self-compassion is correlated with reduced levels of anxiety (Neff, 2003a; Neff et al., 2007), self-criticism (Gilbert & Proctor, 2006), trauma symptoms (Beaumont et al., 2012: Beaumont & Hollins Martin, 2013; Beaumont, Durkin, McAndrew & Martin, 2016) and rumination (Neff & Vonk, 2007). This is supported by Neff and McGehee, (2010) who suggest that self-compassion is linked to psychological resilience. In a sample of adolescents (n=235) and young adults (n= 287), Neff and McGehee, (2010) found that self-compassion was strongly associated with well-being.

Appropriate self-care is viewed by Barnett et al. (2007) as a critical component in the prevention of harm to clients caused by the psychotherapist or psychotherapy. They suggest that training models focusing on both the personal and professional aspects of self-care across the life span, should be incorporated into graduate training

programmes and discuss the importance of practicing self-acceptance and self-compassion. Although the practice of self-compassion has been recommended to promote therapist wellness (Beaumont & Hollins Martin, 2016; Beaumont, Durkin, Hollins Martin & Carson, 2016) and reduce work-related stress (Barnett et al., 2007; Mahoney, 2005), there are very few research studies that have investigated how psychotherapists employ self-compassion (Patsiopoulos & Buchanan, 2011). Boellinghaus et al. (2013) reviewed the effectiveness of mindfulness-based interventions and loving-kindness meditation and report that trainee therapists who undertook a programme of loving kindness meditation found that the practice increased their self-awareness and compassion for self and others. Participants reported that they were able to bring this increased compassion with them to the therapy room and integrate it into their clinical work.

Addressing a potential gap in student psychotherapists training, Beaumont and Hollins Martin (2016) proposed that Compassionate Mind Training, an intervention which was specifically designed to help individuals in clinical populations with high levels of shame and self-criticism (Gilbert, 2009; 2010), be adapted and introduced into student psychotherapy training. Beaumont and Hollins Martin (2016) present a six-step programme that has potential to enhance well-being through incorporating creative interventions, which aim to increase levels of self-compassion.

Compassionate Mind Training

Compassionate Mind Training (CMT) and Compassion Focused Therapy (CFT) were developed for clinical populations to help individuals create self-supportive voices, in response to shame, low mood, and self-criticism (Gilbert, 2005; 2009; 2010; 2014). Individuals with high levels of shame and self-criticism often experience high levels of

external threat, for example, fear rejection and criticism, and also experience high levels of internal threat, for example, feel a failure, inferior or flawed (Gale, et al., 2012). Cultivating a compassionate mind includes having a caring motivation to face suffering, tolerate distress and take action to help alleviate suffering (Gilbert, 2009). Using compassion and wisdom, the skills and attributes of compassion are developed. This process involves integrating self-care strategies into daily life, which aim to help the individual learn to think, behave and react to feelings and physiological responses with compassion. CMT refers to the interventions used to cultivate compassion, whereas CFT comprises the process of therapy. Interventions used within clinical settings include; compassionate letter writing, mindfulness, imagery exercises, working creatively to build a compassionate self and using safe place exercises that aim to trigger affiliative emotions (Gilbert, 2009; 2014).

CFT explores how the evolution of affiliative emotions helps people to regulate threat. Gilbert (2009) postulates that we have three emotion regulation systems; *the threat protection system, the drive resource seeking and excitement system* and *the affiliative/soothing and safeness system. The threat protection system* responds with feelings such as anger, anxiety and disgust which warn the body to take action. The *drive resource seeking and excitement system* developed to motivate animals to find useful resources (e.g., shelter) and seek out sexual opportunities. The *affiliative/soothing and safeness system* is linked to social connection. When this system is activated it creates feelings of security (Gilbert, 2009). Self-care activities that stimulate the *soothing/affiliative system* increase compassion and help regulate threat responses such as self-criticism. In essence, self-criticism ignites *the threat protection system*, whereas *the affiliative/soothing system* creates affiliative feelings,

enabling the individual to self-soothe (see Gilbert, 2014 for a comprehensive exploration of the model).

Rationale

Student CBP's work collaboratively with people experiencing distress, with the goal of helping ease suffering. However, students may experience higher levels of stress if they have high levels of compassion for others but lack self-compassion (Gilbert & Choden, 2013). This is further justification for teaching student CBP's interventions that aim to cultivate compassion.

Symptoms of stress, high levels of self-criticism and a lack of self-care and compassion for oneself, if not managed, could lead to secondary trauma, empathic distress fatigue, compassion fatigue, or burnout. Student CBP's will bear witness to the trauma stories of others and may face difficulties whilst training as a result of organisational, academic, placement and personal demands, which can all prompt a threat response (*see Figure 1*). This makes considering interventions that aim to help individuals cultivate self-compassion potentially important (Beaumont, 2016; Beaumont & Hollins Martin, 2016).

This current study reports on the first phase of a longitudinal project and explores the impact that CMT has on student CBP's. The second phase of the project examines the effect CMT has on students and their CBP practice by collecting qualitative data via a focus group. The long-term aim of this project is to examine whether CMT improves psychotherapists' well-being, compassion levels, and professional quality of life and reduces self-critical judgement.

INSERT FIGURE 1

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Although Cognitive Behavioural Psychotherapy may be combined with CMT or CFT (Gilbert, 2009; 2010) with clients, this is the first study that integrates CMT into a CBT training programme.

Method

Design

This study used a multiple method design (Bryman, 2008), whereby both quantitative and qualitative data were collected. Multiple method approaches enable researchers to collect data in a way that best works to address the research questions. A strength of choosing a multiple method approach is that the data can be collected at different stages of research (Bryman, 2008; Creswell, 2003). A staged design involving two separate phases was used in this project. Quantitative data was collected pre and post training, potentially aiming to generalise the results to a wider population and then qualitative data was collected via a focus group a month after the training. Each phase was designed to answer sub questions, seek convergence across qualitative and quantitative methods (Creswell, 2003; Jick, 1979) and will be triangulated to form a comprehensive whole (Morse, 2003). Phase two of the project will be reported in a separate paper.

This paper examines the results from phase one of the project. A pre and post repeated measures design was used to establish the impact CMT had on student CBP's. Quantitative data were collected at the start of a Post Graduate Diploma in CBP programme and at the end of training. Post training, participants were informed that they would be invited to attend a focus group to discuss the training.

Participants

A non-random convenience sample consisting of thirty-five participants undertaking a Post Graduate Diploma in CBP from a University in England (UK), agreed to take part in the research project. Twenty-one students, which consisted of nineteen female participants and two male completed the training. Nine of the thirty five participants agreed to be part of the control group, however, only three sets of pre and post questionnaires were completed. Two of the nine participants from the control group interrupted their studies to take a break before starting their second module, and four participants did not attend the final session where data were collected post training. Therefore participant numbers in the control group were too small to compare with the experimental condition as this would increase the risk of a type 1 error. A type 1 error occurs when the null hypothesis is rejected when it may be true.

Procedure

In order to train staff to facilitate the additions to the CBP programme, a three-day workshop was commissioned, evaluated and published (Beaumont, Irons, Rayner & Dagnall, 2016). In a sample (n=28) of healthcare providers and educators, Beaumont Irons, Rayner and Dagnall (2016) found an overall statistically significant increase in self-compassion scores and a reduction in self-judgement scores post CFT training. The researchers concluded that compassion training has potential to help healthcare practitioners develop greater self-care and emotional resilience.

All students commencing the first module on the Post Graduate Diploma in CBP were approached and asked if they would like to take part in this study. Students were advised that they could attend the additional sessions even if they decided not to take part in the research. Information sheets and consent forms were given to each student,

followed by a brief presentation and question and answer session. Participants were introduced to the CMT model and to the qualities and skills of compassion (Gilbert, 2009). Various compassion focused practical strategies were practised throughout the training (*see Table 1 for an outline of these*).

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

INSERT TABLE 1

Questionnaires

The Self-Compassion Scale (Neff, 2003b), Compassion-for-Others Scale (Pommier, 2011) and the Interpersonal Reactivity Index (Davis, 1980) were used to collect data.

Compassion-for-Others-Scale (Pommier, 2011)

The *Compassion-for-Others-Scale* contains 24-items and is subdivided into 6 subscales; kindness, indifference, common humanity, separation, mindfulness, and disengagement. To compute a total mean compassion score, the mean of each subscale is calculated after reverse scoring the negative items. Participants respond to items on a 1-5 scale (1 = almost never to 5 = almost always).

Self-Compassion-Scale-Long-Version (Neff, 2003b)

The *Self-Compassion-Scale-Long-Version* comprises of 26-items that measure how individuals respond toward themselves during difficult times. The scale consists of 6 subscales, self-kindness, self-judgement, mindfulness, common humanity, isolation, and over identification, with items scored on a scale (1 = almost never to 5 = almost always). López, et al. (2015) suggests that the scale measures two separate factors,

self-critical judgement and self-compassion. Self-compassion scores were therefore calculated by combining the data from the subscales self-kindness, common humanity and mindfulness and self-critical judgement scores were calculated by collating data from the subscales isolation, self-judgement and over-identification (López, et al., 2015).

The Interpersonal Reactivity Index (Davis, 1980)

The Interpersonal Reactivity Index is a 28 item questionnaire measuring dispositional empathy which provides separate scores for four distinct scales, fantasy (the tendency to strongly identify with a fictional character), perspective taking (the tendency to adopt the perspective of another), empathic concern (the responses of warmth, compassion and concern for others), and personal distress (experiencing feelings of discomfort and anxiety whilst witnessing the negative experiences of other people). Scoring for each subscale is achieved by adding together responses to the seven items making up the subscale (after first reverse-coding the negatively worded items). Scores range from 0 to 4 and each subscale produces a potential score of between 0 – 28. Internal reliability of the four subscales is found to be at satisfactory levels.

Results

Statistical analyses used SPSS 20 for Windows. Following participation in CMT, changes between pre and post scores were assessed using repeated measures paired sample t-tests. It was predicted that post training scores on the Self-Compassion Scale, Compassion For Others Scale and Interpersonal Reactivity Index would improve when compared to pre training scores. Mean and standard deviation scores are presented in *Table 2*.

INSERT TABLE 2

Self-Compassion Scale

Scores were calculated by analysing two separate factors, self-compassion and self-critical judgement. The self-compassion scores were calculated by collating data from the common humanity, self-compassion and mindfulness subscales. Self-critical judgement scores were calculated by collating data from the isolation, self-judgement and over-identification subscales.

Self-compassion

A significant difference was observed pre to post training *(M= 3.26, SD = 0.7 versus M = 3.61, SD = 0.8).* Results revealed a statistically significant increase in self-compassion (t(20) = -2.473, p =0.022) post training.

Self-critical judgement

A significant difference was observed pre to post training (*M= 3.34, SD = 0.9 versus M = 2.96, SD = 1).* Results revealed a statistical significant reduction in self-critical judgement (t(20) = -2.782, p =0.012) post training.

Compassion for Others

Post training, compassion for others scores were higher *(M = 4.10, SD = 0.4 versus M = 4.24, SD = 0.4)* than pre training scores. However, scores did not reach statistical significance (t(17) = -1.559, p =0.139)

Interpersonal Reactivity Index Scales

Pre and post training scores for empathic concern did not differ significantly although scores increased post training ($M = 17.4, SD = 3.8$ versus $M = 17.8, SD = 3.7$), (t(19) = -4.67, p =6.46). Pre and post training scores for the fantasy scale ($M = 14.1, SD = 4.2$ versus $M = 14.3, SD = 4.1$), (t(20) = -3.23, p =7.50) and pre to post training scores for perspective taking ($M = 18.3, SD = 3.6$ versus $M = 17, SD = 4.4$), (t(20) = 1.630, p =1.19) did not differ significantly. Pre and post training scores for personal distress did not differ significantly although scores did reduce post training ($M = 14.4, SD = 3.1$ versus $M = 12.9, SD = 2.6$), (t(20) = 1.552, p =1.37).

To conclude, CMT had favourable effects on SCS ratings. Self-compassion increased and self-critical judgement reduced post training. Compassion for others increased post training although scores did not reach statistical significance and the training had no statistical significant effect on the IRI subscales.

Discussion

This study looked at whether introducing CMT to student CBP's would increase participant's levels of self-compassion, compassion for others, improve empathic qualities and reduce levels of self-critical judgement.

This was only a short addition to the CBP programme where the students' main objective was to develop their skills as a student psychotherapist and pass the course. The results are interesting and feedback post training suggest that students found utilising compassionate mind interventions helpful. Students reported that the model was easy to understand and that they valued using creative methods to cultivate self-compassion. The data from this study suggests that students reported higher levels of self-compassion post training and reported a reduction in self-critical judgement post

training. Students were more aware of the commonality of suffering (that we are all in the same boat) and reported that they felt less isolated post training.

This study supports other research studies in demonstrating that compassion-focused interventions can instigate changes in levels of self-critical judgement and compassion (Barnard & Curry, 2011; Beaumont, Irons, Rayner & Dagnall, 2016; Boellinghaus et al., 2013). If curriculum designers can incorporate interventions into programmes that aim to increase compassion and reduce self-critical judgement, this may help students as they start their psychotherapy journey. Long-term this may improve student well-being, may protect students from the symptoms associated with empathic distress fatigue, secondary trauma, compassion fatigue, and burnout and may improve quality of care.

Students enrolled on counselling and psychotherapy training programmes can experience increased anxiety, self-evaluation and the pressure to succeed without making mistakes (Rønnestad & Skovholt, 2003). The findings from this study add to the growing literature that highlights the importance of cultivating strategies that promote well-being (Beaumont & Hollins Martin, 2016; Harris, 2007). Through the cultivation of self-compassion, students may start to view themselves with increased kindness. Such kindness may encourage openness and honesty during psychotherapy supervision (Liddle, 1986) and reduce the fear of supervisor negative appraisal. Additionally, incorporating CMT interventions into practitioner training could help students remember that failure and imperfection are part of the human experience (Neff & Vonk, 2009). This could help students manage their reaction to negative feedback from clients (Rønnestad & Skovholt, 2003). Neff and Vonk (2009) suggest that increased levels of self-compassion may reduce the need to defend one's ego making it easier for students to admit to mistakes and limitations.

An interesting finding was that dispositional empathy scores did not reach statistical significance. This could suggest that CMT may act as a regulatory factor for the emotional connection usually displayed during empathic engagement. According to Figley (1995) compassion fatigue occurs by virtue of an emotional contagion when expressing empathy towards clients. An alternative explanation could be that the absence of statistical significant results may be due the high scores reported at the pre intervention stage. Comparable results from the IRI questionnaire were reported in studies using mindfulness based interventions (Beddoe & Murphy, 2004; Birnie et al., 2010; Galantino et al., 2005), leaving the researchers to conclude that this may have been due to a ceiling effect of baseline empathy levels. Similarly, pre to post compassion for others scores did not reach statistical significance. However, scores were already high at the start of training, which would be expected for students wanting a career within the helping professions.

Limitations

This is the first study to examine whether CMT could impact on students' level of self-compassion, compassion for others and self-critical judgement. However, there are limitations to consider.

Although nine students volunteered to be part of a control group only three completed pre and post questionnaires were collected, which meant that we could not objectively compare groups. This is a limitation of the study because it makes it difficult to ascertain whether the CBT programme alone would help students develop compassion and reduce self-critical judgement. Participation was voluntary and therefore only students who engage in self-practice and self-reflection may have enrolled on the training.

Further research

The results in this study report on phase one of a multiple method research project. A second paper examining the data collected from a focus group post training is currently underway and suggests that students found immense benefit from CMT. Assessing the long-term benefits of CMT could also provide more fruitful data. For example, examining whether cultivating compassion whilst on clinical training thwarts symptoms of stress, empathic distress fatigue, compassion fatigue, and burnout may be illuminating. A second cohort of students are currently receiving CMT, and in this next stage of the project we hope to have further data to report.

Further research could examine the impact CMT has on student experiences of supervision. Given that non-disclosure for fear of judgement can have an impact on student well-being (Farber, 2006; Wallace & Alonso, 1994), the influence CMT has on disclosure within supervision could also be examined.

Implications

The findings suggest that CBP's students found benefit from CMT. The training appeared to help the students in this sample who were starting on a journey to become a psychotherapist, increase their levels of self-compassion and reduce self-critical judgement.

Summary and Conclusion

Given that CMT has been found useful for helping people experiencing high levels of self-criticism in clinical settings (Beaumont & Hollins Martin, 2015), and has been found useful in helping healthcare educators develop self-compassion (Beaumont, Irons, Rayner & Dagnall, 2016), a CMT teaching programme was designed to explore

whether CMT could help student CBP's develop compassion and empathy, and reduce self-critical judgement. This study provides some preliminary data regarding the impact of CMT on students' level of self-compassion and self-critical judgement. This is important given the difficulties that CBP's face within organisational and clinical settings. Teaching students wanting a career within counselling and psychotherapy techniques that help cultivate self-compassion may help students respond to their own distress with compassion, understanding, and kindness.

References

Barnard, L.K., & Curry, J.F. (2011). "Self-compassion: Conceptualizations, correlates, & interventions", *Review of general psychology*, Vol. 15, No. 4, pp. 289-303.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). "In pursuit of wellness: The self-care imperative", *Professional Psychology: Research and Practice,* Vol. 38, No. 6, pp. 603–612.

Beaumont, E. (2016). Building Resilience by Cultivating Compassion. *Healthcare Counselling and Psychotherapy Journal Vol. 16 (3) 22-27*

Beaumont, E., Galpin, A., & Jenkins, P. (2012). "Being kinder to myself: A prospective comparative study, exploring post-trauma therapy outcome measures, for two groups of clients, receiving either Cognitive Behaviour Therapy or Cognitive Behaviour Therapy and Compassionate Mind Training", *Counselling Psychology Review.* Vol. 27 No. 1, pp. 31-43

Beaumont, E., & Hollins Martin, C.J. (2013). "Using compassionate mind training as a resource in EMDR: A case study", *Journal of EMDR Practice and Research,* Vol. 7, No. 4, pp.186-199.

Beaumont, E., & Hollins Martin, C.J. (2015). "A narrative review exploring the effectiveness of Compassion-Focused Therapy," *Counselling Psychology Review.* Vol. 30, No. 1, pp. 21-32.

Beaumont, E., & Hollins Martin, C. (2016). A proposal to support student therapists to develop compassion for self and others through Compassionate Mind Training. *The Arts in Psychotherapy 50,* 111-118 http://dx.doi.org/10.1016/j.aip.2016.06.005

Beaumont, E., Durkin, M., Hollins-Martin, C.J. & Carson. J. (2016). "Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: A quantitative survey". *Counselling and Psychotherapy Research, 16*(1), pp.15-23.

Beaumont, E., Durkin, M., McAndrew, S., & Martin, C. (2016). Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service personnel suffering with trauma-related symptoms. *The Cognitive Behaviour Therapist,* vol. 9, e34, 1-13. doi:10.1017/S1754470X16000209

Beaumont, E., Irons, C., Rayner, G., & Dagnall, N. (2016). "Does Compassion Focused Therapy Training for Healthcare Educators and Providers increase self-compassion, and reduce self-persecution and self-criticism?", *The Journal of Continuing Education in the Health Professions, 36*(1), pp. 4-10.

Beddoe, A.E., & Murphy, S.O. (2004). "Does mindfulness decrease stress and foster empathy among nursing students?" *Journal of Nursing Education,* Vol 43, No 7, pp. 305–312.

Bell, T., Dixon, A., and Kolts, R. *(2016) Developing a Compassionate Internal Supervisor: Compassion-Focused Therapy for Trainee Therapists. Clin. Psychol. Psychother., doi: 10.1002/cpp.2031*.

Bennett-Levy, J., Thwaites, R., Haarhoff, B., & Perry, H. (2015). Experiencing CBT from the inside out: A self-practice/self-reflection workbook for therapists. New York: Guilford.

Birnie, K., Speca, M., & Carlson, L. E. (2010). "Exploring self-compassion and empathy in the context of mindfulness-based stress reduction (MBSR)".*Stress and Health*, Vol *26, No* 5, pp. 359-371.

Boellinghaus, I., Jones, F. W., & Hutton, J. (2013). "Cultivating self-care and compassion in psychological therapists in training: The experience of practicing loving-kindness meditation", *Training and Education in Professional Psychology*, Vol. 7, No. 4, pp. 267.

British Association of Behavioural and Cognitive Psychotherapy (BABCP) (2010). *Standards of Conduct, Performance and Ethics [Online]*. Available at: http://www.babcp.com/files/About/BABCP-Standards-of-Conduct-Performance-and-Ethics.pdf [accessed 15th March 2016].

Bryman, A. (2008)."Of methods and methodology", Qualitative Research in Organizations and Management: An International Journal, Vol. 3(2) pp. 159 – 168.
Creswell, John. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks: Sage.

Davis, M.H. (1980). "A multidimensional approach to individual differences in empathy", *Journal Supplement Abstract Service (JSAS) Catalog of Selected Documents in Psychology,* Vol. 10, pp. 1-18.

Davis, M.H. (1983) "Measuring individual differences in empathy: evidence for a multidimensional approach", *Journal of Personality and Social Psychology,* Vol. 44, No. 1, pp. 113-126.

De Stefano, J., Atkins, S., Noble, R. N., & Heath, N. (2012). "Am I competent enough to be doing this? A qualitative study of trainees' experiences working with clients who self-injure", *Counselling Psychology Quarterly*, Vol. 25, No. 3, 289-305.

Dorian, M., & Killebrew, J. E. (2014). "A study of mindfulness and self-care: a path to self-compassion for female therapists in training", *Women & Therapy*, Vol. 37, No. 1-2, pp.155-163.

Farber, B.A. (2006). *Self-disclosure in psychotherapy*. Guilford Press, London

Figley, C.R., (1995). *Compassion fatigue: Coping with Secondary Traumatic Stress Disorder In Those Who Treat the Traumatized.* Brunner/Mazel, New York.

Galantino, M.L., Baime, M., Maguire, M., Szapary, P.O., & Farrar, J.T. (2005). "Short communication: Association of psychological and physiological measures of stress in

health-care professionals during an 8-week mindfulness meditation program" Mindfulness in practice. *Stress and Health, Vol 21*, pp. 255–261.

Gilbert, P. (Ed.). (2005). Compassion: Conceptualizations, research and use in psychotherapy, Routledge, New York.

Gilbert, P. (2009). *The Compassionate Mind,* Constable & Robinson, London.

Gilbert, P. (2010). *Compassion Focused Therapy,* Routledge, London.

Gilbert, P. (2014). "The origins and nature of compassion focused therapy", *British Journal of Clinical Psychology*, Vol. 53, No. 1, pp. 6-41.

Gilbert, P., & Choden. (2013). *Mindful Compassion: Using the Power of Mindfulness and Compassion to Transform Our Lives*, Constable Robinson, London.

Gilbert, P., & Procter, S. (2006). "Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach", *Clinical Psychology & Psychotherapy*, Vol. 13, No. 6, pp. 353-379.

Harris, B. (2007). Supporting the Emotional Work of School Leaders. London: Sage.

Hick, S. F., & Bien, T. (2008). *Mindfulness and the therapeutic relationship*, Guilford Press, London.

Jacobsson, G., Lindgren, T., Hau, S. (2012). "Novice students' experiences of becoming psychotherapist", *Nordic Psychology*, Vol.64, No. 3, pp.192-202.

Jick, T., (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly*, *24*(December), 602-611.

Joinson, C. (1992). "Coping with compassion fatigue", *Nursing* Vol. 22, No. 4, pp.116–21.

Klimecki, O., & Singer, T. (2012). "Empathic distress fatigue rather than compassion fatigue? Integrating findings from empathy research in psychology and social neuroscience." In Oakley, B., Knafo, A., Madhavan, G. & Sloan Wilson & D. (Eds) In *Pathological Altruism,* Oxford University Press, New York, pp. 368–83

Liddle, B. J. (1986). "Resistance in supervision: A response to perceived threat", Counselor *Education and Supervision*, Vol. 26, No. 2, pp. 117-127.

López, A., Sanderman, R., Smink, A., Zhang, Y., van Sonderen, E., Ranchor, A., & Schroevers,M.J. (2015). "A reconsideration of the self-compassion scale's total score: self-compassion versus self-criticism" *PloS One*, Vol. 10, No. 7.

Mahoney, M. J. (2005). "Suffering, philosophy, and psychotherapy", *Journal of Psychotherapy Integration,* Vol. 15, No. 3, pp. 337–352.

Moore K. A. & Cooper C.L. *(*1996*) "*Stress in mental health professionals: a theoretical overview", *International Journal of Social Psychiatry* Vol. 42*,* No. 2*, pp.* 150–159*.*

Morse, J. M., (2003). Principles of mixed methods and multimethod research design. Handbook of mixed methods in social and behavioral research, pp.189-208.

Neff, K.D. (2003a) "Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself", *Self and Identity*, Vol. 2, No. 2, pp. 85-101.

Neff, K. D. (2003b). "The development and validation of a scale to measure self-compassion", *Self and Identity*, Vol. 2, No. 3, pp. 223–250.

Neff, K. D., & McGehee, P. (2010). "Self-compassion and psychological resilience among adolescents and young adults", *Self and Identity*, Vol. 9, No. 3, pp. 225–240.

Neff, K., & Vonk, R. (2009). "Self-compassion versus global self-esteem: Two different ways of relating to oneself", *Journal of Personality*, Vol. 77, No. 1, pp. 23–50.

Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). "Self-compassion and adaptive psychological functioning", *Journal of Research in Personality*, Vol. 41, No. 1, pp. 139–154.

Patsiopoulos.A. & Buchanan,M. (2011). "The Practice of Self-Compassion in Counselling: A Narrative Inquiry", *Professional Psychology: Research and Practice* Vol. 42, No. 4, pp. 301–307

Pommier, E.A., (2011). The compassion scale: dissertation abstracts international (Section A). Hum. Soc. Sci. 72, 1174

Reeves, A., Bowl, R., Wheeler, S. & Guthrie, E. (2004). 'The hardest words: exploring the dialogue of suicide in the counselling process a discourse analysis'. *Counselling and Psychotherapy Research Journal, 4*(1), 62–71.

Reeves, A., & Dryden, W. (2008). *Key Issues for Counselling in Action* (2nd edn). Los Angeles: Sage Publications.

Reeves, A. & Mintz, R. (2001). 'The experience of counsellors who work with suicidal clients: an exploratory study'. *Counselling and Psychotherapy Research Journal, 2,* 37–42.

Rønnestad, M. H., & Skovholt, T. M. (2003). "The journey of the counselor and therapist: Research findings and perspectives on professional development", Journal *of career development*, Vol. 30, No. 1, pp. 5-44.

Skovholt, T. M., & Trotter-Mathison, M. J. (2014). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*, Routlege, London.

Wallace, E., & Alonso, A. (1994). Privacy versus disclosure in psychotherapy supervision. In S.E. Greben & R. Ruskin (Eds.), *Clinical perspectives on psychotherapy supervision,* American Psychiatric Press, Washington, DC*,* pp. 211-230.

Wheeler, S., Bowl, R., & Reeves. A. (2004). Assessing risk: confrontation or avoidance—what is taught on counsellor training courses. *British Journal of Guidance & Counselling, 32*(2), 235-247.