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Beaumont, EA, Bell, T, McAndrew, SL and Fairhurst, HL

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The impact of compassionate mind training on qualified health professionals undertaking a compassion-focused therapy module

Elaine Beaumont¹  | Tobyn Bell²  | Sue McAndrew³ | Helen Fairhurst⁴

¹Psychotherapist and Lecturer in Counselling and Psychotherapy, University of Salford, School of Health and Society, Salford, UK

²Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK

³Mental Health and Nursing, University of Salford, School of Health and Society, Salford, UK

⁴Counselling and Psychotherapy, University of Salford, School of Health and Society, Salford, UK

Correspondence

Dr Elaine Beaumont, Psychotherapist and Lecturer in Counselling and Psychotherapy, School of Health and Society, University of Salford, Mary Seacole Building (MS3.17), Salford, M6 6PU.
Email: e.a.beaumont@salford.ac.uk

Abstract

Background: Compassion Focused Therapy (CFT) and Compassionate Mind Training (CMT) aim to help people cultivate compassion for self and others. To date, there is little evidence exploring the effects CMT has on those engaged in or embarking on a career in the helping professions. Interventions that encourage self-reflection and self-practice may help practitioners cultivate self-compassion, leading to the promotion of self-care.

Aim: To explore the impact CMT has on students' levels of self-compassion and self-criticism, and on their work as healthcare practitioners/counsellors/psychotherapists.

Methodology: This was a mixed-methods study ($N = 15$). Pre- and post-quantitative data were collected via three questionnaires: The Self-Compassion Scale-SF, the Forms of Self-Criticising/Self-Attacking and Self-Reassuring Scale and the Functions of Self-Criticising/Self-Attacking Scale. Qualitative data were collected via diaries and a focus group to portray the impact training had on students.

Findings: Results revealed a statistically significant increase in *self-compassion* post-training and a statistically significant increase in scores on the *reassured self* subscale. Statistically significant reductions in *self-correction* scores and *inadequate self* scores were observed post-training. There was no statistical significant difference post-training on the *hated self* or *self-persecution* subscales. Themes identified from the weekly diaries included the following: the benefits of compassion; when compassion arises; and difficulties and opportunities. Themes identified by the focus group data included the following: self-reflection and self-practice; finding balance; and critical self and compassionate self.

Implications: Incorporating interventions into education programmes that help student's foster compassion may help them cultivate a compassionate mindset and learn to be kinder to self.

KEYWORDS

Compassionate Mind Training, Compassion Focused Therapy, Mixed Methods Research, Self-reflection, Self-reflection and Self-practice

[Corrections added on 7 April 2021, after first online publication: Abstract and Keywords have been added, and section headers 13 to 21 have been updated in this version.]

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1 | INTRODUCTION

This paper reports on a study exploring the impact of compassionate mind training [CMT] on 15 qualified health professionals, counsellors, psychotherapists, a psychological well-being practitioner and a registered mental health practitioner, enrolled on a compassion-focused therapy [CFT] module. For the purpose of this paper, those undertaking the course are referred to as 'students', as CFT and CMT were new to all those enrolled on the module.

1.1 | Compassion-focused therapy and compassionate mind therapy

Compassion-focused therapy [CFT] is a therapeutic approach aimed at helping people cultivate compassion for self and others (Gilbert, 2009). CFT enables people to respond to self-criticism and shame with compassion by using a self-supportive inner voice (Gilbert, 2010). CFT is a psychotherapy, having roots in attachment theory (Bowlby, 1973), affective neuroscience and evolutionary psychology (Gilbert, 2000, 2014, 2020). Compassionate mind training (CMT) and CFT examine how, as a result of evolution, we have 'tricky brains' that often get caught up in thinking-feeling loops and three emotional systems (threat, drive and soothing) that serve different functions (Gilbert, 2009). CMT is an integral part of CFT and uses physiological, psychological, contemplative, imaginal and body-based practices. These include attention and mindfulness training, soothing rhythm breathing, memory exercises and compassion-based imagery, all of which are used to help people cultivate compassion (Gilbert, 2009, 2010). These practices have been found to activate the parasympathetic nervous system (Kirby et al., 2017), increase levels of self-compassion and positive emotions, and reduce self-criticism, shame and psychological distress (Matos et al., 2017; McEwan & Gilbert, 2016).

1.2 | The demands of working in the helping professions

The demands of working with people with psychological problems can be challenging, with burnout being prevalent among psychotherapists (Yang & Hayes, 2020). Burnout is a common problem for professionals working in the mental health arena, with service providers reporting between 21% and 67% of staff experiencing burnout (Foster et al., 2018). Whilst helping those who experience distress can be rewarding, it also has the potential to emotionally challenge and overwhelm those providing care, and may lead to personal distress (Singer & Klimecki, 2014). As a result of such challenges, those working in the helping professions may question their ability to undertake therapeutic work, experience fear or anxiety, judge themselves harshly if they believe they have failed their client, and/or feel incompetent (Beaumont et al. 2016; Wheeler et al., 2004).

Self-criticism tends to be activated when people believe they have failed in completing an important task or if they have made a mistake. Self-criticism often encompasses self-blame and self-attack. Self-criticism, including self-blame and self-attack, arises in various forms and may have a multitude of functions: efforts to improve oneself, to keep up standards, and to try and prevent mistakes; or as a result of self-hatred or wanting to harm aspects of the self (Gilbert et al., 2004). In a study undertaken by Beaumont et al. (2016), using a sample ($n = 54$) of student cognitive behavioural therapists and counsellors, high levels of self-criticism were correlated with symptoms of burnout, compassion fatigue and reduced psychological well-being. Conversely, high levels of self-compassion were correlated with lower levels of compassion fatigue and burnout.

To date, there is little research exploring the effects CMT has on those engaged in, or embarking on, a career in the helping professions (Bell et al., 2016). Maratos et al. (2019) evaluated a CMT intervention using a sample of school teachers and support staff. The results showed that training was well received, staff found CMT helpful for dealing with emotional problems and there were significant increases in self-compassion and decreases in self-criticism post-training. Bell et al. (2016) adapted the CMT 'perfect nurturer' exercise in a sample of trainee therapists. In this preliminary study, trainees were encouraged to create a 'compassionate internal supervisor' to support self-reflection, self-care and regulation. The training provided participants with a deeper understanding of the nature of compassion and its potential to support them in their practice and personal lives. In a group of healthcare educators and providers ($n = 28$), Beaumont et al. (2016) found levels of self-compassion increased and levels of self-critical judgement, self-persecution and self-attack reduced following a three-day CPD event focusing on CMT. There was no statistically significant reduction in self-persecution or self-correction scores post-training, the latter being unsurprising given it was only a three-day training course.

Self-care is an ethical imperative for psychological practitioners and a critical element in preventing harm to clients (Barnett et al., 2007). Rimes and Wingrove (2011) argue that educators should incorporate interventions such as mindfulness and loving-kindness meditations into clinical training programmes to help practitioners become mindful of their own well-being. However, Christopher et al. (2006) suggest, due to the demands of professional training, self-care is often presented as a concept that is the practitioner's own responsibility. Techniques and interventions that encourage self-reflection and self-practice can help practitioners cultivate self-compassion, leading to the promotion of self-care, with the potential to build resilience (Bennett-Levy & Lee, 2014; Kolts et al., 2018). Working with students to help them respond with compassion to the demands of training may engender resilience. Beaumont et al. (2017), in a sample ($n = 28$) of student psychotherapists who volunteered to attend 15 hours of CMT, found a statistically significant increase in self-compassion and reduction in self-critical judgement post-training. Boellinghaus et al. (2013) suggest that self-care strategies include the following: building self-awareness, regulating difficult emotions and having the ability to balance one's own needs with others. The researchers explored the effectiveness of

interventions that involved mindfulness and 'loving-kindness' meditations (a form of compassionate and affiliative focusing) in a sample of student therapists. They found the training increased self-awareness and levels of compassion, with participants reporting that it helped them integrate compassion work into their clinical practice. This evidence reinforces the need for practitioners to develop self-care strategies, which are characterised in this paper as developing the ability to cultivate self-compassion.

Self-compassionate individuals feel confident in accepting new challenges, are more likely to modify unproductive behaviours and acknowledge mistakes (Neff, 2009). As such, cultivating a compassionate mind could help practitioners gain more from counselling and psychotherapy training programmes. Orkibi (2012) proposes that self-care can be enhanced through the use of creative interventions and that such strategies may help enhance well-being. CMT includes creative interventions such as compassionate letter writing, imagery, mindfulness and method acting, which may encourage self-care, self-reflection and self-practice and help cultivate self-compassion.

1.3 | Compassionate pedagogy

Lecturers who teach students engaged in the helping professions often face idiosyncratic difficulties (Beaumont & Hollins Martin, 2016). For example, in addition to having a role as educator, lecturers are also gatekeepers for the profession (Edwards, 2013), aiming to provide high quality of care to students at the same time as being mindful of ethical obligations to the counselling and psychotherapy profession. Introducing exercises into training programmes that help students cultivate compassion may help them become more effective therapists.

Compassionate pedagogy may help create a secure base for students and help them feel safe enough to share and reflect on their learning journey (Goldstein, 1999). Compassionate pedagogy is based on kindness being a central feature of teaching and interacting with students and colleagues, followed by actions that promote acceptance and well-being (Waddington, 2018). In attachment theory, a secure base is achieved when there is attunement to physiological and emotional needs and is a base that can be returned to in times of need (Bowlby & Base, 1988). The ability to experience and accept kindness is dependent on having a secure base, as well as mindful acceptance of life's difficulties being part of human experience (Neff, 2003). As educators, encouraging students to consider how they would behave, hear, work with and respond to themselves and others when at their compassionate best could help to alleviate their doubts and self-criticism. The following sections outline the psycho-educational elements used in both CMT and CFT that were incorporated into the training.

1.4 | Gilbert's (2009) three-systems model of emotion

CFT and CMT aim to bring balance to three emotional systems: the *threat*, *drive* and *soothing* systems. The three-systems model (See



FIGURE 1 The three-system model of emotion. Reproduced with permission from Gilbert (2009)

Figure 1) organises emotions by their evolved function. The threat system alerts and directs attention to things that are threatening (Gilbert, 2014). It is motivated to protect and responds to threat by triggering physiological changes in the body and brain in preparation for taking action. The stress response activates the sympathetic nervous system and hypothalamic–pituitary–adrenal axis, which prepares the body for danger. The drive system is activated when joy and/or excitement are experienced. Its function is to energise and to pursue resources that are advantageous: food, social status, relationships and sexual partners (Irons & Beaumont, 2017). When the drive system is activated, positive emotions are experienced, reinforcing behaviour that led to this state of being. Both the threat and drive systems are essential for survival and reproduction. However, if constantly pursued, these systems could lead to exhaustion. Being able to rest, slow down and recuperate is essential, and the soothing system helps to introduce balance to the three systems. The soothing system is linked to the parasympathetic nervous system and plays an important role in calming and regulating the other two systems.

Gilbert (2010, 2014) suggests that the mind can easily get caught up in thinking–feeling loops. These loops can cause distress and are often viewed as glitches in the brain. Thinking–feeling loops are associated with reactions from the 'old' and 'new' brain (Gilbert, 2010, 2020). The 'old brain' is the product of millions of years of evolution, navigating threats faced by human beings and motivating people in pursuing resources that are beneficial for survival. The 'new brain' is more sophisticated and complex, and is linked to the prefrontal cortex. The 'new brain' provides the ability to imagine, consider and plan, think about thinking, and reflect, ruminate and worry (Gilbert, 2009, 2014). External threats (our concerns about how others may think, feel or treat us) and internal threats (our concerns about things that arise inside of us) can activate thinking–feeling loops. For example, thinking 'I'm not good enough' (internal threat) or 'my boss doesn't think I'm good enough' (external threat) can activate old brain emotions such as anxiety and anger (Irons & Beaumont, 2017). Students who believe they are not good enough, are self-critical or

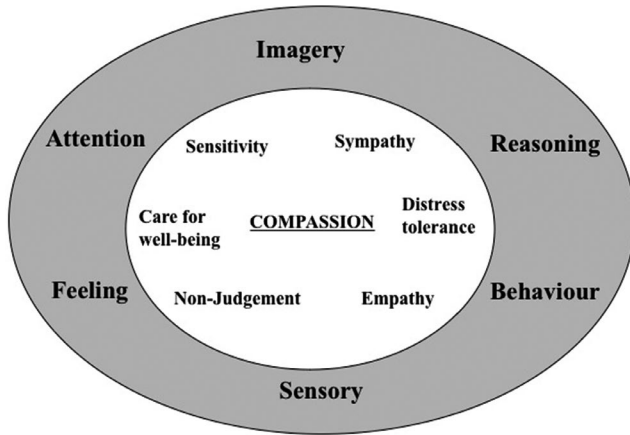


FIGURE 2 The key attributes of compassion and skills of compassion. Reproduced with permission from Gilbert (2009)

compare themselves unfavourably with others often get caught up in thinking–feeling loops associated with the ‘old and new brain’.

1.5 | Qualities of compassion

Gilbert (2009) suggests there are six core qualities of compassion: sensitivity, sympathy, distress tolerance, empathy, being non-judgemental and demonstrating care for well-being. The six attributes enable engagement with, and acknowledgement of, distress and suffering. Gilbert uses the term ‘*first psychology of compassion*’ to refer to these qualities. The ‘*second psychology of compassion*’ refers to the commitment and desire to acquire and apply these skills (Gilbert, 2010). Figure 2 shows both psychologies of compassion—the outer circle shows the six key areas of skills training. Both CMT and CFT aim to develop these attributes and skills using exercises that are described below.

The philosophical underpinnings, concepts of the model, core qualities of compassion, need for self-compassion, nature of the evolved human mind and thinking–feeling loops were all explored within the CFT module. In addition to the above, students were also required to engage in a variety of experiential exercises.

2 | THE PROJECT

2.1 | Aim and objectives

The aim of the project was to explore and examine the impact CMT had on students’ levels of self-compassion and self-criticism, and on their work as healthcare practitioners/counsellors/psychotherapists. The objectives of the project were as follows:

- To evaluate the impact that self-reflection and self-practice had on students enrolled on the module

- To explore whether the training helped provide the students with self-care strategies to manage organisational, placement and academic demands
- To examine whether the training improved levels of self-compassion
- To examine the forms and functions of students’ self-criticism and the impact cultivating compassion had on their levels of self-criticism

It was predicted that post-training scores on the Self-Compassion Scale, the Forms of Self-Criticising/Self-Attacking and Self-Reassuring Scale and the Functions of Self-Criticising/Self-Attacking Scale would improve when compared to pre-training scores.

3 | METHOD

This was a mixed-methods study, using both qualitative and quantitative data collection methods (McLeod, 2011). Mixed-methods research is often considered the ‘third paradigm’, emphasising the integration of data as a key process (Teddlie & Tashakkori, 2011). Mixed methods provide opportunity to triangulate data, ensuring the complexity of the study topic is appropriately reflected in the findings (O’Cathain et al., 2007). In this study, quantitative objective data were integrated with in-depth qualitative data to accurately portray the impact CMT had on students’ self-compassion and self-criticism, and on their client work.

3.1 | Training programme overview

The CFT 12-week module (which ran over a four-month period due to the Easter break) could be taken as part of a Master of Science (MSc) in Cognitive Behaviour Therapy and an MSc in Advanced Counselling and Psychotherapy, or as a stand-alone module. The module incorporates experiential exercises as a means to develop the therapeutic skills necessary to practise CFT and CMT. It was anticipated that acquiring these skills would help students develop empathy for themselves and acceptance of their distress, making them better placed to help others. Introducing the new module and providing opportunity for self-reflection enabled students to examine the impact such interventions had on their levels of self-compassion and self-criticism, and on their work as healthcare practitioners/counsellors/psychotherapists.

In addition to learning about the philosophical underpinnings of the *three-systems model*, thinking–feeling loops and the first and second psychology of compassion, students also explored the concept of compassion as a 3-way flow (Gilbert, 2010, 2014):

- Compassion for others (*compassion flowing out*)
- Compassion from others (*compassion flowing in*)
- Self-compassion (*self-to-self compassion*)

Part of developing compassion involves the individual being sensitive to their own distress and engaging with it in a non-judgemental way. During the module, students learnt the following:

- Breathing exercises for parasympathetic activation (e.g., soothing rhythm breathing)
- Attention and mindfulness training (e.g., mindfulness of sound and body, mindful walking and eating)
- To focus on different memories (e.g., remembering times when they have been in receipt of compassion or showed compassion for another), and demonstrate how memories can be used in clinical work
- Imagery interventions (e.g., creating a calm, soothing place in the mind)
- To develop a compassionate self by using method acting techniques (e.g., using the mind, body posture, voice tones and facial expression to cultivate compassion)
- To create an ideal compassionate other
- Skills of compassionate engagement
- Compassionate letter writing
- To work with their multiple selves and apply compassion to various threat-based emotions (anxiety, sadness and anger)
- To bring compassion to self-criticism
- How to manage fears, blocks and resistances to compassion

3.2 | Recruitment strategy and ethical implications

Ethics approval was gained via the University of Salford postgraduate and staff ethics panel (HSCR13-62).

Prior to starting the module, all students enrolled on the course were sent a participant information sheet, outlining the research and providing contact details of the lead researcher who would answer any questions they had regarding the study. At the first session, the group were given the opportunity to ask further questions. They were also reminded that participating in the study was voluntary and there would be no negative repercussions should they not wish to take part. If they were willing to participate, they were asked to complete a consent form. All data were kept in accordance with General Data Protection Regulations (GDPR; Data Protection Act, 2018). Participants were reassured that care would be taken to maintain their anonymity throughout the project. Regarding the focus group, names were not used during the group discussion and identifying information was removed from transcripts. Within the consent form, all participants signed to say they would keep the focus group discussion confidential.

3.3 | Participants

Participants were students undertaking the 'compassion-focused therapy' module. All participants work in the healthcare profession ($n = 13$ qualified counsellors/psychotherapists, $n = 1$ psychological

well-being practitioner and $n = 1$ registered mental health practitioner). The number of students undertaking the module was 16, with 15 ($n = 8$ male and $n = 7$ female) consenting to take part in the study. Of these, 11 participants fully completed pre- and post-test pairs of questionnaires. Thirteen participants were from the UK, one participant was from the USA, and one was from Finland. Their age range was between 24 and 49 years, and all participants completed the module as a group. The first author was the module leader, with the second and fourth authors having sessional input. The third author facilitated the focus group, but had no input on the module.

4 | DATA COLLECTION AND ANALYSIS

4.1 | Quantitative data

A repeated-measures design was used consisting of three separate questionnaires: Self-Compassion Scale (Neff, 2003), and the Forms and Functions of Self-Criticising/Self-Attacking Scales (Gilbert et al., 2004), the latter consisting of two separate scales. Questionnaires were completed before and after the CFT module to obtain objective data. Scores were collated using a Likert scale.

4.2 | The self-compassion scale-SF

This is a 12-item questionnaire exploring self-compassion (Neff, 2003). The scores are obtained by calculating the mean score for the responses on the questionnaire. This gives a total self-compassion mean score. A mean score of between 1 and 2.5 indicates low self-compassion; between 2.5 and 3.5 indicates moderate self-compassion; 3.5 or above indicates high self-compassion (Neff, 2003).

4.3 | The forms of self-criticising/self-attacking and self-reassuring scale (FSCRS) and the functions of self-criticising/self-attacking scale (FSCS)

These two separate questionnaires measure the *forms* and *functions* of self-criticism and whether individuals engage in self-reassurance (Gilbert et al., 2004). Factor analysis suggests two very different functions for being self-critical. One is to try and improve the self and stop the self from making mistakes, and the other involves expressing hatred and wanting to harm the self.

The 'form' questionnaire is a 22-item scale, developed to measure people's critical and self-reassuring self-evaluative responses to setbacks or disappointments. The 'functions' scale has 21 items measuring why people get critical and angry. For example, some people criticise because they think it helps them keep up standards or show they care about their mistakes. The responses on both questionnaires are given on a 5-point Likert scale (ranging from 0 = not at all like me, to 5 = extremely like me), with Cronbach's alpha being set at 0.92 for correcting and persecuting, respectively.

All three questionnaires are reliable measuring tools, with good test-retest reliability and good internal consistency and validity.

4.4 | Quantitative analysis

A within-subjects *t* test (paired-samples *t* test) was used, as it enables comparisons with a continuous dependent variable (Field, 2005) where pre- and post-data are collected using the same participants.

4.5 | Qualitative analysis

As part of the module, all students were asked to complete practice diaries to monitor their ability to reflect and to prompt use of the interventions taught on the module in their clinical practice. Two free-text, open-ended questions were included within participants' weekly practice diary. The first question asked: 'how often did you practice the exercises during this week?' The second asked: 'in which situations did you find yourself acting or feeling your compassionate self?' Those who agreed to participate in the study were asked to submit their diaries for analysis at the end of the module. The hand-written diary entries were collated and analysed according to Braun and Clarke's (2006) six-stage process. An initial inductive coding of the data generated a set of subthemes that were organised and developed into themes. A final written report of each theme was produced, supported by direct extracts from data in the diaries.

Participants were also invited to take part in a focus group at the end of the module, facilitated by a member of staff not known to them. Eight out of fifteen students participated in this aspect of the project. The purpose of the focus group was to explore the impact CMT had on the students at a personal level and on their current practice. The focus group discussion lasted for 50 min and was audio-recorded. The recording of the session was transcribed verbatim to capture each participant's voice and perspective of the training. The focus group data were also analysed using Braun and Clarke's (2006) thematic analysis by a member of the research team.

All analysed qualitative data were looked at by the research team to explore convergence and divergence. A reflective diary was kept by the second author (who completed the diary analysis), and the data set was independently audited. Authors 1 and 4 initially analysed the focus group data independently and then came together with author 3 to discuss their individual findings and agree on the final themes. Both sets of data, qualitative and quantitative, were considered by the research team in terms of triangulation.

5 | RESULTS

5.1 | Quantitative Results—Analysis of the Questionnaires

Following participation in the training, changes between pre- and post-scores were assessed using repeated-measures

paired-samples *t* tests. It was predicted that post-training scores on the Self-Compassion Scale, the Forms of Self-Criticising/Self-Attacking and Self-Reassuring Scale and the Functions of Self-Criticising/Self-Attacking Scale would improve when compared to pre-training scores. Mean and standard deviation scores are presented in Table 1.

6 | SELF-COMPASSION SCALE

A significant difference was observed pre- to post-training ($M = 2.8$, $SD = 0.8$ versus $M = 3.5$, $SD = 0.4$). Results reveal a statistically significant increase in self-compassion ($t(11) = -3.125$, $p = .01$) post-training.

7 | FSCS INDICATES FUNCTIONS OF SELF-CRITICISING/SELF-ATTACKING SCALE

7.1 | Self-Persecution

Although scores reduced post-training ($M = 7.4$, $SD = 8.6$ versus $M = 3.9$, $SD = 2.9$), no statistically significant difference was observed ($t(11) = 1.303$, $p = .11$) post-training.

7.2 | Self-Correction

A significant difference was observed pre- to post-training ($M = 21.3$, $SD = 11.2$ versus $M = 11.2$, $SD = 6.6$). Results reveal a statistically significant reduction in self-correction ($t(11) = 2.983$, $p = .01$) post-training.

TABLE 1 Pre and post-mean and standard deviation scores on the Self-Compassion Scale, Forms of Self-Criticising/Self-Attacking and Self-Reassuring Scale and the Functions of Self-Criticising and Self-Attacking Scale

	CFT module training, $n = 10$	
	Pre M (SD)	Post M (SD)
SCS		
Self-compassion	2.8 (0.8)	3.5 (0.4)
FSCS		
Self-persecution	7.4 (8.6)	3.9 (2.9)
Self-correction	21.3 (11.2)	11.2 (6.6)
FSCRS		
Inadequate self	19.3 (8.8)	13.1 (4.7)
Reassure self	14.2 (7.2)	19.8 (4.7)
Hated self	4.8 (4.5)	2.5 (1.9)

Abbreviations: SCS indicates Self-Compassion Scale, FSCS indicates Functions of Self-Criticising/Self-Attacking Scale, FSCRS indicates Forms of Self-Criticising/Self-Attacking and Self-Reassuring Scale.

8 | FSCRS INDICATES FORMS OF SELF-CRITICISING/SELF-ATTACKING AND SELF-REASSURING SCALE

8.1 | Inadequate self

A significant difference was observed pre- to post-training ($M = 19.3$, $SD = 8.8$ versus $M = 13.1$, $SD = 4.7$). Results reveal a statistically significant reduction in inadequate self scores ($t(11) = -2.040$, $p = .05$) post-training.

8.2 | Reassure self

A significant difference was observed pre- to post-training ($M = 14.2$, $SD = 7.2$ versus $M = 19.8$, $SD = 4.7$). Results reveal a statistically significant increase ($t(11) = -2.187$, $p = .05$) post-training.

8.3 | Hated self

Although scores reduced post-training ($M = 4.8$, $SD = 4.5$ versus $M = 2.5$, $SD = 1.9$), no statistically significant difference was observed ($t(11) = -1.636$, $p = .07$) post-training.

9 | QUALITATIVE RESULTS—ANALYSIS OF STUDENT DIARIES

The analysis of the qualitative data produced three interacting themes (see table 2).

10 | THEME 1. THE BENEFITS OF COMPASSION

This theme encompassed three subthemes: *soothing and stepping back*; *self-criticism to self-compassionate speech*; and *increasing drive and approach behaviour*.

TABLE 2 Themes identified from the weekly diaries

Themes
1. The benefits of compassion <ul style="list-style-type: none"> a) Soothing and stepping back b) From self-criticism to self-compassionate speech c) Increasing drive
2. When compassion arises <ul style="list-style-type: none"> a) At times of personal difficulty b) At times of connection and contentment c) When caring for others
3. Difficulties and opportunities <ul style="list-style-type: none"> a) Fears and practical blocks b) Difficulties as opportunities

10.1 | Soothing and stepping back

Participants highlighted the role of compassion in physically soothing and regulating distressing emotion. This was frequently framed as a process of 'slowing down' and 'grounding' and was often achieved and experienced via physical means: the 'slowing of breath', the 'softening of facial expressions' and the 'altering of posture'. Such soothing was experienced not only as an absence of physical distress, but also as the presence of positive feelings, described as 'gentle' and 'calm', or as a form of 'softening and tenderness'. This capacity to 'sooth' was identified as an important factor in tolerating difficult emotions, particularly in enabling 'stepping back' and making 'space'. One participant described how stepping back helped her reflect and engage with her compassionate self:

'Familiar patterns emerged and I was able to step back and engage with my compassionate self to self sooth'.

Another participant wrote:

'I felt a sense of softening and tenderness towards myself'.

One diarist wrote:

'When I was under the most stress I managed to be a friend to self...I had this friend by my side that felt very supportive'.

The physical soothing and psychological distancing were mutually supportive, allowing for a more measured and considered way of engaging with both personal and client problems.

10.2 | Self-criticism to self-compassionate speech

Another subtheme was the shift from self-criticism to self-compassion, which was most evident in changes to participants' internal self-talk. Such changes were notable not only for their shifts in perspective and reasoning, but also in their 'intention' and the associated emotions aimed at the self (from anger attacks to kindness and care). One diarist stated:

'I've found more inner warmth towards my personal struggle'.

Another wrote:

'In a difficult situation at work I began to criticize myself and became aware of this...I then put my hand over my heart and gave myself self-compassion'.

Participants highlighted they had been more aware of their self-criticism, and also more aware of their capacity to change their self-talk to one of helpfulness and self-compassion.

10.3 | Increasing drive and approach behaviour

Whilst participants reported compassion was helpful in 'slowing down', others reported compassion helped them to increase their energy and motivation; one participant used the term '*compassionate drive*'. Participants explained how compassion allowed for a positive re-focusing and re-activation of motivation when experiencing obstacles and disappointment. One participant wrote:

'My passionate self accepted this without frustration, it accelerated my drive.'

The role of self-encouragement and self-support appeared important in helping participants approach previously avoided tasks or behaviours. For example, participants recorded that they were able to be assertive with others and/or they could verbalise personal boundaries in ways that they found surprising and novel.

11 | THEME 2. WHEN COMPASSION ARISES

This theme had three subthemes: *at times of personal difficulty*; *at times of connection and contentment*; and *when caring for others*.

11.1 | At times of personal difficulty

Participants particularly identified with their compassionate self and the presence of this during times of personal difficulty. The experience of interpersonal conflict, upsetting emotions, stressful tasks and feelings of vulnerability provided the opportunity for compassion to be identified or applied and valued. One participant noted in her diary:

'Lost half my assignment. Instead of giving up or becoming angry, I took time away from the computer to look after myself and realising it wasn't my fault.'

Another wrote:

'During times when I felt self-critical or angry at myself, I used self-compassion to self soothe and reassess situations.'

Compassion was found to be particularly present and useful with anxiety related to university tasks, personal loss and grief, and during clinical work with clients (see subtheme 'caring for others').

11.2 | At times of connection and contentment

Compassion was also associated with experiences of contentment, relaxation and happiness. Such feelings and associations often

occurred when participants felt connected to specific places or in an interpersonal context with relatives and friends. Other participants associated compassion with specific sensory experiences, such as music with a soothing quality. One participant noted:

'[Contentment] When in the company with someone who makes me happy. Had compassionate moments listening to the ambient relaxation playlist.'

11.3 | When caring for others

Compassion was predominantly reported and identified when caring for others. The instances of care ranged from buying a relative a present to showing empathy to a friend. Compassion was particularly associated with caring for clients, being more focused and attentive, and feeling more '*present and connected*'. Participants identified their increased capacity for self-compassion and '*grounding*', allowing them to be more mindful and open to the distress of the client:

'Working with clients who had suffered very recent suicide of friend, being aware, kind, sitting in the despair, working with the immediacy of loss.'

When reflecting on a situation where they felt at their 'best compassionate self', one diarist wrote: '*When I was looking out for others*'.

12 | THEME 3. DIFFICULTIES AND OPPORTUNITIES

Two subthemes were identified within Theme 3: *fears and practical blocks* and *difficulties as opportunities*.

12.1 | Fears and practical blocks

Despite the benefits gained from the compassionate mind exercises, three participants identified obstacles and difficulties to self-practice. These predominantly related to practical frustrations such as not finding time to practise or remembering to practise, but other participants noted benefits from the exercises '*only helped a bit*' or '*didn't last long*'.

One diarist wrote:

'I had too much to focus on this week. I had a stressful week so only practiced a little.'

Another one reflected:

'Such a busy time and ironically more of the practices (compassionate mind exercises) would have helped yet I did a bit less than normal.'

12.2 | Difficulties as opportunities

The presence of such difficulties became a source of, and subject for, self-compassion. Participants were able to work with their fears and blocks, using the formal exercises with patience and understanding, paradoxically generating the kind of qualities that were being targeted in the exercises. One participant noted:

'Meditation practice has dropped a little for some reason and I don't feel guilty as I am being kinder to myself that I need to prioritise other things'.

13 | QUALITATIVE RESULTS - ANALYSIS OF THE FOCUS GROUP

The analysis of the focus group data produced three inter-related themes (see Table 3).

14 | THEME 1. SELF-REFLECTION AND SELF-PRACTICE

14.1 | Juggling demands

Participants reflected on how they were mindful of other commitments and self-care whilst studying. Issues around juggling academic and placement demands and clinical work were discussed. Participants reported different emotional experiences ranging from an awareness of 'self-protection' to 'self-reflection'. One participant described the need to 'hold back' from the experiential aspects of the course as a form of 'self-protection' because they needed to see clients after class:

'I found that difficult [self-practice] erm... to experience and then going to have to deal with my life. I had to go from here to work... so I kind of needed processing time. So, that led me to... hold back as a protection I guess for myself... like a self-care I suppose for me'.

TABLE 3 Themes identified via the focus group

Themes
1. Self-reflection and self-practice
a) Juggling demands
b) Collaboration and creative integration
c) Reassurance
2. Finding Balance
a) The drive system, motivation and interaction
b) Fears, blocks and resistances
3. Critical self and compassionate self
a) Compassion is an investment and a different way of being

[Corrections added on 7 April 2021, after first online publication: Theme 3 in Table 3 has been updated in this version.]

Another participant reflected on how she was mindful of cultivating compassion for her own struggles:

'It [Self-compassion] helped me not to be so self-critical... being ok with it [emotion]...it's been a relief to remind myself that's its OK to not be OK'.

Time pressures were discussed, with one participant travelling a distance for a three-hour class. Travelling a long distance to study when you also work full-time can add extra pressure on students. This participant stated:

'I think what I'd have preferred is to kind of have it as a block like a full day, like once a month rather than 3 hours every week so I could dedicate not just the time, but my emotional self to it, rather than just it being a snap shot in the middle of my week'.

Trying to find a placement and client work can be difficult and stressful for students, but it can be an opportunity for reflection. One participant shared her reflection:

'I'm not working with a client at the moment, so it has been solely based on my experience, self-reflection and things. So it's kind of helped me to take a step back and really appreciate what is going on around me instead of having tunnel vision. Personally for me I think the self-reflection at home helped'.

14.2 | Collaboration and creative integration

Participants voiced their own experience of how they integrated compassionate mind interventions into their clinical work and collaborated with their clients. Participants suggested the module had provided extra tools in their 'psychotherapy tool kit'. This helped one participant build confidence, as they felt able to tailor therapy to meet their client's needs:

'Tailoring the exercises to the client. I've used it with the strength that the client has brought, so creatively...I use the compassionate first aid kit...it's been a more collaborative thing I guess'.

14.3 | Reassurance

Participants expressed a need for reassurance from self, the compassionate mind model, and from others, needing to know that they were integrating the model into their practice appropriately. One participant stated:

'I'm doing a lot of processing and reflecting and I'm needing a lot of reassurance'.

Participants reported that they were reassured by the principles, theory and scientific evidence that underpin the CFT model:

'There was a lot of reassurance from this, working with mindfulness and compassion-based approaches because of the research sources and the science. So, yeh, I feel very reassured, and also want to utilise even more these ways of working and like one of our colleagues was saying I wish to delve deeper into this work'.

Another participant stated:

'Some of the techniques we have learnt have been incredibly useful and the formulations that were required kind of formalise the sort of theory behind what we've learned as well'.

Throughout the module, students were encouraged to learn about the model from the 'inside out'. One participant felt reassured and acknowledged the importance of self-practice to re-enforce what they had learned:

'It's about re-enforcement and re-enforcement and practise and reinforcement...to build up that sense of self confidence and some kind of muscle memory'.

15 | THEME 2. FINDING BALANCE

15.1 | The drive system, motivation and interaction

Participants drive systems were activated during the module. One participant spoke of:

'Looking into our own drive systems and taking this forward... it does feel like a springboard... like being on a fantastic journey. Thank you to the lectures sharing their knowledge and experience'.

Participants reported a desire to connect with the model and were motivated to interact with the module team. Words such as 'precious', 'inspiration' and 'strengths' were used. One participant talked about:

'A different skill set that they brought...modelling different ways of being...I had a need and a thirst to learn more...my interest peaked so I want to do more now'.

Another participant responded by saying:

'All that for me and... a lot of inspiration, enthusiasm from lecturers, the science...this is a useful path to be exploring'.

15.2 | Fears, Blocks and Resistances

Two participants reported that they initially struggled with what they perceived as the clinical nature of some aspects of the CFT model. This may have been compounded by the module being delivered in a traditional classroom setting. Some students who had undertaken a counselling course were used to sitting in a circle. One participant suggested:

'We've been behind our little walls here haven't we... with our back to each other...clinical tables and clinical slides...none of us have said it the whole time'.

Some participants recognised that they had built up an initial resistance to learning about the model, linking the model to CBT and struggling with some of the terminology used:

'The terminology...trying to get your head around that was quite difficult at first, it felt...I guess a lot of stuff has come from the CBT angle or it's had a real flavour of that for me, I suppose, coming from a humanistic point of view'.

One participant reflected how they initially viewed it as a threat-based experience, due to their assumptions about the model. This participant also reflected on their own process of acceptance and how this was part of a learning process:

'It can be an integrative approach and yet I came at it anyway thinking is this is going to be a CBT thing, and I'm going to find I'll struggle with this. And so I did to start with, and I've come through the process of that which is good learning anyway'.

16 | THEME 3. CRITICAL SELF AND COMPASSIONATE SELF

Participants demonstrated an awareness of their self-criticism, but they were also cognisant of how cultivating a compassionate mind is an investment in oneself. They were able to take a step back and connect with their compassionate self. One participant stated:

16.1 | Compassion is an investment and a different way of being

Participants acknowledged that they did not want to lose their self-critic, as it served as a way of keeping up standards, but they could cultivate a relationship between both that they believed could be helpful. One of the participants spoke of how:

'An important concept of that is the self-critic is a kind of big thing and the idea of not being so self-critical is very

unfamiliar to me. It's [self-compassion] an investment, not just focusing on the negatives...I can see that it's also useful with clients...self-compassion fills a gap'.

Another participant offered a more balanced view of giving 'self' permission to attend to their 'own' needs without inner judgement being placed on them:

'I think that what this has enabled me to do is to not feel as critical of myself and to recognise when I need something it is okay...not judging myself'.

Participants gave insight into how they developed the capacity to have an attentional awareness of their thinking cycle, enabling re-engagement and broadening their perspective, with one participant stating:

'It's kind of helped me to take a step back and really appreciate what's going on around me instead of having tunnel vision'.

17 | DISCUSSION

This study looked at the impact CMT had on students working in the helping professions. Statistically significant differences post-training were found on the SCS, which suggests that CMT helped students cultivate self-compassion. This finding supports existent research, which suggests that involving students in compassion-based experiential exercises can bring about changes in self-compassion (Beaumont et al., 2016, 2017; Boellinghaus et al., 2013). Findings from individual diaries and from focus group data highlight the role of compassion in helping participants soothe and regulate distressing emotions. Participants reported how *'slowing down'*, *'grounding'* themselves and the use of body language, such as adopting an open, upright position, and facial expression enabled them to self-soothe and experience the presence of positive feelings. Words such as *'gentle'* and *'calm'* were used when discussing important factors for tolerating difficult emotions, helping some participants to take a step back and make space for self-compassion.

The quantitative data compliment the qualitative findings, as there was a shift from self-criticism to self-compassion post-training, a finding in keeping with previous research (Beaumont et al., 2017; Maratos et al., 2019). One participant wrote: *'I've found more inner warmth towards my personal struggle'*, suggesting an inner kindness, supportive self-talk and a potential move away from self-attacks towards self-compassion. Qualitative analysis suggests that participants became not only more aware of their self-criticism, but also more aware of their capacity to change their thinking process to one of helpfulness and self-compassion.

Scores suggest a statistically significant difference post-training for self-correction, suggesting that students were less inclined to criticise themselves post-training. There was also a statistically

significant change post-training on the inadequate self-subscale and the reassured self-subscale. The change post-training compliments the findings from the qualitative data. Post-training, participants were more supportive of themselves, connected with their compassionate self, were able to reassure themselves during times of personal difficulty and able to remind themselves of this being an opportunity for compassion to be applied and valued.

Compassion was useful in helping some participants slow down, whilst others reported that compassion helped increase their energy levels and channel it in a way that supported their motivation to be caring and able to use their *'compassionate drive'*. Participants explained how compassion helped them reduce distress, when they experienced obstacles or frustration. CFT is grounded in attachment theory and seeks to use the compassionate mind as a secure base and safe haven for individuals to utilise within themselves. The evidence emanating from this study suggests that students do use their compassionate mind in a similar way, using it not only to regulate and soothe when experiencing difficulty, but also to encourage drive-based exploration and seeking, linked to their healthcare values.

Throughout the course, students were encouraged to use interventions that promoted self-reflection and self-practice. Being aware of one's own self-doubt and self-criticism may have led to the promotion of self-care. This echoes the work of Bennett-Levy and Lee (2014) and Kolts et al. (2018), who suggest self-reflection and self-practice help build resilience. Students were encouraged to create *'a compassionate other'* and/or a *'perfect nurturer'* (Bell et al., 2016), an image of something or someone that has their best interests at heart. Results support the findings of Bell et al. (2016), who found trainee CBT therapists were able to support themselves and regulate emotion with the help of their *'compassionate internal supervisor'*. The role of self-encouragement and self-support was important in helping participants approach previously avoided tasks or behaviours. For example, some participants suggested they were able to be assertive and verbalise personal boundaries in ways they had not done previously. Barriers regarding terminology were explored with participants being mindful of misconceptions, welcoming opportunities to learn and reflect. In fact, there are misconceptions regarding the CFT model. Whilst CFT can be integrated and used with other therapeutic modalities, it is a theoretical stand-alone model, created to help people who experience high levels of self-criticism and shame (Gilbert, 2009, 2014).

Although scores reduced post-training on the self-persecution and self-hatred subscales, they did not reach statistical significance. Beaumont et al. (2016) found no statistically significant difference in self-persecution scores in a sample of healthcare educators and providers post-CMT training. However, there are multiple ways of self-relating (e.g., compassionately, critically, judgementally). For some students, it may have been easier to increase their capacity for self-compassion, but not as easy to dismiss self-critical judgement. It is also possible that statistical significance was not reached because of the small sample size.

Being mindful of a variety of demands and the importance of self-reflection and self-practice was foregrounded within the qualitative

data. Many participants felt reassured by their ability to understand Gilbert's model, seeing it as something tangible to use with self and others in their clinical practice. Some participants reported an initial lack of confidence or self-doubt, which is often described as a 'normal' process for students, with some questioning their ability, experiencing anxiety or feeling overwhelmed (Reeves & Mintz, 2001; Wheeler et al., 2004). One student emphasised the need to 'reinforce' and 'practise skills' to help build on self-compassion. The results from this mixed-methods study suggest that personal practice and self-reflection helped students cultivate a compassionate mindset and increase levels of self-compassion.

18 | LIMITATIONS

The current study does involve a number of limitations that warrant reflection: firstly, the small sample size, particularly in relation to the quantitative aspect of the study. Fifteen students agreed to take part in the study, and whilst all fifteen completed individual diaries, only eleven completed sets of pre- and post-questionnaires were obtained. Secondly, it is not possible to extrapolate whether the changes were as a result of CMT or as a result of external factors as there was no control group. Thirdly, participants were students registered on the CFT module and had enrolled on the course because they had an interest in the subject. Therefore, consideration needs to be given to selection bias and the generalisability of findings as the sample does not represent the wider population. A further limitation is the possibility that participants may have chosen to answer questions in a certain way to please the experimenter. To minimise risk of 'social desirability', the focus group was facilitated by a member of staff who was not part of the teaching team. The module team also attempted to minimise potential bias by advising participants prior to the focus group that all of their experiences were of interest to the study.

19 | IMPACT AND IMPLICATIONS

Despite the limitations of this study, participants reported that they valued the experience and welcomed the opportunity to be part of a research project for an innovative module exploring a relatively new approach in psychotherapy. Counselling and psychotherapy students face a unique set of challenges. For example, not only are they learning about new modalities and interventions, but they also need to find time and space to reflect, manage their own well-being, work with clients/patients and balance family life and academic pressures. Making time and space for personal practice and self-reflection within an educational setting can help address some of these issues, potentially enabling students to build resilience, cultivate a compassionate mindset and learn to be kinder to self.

Educators and practitioners aim to create opportunities in learning environments that enhance confidence and encourage personal growth. Creating learning environments that adopt compassionate

pedagogy is one way that this can be achieved. Learning to bring a compassionate mind to situations that arise in the educational setting may help students as they move forward through their training.

20 | FURTHER RESEARCH

Further research could explore whether participants felt more compassion towards other students as a result of hearing about their difficulties, blocks or resistances to compassion. Further research is needed to explore the longitudinal effects of CMT on students and to examine what specific elements of CMT participants find most beneficial.

21 | CONCLUSION

Compassion-based approaches can be incorporated into counselling and psychotherapy training programmes and have the potential to help students learn to be kinder to themselves. People training to deliver psychotherapy face many different challenges; therefore, incorporating interventions into education programmes that can potentially boost well-being, may help students cultivate a compassionate mind and ultimately improve their practice.

ORCID

Elaine Beaumont  <https://orcid.org/0000-0002-8259-5858>

Tobyn Bell  <https://orcid.org/0000-0001-5535-551X>

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