COUNSELOR-IN-TRAINING EXPERIENCES OF SELF-COMPASSION TRAINING IN GROUP SUPERVISION

A Dissertation

by

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BA, Texas A&M University, 2012
MS, Texas A&M University, 2015

Submitted in Partial Fulfillment of the Requirements for the Degree of

DOCTOR of PHILOSOPHY

in

COUNSELOR EDUCATION

Texas A&M University-Corpus Christi
Corpus Christi, Texas

August 2018

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

The purpose of this descriptive phenomenological study was to explore the lived experiences of counselors-in-training(CITs) who participated in self-compassion interventions as part of their internship group supervision course. A total of 11 internship students participated in journaling and individual interviews, four of whom additionally participated in a focus group. Purposeful sampling was used and participants were recruited from two sections of the internship group supervision course. Participants completed the Self-Compassion Scale-Short Form once prior to participation in in five self-compassion interventions that took place during their group supervision class and journaled about their experiences. Participants were interviewed individually and those who were available participated in a focus group. Data was collected in the form of journal entries, and responses during individual interviews and responses as part of a focus group. Giorgi's descriptive phenomenological methodology was used to analyze detailed and conscious descriptions provided by CITs concerning their experience with the phenomenon.

The findings of this study enhance our understanding of CITs' experiences participating in self-compassion training during group supervision. Nine constituents emerged during analysis as part of a single structure of participant experience: presence; relaxation; a reflective and evaluative process; thinking about, defining and applying self-compassion; heightened self-awareness; desire to engage in personally meaningful activities and practices; sometimes difficult to do; consideration of clients; and wanting more.

Researchers should continue to examine whether self-compassion training can be an effective strategy to encourage CITs to engage in self-care and whether self-compassion training would have lasting impact on development of burnout. Additionally, researchers should consider

that participants wanted more than was provided in the self-compassion training, and at times were not able to differentiate topics and concepts covered in the training.

Keywords: self-compassion, supervision

DEDICATION

To my mother, who needed self-compassion more than anyone.
In Loving Memory

To counselors-in-training in programs everywhere.
Your compassion for others may have brought have you here, but I believe having compassion for yourself will sustain you through your endeavors.

And lastly, this dissertation is dedicated to Frank Castillo,
who is feasting at the great table.
In Loving Memory

ACKNOWLEDGEMENTS

I express with immense gratitude a sincere thanks to my committee chair, Dr. Marvarene Oliver, for devoting her time, expertise, guidance, and endless support throughout the entire dissertation process. Your dedication truly allowed me to think, design, and execute from the mind of a qualitative researcher where I took ideas I was both curious and passionate about and brought them to life through this study. Additionally, I want to thank my committee members, Dr. Yvonne Castillo, Dr. Stephen Lenz, and Dr. Gina Glanc for the unique contributions each of you made from proposal to defense and your encouragement throughout this entire endeavor.

I absolutely must thank Dr. Yvonne Castillo and Dr. Mary Alice Fernandez for planting a seed of compassion for supervision in my heart. Their wisdom as Licensed Professional Counselor Supervisors and their compassion for training counselors became an inspiration in my life. Additionally, I want to thank all the graduates and current counselors-in-training who completed hours at the Texas A&M University-Corpus Christi Counseling and Training Clinic during the time I served as Assistant Director. You inspired this study more than you know. I also must acknowledge my doctoral cohort of Wonder Women for empowering me, reassuring me, and supporting me on days I needed it most.

Lastly, I want to thank family members who supported me from a far and close by. Thank you to my husband, parents, in-laws, and my brother, for being so understanding and encouraging throughout the many sacrifices I had to make leading up to this accomplishment. I must acknowledge the role my husband and my house church family at Emmaus Church played in the completion of this dissertation. Without your fellowship, discernment, and biblical encouragement, this feat would have been impossible. Thank you so much. *James 1:2-5 "Consider it pure joy, my brothers and sisters, whenever you face trials of many kinds, because*

you know that the testing of your faith produces perseverance. Let perseverance finish its work so that you may be mature and complete, not lacking anything. If any of you lacks wisdom, you should ask God, who gives generously to all without finding fault, and it will be given to you."

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CHAPTER I: INTRODUCTION

Counselor training encompasses demands that are both professionally and personally challenging (Thompson, Frick, & Trice-Black, 2011). Counselors-in-training (CITs) are required to complete specific coursework before they can begin to work with clients according to most program requirements and current standards from the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015). However, it is possible CITs may not be fully prepared to handle the emotional and interpersonal demands of becoming a counselor. The exposure to trauma and life stressors creates an environment for individuals working in the mental health field to become vulnerable to the effects of stress, such as burnout (Thompson et al., 2011) and compassion fatigue (Merriman, 2015). Burnout is described as a psychological syndrome that develops in response to chronic emotional and interpersonal stress and encompasses emotional exhaustion, depersonalization (used as a maladaptive coping so the counselor can create psychological space from clients), and feelings of ineffectiveness (Thompson et al., 2011). Compassion fatigue is considered "a product of exposure to the suffering of clients, with little to no emotional support in the workplace, and poor self-care" (Merriman, 2015, p. 371). Moreover, Joinson (1992) considers compassion fatigue to be a type of burnout. Burnout is the foremost cause of impairment in mental health professions and can impact quality of work with clients (Awa, Plaumann, & Walter, 2010; Coates & Howe, 2015), which makes training CITs to cope with issues like burnout and compassion fatigue imperative.

Counselors-in-training are at an increased risk for burnout due to factors such as age and experience. Age is a predictive factor in burnout among mental health professionals and as age decreases, burnout increases (Craig & Sprang, 2010). Less experienced mental health professionals also report increased rates of burnout when compared to more experienced

professionals, demonstrating professionals are at a greater risk for burnout towards the start of their professional careers (Craig & Sprang, 2010). Even though CITs are not yet categorized as mental health professionals, some researchers suggest they too are at risk for increased vulnerability to burnout (Wardle & Mayorga, 2016). Wardle and Mayorga (2016) called for additional research to explore ways counseling programs can include current wellness and self-care practices into counseling curriculum in order to expose CITs to ways to cope with burnout.

Relevance of Self-Care Practice for CITs

Self-care practices are essential to the professional and personal development of CITs to best prepare them to combat burnout and consistently provide quality service to clients (American Counseling Association [ACA], 2004; ACA, 2015; Brownlee, 2016; Coates & Howe, 2015). Self-care can be described as personal care one engages in to meet one's own personal needs such as diet, exercise, sleep, social support, solitude, connection to one's spirituality, and leisure. According to Brownlee (2016), CITs tend to neglect care for themselves during counselor training as a result of their concentrated focus on client care. Nelson, Hall, Anderson, Birtles, and Hemming (2017) agreed, and indicated that even though "self-care is vital to helping professionals, few students learn specific self-care skills to integrate into their own self-care practice" (p. 1).

One way self-care strategies are incorporated into counselor training is through supervision courses, where supervisors can "model self-care and positive coping strategies for stress which may influence supervisees' practice of self-care" (Thompson et al., 2011, p. 153). However, other researchers (Dorian & Killebrew, 2014; Christopher & Maris, 2010) indicated that very few clinical and educational programs are directly teaching self-care strategies to CITs. Nelson et al. (2017) further suggested self-care is often included in counselor training in the form

of “a recommendation to incorporate self-care into his or her life” (p.1), which may not be effective in teaching CITs the importance of self-care. They further indicated CITs may perceive self-care as optional or less important when self-care is not a required part of the curriculum and proposed including self-compassion based interventions is “an effective way to model and practice self-care” (Nelson et al., 2017, p. 2).

Self-Compassion and Self-Care

There are many evidenced based recommendations for burnout prevention, such as self-care (Thompson et al., 2011), wellness interventions (Ohrt, Prosek, Ener, & Lindo, 2015), mindfulness based stress reduction (Kabat Zinn, 1982), and stress management (Beaumont Durkin, Hollins, & Carson, 2016), none of which specifically address self-compassion. Self-compassion can be described as “being open to and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one’s inadequacies and failures, and recognizing that one’s own experience is part of the common human experience” (Neff, 2003a, p. 224). A more simplified definition describes self-compassion as how “one is emotionally supportive toward both the self and others when hardship or human imperfection is confronted” (Yarnell & Neff, 2012, p. 147). Self-compassion has correlated positively with constructs such as perceived confidence, lesser fear of failure, and more effective coping (Neff, Hseih, & Dejitthirat, 2005). In addition, professional counselors with high levels of self-compassion report less burnout and less maladaptive ways of coping (Thompson et al., 2011). Self-compassion, however, has not been explicitly studied with CITs. Participation in a self-compassion based interventions as part of counselor training could possibly serve as a method to teach self-care practice and may impact client work.

Self-Compassion in Group Supervision

One of the current ways CITs are trained to cope with burnout involves exploring and discussing self-care in the context of group supervision (Brownlee, 2016). Group supervision is a common type of clinical supervision utilized in counseling programs and is in accredited programs (CACREP, 2015; Melnick & Fall, 2008). In group supervision, the key focus of the supervisor is to monitor the welfare of clients and facilitate not only the professional growth but also the personal growth of CITs (Melnick & Fall, 2008). While self-care is commonly thought of as individual practices to increase one's personal wellness, such as getting enough sleep, fitness activities, or other general forms of leisure, self-care can also take place via a variety of professional activities such as consultation, supervision, peer support, and attending conferences and training (Brownlee, 2016). According to Devenish-Meares (2015), specific ways self-compassion can be used with mental health professionals as part of self-care is a worthy topic where more research is needed. Research concerning CITs may add depth to the current literature on ways counselor education can be further improved. More specifically, research on self-compassion in the context of university group supervision may support the relevance of incorporating self-compassion into counselor training. It is possible infusing self-compassion based interventions into group supervision may be beneficial for CITs as a way to implement training in self-care practice to mitigate the risk of compassion fatigue and burnout (Beaumont et al., 2016) which in turn may improve the interactions of CITs with clients.

Statement of the Problem

An occupational hazard of working in the helping fields is that such work often involves frequent exposure to the traumatic or painful experiences of others (Thompson, Amatea, & Thompson, 2014), which may put counselors-in-training (CITs) at a higher risk for burnout due

to factors like age and decreased counseling experience (Craig & Sprang, 2010) when compared to mental health professionals. Consequently, burnout, compassion fatigue, and vicarious trauma can undesirably impact the therapeutic functioning of CITs and can prevent them from being fully present with clients, impact communication skills, cause physical health problems (Baker, 2003; Beaumont et al., 2016), and ultimately decrease the quality of service delivered to clients (Awa, Plaumann, & Walter, 2010; Coates & Howe, 2015). Brownlee (2016) similarly reported when client care is the professional focus for CITs, self-care can become de-emphasized and may lead to unmet personal needs that can in turn impact client care (Brownlee, 2016). Training CITs to cope with burnout is critical to their counseling education. Furthermore, Newsome, Waldo, and Gruska (2012) argued that becoming an effective helper without the ability to be self-compassionate will also present many challenges to individuals who desire to be a part of helping professions such as counseling.

Accredited counseling programs are required to "teach self-care strategies appropriate to the counselor role" (CACREP, 2015, p. 10). One way to teach self-care strategies, encouraged by Wardle and Mayorga (2016), is to infuse current wellness and self-care information into the counseling curriculum. Wardle and Mayorga (2016) also described a need for counselor educators to emphasize wellness "not only from the client perspective, but also from the perspective of the professional counselor, as well as the future professional counselor" (p. 13) to further address ways to help CITs cope with burnout. Even though self-care is discussed in mental health counseling programs, many researchers indicate CITs are not being taught how to implement self-care to cope with burnout (Baker, 2003; Christopher, et al., 2011; Newsome, et al., 2012). One of the current ways of training CITs to cope with burnout involves exploring and discussing self-care in the context of group supervision (Brownlee, 2016). Fulton (2016) stated

that “incorporating self-compassion exercises into training and/or supervision may be fruitful given the difficulty students have coping” (p. 371).

Purpose of the Study

The purpose of this study is to describe the lived experiences of CITs who participate in self-compassion interventions when infused into internship group supervision coursework. This study aimed to understand the structure of how CITs describe their experiences as they participate and reflect on their experience with self-compassion interventions as part of the group supervision course. Additional purposes of this study were to understand how CITs perceive their self-care practices or their work with clients has or has not related to their participation in self-compassion based interventions during group supervision.

Research Questions

The primary research question for this study was: How do CITs describe their experience participating in self-compassion interventions in group supervision? Additional questions informing the research include: (a) How do CITs experience self-compassion interventions in group supervision in relation to their self-care practices?; and (b) How do CITs experience self-compassion interventions in group supervision in relation to their work with clients?

Significance of the Study

How to best prepare counselors is a question pondered by many in counselor education. Critiques of counseling programs include an emphasis on training in knowledge and skill development above the personal development of CITs (Hansen, 2009; McAuliffe 2002; McNichols, 2010). Shuler and Keller-Dupree (2015) suggest that professional and personal development are not mutually exclusive concepts, but interrelated. Hinton & Goodwin (2016) imply departmental support for integrating personal growth topics and self-care activities into the

counselor education curricula will enhance CITs' understanding that these areas are valued and critical parts of becoming a professional counselor.

Clinical supervision serves as a capstone experience during which CITs' levels of personal and professional development are enriched and evaluated, making it an integral component of counselor training (Bernard & Goodyear, 2014). The approaches and techniques used in supervision relate to the interaction between counselor educators and CITs and parallel the interactions between CITs using approaches and techniques with clients (Blount & Mullen, 2015). Research concerning supervision practices can make a difference in how supervision is conducted and thus on the impact it has on CIT development and ultimately counselor burnout and client care. The current study, which examined infusion of self-compassion interventions into group supervision, expands the supervision literature. Understanding the experiences of CITs who participate in such training may provide information about the structure of their experience as well as inform counselor educators about practices that have the potential to mitigate factors like compassion fatigue and burnout among CITs.

Method

Phenomenological Approach

This study utilized a qualitative design. Qualitative research is conducted with the goal of deepening what is understood about the meanings and interpretations people attribute to their experiences and the process of how people construct their worlds (Merriam, Tisdell, & Ebrary, 2015). Qualitative research is difficult to define clearly (Denzin & Lincoln, 2011) as it does not embody one generic approach, but includes a plethora of theoretical paradigms and methods.

I used a phenomenological design to capture a description of the essence of the lived experience of a specific phenomenon for a group of people (Patton, 2015). Specifically, I used

Giorgi's (2009) descriptive approach to phenomenological inquiry, which is designed to gain a deepened understanding of the structure of a phenomenon as it appears "to the consciousness" (p. 10). Phenomenology was first introduced to the social science realm by philosopher Husserl in 1913, who believed awareness of one's own experience is developed by attending to perceptions and meanings that stimulate our conscious awareness (Giorgi, 2009). My aim was to describe the structure of the chosen phenomenon, participation in self-compassion interventions in the context of group supervision, so that it could be understood in a more comprehensive way than other research methods could offer. Chiefly, I was concerned with how participants described the meaning of these lived experiences as opposed to objective explanations of participant behavior.

Population and Sample

Because qualitative research requires information-rich sources, purposeful sampling is generally necessary. More specifically, in phenomenological research, individuals are recruited to participate who experiences truly encompass what the researcher wants to investigate (Wertz, 2005). Giorgi's (2009) methods require participants who have direct experience with the phenomenon in question, and further suggested a minimum of three participants is necessary in order to obtain relevant variations within the data. Explicitly, the population from which participants were drawn included 24 internship students (CITs) enrolled in two sections of the internship course, which are required as part of a CACREP-accredited counseling program in the southern region of Texas. In addition, internship students are more intensely immersed in client care than practicum students. I sought permission from faculty members who were teaching internship courses to solicit participants for the study in their classes and conduct self-compassion interventions as part of the group supervision.

Utilizing a recruitment script, I informed students of the study on the first class night and requested participation. Students were given a week to consider whether they wished to provide consent. I also talked about my role in the class and explained that I would attend all classes of each group and would serve as a teaching assistant, with the exception of evaluative functions. All students in the internship classes, regardless of whether they were participants in the study, participated in the in-class activities regarding self-compassion.

Data Collection

On the first class day, I read a recruitment script that included a brief description of the study and what participant involvement would entail. I provided an informed consent document and contact information document at that time and asked that all students, whether they wished to participate or not, bring the documents to the second class meeting. At the beginning of the second class meeting, I answered any questions students had and asked that all consent documents, signed or unsigned, and contact information sheets, completed and uncompleted, be placed in a large envelope, which I collected.

In addition, all students completed the Self-Compassion Scale-Short Form (SCS-SF; Raes, Pommier, Neff & Van Gucht, 2011) on the first night of class. Students self-scored the instrument and I provided a brief explanation of results. Even though all students took the assessment in order to provide them with an introduction to self-compassion, only data from those who provided consent to participate in the study was used in the research. The SCS-SF results from participants was used to further describe the sample and provide context for the study. Giorgi (2009) stated all research must begin with "the specification of the research situation and the determination of the data to be obtained" (p. 121). In order to increase the

richness and depth of participant descriptions of their experience, I collected data in multiple forms, including journal entries, individual interviews, and a focus group.

Participant Journals. According to Giorgi (2009), "understanding the phenomenal world of the other is dependent upon some form of expressiveness" (p. 108) and one way data can be collected is through participant writing. All class members were asked to maintain journals for the duration of the study, and were expected to complete a minimum of four entries. Five to ten minutes of class time was set aside for journaling; however, students were able to add to their journals as they wished outside of class. All participants were asked to use a pseudonym to identify their journals. There were three different journal prompts, with two of the prompts assigned twice. Prompts were assigned on days students participated in the self-compassion intervention (See Appendix F). Individual interviews began after all self-compassion based interventions were facilitated in class. I collected journals from participants only when each participant arrived for their individual interview.

Individual Interviews. Eleven participants participated in an individual interview once the intervention sessions were completed. Individual interviews as part of phenomenological research are easy to describe, but more difficult to execute (Giorgi, 2009). The goal of the interview is to obtain "a complete description as possible of the experience that a participant has lived through" (p. 122). Giorgi (2009) stated there is a "spontaneous quality to a good interview" (p. 122); thus, I utilized semi-structured interviews (See Appendix G), which allow for follow-up questions to foster a deepened understanding of participants' experiences. Interviews took place in the Counseling and Training Clinic (CTC) on campus and were audio recorded and transcribed. All participants were assigned a number and a random number generator was used to determine the order of interviews. Interviews stopped when saturation of data was achieved. A

brief demographic survey (see Appendix C) was administered and collected before the individual interview began. Individual interviews lasted between 25 minutes and 1 hour and 45 minutes.

Focus Group. Once individual interviews were conducted and initial analysis was completed, I conducted a focus group with four participants, which also took place in the CTC. The focus group lasted 1 hour and 15 minutes. Questions were based on initial ideas about themes derived from the journals and individual interviews. The focus group was audio recorded and transcribed. In phenomenological research, the language of participants is essential for understanding participant experiences and giving voice to those experiences; thus, the focus group provided an additional opportunity for participants to do so.

Data Analysis

Giorgi's (2009) method of descriptive phenomenology "offers both openness and rigor" (p. 70) and was used to analyze the data in this study. Giorgi's data analysis includes five global steps that move from understanding the experience as a whole, creating units of meaning, and then synthesizing meaning into a final statement about structure and description of how participants experienced the phenomenon (Giorgi, 2009; 2012). Before I began data analysis, I adopted an attitude of phenomenological reduction (Giorgi, 2012). In accordance with Giorgi's (2009) five global steps to data analysis, I first "read for a sense of the whole" (p. 128). The second step was to determine meaning units within the data. The third step involved the "transformation of participant's natural attitude expressions into phenomenologically sensitive expressions" (p. 131). The fourth step of data analysis involved *free imaginative variation* wherein the essential structure of the experience was created (Giorgi, 2012). Finally, I created a final synthesis to make a statement about the structure of participant experience, which describes the essence of the experience studied (Giorgi, 2012).

I read and re-read each participant's journal, which I collected at the time of each individual interview. In addition, I began transcription of each interview as soon as possible following the interview and began analysis of each interview once transcription was complete. Similarly, I transcribed the focus group and began analysis of that transcript once I completed initial analysis of each individual interview. A complete description of the data analysis process is contained in Chapter 3. This process is consistent with Giorgi's (2009) method.

Lens of the Researcher

Qualitative researchers must be aware that their own lenses may impact the ways in which they understand and unravel the experiences of participants; thus, transparency about the researcher's lens is critical. During my own journey as a CIT, I struggled with being self-compassionate and believe the inclusion of self-compassion training could have impacted my own personal and professional growth. Since starting my career as a counselor, I found that as I became more self-compassionate, my self-care improved, as did the quality of my work with clients. I also believe that to truly experience self-compassion, a person must have the ability to be mindful. Lastly, I have vested interest in the success of CITs, as I am a supervisor and assistant director of a counseling and training clinic and an aspiring counselor educator. Consistent with Giorgi's thinking, I had to separate my own beliefs, attitudes, and knowledge by adopting an "attitude of phenomenological reduction" (Giorgi, 2012, p. 4) towards the experiences observed and the data that emerged from participant experience. Thus, in order to suspend judgments I had about CIT experiences and the phenomenon of self-compassion, I bracketed past personal experiences and knowledge (Giorgi, 2009).

Limitations

There are several possible limitations for this research. One limitation involves the trueness of participant responses. Participants may have viewed the information needed for a phenomenological approach as intrusive into their private personal experiences, which may have in turn limited the trust of participants and thus the fullness of their responses (Wilson, 2015). To partially address this possibility, I strove to demonstrate ethical and trustworthy behavior throughout my engagement in classes and interactions with participants. Similarly, the use of the focus group, particularly among students who know each other and are involved in the same academic program, may have impacted how open they were in their discussion of the phenomenon. It is also possible that dynamics between and among students who likely had previous experiences with each other over the course of their academic journey impacted willingness to be open in the focus group. A third possible limitation is the design of the series of self-compassion interventions itself. Use of different activities or focus on different aspects of self-compassion may yield different results. A fourth limitation is that several of the self-compassion interventions are structured within mindfulness practices. Thus, while the focus of the research is self-compassion, it is difficult to ascertain whether or the extent to which results were impacted by mindfulness practice or whether self-compassion practice, apart from mindfulness, would yield similar results. Finally, it may be that the positional power I held as the teaching assistant for the internship courses and as the director of the within-department counseling and training clinic impacted participant experiences and/or their responses in interviews and the focus group. Future research can address these limitations by examining different interventions, by designing studies intended to investigate overlap of impact between

mindfulness and self-compassion interventions, and by provision of interventions by someone who is not involved with participants to the same degree that I was.

Definition of Terms

Self-compassion

"Involves being open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one's inadequacies and failures, and recognizing that one's own experience is part of the common human experience" (Neff, 2003a, p. 224).

Supervision

A meeting between a junior member of a profession with a more senior member of a profession aimed to support supervisees as they develop clinical skills, to safeguard the welfare of clients, to convey professional ethics and values, and to observe the preparedness of a supervisee for competence as a professional (Bernard & Goodyear, 2014).

CHAPTER II: REVIEW OF THE LITERATURE

The highly complex and intimate nature of work in counseling often includes recurrent exposure to the traumatic or stressful experiences of others (Thompson et al., 2014). Burnout is a validated occurrence among mental health professionals and there are many evidenced based recommendations for burnout prevention, such as self-care, holistic wellness, mindfulness based stress reduction (MBSR), and stress management (Beaumont et al., 2016); however, there is limited research concerning ways self-compassion might be used to alleviate burnout among mental health professionals. While self-care is discussed in mental health counseling programs, it is problematic that counselors-in-training (CITs) are not fully developing an understanding for how to implement self-care (Baker, 2003; Christopher et al., 2011; Newsome et al., 2012).

Counselors-in-training can be perceived as more vulnerable to burnout as they are in the process of developing certain professional skill sets like managing work stress and trying to incorporate self-care while also maintaining a busy routine as a graduate student (Newsome et al., 2012). Not only are CITs encouraged to practice self-care activities to promote wellbeing, but the *Code of Ethics* (ACA, 2015) also implies that CITs have an ethical responsibility to engage in self-care in order to fulfill the same obligations to clients as professionals. The *Code of Ethics* (ACA, 2015) also specifically states that students "monitor themselves for signs of impairment" (p. 13). Further, counselor educators are required to ensure that students are aware of their responsibilities (ACA, 2015).

The Council for the Accreditation of Counseling and Related Educational Practices (CACREP, 2015) has acknowledged the importance of infusing education about wellness into counselor preparation. Counselors have a duty to maintain their own personal wellness in part because of the significant impact their self-care has on therapeutic alliance (Ackerman &

Hillsenroth, 2003; Norcross, 2002; Roach & Young, 2007). In recent years, research has emerged that supports the notion that self-compassion might play a part in ways to reduce burnout. For instance, Raab (2014) described implications for self-compassion as a vital component of prevention for compassion fatigue and to promote compassionate care towards others. Pace et al. (2010) reported self-compassion interventions, often called compassionate meditations, have also been successfully used to decrease stress. Thompson et al. (2014) further reported levels of self-compassion correlate with less burnout and less maladaptive ways of coping among professionals in the helping field. Gilbert (2005) further described self-compassion as "an important pre-requisite for continuing to serve as an attachment figure for needy others" (p. 140). While some researchers have stated training in self-compassion may be productive for individuals in the helping field to increase participation in self-care activities (Fulton, 2016; Gilbert, 2005; Kret, 2011), there is limited research on how self-compassion can be included into counselor education with CITs. The remainder of this chapter includes a review of literature regarding burnout among mental health professionals, self-care and counselor preparation, self-compassion, and self-compassion and compassion for others.

Burnout Among Mental Health Professionals

More Americans are dealing with mental health problems than in previous years, and 44 million Americans are expected to experience a mental illness in each year. In 2015, 16 million Americans had at least one major depressive episode, and 18% of Americans met the diagnostic criteria for an anxiety disorder such as post-traumatic stress disorder (National Alliance on Mental Illness, 2015). Hunt and Eisenberg (2010) acknowledged the rise of mental health issues in the United States, especially in young adults. Hunt and Eisenbery (2010) further noted such

issues currently account for almost half of the disease burden for young adults in the United States.

Mental health professionals aspire to meet the unique challenges presented by individuals struggling with a range of symptomology, including but not limited to stress, anxiety, depression, suicidal ideation, domestic violence, marital discord, and bereavement (Huprich & Rudd, 2004; Thompson et al., 2011; Wardle & Mayorga, 2016). The exposure to trauma and life stressors creates an environment for mental health professionals to become vulnerable to effects of stress such as burnout (Thompson et al., 2011). Compared to the general population, mental health professionals are at a greater risk of having a mental health disorder because of the frequent exposure to life stressors (Lawson & Venart, 2005). Mental health professionals must be taught deliberately how to care for themselves to cope with burnout because exposure to life stressors are an ever-present occupational hazard (Thompson et al., 2011).

Burnout is described as a psychological syndrome that develops in response to chronic emotional and interpersonal stress and encompasses emotional exhaustion, depersonalization (used as a maladaptive coping so the counselor can create psychological space from clients), and feelings of ineffectiveness (Thompson et al., 2011). Burnout can lead to a deficit in the ability to be present with clients and ultimately can lead to a decrease in quality service delivery to clients (Emerson & Markos, 1996). Burnout is the foremost cause of impairment in mental health professions and since it can negatively affect quality of work with clients (Awa et al., 2010; Coates & Howe, 2015); thus, training CITs to prevent and cope with burnout is an imperative component of counselor preparation.

Certain variables such as age and experience are known to increase burnout within the mental health community (Craig & Sprang, 2010). Age is predictive factor in burnout among

mental health professionals; as age decreases, burnout increases (Craig & Sprang, 2010). Craig and Sprang (2010) found that less experienced mental health professionals reported increased rates of burnout when compared to more experienced professionals, which they believe suggested professionals are at a greater risk for burnout towards the start of their professional careers. A wide range of variables have been shown to shield mental health professionals from the development of burnout, including access to clinical supervision, perceived coping ability, amount of clinical experience, and self-care strategies (Coates & Howe, 2015; Craig & Sprang, 2010). Since clinicians most commonly deal with those who suffer, nurturing their own well-being is an obligation (Beaumont & Martin, 2016). Research examining interventions that aspire to promote self-care and foster self-compassion should be further considered (Beaumont & Martin, 2016; Richards, 2013) to diminish burnout among healthcare professionals.

Self-Care and Counselor Preparation

Licensed counselors must abide by ethical codes in the states where they are licensed. Whether or not they are members of ACA, counselors should also abide by the ethical framework of the *Code of Ethics* (ACA, 2015) and consequently, are held responsible for preventing "imminent harm to clients" (ACA, 2015, p. 9) caused by impairment. The *Code of Ethics* (ACA, 2015) defines impairment as "significantly diminished capacity to perform professional functions" (p. 20). Despite the importance of avoiding professional impairment and ethical directive to engage in self-care, a survey administered by the ACA Task Force on Counselor Wellness and Impairment (2004) discovered, in a random sample of 770 ACA members, 63.5% of respondents knew a colleague they would consider impaired. Since this survey report was published, CACREP (2016) standards were adapted to include self-care strategies as a component of counselor education curriculum. The task force (ACA, 2004)

recommended counselors be cautious when they notice they are struggling with the unique challenges of their work as counselors, as their ability to monitor their own wellness may become impaired. The task force report (ACA, 2004) noted a counselors' ability to care for others will be limited by the care they provide for themselves.

Hinton and Goodwin (2016) reported that the majority of the existing literature on self-care has focused on self-care among mental health professionals rather than counseling students during their training, and acknowledged there is limited research about the barriers to carrying out wellness objectives for CITs. There is, however, some existing literature regarding self-care among counseling students. Researchers (Hinton & Goodwin, 2016; Wardle & Mayorga, 2016) noted the stressors experienced by CITs are not necessarily experienced by mental health professionals, as CITs are more vulnerable to trauma and life stressors due to lack of experience. Counselors-in-training also experience the combined stress of field work and demands of graduate work (Schure, Christopher, & Christopher, 2008; Thompson et al., 2014). Subsequently, Hinton & Goodwin (2016) identified barriers to sixteen areas of wellness, including barriers to self-care. These authors categorized barriers to self-care as a barrier to the essential self, the self that creates meaning in relation to life, self, and others. Additionally, Hinton and Goodwin (2016) encouraged programs to infuse self-care into counselor education and recommended ways wellness objectives can be more aligned with existing priorities in counselor preparation programs. These include infusing wellness objectives into existing courses, providing academic credit for participating in wellness objectives, modeling by faculty, and including of departmental physical space designated for wellness activities (Hinton & Goodwin, 2016).

Similarly, Brownlee (2016) suggested the need for the counseling community to acknowledge self-care needs to be "modeled, taught, and supported as a professional resource" (p. 16). Her qualitative inquiry involving the perceptions and practices of self-care of counselors and counseling students revealed several themes, including the meaning of self-care, examples of self-care, the motivation behind self-care, the challenges of being a CIT, fostering an environment of self-care, and barriers to self-care. Brownlee (2016) reported that, during childhood, participants "had learned to look after others and to elevate the needs of others above their own" (p. 16) to varying degrees. Brownlee (2016) further provided a description of her own experience after she started her professional career as a counselor when she realized she was not offering herself the same kindness and compassion she was offering clients and acknowledged the role of self-compassion was vital in her understanding of self-care.

Additionally, Beaumont, et al. (2016) implied that self-compassion based interventions, which aim to foster healthy self-care practices among CITs, are important to training because the inclusion of these interventions help protect CITs from burnout and compassion fatigue and improve the quality of their professional lives. These authors noted interventions to help CITs who experience burnout, stress, self-criticism, and low levels of self-compassion during counselor preparation need further consideration, since it is a topic that has not been largely researched (Beaumont et al., 2016). More recently, Nelson, Hall, Anderson, Birtles, and Hemming (2017) described how self-compassion interventions not only "can support the work of counselor educators and enhance the relational practices of their students" but also noted that "self-compassion activities bring to life the notion of self-care" (p. 11). They further suggested incorporating self-compassion into counselor education could also potentially impact how CITs work with their clients (Nelson et al., 2017).

Self-Compassion

While self-compassion has been a key part of Buddhist psychology for hundreds of years, it was not considered a psychological construct in the Western world until the early to mid 1990s when a number of independent researchers (Bandura, 1990; Deci & Ryan, 1995; Seligman, 1995) aspired to find an alternative way to measure what Neff (2003b) called a "healthy attitude and relationship towards oneself" (p. 86) different from the existing construct of self-esteem. As the desire for a construct that differed from self-esteem emerged, Neff (2003a) noted that the inclusion of Buddhist philosophy in Western psychology practice presented the concept of self-compassion. Exploring the place of self-compassion as a construct in Buddhist philosophy is helpful for understanding how ideas about self-compassion have changed over the past decade.

Self-Compassion Defined from Buddhist Philosophy

Originating from Buddhist philosophy, self-compassion as a psychological construct in Western psychology was heavily influenced by the concepts of compassion and mindfulness practice (Neff, 2003a; Neff 2003b; Neff & Germer, 2013). From this perspective, compassion is a form of empathy, and when compassion and wisdom are both present, emotional wellbeing will flourish (Makransky, 2012). A major tenant of Buddhism is the belief that it is as vital "to feel compassion for oneself as it is for others" (Neff, 2003a, p. 244). Buddhist philosophy promotes the idea that one will be able to enhance personal happiness and relieve suffering by developing "skillful means to understand the functioning of the mind" (p.749) and the idea this happens through meditation practice (Rodríguez-Carvajal, García-Rubio, Paniagua, & García-Diex, 2016). The goal of meditation in Buddhist philosophy is to cultivate "four immeasurable sublime attitudes, called *brahma-vigaras"* (p. 28) which include self-compassion (Goldstein & Knorfield, 2001) and the ability to be mindful. Some researchers believe mindfulness and self-

compassion are interconnected in this philosophy (Neff, 2003a, 2003b, Neff & Germer, 2013; Hofmann, Grossman, & Hinton, 2011). Buddhist philosophy sets forth the notion that to extend compassion towards self, an individual must attend to their current thoughts and emotions with balance and a realistic perspective. A key focus of Buddhist philosophy involves "understanding the nature of the self" (p. 223) in other words, having empathy for what it is like to be human (Neff, 2003a).

Self-Compassion from a Western Perspective

Little research was explicitly produced on self-compassion as a psychological construct until Kristin Neff (2003a) defined and made the construct of self-compassion significant in research. Neff (2003a) described developing an interest in self-compassion after the emergence of Kabat Zinn's mindfulness based stress reduction programs in 1988 and 1992 and her own observation of "an increasing dialogue between Eastern philosophical thought, Buddhism in particular, and Western psychology" (p. 223). At the time, she conceptualized self-compassion as a measurable construct in research and sought to fill a need to provide a way to differentiate self-compassion from compassion in the Western world. Neff (2003a) indicated that "all people, oneself included, are worthy of compassion" (p. 224).

Self-compassion as a construct has been rigorously studied by Neff (2003a; 2003b; 2015; 2016a; 2016b; Neff & Germer 2013; Neff & Dahm, 2016; Pommier, Neff, & Van Gucht, 2011; Neff and Whittaker, 2017; Raes, et al., 2011). She derived her definition for self-compassion from a broader focus on the constructs of compassion and mindfulness rooted in Buddhist philosophy. Compassion was generalized as the idea of being impacted by the pain of others. Neff (2003a) argued that compassion embodies the idea of expressing understanding without judgement towards all those who do wrong since failure is a part of the human condition, which

involves aspects of mindfulness. She then turned compassion inward to foster the idea people are just as capable of extending the same compassion they extend towards others to the self. In 2013, Neff and Germer defined self-compassion as "simply compassion directed inward" (p. 856). As Neff began to develop the construct of self-compassion further, she included the role of mindfulness as a central component of how she personally defines it. In recent years, Neff has used the phrase *mindful self-compassion* synonymously with her construct self-compassion, as she fully embraces the emphasis on mindfulness as a key part of the construct (Neff & Germer, 2013).

In 2003, Neff created and validated the Self-Compassion Scale (SCS) as an instrument to measure self-compassion (Neff, 2003b; Neff, 2015; Neff, 2016a) in American men and women over the age of 14. Since the creation of the Self-Compassion Scale, the instrument has been cross culturally adapted and validated with other populations such as Portuguese adolescents (Cunha, Xavier & Castilho, 2016), Turkish college students (Deniz, Kesici, & Sümer, 2008), Italian adults (Petrocchi, Ottaviani & Couyoumdjian, 2014), Japanese adults (Arimitsu, 2014), Greek adults (Mantzios, Wilson, & Giannou, 2015), and Chinese college students (Chen, Yan, & Zhou, 2011). Since Neff's first two articles were published introducing the construct and scale of measurement, (Neff, 2003a; Neff 2003b) self-compassion has been written about in over 200 journal articles and dissertations (Neff & Dahm, 2016). In 2011, Neff created and validated the Self-Compassion Scale-Short Form (SCS-SF; Raes et al., 2011), which correlated almost perfectly to the SCS. Neff's instruments to measure self-compassion are currently the only two forms of measurement for this construct.

The development of the SCS has allowed researchers to quantitatively demonstrate levels of self-compassion significantly predict psychological well-being (Barnard and Curry 2011;

Neff, Kirkpatrick & Rude, 2007; Zessin, Dickhäuser, & Garbade, 2015), depression, and anxiety (MacBeth & Gumley, 2012). The SCS has been efficaciously demonstrated to negatively correlate with other constructs like depression, anxiety, life satisfaction, and neurotic perfectionism (Neff, 2003a). Neff, Rude, and Kirkpatrick (2007) reported an association between self-compassion and wellbeing, positive affect, optimism, and happiness. Additionally, self-compassion has been demonstrated to correlate positively with constructs such as perceived confidence, lesser fear of failure, and the ability to cope with life stressors (Neff, et al., 2005).

Since the creation of the SCS, the majority of studies about self-compassion have utilized quantitative methodology with correlational designs. While Neff's description of self-compassion as a construct has only been challenged by a few (Lopez Angarita et al., 2015; Zeng, Wei, Oei, & Liu, 2016), other researchers have expanded the areas to which it may be applicable. For instance, Breines and Chen (2012) conducted a study concerning the influence of self-compassion on self-improvement motivation in a sample of male and female undergraduates. They found self-compassion leads to increased self-improvement motivation (Breines & Chen, 2012). The researchers further elaborated on their quantitative findings and stated that self-compassion provides a supportive environment for individuals to "confront negative aspects of the self and strive to better them" (Breines & Chen, 2012, p.1140).

Additionally, Gilbert and Proctor (2006) discovered self-compassion can promote emotional resilience among adults in an outpatient setting. They suggested the reason self-compassion provides emotional resilience is because when an individual experiences self-compassion, the brain's threat system is deactivated (associated with feelings of insecure attachment, defensiveness, and autonomic arousal) and the caregiving system becomes activated (associated with feelings of secure attachment, safety, and the oxytocin-opiate system). Gilbert

and Proctor (2006) described their understanding of self-compassion as relating the following competencies to self: a desire to care for wellbeing, distress/sensitivity recognition, sympathy, distress tolerance, empathy, non-judgement, and warmth.

In a qualitative inquiry about perceptions of self-compassion in a non-clinical sample, Campion and Glover (2017) used thematic analysis to discover that participants found it easier to be critical of themselves rather than to be self-compassionate. After participants watched a psychoeducational video and participated in one self-compassion based intervention, they participated in semi-structured interviews. The researchers noted that results might have been different had participants had the chance to explore the compassion more fully by expanding the intervention; nonetheless, they identified three major themes from their data: benefits of self-compassion, being self-compassionate, and barriers to self-compassion. Among other findings of the study, participants indicated that self-compassion does not easily fit into social normalcy in the Western world. Participants noted that a key barrier to self-compassion is that it must be permitted at a societal level and that they needed permission from others in order to be self-compassionate. Campion and Glover (2017) highlighted the need to be aware of cultural norms and systemic influences surrounding individuals when encouraging self-compassion.

The Impact of Self-Compassion Based Interventions

Researchers have only recently reported on the impact of self-compassion interventions. In a study that explored stress levels in adults, researchers Rockliff, Gilbert, McEwan, Lightman, and Glover (2008) found that individuals who participated in a brief self-compassion exercise experienced lower levels of cortisol, a stress hormone. This is similar to the findings by Pace et al. (2010) who reported self-compassion interventions, often called compassionate meditations, have been successfully used to decrease stress. Additionally, self-compassion interventions have

been demonstrated to enhance ability to self-soothe (Porges, 2007), which is similar to findings from a study by Beaumont et al. (2016), who found creating affiliative feelings towards self and others through self-compassion helped individuals self-soothe. The findings from these studies support the notion that engagement in self-compassion based interventions lowers stress and helps individuals self-soothe.

Self-Compassion and Compassion for Others

While some researchers have made claims that a consequence of self-compassion is increased compassion for others (Barnard & Curry, 2011; Figley, 2002; Hofmann, Grossman, & Hinton, 2011; Neff, 2003a; Reyes, 2012), few studies have demonstrated a direct impact between having self-compassion and one's ability to be compassionate towards others, even though that is a key premise of the Buddhist philosophy of self-compassion (Neff, 2003a). Particularly, Beaumont and Martin (2016) explored self-judgement, compassion for others, quality of life, and mental wellbeing measures through survey results in a sample of 103 student midwives. Beaumont and Martin (2016) found that when student midwives judged themselves unsympathetically they experienced less self-compassion and less compassion for others, which was associated with greater levels of burnout and compassion fatigue, as well as reduced levels of well-being. Beaumont and Martin 2016 further suggested self-compassion should be added to midwifery education to help student midwives reduce stress and develop coping strategies to promote self-care and improve compassionate care offered to others.

Neff and Pommier (2013) also examined whether self-compassion was associated with other-focused concern in a sample that included college undergraduates, older adults not enrolled in college, and adults practicing Buddhist meditation. Their findings indicated self-compassion is significantly associated with other-focused concern; however, the nature of the association varied

based on age and gender. They reported that lower age correlated with lower scores of self-compassion and suggested this is because development may impact one's ability to be compassionate towards self and others as a result of increased emotional maturity. Even though both men and women demonstrated having a significant association between self-compassion and compassion for others, correlations were weaker for women when compared to those for men in the study. Neff and Pommier (2013) further noted that more research is needed to understand why the results yielded lower self-compassion scores for women, but indicated that gender socialization is likely to negatively impact women's preference to invest in being self-compassionate compared with their investment in being more compassionate towards others. Nonetheless, they concluded from their findings that "self-compassion and compassion for others tend to go hand-in-hand" (Neff & Pommier, 2013, p. 173).

Additionally, Sinclair, Kondejewski, Raffin-Bouchal, King-Shier, and Singh (2017) conducted a systematic review of the literature to answer the question: "Can self-compassion promote health care provider well-being and compassionate care to others?" (p. 168). They found that suggestions to incorporate self-compassion into health care provider training programs are abundant and further noted the majority of studies on self-compassion have significant limitations because most are conducted using the SCS (Sinclair et al., 2017). They argued the content validity of the SCS is questionable and claim this diminishes the clinical relevance and utility of reported results. They further suggested that "self-compassion be critically re-examined, and its applicability to clinical practice reconsidered" (Sinclair et al., 2017, p. 198).

Summary

This chapter provided a condensed review of the current literature on burnout experienced by mental health professionals, self-care and counselor preparation, self-compassion, and self-compassion and compassion for others. This chapter reflects that there is a dearth in information related to how individuals, more specifically CITs, experience self-compassion and the consequences of how their experience may be impacted when self-compassion interventions are infused into counselor education. The next chapter provides a detailed explanation of the design and methods used in data collection and data analyzation.

CHAPTER III: METHOD

This study was designed to investigate how CITs describe their experience when self-compassion based interventions are a component of their counseling education. This chapter provides a description of the design and method chosen that enabled me to explore this experience among CITs.

Qualitative Design Rationale

Qualitative research targets data in the form of meaningful words as opposed to quantifiable numerical data (Polkinghorne, 2005). Data in qualitative research is also "actively constructed, rather than passively observed" (Yeh & Inman, 2007, p. 370). The goal of this type of research is to describe the meaning of the lived experience of a phenomenon by those who have experienced the phenomenon first hand (Starks & Brown Trinidad, 2007). I chose a phenomenological approach to allow me to understand the personal experiences of CITs who participated in self-compassion based interventions. While there are many articles about self-compassion, I did not find any research which specifically identifies how individuals experience self-compassion, how it is used in counselor education, how it may facilitate the ability to be compassionate to others, or how it may relate to the self-care practices of CITs. I designed the current study to explicate the lived experiences of CITs who participate in training in self-compassion as part of their internship supervision experience. This study aimed to address the overarching research question: How do CITs describe their experience participating in self-compassion interventions in group supervision? Sub questions that further inform the research include: (a) How do CITs experience self-compassion interventions in group supervision in relation to their self-care practices?; and (b) How do CITs experience self-compassion interventions in group supervision in relation to their work with clients?

The study design was constructed based on the philosophical framework known as descriptive phenomenology (Giorgi, 2009, 2012). Descriptive phenomenology is a type of qualitative phenomenological design that aspires to capture a subjective-psychological perspective inclusive of thoughts, impressions, interpretations, emotions, and understanding through descriptions of experience (Giorgi & Giorgi, 2003). Giorgi (2009) created the descriptive phenomenology method to answer his question: "How does one analyze a description of a concrete experience in a psychologically meaningful way and achieve at least the same degree of objectivity that quantitative analyses reach?" (p. 121). Giorgi grounded his approach in Husserlian phenomenology because it provides an "eidetic science to support empirical findings" (p. 121) in qualitative research (Giorgi, 2009). In this chapter, I describe in depth the methodology of my design, the personal lens which influenced my research, data collection and analysis procedures, and how I ensured trustworthiness in my design.

Design Methodology

This study was implemented using two different internship group supervision courses. I selected five self-compassion based interventions which I facilitated as training during the group supervision course. All students enrolled in the courses participated in the training activities, regardless of whether they chose to be part of the study. On the first night of each group supervision class, I read from a recruitment script and passed out copies of the informed consent to all students. Attached to the informed consent was an information sheet for students who chose to participate that requested student contact information so that I could contact them to schedule individual interviews as well as the focus group. Students had until the start of the second night of each supervision class meeting to decide if they would like to participate. On the second class night, I collected all completed and incomplete consent forms in a large envelope.

As part of the course, on the first class night, all students completed the SCS-SF (Raes et al., 2011) both to give me initial information about each group and to allow me to obtain descriptive data about my sample for students who were participants in the research, since levels of self-compassion may vary among students prior to engagement in the self-compassion interventions. All students began a journal process beginning the second night. The journals of those students who chose to participate were used as data in the research. Students who choose to participate created a minimum of four journal entries, completed an individual interview and were invited to participate in a focus group. Results were derived from how participants described their experience utilizing data from these three sources. Giorgi's descriptive phenomenology (2009, 2012) informed how I analyzed and understood participants' description of their experience.

Descriptive Phenomenology

I used Giorgi's (2009) descriptive phenomenology method to obtain concrete and detailed descriptions from a sample of CITs who directly experienced the phenomenon of interest, participation in self-compassion based interventions as part of their counseling education. Giorgi's descriptive phenomenology (2009) is grounded in Husserl's phenomenological approach to science, which regards human experience as a *legitimizing cognition* that should be both respected and trusted and should be accepted "only within the limits in which it was presented" (Husserl, 1983, p. 44). For my design, the words spoken and written by my participants were collected and analyzed to allow me to understand how they described their experience with self-compassion based interventions as part of their group supervision course.

A guiding technique of Giorgi's (2009) method involves the use of free imaginative variation in order "to discover the essence of a phenomenon or attempting to clarify the

meaningful structure of an experience" (p. 69). This requires the researcher to remove important parts of the phenomenon in order to visualize whether removal of a specific aspect would transform the data in a critical way. If what is understood is completely different after removing that aspect, then I may conclude that specific aspect may be essential (Giorgi, 2009). Openness and rigor are fundamental aspects of the descriptive phenomenology approach. Because I used this approach, I needed to be open to anything that is experienced by my sample. I also was open to the process of free imaginative variation to determine critical aspects of what was considered relevant as the data analyzation phase commenced. Rigor was established by ensuring that "whatever is given is described precisely as it presents itself" (Giorgi, 2009, p. 70). Also, aligning with Giorgi's approach, I used bracketing to account for differences in my personal past experience with the phenomena and participant experience with the phenomena. The researcher cannot allow past knowledge to be considered while examining the data to identify the content of the experience of the phenomenon (Giorgi, 2009).

According to Giorgi (2009), description of participant experiences differs from explanation and construction of their experiences. The goal was not to interpret, but to gain knowledge about how participants described their experience. Giorgi (2009) asserts the goal of descriptive phenomenology is to describe a single structure to summarize all the data. Results have been expressed in the form of a singular structure which describe participant experience, where similarities among participant descriptions of experience are combined as one structure. Ultimately, Giorgi's (2009) approach aims to reveal "the psychological aspects of the experience in a heightened way" (p. 103).

Role of the Researcher

In qualitative research, the researcher is considered an instrument of research (Denzin & Lincoln, 2005). I maintained multiple roles as I conducted this study, acknowledging and maintaining awareness of such roles in an intentional manner. Overall, I maintained an etic, or outsider, role, as I did not experience what participants were experiencing, and what they experienced is not what I experienced. I served as researcher, teaching assistant/supervisor, facilitator, and interviewer. During this study, I served as a teaching assistant in the group supervision courses, which means I provided students with feedback and suggestions based on cases and video tapes of their work presented throughout the course. While I was the teaching assistant, I did not evaluate any of the students work regardless of participation in my study. I also facilitated self-compassion based interventions on five separate occasions. I served as interviewer, as I conducted individual interviews and a focus group with participants. Lastly, as researcher, I employed an attitude of phenomenological reduction and used bracketing (Giorgi, 2009) to separate my own assumptions and experience with self-compassion. For the duration of the study, I kept my own digital journal with field notes about my observations during interventions, interviews, and the focus group and tracked my reactions and decision-making processes throughout the entirety of the research process. I also clarified potential biases that may have otherwise impacted data analysis.

Lens of the Researcher

Giorgi (2009) stated, "The curiosity of humans is such that whatever is encountered in the world can also be interrogated further in order to be better understood" (p. 1). My personal experience with self-compassion ignited my interest in understanding how others would describe their experience with self-compassion. This study is connected to me on many personal levels.

The first way I connect with my topic is through previous identification as a CIT who struggled with preventing and managing symptoms related to compassion fatigue and burnout throughout my counseling education. Secondly, my personal experience searching for ways to engage in self-care as a CIT influenced the design of this study. With the growing influence of wellness on the counseling field (Kaplan, Tarydives, and Gladding, 2014), I found a lack of self-compassion was one of my biggest impediments to engaging in holistic wellness, especially in regards to self-care practice. I knew what to do to take care of myself, yet I struggled to view self-care with as much priority as caring for others in my life.

During my training as a CIT, I was exposed to mindfulness as both a skill and a practice. Three years later, I continued to practice mindfulness daily on my own, and my ability to be more present and accept the realities of one moment to the next allowed me to realize my struggle with wellness was rooted in a struggle to be self-compassionate. After this realization, I began to explore the role of self-compassion in research, clinical practice, and in my own self-care journey. Engaging in mindfulness practice, which is one way people can be more self-compassionate (Neff & Dahm, 2016; Neff & Germer, 2013), allowed me to recognize when I was being too self-critical, over identifying with my inadequacies, or putting my own personal needs as a lesser priority. Moreover, I believe I am a better version of myself and a better counselor when I am more self-compassionate. While I have been deeply impacted by becoming more self-compassionate, I was intrigued by how others might experience self-compassion. Was my experience as a counselor learning about and experiencing self-compassion unique to me, or were similar experiences also had by others in counseling? If so, how could I make my understanding of self-compassion useful to others, such as counselor educators? My ability to be

self-reflective about my own experience with self-compassion allowed me to be aware of my own personal biases on this topic.

As a researcher, transparency about my own privilege and positional power is necessary to acknowledge that parts of my identity may have strongly influenced not only my presence in my interactions with participants, but may have largely impacted the ways in which I view the world and possibly the role of, my ability with, and my capacity for self-compassion. I am a white, heterosexual, female, graduate student, who is married, has no children, and identifies with Gospel Centered Christianity, which has allotted me certain privilege that may or may not impact my own views about the role of self-compassion. I held positional power in the setting where the study took place; thus, I may have been viewed as expert or more knowledgeable to participants because of the experience I had, the positions I held as teaching assistant for their group supervision course and assistant director for the counseling program's training clinic, and my status as a doctoral student. This may have impacted how participants experienced self-compassion interventions as part of their course. To minimize any impact related to my positional authority, I did not individually supervise or participate in grading or evaluation procedures for participants.

Sample and Setting

Participants

The participants in this study were selected from a sample of 24 counseling students enrolled in two different sections of the internship group supervision course, and all students met criteria for participation. While originally 17 counseling internship students agreed to participate, only 11 participants submit their journals and were interviewed. Four of the 11 participants who submit their journals and were individually interviewed participated in the focus group. Among

the 11 participants, 2 were male and 9 were female. Two participants were between 18 and 24 years old, four were between 25 and 34 years old, four were between 35 and 44 years old, and one was between 45 and 54 years old. Six participants identified as Caucasian, one as African American, and four as Hispanic. Six participants were Internship I students, and five participants were Internship II students.

Two participants were on the marriage and family counseling track, five were on the clinical mental health track, two were on the school counseling track, one was on the addictions counseling track, and one reported fulfilling requirements for both the addictions counseling and the clinical mental health counseling tracks. Participant scores on the SCS-SF ranged from scores of low self-compassion to high self-compassion with seven participants' scores of total self-compassion falling into the average self-compassion threshold, one participant's score falling into the low self-compassion threshold, and three participants' scores falling into the high levels of self-compassion threshold prior to training. Two participants revealed during the interview process that they were concurrently enrolled in the Strategies for Stress Management course at the time of participation in this study.

Participant Recruitment

Participants were recruited from two sections of internship group supervision courses because students in these courses worked directly with clients. Practicum students were not included because practicum students also are required to meet regularly with a doctoral student assigned as a supervisor, and I wanted to control for any impact this relationship may have on participants during the semester I conducted the intervention. In addition, internship students were more immersed in client work, and possibly were in more in need of an intervention aimed

at burnout reduction and self-care implementation as they were more intensely engaged with clients.

My sample included 11 master's counseling students. Participants were enrolled in internship group supervision coursework at a moderately sized university in South Texas. Purposeful sampling method was used as information-rich sources are important in qualitative research. In phenomenological research, individuals are recruited to participate "whose experience most fully and authentically makes accessible what the researcher is interested in" (Wertz, 2005, p. 171). I purposefully selected individuals on volunteer basis from a pool of internship students (CITs) enrolled in two sections of the internship course, which are required as part of a CACREP-accredited counseling program in the southern region of Texas, and who would have direct experience with the phenomenon, participation in self-compassion interventions as part of their group supervision internship course. Giorgi (2009) reported in order to obtain relevant variations in the data, a minimum of three participants is necessary when using a descriptive phenomenological approach.

Students were invited to participate in this study on the first night of their internship class. I attended and used a recruitment script to describe the study and what participation would entail. I also talked about my purpose and role as their teaching assistant and handed out copies of informed consent to all students. Potential participants were given a week to consider participation and to ask questions about participation. During the second class of the semester, I passed out an envelope for all students to submit their completed or blank copies of the informed consent in order to protect confidentiality of those who chose to participate. Completed or blank copies of the participant contact information sheets were also at that time and placed in the same envelope with the informed consents. Each participant was assigned a number and a random

number generator was used to determine the order of interviews. Individual interviews stopped when saturation of data was achieved. Students also completed a demographic information sheet when they met with me to be individually interviewed.

Setting

The study was conducted at a moderately sized university in South Texas that accommodates many non-traditional students and is a Hispanic-Serving Institution. Participants were enrolled in a CACREP-accredited master's program that offers four emphasis areas: clinical mental health; marriage, couple, and family counseling; school counseling; school counseling; and additions counseling. Many of the students enrolled in the program maintain fulltime or part-time employment and are parents, spouses, and/or care-takers to family members in addition to their role as graduate student counselors.

Descriptive Measurement

I chose to include the SCS-SF (Raes et al., 2011) as a way to gain knowledge about total levels of self-compassion of participants prior to participation in the self-compassion based interventions and to provide students in the classes an introduction to the concept. The SCS-SF was developed as a condensed measure of the SCS (Neff, 2003) to assess for levels of self-compassion in an adult sample. The SCS has been found to be a valid theoretically coherent measure of self-compassion and has "strong psychometric validity generalizable to clinical and non-clinical samples" (Costa, Marôco, Pinto-Gouveia, Ferreira, & Castilho, 2016, p. 460). The SCS-SF correlates almost perfectly to the SCS (Raes et al., 2011). A confirmatory factor analysis of the SCS-SF demonstrated a high score for internal consistency (Cronbach's alpha ≥ 0.86 in all samples; Raes et al., 2011); therefore, the SCS-SF empirically represents a reliable and valid alternative to the SCS (Raes et al., 2011). The SCS-SF was used to measure the CIT's overall

level of self-compassion as a descriptive measure before they participated in self-compassion interventions as part of the group supervision course. The SCS-SF is a 12-item self-reporting measure that uses a Likert scale to rate statements such as, "I try to see my failings as part of the human condition" and "When I'm going through a very hard time, I give myself the caring and tenderness I need."

While the use of the SCS is questioned by some researchers (Lopez Angarita et al., 2015; Sinclair et al., 2017; Zeng et al., 2016), the SCS-SF was selected for the purpose of providing a total score of self-compassion and was used solely as a descriptive measure for participants prior to engagement in the self-compassion based interventions during the group supervision internship course. Much of what has been questioned concerning the SCS has to do with the use of Neff's subscales as a valid form of measurement for self-compassion. Raes et al. (2011) do not recommend using the SCS-SF for use of the subscales, but to derive a total score of self-compassion from participants. The SCS-SF was selected based on my desire to obtain a total score for self-compassion from participants prior to participation in the self-compassion training, and subscale scores were not used; additionally, the SCS-SF was selected over the SCS as a matter of efficiency in allotted class time because it is much shorter and quicker to score than the SCS. Scores on the SCS-SF are ranked in three categories: low, average, and high. Overall scores of 1 or 2 mean the participant has a lower amount of self-compassion compared with the norming sample. A score of 3 means the participant has an average amount of self-compassion compared with the norming sample and scores of 4 or 5 mean the participant has high amount of self-compassion compared with the norming sample.

On the first night of each group supervision class, I administered paper copies of the SCS-SF to all students in class to complete. I instructed students to self-score the assessment and

provided an explanation for how to interpret results. I directed students to use only a pseudonym on their assessments. After all students completed and reviewed their individual results, I collected the instrument from all students. I made paper copies of the SCS-SF for all students, and returned the original copies the next time the class met. I did not use data from students who were not participants.

Interventions

Even though the concept of self-compassion has increased in appearance in recent literature, literature review did not reveal any evidence-based practices for the use of self-compassion as a training component in counselor education. The self-compassion interventions were selected from various self-compassion based intervention materials available to clinicians. Selection of the self-compassion interventions was based primarily on what resources were available and adaptable to a classroom setting. Subsequently, my own experience as a CIT, counselor, and supervisor played a key part in the selection process. While most of the interventions I have selected are delivered through mindfulness practice, the focus is on the component of self-compassion that is believed to be achieved through each intervention (Salzburg, 2002; Willard, Abblett & Desmond, 2017). On five different occasions during the course of one semester, I used the first 10-15 minutes of the group supervision class to provide some information about the self-compassion based intervention, facilitated the intervention, and then processed and answered any questions and reactions students had as a result of participation in the intervention. In addition, I made a statement prior to each intervention that students may wish to practice these interventions during their own time outside of class. During the last five minutes of class, all students responded to journal prompts about the experience of engaging in the intervention as part of their group supervision course (See Appendix F).

In order to remain a participant in this study, participants had to be present for at least four out of five of the self-compassion based interventions. During recruitment, I asked students to email me if they needed to miss a class, so I could coordinate their attendance in the other internship class with the date of the intervention they would miss. Attendance was a key requirement of the internship group supervision course, so students were required to be present for a specific number of hours to meet the requirements to pass the course. I also encouraged students who participated in my study to be present for all class periods.

Intervention 1: Loving Kindness Meditation

As part the first self-compassion training, I briefly re-introduced the topic of self-compassion and described what it is and how it relates to mindfulness practice (Desmond, 2017). The emphasis was on self-compassion and not mindfulness. I led students in the loving kindness meditation, which is designed to extend kindness towards self and then direct the kindness outward towards others. I chose the loving kindness meditation as the first intervention because two groups of researchers found using the loving kindness meditation can increase self-compassion among participants (Shahar et al., 2015; Smeets, Neff, Alberts, and Peters, 2014).

Intervention 2: Self-Compassion as a Skill

For the second intervention, I framed self-compassion as a skill and a practice and briefly explained basic neuroscience that describes how self-compassion strengthens what Desmond (2017) referred to as the care circuit in the brain. The self-compassion based intervention *A Friend Indeed* involves using a guided meditation intended to encourage an individual to reflect on what they would offer a friend at the end of a hard day that they could offer themselves in the present moment (Willard et al., 2017). I selected this intervention because the instructions specifically asked participants to reflect on how they might encourage a friend, then to redirect

the same quality of engagement to themselves. I also chose this intervention because I perceived it was something CITs could easily repeat on their own if desired without having to memorize a script or have written instructions. In addition, I believed this intervention could lead to an awareness of the type of self-talk CITs use in comparison to how they would talk to someone they care about.

Intervention 3: Self-Compassion in the Present Moment

Before facilitating the third self-compassion based intervention, I briefly explained that one way self-compassion is believed to be cultivated is through mindfulness practice over time (Desmond, 2017). I explained problems experienced related to our thoughts that keep us from being self-compassionate, such as when we treat our thoughts as if they are facts or when our thoughts distract us from being present (Desmond, 2017). The self-compassion based intervention *Present Moment* (Willard et al., 2017) encourages individuals to give themselves permission not to think about anything unpleasant for just a moment and essentially scan the present for good. This activity was designed to encourage students to give themselves permission to acknowledge thoughts related to the good (peace, contentment, or calm) that takes place in the present moment of their experience. I selected this intervention because I believed it might allow CITs to explore their ability to access feelings of self-compassion during ordinary moments such as during class. This intervention is also something that could easily be repeated outside of class if the student desired.

Intervention 4: When Self-Compassion is Difficult

For the fourth self-compassion based intervention, I briefly explained how embracing a specific obstacle with compassion and understanding can be helpful when self-compassion is difficult (Desmond, 2016, 2017). I utilized two main obstacles common for counseling students:

being overwhelmed and working with difficult clients. The self-compassion based intervention *Working with Difficult Clients* (Desmond, 2016) that I facilitated is a guided meditation that I adapted for the classroom. I chose this intervention because it was designed to help clinicians experience self-compassion when they are working with clients they would describe as difficult; thus, it is consistent with the research questions posed in this study.

Intervention 5: Prioritizing Self-Care through Self-Compassion

For the fifth and last intervention, I provided information about how self-compassion may allow us to care for ourselves as professionals. I described a philosophical view that when we learn to be self-compassionate, being fully present can allow us to know when we need to give ourselves care (Desmond, 2016). I briefly described the risk mental health professionals face for burnout and compassion fatigue and identified common obstacles to self-care for mental health professionals. I then led a guided meditation, adapted from *The Sweet Spot* (Willard et al., 2017) wherein I asked students to realistically consider an act of self-compassion and self-care that can be undertaken that day that was neither self-denial nor self-indulgence. During the meditation, students were encouraged to use the moment to derive a plan to enact what they identified. I chose this intervention because I believed after participation in the first four interventions, participants would have an idea of what may help them feel self-compassionate. I incorporated this intervention last to set the stage for students to engage in self-compassion interventions independently outside of the classroom. I believed the intervention of planning to engage in self-compassion could be a self-compassionate experience in itself for CITs.

Data Collection

Using the descriptive phenomenological approach, I collected descriptions of experience from CITs that provided sufficient depth so I could obtain new knowledge about self-compassion

training in group supervision. I used multiple sources of data, including journals, individual interviews, and a focus group. To gain a description of participants, I also collected demographic information and total scores on the SCS-SF to understand how self-compassionate participants may have been prior to participation in the self-compassion based interventions as part of their group supervision internship course. Since I selected the descriptive phenomenology approach, my aim was to "make the meanings of expressions more precise, which is what the descriptive phenomenological method aims to do" (Giorgi, 2009, p. 122). What I was seeking to gain from the data was detailed descriptions of the experiences of CITs participating in self-compassion based interventions.

Participant journals. One way to gain concrete and detailed information about participant experiences is to ask people to write a description of the experience itself (Giorgi, 2009). All students in the class were given a journal with allocated class time for writing a minimum of four entries about their experience. In-class journaling occurred on the days that self-compassion training was conducted. In addition, all students were invited to write outside of class about their experiences with self-compassion based interventions. During the five classes in which self-compassion based interventions were facilitated, students were asked to write at least one entry about their experience based on a specific journal prompt per intervention. (See Appendix F). There were three different journal prompts; two prompts were assigned twice and one assigned only once. To enhance confidentiality, participants utilized the pseudonym selected for the SCS-SF as identifiers on their journals. I handed out blank notebooks to all students during the first class wherein I facilitated the first self-compassion based intervention. Students kept these journals in their personal possession until the time of their individual interview. Journals were collected at the time of the individual interviews, which were scheduled based on

participants' availability, outside of the allocated classroom meeting time, and in a location separate from where students and professors typically gather in the department. Only journals of those who chose to participate in the study and were selected for interviews were collected. Journals of students who did not elect to participate were not collected. Use of pseudonyms on journals as well as collection of journals at the time of interviews enhanced confidentiality for participants.

Individual interviews. Once all five self-compassion based interventions were facilitated, participants met with me for an individual interview. Giorgi (2009) argued good interviews cannot simply be prescribed, which makes formulating systematic questions in advance difficult. I used a semi-structured interview (See Appendix G) to allow for follow up questions to foster a deepened understanding of CIT experiences. During the time of the interview, participants completed a brief demographic survey (See Appendix C) when they arrived for the interview. Interviews lasted between 25 minutes and one hour and 45 minutes and were audio recorded and transcribed. Giorgi (2009) stated is important for the researcher to distinguish between directing and leading participants. During the interview process, I sought to be mindful of appropriate situations to re-direct participants back their experience with the phenomenon under study. Throughout the interviews, I kept the scope of the study in mind (Giorgi, 2009).

Focus group. Once interviews were completed, I conducted a focus group. Questions were based on initial ideas about themes derived from the journals and individual interviews. The focus group was audio recorded and transcribed. While Giorgi's method does not specifically include the use of focus groups, his method of descriptive phenomenology does not eliminate their use. The use of a focus group served as another way to check with members about

my understanding of what participants described about their experience. Checking with participants in a focus group context helped me use descriptions of their experience to synthesize a final structure of their experience and to check that my analysis "holistically and relationally" (Giorgi, 2009, p. 102) described participant similarity and variations among their experience.

Data Analysis

Before data could be analyzed, I had to assume the appropriate mindset referred to as the attitude of phenomenological scientific reduction, to sensitively review data from a lens focused solely on the experience of the participants (Giorgi, 2009). After assuming this attitude through the use of bracketing, I began data analysis by reading and re-reading participant journal entries. During this phase, I also began to transcribe each individual interview. Once an interview was transcribed, I read and re-read it in order to gain a sense of the whole (Giorgi, 2009). In accordance with Giorgi's (2009) first step, I did not go beyond attempting to gain a global understanding of the phenomenon as I continued to read and re-read for a sense of the general experience (Giorgi, 2009).

The second step of Giorgi's (2009) data analysis is the determination of meaning units within the data. Giorgi (2009) described this process as more of a spontaneous process than an intellectual one and noted that meaning units should be selected based on sensitivity to a psychological perspective. The process of selecting meaning units involved reading and re-reading descriptions and marking clusters of words to establish some units of meaning that are contained within the description (Giorgi, 2009). Giorgi (2009) noted it is important for the researcher to maintain the psychologically sensitive perspective, and must focus on the phenomenon under investigation because the meaning units selected are often correlated with the attitude of the researcher; however, this is not problematic because the meaning units carry no

theoretical weight and are intended to make the description manageable (Giorgi, 2009). Giorgi (2009) further stated, "there are no objective meaning units" (p. 130) and what matters the most is how the meaning units are transformed.

The third step of this approach is considered by Giorgi (2009) the most time consuming and laborious of his approach. I read and re-read the descriptions from the individual interviews again after the meaning units were established. I *interrogated* each meaning unit to find out how to express it in a way that is most true to the description and its connection to the phenomenon (Giorgi, 2009). The goal of the third step is to transform each participant's natural attitude of description into expressions sensitive to the phenomenon under investigation. These expressions were derived from the phenomenological psychological attitude of the researcher (Giorgi, 2009). In Giorgi's (2009) words, expressions are "not just lying there, fully blown, ready to be picked out. It has to be detected, drawn out, and elaborated" (p. 131).

In accordance with the fourth step of Giorgi's method, I used free imaginative variation (Giorgi, 2012) and began to formulate the essential structure of the experience. I mentally took out pieces of data from the individual interviews to see how each piece was relevant or irrelevant to the structure by imagining how the rest of the data was impacted by taking out those pieces. The aim of this process was to reveal crucial psychological aspects in my data. I shaped my initial understanding of how participants described their experience and allowed these initial thoughts to aid the development of semi-structured interview questions which I used for the focus group. After the focus group interview was complete, I continued my analysis as I transcribed the focus group interview which allowed me begin to synthesize descriptions as I began to create the final essential structure of participant experience.

During the last phase of analysis, I created a final synthesis to make a statement describing CIT experience in self-compassion based interventions as part of their counseling education. The synthesis was created with the data from all three sources using the participants' own words, which I transformed "into psychologically pertinent expressions, but without using jargon of mainstream psychology" (Giorgi, 2009, p. 137). It is important to note that data analysis was used to describe my results and not interpret them as this is "an attitudinal difference between interpretive and descriptive analysis; a descriptive analysis does not try to go beyond the given" (Giorgi, 2009, p. 127). I was only able to describe what was given to me in the form of a description by my participants, and nothing beyond.

Trustworthiness

Giorgi (2009) asserted phenomenology "offers a certain logic for legitimizing qualitative descriptions with rigor" (p. 5). A key way researchers who use the descriptive phenomenological approach ensure rigor is through assuming an attitude of phenomenological reduction. Researchers assume this attitude through use of bracketing (Giorgi, 2009). Hamill (2010) described bracketing as a process that ought to extend in research beyond the data collection and analysis phase of research, and explained his view that bracketing should be maintained throughout the entire research process. In addition, Hamill (2010) noted the necessity of bracketing as a critical component of producing data and descriptions of the phenomenon under study that have not been "adjusted, massaged, embellished or misinterpreted by participants or researchers alike." (p. 23). To analyze from an attitude of phenomenological reduction, I first needed to be aware of my own experience with self-compassion and as a CIT. Secondly, I engaged in bracketing to differentiate my own current and previous experience with self-compassion from the participant descriptions of experiences to avoid imposing my own reality

during data analysis. Bracketing helped me remain objective towards the phenomenon I sought to describe and helps to ensure validity during the data collection phase (Shosa, 2012).

To help me engage in an ongoing process of bracketing, I wrote in a self- reflective and reflexive journal. Hamil (2010) described the use of a reflective journal as one way to achieve bracketing, as maintaining the journal allowed me to track my way of thinking about my data during analysis and as I discussed my findings with my peer debreifer and chair, as well as consider how my own experiences could influence analysis. In terms of reflexivity of the researcher, Fischer (2009) stressed the importance of looking back and inward to assess with self-awareness whether one is imposing meanings onto the data. Fischer (2009) explained reflexivity also entails re-observing the data to see what other meanings might emerge.

Furthermore, Giorgi (1997) stated that it is more rigorous for a researcher to adopt an attitude that identifies existing knowledge about the phenomenon and take this pre-known knowledge into account as they analyze, rather than ignore it entirely. Using the journal, I tracked descriptions of my own observations and reactions as they were relevant as well as what I knew from literature. I evoked an attitude of *epoché* (Giorgi, 2009), consistent with phenomenology, where I bracketed my own assumptions and judgement while I sought to understand descriptions of participant experience. The ability to be both self-reflexive and reflective aided my ability to be sincere, one criteria for excellent qualitative research (Tracy, 2010). To further aid in my trustworthiness, I additionally maintained an audit trail to track my thinking as I began formulating the structure of participant experience. Hamil (2010) advised the use of audit trails to provide a framework for establishing trustworthiness in qualitative research.

I established credibility through use of multiple sources of data, including journals, individual interviews, and a focus group. The focus group allowed me to check with critical

others, participants themselves, to further establish credibility (Giorgi, 2009). Multiple types of data promote credible research wherein "thick description, triangulation or crystallization, and multivocality" (p. 843) is used in analysis and reporting results (Tracy, 2010). The general synthesis was able to comprehensively describe the essential experiences of participants and resulted in a single structure comprised of nine constituents. One or more participants did not describe having individual experiences that differed from the general synthesis; therefore, formulating an additional structure for a separate description, or reporting on multiple structures of description was not appropriate.

Additionally, I used a peer de-briefer to help me strengthen credibility of the study. The peer de-briefer was an individual I contacted on an as needed basis throughout my data collection and analysis phase to discuss impressions and judgements I was forming throughout the study. This individual had no contact with participants and was not involved with the classes or study in any way. The use of debriefing allowed me to uncover bias, perspectives, or assumptions that formed during the study, helped with my own self-awareness regarding my posture toward data and analysis, and allowed me to test and defend emergent ideas and see if they seemed reasonable and plausible to a person uninvolved with the study (Lincoln & Guba, 1985). While this is not required by Giorgi's methods, it was a necessary step to allow me to remain objective throughout the study.

Summary

A detailed description of the study's research design and methodology was provided in this chapter. Descriptions of design rationale, my role as a researcher, the personal lens which influenced my research, data collection and analysis procedures, and how I ensured trustworthiness are included in this chapter. In lieu of chapters four and five, which typically

would include the results of my study and a meaningful discussion of them, I prepared and submitted a manuscript inclusive of these components to a scholarly journal, in hopes of adding the existent literature on self-compassion and group supervision practices in counselor education.

References

Ackerman, S. J., & Hillsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting therapeutic alliance. *Clinical Psychology Review, 23*, 1–33. doi:10.1037/0033-3204.38.2.171

American Counseling Association (ACA). (2015). *Code of Ethics*. Alexandria, VA: Author

American Counseling Association (ACA). (2004) *American Counseling Association's Task Force on Wellness and Impairment*. Available from http://creating-joy.com/taskforce/tf_wellness_strategies.htm (accessed 2 October, 2016)

Arimitsu, K. (2014). Development and validation of the Japanese version of the self-compassion scale. *Japanese Journal of Psychology, 85*, 50-59. doi:10.4992/jjpsy.85.50

Awa, W. L., Plaumann, M., & Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education & Counseling*, *78*, 184-190. doi:10.1016/j.pec.2009.04.008

Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. Washington, DC: American Psychological Association.

Barnard, L. K., & Curry, J. F. (2011). The relationship of clergy burnout to self-compassion and other personality dimensions. *Pastoral Psychology, 61,* 149-163. doi:10.1007/s11089-011-0377-0

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 behavioral psychotherapists: A quantitative survey. *Counselling and Psychotherapy Research, 16*, 15-23. doi:10.1002/capr.12054

Beaumont, E., & Martin, C. H. (2016). Heightening levels of compassion towards self and others through use of compassionate mind training. *British Journal of Midwifery*, *24*, 777-786.

Bernard, J. M., & Goodyear, R. K. (2014). Fundamentals of clinical supervision. Upper Saddle River, NJ: Merrill/Pearson.

Blount, A., & Mullen, P. (2015). Development of an integrative wellness model: Supervising counselors-in-training. *The Professional Counselor, 5*, 100-113. doi:10.15241/ajb.5.1.100

Breines, J. G., & Chen, S. (2012). Self-compassion increases self-improvement motivation. *Personality and Social Psychology Bulletin, 38),* 1133-1143. doi:10.1177/0146167212445599

Brownlee, E. (2016). How do Counsellors view and practice self-care? *Healthcare Counselling & Psychotherapy Journal, 16,* 15-17.

Campion, M., & Glover, L. (2017). A qualitative exploration of responses to self-compassion in a non-clinical sample. *Health & Social Care in the Community, 25,* 1100-1108. doi:10.1111/hsc.12408

Chen, J., Yan, L., & Zhou, L. (2011). Reliability and validity of Chinese version of the self-compassion scale. *Chinese Journal of Clinical Psychology*, *19*, 734-736.

Christopher, J. C., Chrisman, J. A., Trotter-Mathison, M. J., Schure, M. B., Dahlen, P., & Christopher, S. B. (2011). Perceptions of the long-term influence of mindfulness training on counselors and psychotherapists: A qualitative inquiry. *Journal of Humanistic Psychology, 51*, 318-349. doi:10.1177/0022167810381471

Christopher, J. C., & Maris, J. (2010). Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling and Psychotherapy Research, 10,* 114–125. doi:10.1080/14733141003750285

Coates, D., & Howe, D. (2015). Combatting staff burnout in mental health: Key managerial and leadership tasks that are fundamental to staff wellbeing and retention. *Asia Pacific Journal of Health Management*, *10*, 24-32.

Costa, J., Marôco, J., Pinto-Gouveia, J., Ferreira, C., & Castilho, P. (2016). Validation of the psychometric properties of the self-compassion scale. testing the factorial validity and factorial invariance of the measure among borderline personality disorder, anxiety disorder, eating disorder and general populations. *Clinical Psychology & Psychotherapy, 23,* 460-468. doi:10.1002/cpp.1974

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*. Retrieved from http://www.cacrep.org/wpcontent/uploads/2012/10/2016-CACREP-Standards.pdf

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping, 23,* 319-339. doi: 10.1177/1534765612471144

Cunha, M., Xavier, A., & Castilho, P. (2016). Understanding self-compassion in adolescents: Validation study of the self-compassion scale. *Personality and Individual Differences, 93,* 56-62. doi:10.1016/j.paid.2015.09.023

Deniz, M. E., Kesici, Ş., & Sümer, A. S. (2008). The validity and reliability of the Turkish version of the self-compassion scale. *Social Behavior & Personality: An International Journal*, *36*, 1151-1160.

Denzin, N. K., & Lincoln, Y.S. (2011). *The SAGE handbook of qualitative research*. Thousand Oaks: SAGE.

Denzin, N. K., & Lincoln, Y. S. (2005). *The SAGE handbook of qualitative research*. Thousand Oaks: SAGE.

Desmond, T. (2017). *The self-compassion skills workbook: A 14-day plan to transform your relationship with yourself*. New York, NY: W.W. Norton & Company, Inc.

Desmond, T. (2016). *Self-compassion in Psychotherapy*. New York, NY: W.W. Norton & Company, Inc.

Devenish-Meares, P. (2015). Call to compassionate self-care: Introducing self-compassion into the work process. *Journal of Spirituality in Mental Health, 17,* 75-87, doi:10.1080/19349637.2015.985579

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, 37*, 155–163. doi:10.1080/02703149.2014.850345

Emerson, S., & Markos, P. A. (1996). Signs and Symptoms of the Impaired Counselor. *Journal of Humanistic Education and Development*, *34*, 108-117.

Figley, C.R., (2002). *Treating Compassion Fatigue*. Brunner/Mazel, New York.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19,* 583-590. doi:10.1080/10503300902798375

Fulton, C. L. (2016). Mindfulness, self-compassion, and counselor characteristics and session variables. *Journal of Mental Health Counseling, 38*, 360-374. doi:10.17744/mehc.38.4.06

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

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, 13*, 353–379. doi: 10.1002/cpp.507

Giorgi, A. (2012). The descriptive phenomenological psychological method. *Journal of Phenomenological Psychology, 43*, 3-12. doi:10.1163/156916212X632934

Giorgi, A. (2009) *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburg, PA: Duquesne University Press.

Giorgi A (1997) The theory, practice and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology, 28,* 235-260.

Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 243- 273). Washington, DC: American Psychological Association.

Hamill, C. (2010). Bracketing-practical considerations in Husserlian phenomenological research. *Nurse Researcher, 17*, 16. doi:1.7748/nr2010.01.17.2.16.c7458

Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs. *Journal of Counseling & Development*, *89*, 288-295. doi: 10.1002/j.1556-6678.2011.tb00091.x

Hinton, O. S., Goodwin, L.R. (2016) *Barriers to wellness for counseling students*. Retrieved from http://www.counseling/org/docs/default-source/vistas/article_5649f227f16116603abcaff000bee4e7.pdf?sfvrsn=4

Hofmann, S. G., Grossman, P., & Hinton, D.E. (2011). Loving-kindness and compassion meditation: Potential for psychological interventions. *Clinical Psychology Review, 31*, 1126–1132. doi:10.1016/j.cpr.2011.07.003.

Hunt, B. (2011). Publishing qualitative research in counseling journals. *Journal of Counseling and Development, 89,* 296-300. doi: doi:10.1002/j.1556- 6678.2011.tb00092.x

Hunt, J. & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health, 46,* 3–10.

Huprich, S. K., & Rudd, M. D. (2004). A national survey of trainee impairment in clinical, counseling, and school psychology doctoral programs and internships. *Journal of Clinical Psychology*, *60*, 43-52. doi: 10.1002/jclp.10233

Husserl, E. (1983). Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. *Book 1*. Translated by F. Kersten. The Hague: Martinus Nijhoff. (Orig. pub. German, 1952).

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*, 116-120.

Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry, 4,* 33-47. doi:10.1016/0163-8343(82)90026-3

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A vision for the future of counseling: The new consensus definition of counseling. *Journal of Counseling & Development, 92*, 366-372. doi:10.1002/j.1556-6676.2014.00164.x

Kret, D. D. (2011). The qualities of a compassionate nurse according to the perceptions of medical-surgical patients. *Medsurg Nursing, 20*, 29–36.

Lawson, G. & Venart, E. (2005). Preventing counselor impairment: Vulnerability, wellness, and resilience. In. G. R. Walz & R. Yep (Eds.), *VISTAS: Perspectives on Counseling 2005* (pp. 243-246). Alexandria, VA: American Counseling Association.

Lincoln, YS. & Guba, EG. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lindlof, T. R., & Taylor, B.C. (2002). *Qualitative communication research methods* (2nd ed.). Thousand Oaks, CA: Sage.

Lopez Angarita, A., Sanderman, R., Smink, A., Zhang, Y., van Sonderer, E., Ranchor, A., & Schroevers, M. J. (2015). A reconsideration of the self-compassion scale's total score: Self-compassion versus self-criticism. *Plos One, 10,*1-12. doi:10.1371/journal.pone.0132940

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*, 545-552. doi:10.1016/j.cpr.2012.06.003

Mantzios, M., Wilson, J. C., & Giannou, K. (2015). Psychometric properties of the Greek versions of the self-compassion and mindful attention and awareness scales. *Mindfulness*, *6*, 123-132. doi:10.1007/s12671-013-0237-3

Melnick, J., & Fall, M. (2008). A gestalt approach to group supervision. *Counselor Education and Supervision, 48*, 48-60. doi:10.1002/j.1556-6978.2008.tb00061.x

Merriam, S. B., Tisdell, E. J., & Ebrary, I. (2015). *Qualitative research: A guide to design and implementation* (Fourth ed.). San Francisco, CA: Jossey-Bass.

Merriman, J. (2015). Enhancing counselor supervision through compassion fatigue education. *Journal of Counseling & Development, 93,* 370-378. doi:10.1002/jcad.12035

National Alliance on Mental Illness. (2015). Mental Health by the Numbers. Retrieved from

http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

Neff, K. D. (2016a). The Self-Compassion Scale is a valid and theoretically coherent measure of self-compassion. *Mindfulness, 7*, 264–274. doi: 10.1007/s12671-015-0479-3

Neff, K. D. (2016b). Does self-compassion entail reduced self-judgment, isolation, and over-identification?: A Response to Muris, Otgaar, and Petrocchi (2016). *Mindfulness*. Advance online publication. doi: 10.1007/s12671-016-0531-y

Neff, K.D. (2015). The Self-Compassion Scale is a Valid and Theoretically Coherent Measure of Self-Compassion. *Mindfulness, 7,* 1-11. doi: 10.1007/s12671-015-0479-3

Neff, K. D. (2003a). Development and validation of a scale to measure self- compassion. *Self and Identity, 2,* 223-250. doi: 10.1080/15298860390209035

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*, 85–102. doi:10.1080/15298860390129863

Neff, K.D. & Dahm, K.A. (2016). Self-compassion: What it is, what it does, and how it relates to mindfulness. (Eds.) *Mindfulness and Self-Regulation*. New York, NY: Springer.

Neff, K. D. and Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*, 28–44. doi:10.1002/jclp.21923

Neff, K. D., Hseih, Y., & Dejitthirat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity, 4,* 263–287. doi:10.1080/13576500444000317

Neff, K. D., Kirkpatrick, K., & Rude, S. S. (2007). Self-compassion and its link to adaptive psychological functioning. *Journal of Research in Personality, 41*, 139-154. doi: 10.1016/j.jrp.2006.03.004

Neff, K. D., & Pommier, E. (2013). The relationship between self-compassion and other-focused concern among college undergraduates, community adults, and practicing meditators. *Self and Identity, 12,* 160-176. doi:10.1080/15298868.2011.649546

Neff, K. D., & Rude, S. S., & Kirkpatrick, K. (2007). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of Research in Personality, 41*, 908- 916. doi: 10.1016/j.jrp.2006.08.002

Neff, K. D., Whittaker, T. & Karl, A. (2017). Evaluating the factor structure of the self-compassion scale in four distinct populations: Is the use of a total self-compassion score justified? *Journal of Personality Assessment, 99,* 1-12. doi: 10.1080/00223891.2016.1269334

Nelson, J. R., Hall, B. S., Anderson, J. L., Birtles, C., & Hemming, L. (2017). Self-compassion as self-care: a simple and effective tool for counselor educators and counseling students. *Journal of Creativity in Mental Health. 12,* 1-13. doi:10.1080/15401383.2017.1328292

Newsome, S. Waldo, M. & Gruszka, C. (2012). Mindfulness group work: Preventing stress and increasing self-compassion among helping professionals in training. *The Journal for Specialists in Group Work, 37,* 297-311. doi:10.1080/01933922.2012.690832

Norcross, J. C. (Ed.). (2002). Psychotherapy relationships that work: Therapist contributions and responsiveness to patients. New York, NY: Oxford University Press.

Ohrt, J. H., Prosek, E. A., Ener, E., & Lindo, N. (2015). The effects of a group supervision intervention to promote wellness and prevent burnout. *The Journal of Humanistic Counseling, 54,* 41-58. doi:10.1002/j.2161-1939.2015.00063.x

Pace, T. W., Negi, L., Sivilli, T. I., Issa, M. J., Cole, S. P., Adame, D.D., & Raison, C. L. (2010). Innate immune, neuroendocrine, and behavioral responses to psychosocial stress do not

predict subsequent compassion meditation practice time. *Psychoneuroendocrinology, 35,* 310–315. doi:10.1016/j.psyneuen.2009.06.008

Patton, M. Q. (2015) *Qualitative research and evaluation methods*. (4th ed.). Thousand Oaks: CA. SAGE.

Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods* (3rd ed.). Thousand Oaks, CA: SAGE.

Petrocchi, N., Ottaviani, C., & Couyoumdjian, A. (2014). Dimensionality of self-compassion: Translation and construct validation of the self-compassion scale in an Italian sample. *Journal of Mental Health, 23,* 72-77. doi:10.3109/09638237.2013.841869

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*, 137-145. doi: 10.1037/0022-0167.52.2 .137

Porges, S. W. (2007). The polyvagal perspective. *Biological Psychology, 74*, 116-143. doi: 10.1016/j.biopsycho.2006.06.009

Raab, K. (2014). Mindfulness, self-compassion, and empathy among health care professionals: A review of the literature. *Journal of Health Care Chaplaincy, 20*, 95-108. doi:10.1080/08854726.2014.913876

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the self-compassion scale. *Clinical Psychology & Psychotherapy*. *18*, 250-255. doi: 10.1002/cpp.702

Reyes, D. (2012). Self-compassion: A concept analysis. *Journal of Holistic Nursing, 30,* 81-89. doi:10.1177/0898010111423421

Richards, K. (2013). Self-care is a lifelong journey. *Nurs Econ 31,* 198-202. doi: 10.1177/1527154408318253

Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education and Supervision, 47*, 29–45. doi:10.1002/j.1556-6978.2007. tb00036.x

Rockcliff, H., Gilbert, P., McEwan, K., Lightman, S., & Glover, D. (2008). A pilot exploration of heart rate variability and salivary cortisol responses to compassion focused imagery. *Clinical Neuropsychiatry 5,* 132-139.

Rodríguez-Carvajal, R., García-Rubio, C., Paniagua, D., & García-Diex, G. (2016). Mindfulness integrative model (MIM): Cultivating positive states of mind towards oneself and the others through mindfulness and self-compassion. *Anales De Psicología, 32,* 749-760. doi:10.6018/analesps.32.3.261681

Salzberg, S. (2002). *Lovingkindness: The Revolutionary Art of Happiness*. Boston, MA: Shambhala Publications, Inc.

Schure, M. B., Christopher, J., & Christopher, S. (2008). Mind-body medicine and the art of self-care: Teaching mindfulness to counseling students through yoga, meditation, and qigong. *Journal of Counseling & Development*, *86*, 47-56. doi:10.1002/j.1556-6678.2008.tb00625.x

Shahar, B., Szsepsenwol, O., Zilcha-Mano, S., Haim, N., Zamir, O., Levi-Yeshuvi, S., & Levit-Binnun, N. (2015). A wait-list randomized controlled trial of loving-kindness meditation programme for self-criticism. *Clinical Psychology & Psychotherapy, 22,* 346-356. doi: 10.1002/cpp.1893

Shosa, G.A. (2012). Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. *European Scientific Journal, 8*, 31-43. doi:10.1177/1053825915609950

Shuler, M., & Keller-Dupree, E. (2015). The impact of transformational learning experiences on personal and professional counselor-in-training identity development. *The Professional Counselor, 5,* 152-162. doi:10.15241/mks.5.1.152

Sinclair, S., Kondejewski, J., Raffin-Bouchal, S., King-Shier, K. M., & Singh, P. (2017). Can self-compassion promote healthcare provider well-being and compassionate care to others?: Results of a systematic review. *Applied Psychology: Health and Well-Being, 9,* 168-206. doi:10.1111/aphw.12086

Smeets, E., Neff, K., Alberts, H., & Peters, M. (2014). Meeting suffering with kindness: Effects of a brief self-compassion intervention for female college students. *Journal of Clinical Psychology, 70*, 794-807. doi: 10.1002/jclp.22076

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*, 1372-1380. doi:10.1177/1049732307307031

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36,* 58-77. doi:10.17744/mehc.36.1.p61m73373m4617r3

Thompson, E. H., Frick, M. H., & Trice-Black, S. (2011). Counselor-in-training perceptions of supervision related to self-care and burnout. *The Professional Counselor, 1,* 152-162. doi: 10.15241/eht.1.3.152

Tracy, S. J. (2010). Qualitative quality: eight big-tent criteria for excellent qualitative research. *Qualitative* Inquiry, *10*, 837. doi: 10.1177/1077800410383121

Wardle, E.A., & Mayorga, M.G. (2016). Burnout among the counseling profession: A survey of future professional counselors. *Journal on Educational Psychology, 10*, 9-15.

Wertz, F. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*, 167-177. doi:10.1037/0022-0167.52.2.167

Willard, C., Abblett, M. & Desmond, T. (2017). *The self-compassion deck: 50 mindfulness-based practices*. United States. PESI Publishing & Media.

Wilson, A. (2015). A guide to phenomenological research. *Nursing Standard, 29*, 38-43. doi:10.7748/ns.29.34.38.e8821

Yarnell, M & Neff, K. D. (2012). Self-compassion, interpersonal conflict resolutions and wellbeing. *Self and Identity, 12,* 146-159. doi: 10.1080/15298868.2011.649545

Yeh, C. J., & Inman, A. G. (2007). Qualitative data analysis and interpretation in counseling psychology: Strategies for best practices. *The Counseling Psychologist, 35*, 369-403. doi:10.1177/0011000006292596

Zeng, X., Wei., J., Oei, T.P., & Liu, X. (2016). The self-compassion scale is not validated in a Buddhist sample. *Journal of Religion and Health, 55,* 1996-2009. doi:10.1007/s10943-016-0205-z

Zessin, U., Dickhäuser, O., & Garbade, S. (2015). The relationship between self-compassion and well-being: A meta-analysis. *Applied Psychology: Health and Well-Being, 7,* 340-364. doi:10.1111/aphw.12051

CHAPTER IV: ARTICLE

Counselor-In-Training Experiences of Self-Compassion Training in Group Supervision

The Clinical Supervisor

The Clinical Supervisor, a scholarly peer reviewed journal, publishes interdisciplinary work that chiefly deals with clinical supervision, which is regarded as both an art and science. Two issues of The Clinical Supervisor are published each year containing a range of manuscripts covering topics applicable for conducting supervision and working with supervisees. The Clinical Supervisor accepts quantitative, qualitative, and reflective pieces and is open to receiving manuscripts that deal with new techniques to support the advancement of psychotherapy and mental health.

I chose to submit my manuscript to The Clinical Supervisor because not only does the journal adhere to high standards for publication, but the manuscript appropriately aligns with the aims and scope of the journal since the focus of my study involves infusing an innovative form of training into group supervision. The Clinical Supervisor is interdisciplinary and may reach a wide audience inclusive of supervisors and faculty across mental health disciplines. Additionally, I observed the impact factor for The Clinical Supervisor has grown steadily since 2010, doubling its impact factor from .28 to .60. I believe my article will make for a unique submission that supports the concentration of the journal.

Abstract

The purpose of this study was to describe the experiences of counselors in training (CITs) who participated in self-compassion based interventions (SCIs) as a part of their group supervision internship course by using descriptive phenomenological inquiry. The primary research question was, how do CITs describe their experience participating in SCIs in group supervision? Eleven participants were interviewed and a structure comprised of nine constituents emerged: presence; relaxation; a reflective and evaluative process; thinking about, defining and applying self-compassion; heightened self-awareness; desire to engage in personally meaningful activities and practices; sometimes difficult to do; consideration of clients; and wanting more. Implications for counselor educators and supervisors and suggestions for future research are discussed.

Keywords: self-compassion, supervision

Counselor-In-Training Experiences of Self-Compassion

Training in Group Supervision

Burnout is the foremost cause of impairment in mental health professions and can impact quality of work with clients (Coates & Howe, 2015; Awa, Plaumann, & Walter, 2010), which makes preparing counselors-in-training (CITs) to cope with issues like burnout and compassion fatigue critical to their counseling education. Wardle and Mayorga (2016) reported that even though CITs are not yet categorized as mental health professionals, they too are at risk for increased vulnerability to burnout, and call for additional research to explore ways counseling programs can include self-care practices into curriculum. Inclusion of self-care strategies into counseling curriculum is now a standard for programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), which are required to "teach self-care strategies appropriate to the counselor role" (Council for the Accreditation of Counseling and Related Educational Practices [CACREP], 2015, p. 10).

Although CACREP recognized the importance of self-care for CITs, methods to infuse self-care strategies into counselor training may need further development. Exploring and discussing self-care in the context of group supervision (Brownlee, 2016) is one way counseling programs are training CITs to cope with burnout. Group supervision courses are one place where supervisors can "model self-care and positive coping strategies for stress, which may influence supervisees' practice of self-care" (Thompson, Frick, & Trice-Black, 2011, p. 153). While the key focus of the supervisor is to monitor the welfare of clients and facilitate the professional and personal growth of CITs (Melnick & Fall, 2008), some researchers (Christopher & Maris, 2010; Dorian & Killebrew, 2014; Newsome, Waldo, & Gruska, 2012) have noted that very few clinical and educational programs are directly teaching self-care strategies to CITs even though "self-

care is vital to helping professionals" (Nelson, Hall, Anderson, Birtles, & Hemming, 2017, p. 1). Instead, self-care is often included in counselor training as "a recommendation to incorporate self-care into his or her life" (Nelson et al., 2017, p.1). This is problematic because CITs tend to neglect care for themselves during counselor training as a result of their concentrated focus on client care (Brownlee, 2016). Further, counselor educators play a significant role in the personal and professional development of CITs (Shuler & Keller-Dupree, 2015); thus, CITs may perceive self-care as optional when it is not part of the curriculum (Nelson et al., 2017).

Some researchers believe self-compassion may serve as a viable means to provide CITs with a foundation in self-care and burnout reduction (Nelson et al., 2017; Brownlee, 2016; Fulton, 2016). Nelson et al. (2017) proposed including self-compassion based interventions in counselor training as "an effective way to model and practice self-care" (p. 2). Fulton (2016) also thought incorporating self-compassion into counselor training would be "fruitful given the difficulty students have coping" (p. 371). However, a review of the literature revealed no studies about inclusion of such training. The aim of this study was to begin to fill this gap by exploring how CITs described their experience participating in SCIs as a part of their group supervision course, and to additionally explore if this served as a means to teach self-care practice or related to their work with clients in any way.

Defining Self-Compassion

Neff (2003a) described the term *self-compassion* as "being open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one's inadequacies and failures, and recognizing that one's own experience is part of the common human experience" (p. 224). While the concept of self-compassion is relatively new to western culture, it has been a key part of Buddhist

psychology for hundreds of years (Neff, 2003b). From the Buddhist perspective, self-compassion and mindfulness are closely interconnected. Buddhists believe to extend compassion towards self, an individual must attend to their current thoughts and emotions with balance and a realistic perspective, which involves "understanding the nature of the self," (p. 223) or having empathy for what it is like to be human (Neff, 2003a). Additionally, Buddhism maintains it is as vital "to feel compassion for oneself as it is for others" (Neff, 2003a, p. 244).

Self-Compassion from a Western Perspective

In the western world, little research was explicitly produced on self-compassion as a psychological construct before Neff (2003a) began her work examining it. Neff's (2003a) interest in self-compassion emerged after Kabat Zinn's mindfulness based stress reduction programs were developed in 1988 and 1992 when she observed "an increasing dialogue between Eastern philosophical thought, Buddhism in particular, and Western psychology" (p. 223). In line with Buddhist philosophy, Neff also believes self-compassion and mindfulness are interrelated; thus, she included the role of mindfulness as a central component of the construct as she defined it. In recent years, Neff has used the phrase *mindful self-compassion* synonymously with her construct self-compassion (Neff & Germer, 2013).

Neff also developed the first instrument to measure self-compassion, the Self-Compassion Scale (SCS; 2003a). Since the development of the SCS, researchers have quantitatively demonstrated levels of self-compassion significantly predict psychological well-being (Barnard and Curry 2011; Neff, Kirkpatrick & Rude, 2007; Zessin, Dickhäuser, & Garbade, 2015), depression, and anxiety (MacBeth & Gumley, 2012) and is associated with positive affect, optimism, and happiness (Neff et al., 2007). The SCS has been demonstrated to negatively correlate with constructs like depression, anxiety, life satisfaction, and neurotic

perfectionism (Neff, 2003a) and to correlate positively with constructs such as perceived confidence, lesser fear of failure, and the ability to cope with life stressors (Neff, Hseih, & Dejitthirat, 2005). Additionally, Neff et al. (2007) reported an association between self-compassion and well-being, positive affect, and happiness.

While Neff's description of self-compassion as a construct has only been challenged by a few (Lopez Angarita et al., 2015; Zeng, Wei, Oei, & Liu, 2016), other researchers have expanded the areas to which it may be applicable. For example, Gilbert and Proctor (2006), who found self-compassion promotes emotional resilience in adults in an outpatient setting, suggested the reason for this is because when self-compassion is experienced, the brain's threat system is deactivated and the care-giving system becomes activated. Breines and Chen (2012) found self-compassion leads to increased self-improvement motivation and elaborated on their findings by stating that self-compassion provides a supportive environment for individuals to "confront negative aspects of the self and strive to better them" (p. 1140). Furthermore, Campion and Glover (2017), in a study using thematic analysis, reported participants found it easier to be critical of themselves rather than to be self-compassionate and highlighted the need to be aware of cultural norms and systemic influences surrounding individuals when encouraging self-compassion.

The Impact of Self-Compassion Based Interventions

Researchers have only recently reported on the impact of SCIs. In a study that explored stress levels in adults, researchers Rockliff, Gilbert, McEwan, Lightman, and Glover (2008) discovered individuals who participated in a brief self-compassion exercise experienced lower levels of cortisol, a stress hormone. This is similar to the findings by Pace et al. (2010) who reported SCIs, often called compassionate meditations, have been successfully used to decrease

stress. Self-compassion interventions have also been demonstrated to enhance the ability to self-soothe (Beaumont, Durkin, Hollins, & Carson, 2016; Porges, 2007).

Self-Compassion and Self-Care

Counselors have a duty to maintain their personal wellness in part because of the significant impact self-care has on therapeutic alliance (Ackerman & Hillsenroth, 2003; Norcross, 2002; Roach & Young, 2007). There are many evidenced-based recommendations for burnout prevention, such as self-care (Thompson et al., 2011), wellness interventions (Ohrt, Prosek, Ener, & Lindo, 2015), mindfulness based stress reduction (Kabat Zinn, 1982), and stress management (Beaumont et al., 2016), none of which specifically address self-compassion. In recent years, research has emerged that indicates self-compassion may play a role in reducing burnout. Raab (2014) described implications for self-compassion as a vital component of prevention for compassion fatigue and to promote compassionate care towards others. Thompson et al. (2011) noted professional counselors with high levels of self-compassion report less burnout and less maladaptive ways of coping, which is similar to findings from Neff et al. (2005) that self-compassion has correlated positively with more effective coping. Even though some researchers have stated training in self-compassion may be productive for individuals in the helping field to increase participation in self-care activities (Fulton, 2016; Gilbert, 2005; Kret, 2011; Nelson et al., 2017), there is limited research on how self-compassion can be included into counselor education with CITs or how self-compassion could serve as a method to teach self-care practice or relate to client work.

Self-Compassion and Compassion for Others

There is little research about the relationship between self-compassion and compassion for others. However, some researchers have made claims that a consequence of self-compassion

is increased compassion for others (Barnard & Curry, 2011; Figley, 2002; Hofmann, Grossman, & Hinton, 2011; Neff, 2003a; Reyes, 2012). Two studies are of note regarding the potential relationship between self-compassion and compassion for others. In the first, Beaumont and Martin (2016) found that when student midwives judged themselves unsympathetically, they not only were less self-compassionate, but they had less compassion for others. Neff and Pommier (2013) reported that self-compassion is significantly associated with other-focused concern; however, the nature of the association varied based on the participant's age and gender. Nonetheless, they concluded from their findings that "self-compassion and compassion for others tend to go hand-in-hand" (p.173). Given the importance of the therapeutic relationship in client outcomes, more information about connections between these two constructs would be useful.

Purpose and Rationale for Study

Given the emerging view that self-compassion may be a productive approach for training counselors about self-care, a reasonable first step is to consider how self-compassion training is experienced by those receiving the training. Therefore, the purpose of this study was to describe the lived experiences of CITs who participated in SCIs when infused into internship group supervision coursework. This study aimed to understand the essential structure of how CITs described their experiences as they participated and reflected on their experience during the self-compassion training. The primary research question for this study was: How do CITs describe their experience participating in SCIs in group supervision? Additional questions informing the research included: (a) How do CITs experience SCIs in group supervision in relation to their self-care practices? and (b) How do CITs experience SCIs in group supervision in relation to their work with clients?

Method

I utilized Giorgi's (2009) descriptive phenomenological approach to qualitative inquiry because I sought to gain a deepened understanding and description of the structure of the chosen phenomenon, the experience of CITs who participated in SCIs during group supervision. This methodology provided a comprehensive way to understand the experience as it allows the researcher to obtain "concrete and detailed descriptions" (Giorgi, 2009, p. 122). Giorgi's descriptive phenomenology (2009) is grounded in Husserl's phenomenological approach to science, which regards human experience as a *legitimizing cognition* that should be both respected and trusted and should be accepted "only within the limits in which it was presented" (Husserl, 1983, p. 44). Analysis and description of participants' experience utilized Giorgi's methods (2009, 2012).

Role and Lens of the Researcher

Both my role in the research and my lens regarding the phenomenon must be acknowledged. I maintained an etic, or outsider, role. I was not part of the same experience in the same way as participants. I filled several roles over the course of the study, including that of teaching assistant, facilitator of SCIs, interviewer, and data analyst. To separate my own assumptions and experience with self-compassion, I employed an attitude of phenomenological reduction and used bracketing (Giorgi, 2009). I utilized a digital journal to record field notes about my observations during interventions, interviews, and focus group and tracked my reactions and decision-making processes.

My personal experience with self-compassion came about through daily mindfulness practice as a CIT, during which I realized my struggle with wellness was rooted in a struggle to be self-compassionate. That realization fostered deep curiosity about self-compassion, including

its role in clinical practice and training, which in turn led to intentional examination of available research. My personal belief is that I am a better version of myself and a better counselor when I am more self-compassionate and I became intrigued by how others might experience self-compassion. My ability to be self-reflective about my own experience with self-compassion allowed me to be aware of my own personal biases on this topic.

Trustworthiness

"Phenomenology offers a certain logic for legitimizing qualitative descriptions with rigor" (Giorgi, 2009, p. 5). Trustworthiness during data collection and analysis was established by assuming attitudes of epoché and phenomenological reduction, where I engaged in bracketing and suspended all judgements about the phenomenon. Hamill (2010) noted the necessity of bracketing as a critical component of producing data and descriptions of the phenomenon under study that have not been "adjusted, massaged, embellished or misinterpreted by participants or researchers alike" (p. 23). To analyze from an attitude of phenomenological reduction, I first needed to be aware of my own experience with self-compassion and as a CIT. Secondly, I engaged in bracketing to differentiate my own current and previous experience with self-compassion from the participant descriptions of experiences to avoid imposing my own reality during data analysis. Bracketing helped me remain objective towards the phenomenon I sought to describe and helps to ensure validity during the data collection phase (Shosa, 2012).

Additionally, throughout the study, I used a self-reflective and self-reflexive journal to track my thinking and reactions related to the data. Fischer (2009) stressed the importance of looking back and inward to assess with self-awareness whether one is imposing meanings onto the data. Reflexivity entails re-observing the data to see what other meanings might emerge (Fischer, 2009). I also used a peer-debreifer who was not connected to the study or participants

during moments where I found it difficult to maintain both attitudes. The use of debriefing allowed me to uncover bias, perspectives, or assumptions that formed during the study, helped with my own self-awareness regarding my posture toward data and analysis, and allowed me to test and defend emergent ideas and see if they seemed reasonable and plausible to a person uninvolved with the study (Lincoln & Guba, 1985). While this is not required by Giorgi's methods, it was a vital part of remaining true to the data as it was presented. In addition, I used multiple sources of data and engaged in a process of checking with critical others, the participants, through a focus group (Giorgi, 2009), both of which help to establish credibility.

Participant Characteristics

The participants in this study were selected from a sample of 24 counseling students enrolled in two different sections of the internship group supervision course. While originally 17 counseling internship students agreed to participate, only 11 participants submited their journals and were interviewed. Four of the 11 participants who were individually interviewed participated in the focus group. Among the 11 participants, two were male and nine were female. Two were between 18 and 24 years old, four were between 25 and 34 years old, four were between 35 and 44 years old, and one was between 45 and 54 years old. Six participants identified as Caucasian, one as African American, and four as Hispanic. Six participants were Internship I students, and five participants were Internship II students. Two participants were on the marriage and family counseling track, five on the clinical mental health track, two on the school counseling track, one on the addictions counseling track, and one reported fulfilling requirements for both the addictions counseling and the clinical mental health counseling tracks. Two participants volunteered they were concurrently enrolled in the Strategies for Stress Management course at the time of participation in this study.

Participants completed the Self-Compassion Scale Short Form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) and scores of the SCS-SF are ranked in three categories: low, average, and high. Overall scores of 1 or 2 mean the participant has a lower amount of self-compassion compared with the norming sample. A score of 3 means the participant has an average amount of self-compassion compared with the norming sample and scores of 4 or 5 mean the participant has high amount of self-compassion compared with the norming sample. Participant scores on the SCS-SF ranged from scores of low self-compassion to high self-compassion with seven participants' scores of total self-compassion falling into the average self-compassion threshold, one participant's scores falling into the low self-compassion threshold, and three participants' scores falling into the high levels of self-compassion threshold.

Setting of the Study

The study was conducted at a moderately sized university in South Texas that accommodates many non-traditional students and is a Hispanic-Serving Institution. Participants were enrolled in a CACREP-accredited master's program that offers four emphasis areas: clinical mental health; marriage, couple, and family counseling; school counseling; and additions counseling. Many of the students enrolled in the program maintain fulltime or part-time employment and are parents, spouses, and/or care-takers to family members in addition to their role as graduate student counselors.

Descriptive Measure

The Self-Compassion Scale Short Form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) was used to measure the CITs' overall level of self-compassion as a descriptive measure before they participated in SCIs as part of the group supervision course. The SCS-SF was developed as a condensed measure of the SCS to assess for levels of self-compassion in an adult

sample and correlates almost perfectly to the SCS (Raes et al., 2011). The SCS-SF is a 12-item is a self-reporting measure that uses a Likert scale to rate statements such as, "I try to see my failings as part of the human condition" and "When I'm going through a very hard time, I give myself the caring and tenderness I need." The SCS-SF was selected over the SCS as a matter of classroom efficiency since it is much shorter and quicker for students to complete and self-score than the SCS.

On the first night of each group supervision class, I administered paper copies of the SCS-SF to all students in class to complete. I instructed students to self-score the assessment, and provided an explanation for how to interpret results. I directed students to use only a pseudonym on their assessments. After all students completed and reviewed their individual results, I collected the instrument from all students, made copies, and returned the originals at the next class meeting. I did not use data from students who were not participants.

The Interventions

Even though the concept of self-compassion has increased in appearance in recent literature, literature review did not reveal any evidence-based practices for the use of self-compassion as a training component in counselor education. The SCIs were selected from various self-compassion based intervention materials available to clinicians. Selection of the SCIs was based primarily on what resources were available and adaptable to a classroom setting. My own experience as a CIT, counselor, and supervisor also played a key part in the selection process. While most of the interventions I selected are delivered through mindfulness practice, selection was focused on the component of self-compassion that is believed to be achieved through each intervention (Salzburg, 2002; Willard, Abblett & Desmond, 2017). In five of the group supervision classes, I used the first 10-15 minutes of the class to provide some information

about the SCI, facilitate the intervention, and process and answer any questions and reactions students had that resulted from participation in the intervention. I made a statement prior to each intervention suggesting students may wish to practice these interventions during their own time outside of class. During the last five minutes of class, all students responded to journal prompts about the experience of engaging in the intervention as part of their group supervision course (Insert TABLE 1 about here).

Data Collection

After all five SCIs were facilitated in class, I used the contact information provided by participants at the time of consent to schedule individual interviews. I assigned participants a number and used a random number generator to determine the order of participants that I contacted to schedule interviews. I collected participant journals at the time of the scheduled individual interview and continued interviews until data was of sufficient depth that I could derive new knowledge about self-compassion training in group supervision and no new data was being presented. After the individual interviews took place and were recorded and transcribed, all participants were invited to participate in a focus group interview. My intention was to "make the meanings of expressions more precise, which is what the descriptive phenomenological method aims to do" (Giorgi, 2009, p. 122). What I sought to gain from the data was detailed descriptions of the experiences of CITs participating in SCIs.

Journals. One way to gain concrete and detailed information about participant experiences is to ask people to write a description of the experience itself (Giorgi, 2009). All students in the class were given a journal with allocated class time for writing about their experience. There were three different journal prompts; two prompts were assigned twice and one assigned only once. The journal prompts were: a) "What was it like to participate in the self-

compassion intervention?" b) "When I think about self-compassion…" and c) "Self-compassion interventions have…" Only journals of those who chose to participate in the study and were selected for interviews were collected.

Individual Interviews. Once all five SCIs were facilitated in class, participants participated in an individual interview. Giorgi (2009) argued good interviews cannot simply be prescribed, which makes formulating systematic questions in advance difficult; therefore, I constructed a semi-structured interview guide to allow for follow up questions to foster a deepened understanding of CIT experiences. Interviews lasted between 25 minutes and one hour and 45 minutes and were audio recorded and transcribed. As I interviewed my participants, I kept the scope of the study in mind (Giorgi, 2009).

Focus Group. Once interviews were completed, I conducted a focus group which was attended by four participants. Questions were based on initial ideas about constituents derived from the journals and individual interviews. Checking with participants in a focus group context helped me use descriptions of their experience to synthesize a final structure of their experience and served as a way for me to check that my analysis "holistically and relationally" (p. 102) described participant similarity and variations among their experience (Giorgi, 2009).

Data Analysis

I began data analysis by reading and re-reading participant journal entries and by transcribing each individual interview. Once an interview was transcribed, I read and re-read it in order to gain a sense of the whole (Giorgi, 2009). Next, in accordance with Giorgi's (2009) second step of data analysis, I determined meaning units within the data, which Giorgi (2009) described as more of a spontaneous process than an intellectual one. The process of selecting meaning units involved reading and re-reading descriptions and marking clusters of words to

establish units of meaning that were contained within the description, selecting those based on sensitivity to a psychological perspective (Giorgi, 2009).

The third step of this approach was the most time consuming of his approach (Giorgi, 2009). I read and re-read the descriptions from the individual interviews again after the meaning units were established and then *interrogated* each meaning unit to find out how to express it in a way that is most true to the description and its connection to the phenomenon (Giorgi, 2009). I sought to transform each participant's natural attitude of description into expressions sensitive to the phenomenon under investigation. In Giorgi's (2009) words, expressions are "not just lying there, fully blown, ready to be picked out. It has to be detected, drawn out, and elaborated" (p. 131).

To complete the fourth step of Giorgi's (2009) method, I used *free imaginative variation* wherein I began to formulate the essential structure of the experience. I mentally took out pieces of data from the individual interviews to see how each piece was relevant or irrelevant to the structure by how I imagined the rest of the data was impacted by taking out certain pieces. The aim of this process was to reveal crucial psychological aspects in my data. I shaped my initial understanding of how participants described their experience and allowed these initial thoughts to aid the development of semi-structured interview questions which I used for the focus group. After the focus group interview was complete, I continued my analysis as I transcribed the focus group interview, which allowed me begin to synthesize descriptions as I created the essential structure of participant experience.

During the last phase of analysis, I created a final synthesis to make a statement describing CIT experience of SCIs as part of their counseling education. The synthesis was created with the data from all three sources using the participants' own words, which I

transformed "into psychologically pertinent expressions, but without using jargon of mainstream psychology" (Giorgi, 2009, p. 137). It is important to note that data analysis was used to describe the results and not interpret them as this is "an attitudinal difference between interpretive and descriptive analysis; a descriptive analysis does not try to go beyond the given" (Giorgi, 2009, p. 127). I was only able to describe what was given to me in the form of a description by my participants, and nothing beyond.

Results

Analysis of data revealed 9 essential constituents of participants' experience of participation in self-compassion interventions during their internship group supervision. These include presence; relaxation; reflective and evaluative process; thinking about, defining, and applying self compassion; heightened self-awareness; desire to engage in personally meaningful activities and practices; sometimes difficult to do; consideration of clients; and wanting more.

Presence

An important element of participants' experience dealt with a connection to the present moment during their participation throughout class. Participants described their experience as becoming more focused, attentive, clear-minded, and present. Multiple participants shared that they experienced a separation from thinking about things that were not a part of what was taking place during the intervention and the rest of the class. Tessa said this most succinctly when she stated, "It helped me to center myself, get ready for class, and focus on class, instead of focusing on everything I had to do" and further explained it helped her "listen to my peers verses being distracted." Allyson indicated that as she continued to participate in the interventions, the more "in the moment" she was able to be.

Participants described how becoming more present impacted their participation quality during class. Jack Rabbit explained, "It helped me refocus so I can be present and support my classmates." Similarly, Ted stated, "It gave me a clear head so that I could better use my input to help my peers with feedback." Some participants even connected presence with self-compassion. For instance, Ted indicated, "It is important to practice self-compassion because it will allow you to be able to slow down and be in the present moment." Jack Rabbit explained, "well maybe that's what self-compassion is . . . it is just being able to exist in the moment and tell yourself: I am just going to sit here and just be." While the concept of presence was described as an important element of the experience, some participants acknowledged that it was difficult to maintain, particularly in the last five minutes when the journaling was taking place. Reagan encapsulated this difficulty when she said, "At that time, I was already thinking about what I needed to do when I got home and what do I need to do to get ready for tomorrow. It was hard to stay present at the end."

Relaxation

All participants described experiencing relaxation to varying degrees during their participation in the self-compassion interventions. Participants referred to the experience itself as relaxing and some participants shared relaxing more intentionally outside of the self-compassion training. Participants described the experience of relaxation as "feeling more serene" (Tessa) and "calm" (Ted, Aqua Mind, and Allyson). Raegan indicated she felt as if she had taken a "little nap" after a particular intervention, while Jack Rabbit shared feeling "at peace." Allyson disclosed, "I came into the class nervous because of my presentation, but after the activity I was relaxed" and remained "relaxed throughout the class." Stating that she found the self-compassion training "to be relaxing", Mrs. Johnny Bravo elaborated: "It was really nice to come into class

and have five minutes at the beginning and five minutes at the end to just really have some quiet time for myself." Ted noted that, "Self-compassion interventions have . . . a relaxing tone to it, to allow growth." Some participants described relaxing more outside of class (Ted, Maggie, and Allyson). Maggie shared, "I take time to relax and do things for myself more." Similarly, Allyson decided to relax more with her children; she explained ". . . because I saw that we were getting overwhelmed and we were becoming frustrated and stressed . . . I just decided to take that day for ourselves to just relax and take it easy."

Reflective and Evaluative Process

The essence of this element has to do with on-going reflection and evaluation about self on the part of participants throughout the SCIs. Ways in which participants described this process varied. For instance, Mrs. Johnny Bravo described the process as "self-reflection . . . self-reflection . . . and more self-reflection . . . and then how can I make some changes going forward?" Sheila stated, "I would think about myself in ways that you don't usually sit and just think about, like how you treat yourself." Sandy said her experience entailed "reflecting on self and really talking to yourself . . . in a way where you are really introspectively getting to the core of the person that you are." Self-reflection sometimes entailed realization of what their experiences have to do with their care of clients or other people in their lives. Ted shared, "All these things that I was trying to teach other people to do, to help them with those feelings, and being in class, we were going through the self-compassion . . . I felt it for myself . . . the reduced stress . . . the reduced racing thoughts." Allyson noted that she "never really thought about myself . . . about what I needed" and later reflected on how her own self-care had changed. She stated, "At the same time that I am doing it for myself, I am also doing it for them [her children] . . . How I am going to be there for them, if I cannot be there for myself?"

Not surprisingly, the self-reflective process involved evaluation. As Tessa put it, her experience of the SCIs "asked me to be evaluative about my day and what I am doing." Similarly, Mrs. Johnny Bravo indicated, "It really provided me with more of a check in time, for my wellness. It gave me the time to really reflect about the week, how I was feeling, and what I needed to do more of." Sheila also saw her experience as "good for me, because I am doing what I need to do and doing things seen as self-compassion for me." Aqua Mind, also evaluating herself and her experience, stated "I don't feel I was able to be self-compassionate" while Maggie expressed that "it is easy for me to be compassionate towards others." Maggie revealed, "During the mindfulness exercises, and while journaling, it brought up some questionable attitudes and behaviors that I didn't like seeing in myself."

The evaluation extended to the interventions themselves. Mrs. Johnny Bravo said, "I like these interventions because they can be done anywhere and take very little training, but lots of practice" while Ruby reported, "I am way past this. I know I need to do self-care." Participants varied in their evaluation of whether the SCIs were personally useful, with assessments ranging from "Self-compassion interventions have been somewhat helpful for me" (Raegan) to "Self-compassion interventions have been extremely helpful for me this semester" (Sandy), and even to "I'm not sure if it was helpful or unhelpful, but it sure felt good" (Tessa).

Thinking about, Defining, and Applying Self-Compassion

A key part of participant experience involved thinking about self-compassion, defining it for themselves, and applying it in their own lives. This process was not a linear process for participants, but was expressed synchronously within their descriptions. When thinking about self-compassion, some participants compared it to concepts they were more familiar with. For example, Jack Rabbit initially described thinking, "Self-compassion and self-awareness seem

inseparable in my mind" while Mrs. Johnny Bravo shared, "When I think of self-compassion, I think of the wellness wheel." Others thought about consequences of being self-compassionate, such as when Sandy stated, "When we have compassion for ourselves and our brains are not going 20 miles an hour all the time, we can take time to reflect in a way that is peaceful and helpful." For some participants, a part of thinking about and defining self-compassion also dealt with questioning what it is. For example, Jack Rabbit and Mrs. Johnny Bravo wondered about what self-compassion is and questioned how it is different from self-care or wellness.

Participants defined self-compassion for themselves and described what they thought it was in ways that had to do with a kind disposition towards self. For example, Ruby stated that "Self-compassion is about doing something to show yourself love" while Allyson indicated, "Self-compassion is taking care of yourself." Other descriptions included definitions of self-compassion as "unconditional acceptance of my circumstances and reactions to my circumstances" (Aqua Mind), "giving myself permission to heal" (Sandy) and "giv(ing) yourself leeway" (Sheila). Jack Rabbit noted that it is "the antithesis of perfection."

Participants also considered how they incorporated this concept into their lives. All participants shared ways of being self-compassionate. As Allyson put it, "It's not just about breathing . . . it's about positive thinking. It's about thinking about ways that you can help others and how you can put that to yourself." Ways of incorporating self-compassion were varied, and included such things as rest and relaxation, time with family, coping, turning one's phone off, doing little things for oneself, doing something that will be helpful to themselves in the long run, grieving, and getting out of stressful environments.

Two of the most prevalent ways participants described application of self-compassion involved self-talk and self-compassion as stress relief. The most common phrase referenced by

participants was “it will be okay,” used during difficult moments (Sheila, Tessa, Raegan, Allyson, Ruby, and Jack Rabbit). Other examples were provided by Jack Rabbit and Tessa. Jack Rabbit indicated that “self-compassion is being able to say: I don’t have to do anything right now” when needed and Tessa stated, “I guess I have been self-compassionate because I have been making a concentrated effort to have more positive self-talk.” Participants also described applying the concept of self-compassion in their lives in ways that prevent or alleviate stress, such as when Raegan speculated, “I think this will be useful during stressful weeks when my schedule is super busy.” Ted noted, “It took a lot more for me to get to a certain point of feeling anxious or overwhelmed if I was doing the self-compassion interventions as opposed to when I wasn’t.” Allyson similarly shared the SCIs “have given me outlets when I feel stressed or ready to quit.”

Heightened Self-Awareness

Participants described becoming more self-aware during their experience participating in the self-compassion training. Allyson stated succinctly what other participants described similarly when she said, “self-compassion interventions have allowed me to truly be aware of myself.” Some participants became more aware of self-compassionate things they were already doing for themselves. Sheila noted, “It was more of a shock or surprise . . . I already do a lot of these things.” Raegan shared that the experience of self-compassion training “brought more awareness to it [what she already does for herself].” Other participants expressed a deeper awareness of self more broadly. For example, Allyson indicated that “Now, at times I will catch myself doing or thinking about things for myself . . . how certain things make me feel . . . how I have been able to accomplish so much in the last year that I never thought possible.” Aqua Mind reflected, “Now I can identify exactly what is happening in my mind . . . Before, I was less

aware." Some participants seemed simply to tune in more to themselves, as illustrated by Mrs. Johnny Bravo when she indicated, "I just don't listen to myself at all" and Aqua Mind described "just paying more attention to myself."

Desire to Engage in Personally Meaningful Activities and Practices

Participants described having a desire to engage in personally meaningful activities and practices during their experience in the self-compassion training. In addition to thinking about various activities that were already a part of their life rhythm, participants noticed a desire to continue doing or engaging more in activities they individually identified as self-compassionate. Mrs. Johnny Bravo stated, "It's what we crave too . . . we are craving more spirituality, we are craving more fitness, we are craving more down time to just veg out and watch TV". Similarly, Sheila indicated the experience of self-compassion training "reinforced the things that intrinsically we wanted to do" relating to areas of life Tessa described as "valuable."

What constituted meaningful activities for participants was also individualized. A few participants described a desire to participate more in spiritually- related practices. Tessa stated, "Two weeks has gone by and I haven't done daily devotionals, so this kept me more on track, even though that's been my goal for a long time . . . having that kept me more on track and helped me put some action behind the intent." Sandy noted, "I've taken more time to just have daily prayer." She also shared about grieving the loss of a child and expressed how her experience of self-compassion training "has given me a way to give myself permission to mourn the loss of my son in a healthier way." Aqua Mind expressed a desire to re-implement yoga "back into my life for restorative balance and healing." Regardless of the particulars, participants experienced a desire to do the things that mattered to them.

Sometimes Difficult to Do

At some point during participation, participants seemed to encounter difficulty related to some aspect of their experience in the self-compassion training, whether directly related to the concept or experience of self-compassion or with some aspect of participation such as engagement in the SCIs. Ruby, Mrs. Johnny Bravo, Maggie, Jack Rabbit, and Allyson described participation as "difficult" and Aqua Mind and Raegan described part of their experience as "a challenge" related to participation during one or multiple interventions. Sheila noted, "Self-compassion was difficult for me to grasp in the beginning" and described the topic of self-compassion as "ambiguous" and "not really something taught." Other participants described difficulties related to participation in a specific intervention (Maggie, Ruby, Allyson, and Ted). For example, Maggie indicated, "In the first intervention, you wanted us to send compassion toward someone in our life who had maybe hurt us . . . but I didn't want to . . . it was more like an internal conflict . . . it was just rough to finally sit there and self-reflect on what I felt."

Consideration of Clients

An element that arose repeatedly dealt with considering their clients to varying extents during their experience. While one of the interview questions asked all participants about whether they believed their experiences may have impacted their work with clients, some participants referenced thinking about clients during journaling and in the interview prior to being asked about it. Some participants considered ideas about how their experiences in the self-compassion training was incorporated into ways they thought about clients. Sheila stated that "It increased my awareness of what may be going on with the client." Tessa offered, "Self-care, and talking about what I am doing for myself, and how that impacts my care for my clients has really become a major focal point this semester in a way that it hadn't been before." Other participants

considered ways clients could benefit from having similar experiences, such as when Ruby considered using one of the interventions with clients. She stated, "That intervention, to me, I will probably use in a session . . . because it was so impactful to me, I know it could probably help someone else." Allyson shared more broadly how her experience "taught me that it is really beneficial and it is something that could be beneficial to certain clients."

Some participants considered how they directly incorporated certain components from their experience into session with a specific client, whether it related to encouraging self-compassion or had another purpose. Aqua Mind stated she paid more attention in session to the language used by her clients. She described how "Now, I caveat [*sic*] with how else could you say this or how can we put this in a positive light . . . I think it does for them what it does for me . . . it makes them more cognizant of what they are saying" to themselves. In describing her experience working with a "busy mom", Reagan said, ". . . so we started talking about self-care and what she enjoys doing and not to feel guilty about doing something you enjoy . . . I think with that client, this helped . . . being better able to explain self-compassion and self-care." Ted reported that he viewed the self-compassion interventions as a means of coping that allowed him to learn a different way to structure his sessions. He noted, "Doing the coping skills (in session) to begin with, as opposed to the very end, helped him (a client) calm down a little bit . . . we were more equal in terms of our stress level" as the session continued.

Wanting More

This element of participants' experience has to do with a variety of things they wanted more of during and following the training, such as time, opportunity, and reminders, as well as wanting more self-compassion. While what participants wanted was unique to the individuals, nonetheless there was strong indication of wanting more of *something* during or following the

training. Some participants wanted more time for journaling. As Aqua Mind explained, "At the end it was kind of hurried . . . we would run out of time right when I was in the middle of it, so I would kind of let my thought trail off . . . It ended abruptly, so that was kind of hard." Others wanted more time for interventions. Tessa noted that "Five minutes isn't usually anywhere near enough" for the interventions and Mrs. Johnny Bravo stated "I think 10 minutes more could really let it sink in just a little bit more." Sheila also wanted more engagement with peers during the self-compassion training. She shared she believed it would be helpful to her learning if during the training she could "talk to more students in class about what they wrote, or about the journal prompt before we wrote."

Another aspect of wanting more dealt with wanting more in relation to their formal learning environment. Many of the participants talked about the idea of making aspects of their participation into a required class or built into courses. For instance, Mrs. Johnny Bravo said "Maybe everyone should be required to take a class on relaxation" and added, "requiring some sort of wellness class like an hour a week" would be her recommendation. Jack Rabbit volunteered, "I think every class in our program should start with five minutes of self-compassion or mindfulness, or self-care, or stretching, or doing real simple yoga poses or something, to help everybody get re-centered." Tessa concisely stated, "We should do this in every class."

Additionally, some participants expressed wanting more in the sense of wanting to increase doing things they considered self-compassionate outside of class. Sandy shared, "I would like to incorporate this into my daily life." Ted and Mrs. Johnny Bravo both reported wanting a reminder so they could do more of what was done in class in their own time. As Ted said, "something to remind myself about self-compassion on a consistent basis would really help

me overall." Maggie and Jack Rabbit expressed a desire for more self-compassion. Maggie expressed the hope that she "can continue being self-compassionate," while Jack Rabbit shared wanting "more time for self-compassion" and described self-compassion as something "which I am trying to do more of."

One additional finding, while not an essential constituent of the experience, is worth noting. Language participants used for what they were engaged in encompassed a variety of terms, which may indicate only beginning knowledge about various concepts commonly discussed in counseling. Wellness, mindfulness, self-compassion, and self-care were used interchangeably by participants throughout their journal entries and the interviews.

Discussion

The aim of the present study was to describe the experiences of CITs who participated in self-compassion training during group supervision. A strength of this study involves obtaining knowledge about the experiences of CITs as participants who directly experienced participation in self-compassion training. Despite many recommendations for the inclusion of self-compassion training in counselor education (Beaumont et al., 2016; Fulton, 2016; Nelson et al., 2017), experiences of CITs who have directly experienced self-compassion training had not previously been considered in the available scholarly literature.

Given the design of the self-compassion training, it is not surprising that certain constituents emerged. For example, participants described their experiences participating in the SCIs as involving presence and heightened self-awareness, which are common consequences of mindfulness practice (Neff, 2003b). Given that the SCIs utilized were comprised of guided meditations, often referred to as mindfulness interventions, it would be more surprising if presence and heightened self-awareness were not both constituents of the experience.

Conversely, it is important to recognize participant experience in the SCIs contained relaxation. Mindfulness practice differs from relaxation training since the goal of mindfulness asserts to focus on what is happening in the present moment, rather than changing it to one that may be more calm and serene (Newsome et al., 2012).

A noteworthy a part of participant experience contained a desire to engage in personally meaningful activities and practices, which included a diverse range of activities that can be viewed as acts of self-care. Similarly, Nelson et al. (2017) report practicing self-compassion should consequently allow one to engage in activities that promote one's sense of wellbeing. Many of the activities participants desired to engage in were activities they also considered acts of self-compassion. As participants thought about, defined, and applied the concept of self-compassion to their lives, many of these activities overlapped as activities participants desired to engage in that were personally meaningful.

Moreover, participants not only experienced a desire to engage in personally meaningful activities and practices, they also considered their clients during their experience in the SCIs as well. Reyes (2012) reported self-compassion leads to increased relatedness to others which is consistent with Neff's (2003b) claim that self-compassion also fosters a sense of connectedness that encourages feelings of responsibility toward others. It is also important to acknowledge the study took place in the context of group supervision, where considering clients is a natural and intentional focal point of the course.

That participants engaged in a reflective and evaluative process as an essential part of their experience is meaningful to the current available literature. Shuler and Keller-Dupree (2015) described how the ability to self-reflect plays a critical role in counselor development that is on-going verses stagnant due to burnout. Shuler and Keller-Dupree (2015) noted there is a

dearth of literature regarding how counselor educators can incorporate student self-reflective experiences into curriculum. CACREP (2015) currently recommends counseling programs to include "strategies for personal and professional self-evaluation" (p. 11) into curriculum. Shuler and Keller-Dupree (2015) implied more research is needed on ways to incorporate methods that encourage self-reflection and evaluation into counseling curriculum. Given that an essential part of participant experience contained a reflective and evaluative process, self-compassion training may be a means to do so.

Finally, participant's usage of a variety of terms to describe their experience in self-compassion training may support current literature that connect the terms, albeit not in the same way that scholars have noted. For example, Nelson et al. (2017) described self-compassion as "a self-care strategy" and Reyes (2012) reported self-compassion leads to an increased capacity for self-care, so it makes sense that participants receiving self-compassion training saw a similarity between the two concepts.

Limitations

This study has several limitations. First, participants may have viewed the information needed for a phenomenological approach as intrusive into their private experiences, which may have in turn limited the trust of participants and thus the fullness of their responses (Wilson, 2015). I strove to demonstrate ethical and trustworthy behavior throughout the conduct of the classes and interactions with participants. Similarly, the use of the focus group, particularly with students who knew each other and were involved in the same academic program, may have impacted how open they were in their discussion of the phenomenon. It is also possible that dynamics between and among students who likely had previous experiences with each other over the course of their academic journey impacted willingness to be open in the focus group. A third

limitation is that the majority of the participants were female. A participant group with more males may have rendered different results. A fourth possible limitation is the design of the series of self-compassion interventions itself. Use of different activities or focus on different aspects of self-compassion may have resulted in different findings. A fifth limitation is that several of the self-compassion interventions are structured within mindfulness practices. Thus, while the focus of the research was self-compassion, it is difficult to ascertain whether or the extent to which results were impacted by mindfulness practice or whether self-compassion practice, apart from mindfulness, would yield similar results. An additional limitation is that two of the participants reported concurrently receiving a training in stress management strategies during the semester they participated in this study, which could have impacted their experience during participation. Finally, the fact that I was known to many of the students as a teaching assistant and Counseling Training Clinic Assistant Director may have impacted their responses. Future research can address these limitations by examining different interventions, designing studies intended to investigate overlap of impact between mindfulness and self-compassion interventions, including a more gender-balanced population, and provision of interventions or interviews by someone not as involved with participants as I was.

Implications

This study gave voice to participants, which may inform counseling educators and supervisors who might be searching for ways to teach self-care strategies or infuse self-compassion into counselor training. First, self-compassion training may be an effective strategy to encourage CITs to engage in self-care. Given the dynamic ways CITs described engaging in self-compassion or wanting to engage more in personally meaningful activities and practices, the

self-compassion training might serve as a more direct method of infusing self-care strategies into training and better prepare CITs to engage in self-care at the very start of their careers.

Second, counselor educators and supervisors should consider that participants wanted more than what was provided in the self-compassion training. Whether developed into its own course, infused into already existing courses, or infused into forms of supervision, more time and engagement in the self-compassion training was desired from participants. As was clear from participants' responses, brief periods within one course was insufficient.

The fact that participants' descriptions of their experiences included terms that are related but not synonymous may have relevance for researchers and counselor educators. Whether the constructs themselves have significant overlap, participants lacked sophisticated understanding of what the terms encompass, or some combination of both, it is important for counselor educators and supervisors to be aware that CITs may not be able to distinguish topics and concepts that may be infused into coursework. If CITs are not able differentiate concepts such as wellness and self-compassion, the likelihood is they are not fully aware of what these concepts are and how they interrelate. Lack of awareness may impact both their own self-care as well as their work with clients.

More research is needed to determine whether self-compassion training may be one method that helps prevent burnout during and following counselor preparation and whether any impact would be lasting. Research concerning elements of wellness practices, self-care strategies, self-compassion training, mindfulness interventions, and other strategies believed to enhance well-being and serve as protective factors could be examined to determine whether there are differential impacts among CITs.

Conclusion

Counselors are required to deal with the demands of the profession that lead to burnout and compassion fatigue (Awa et al., 2010; Coates & Howe, 2015). Scholars have previously indicated that counseling programs are not adequately training counselors to engage in self-care (Christopher & Maris, 2010; Dorian & Killebrew, 2014; Newsome et al., 2012). Self-compassion has been suggested as a possibly effective method to infuse strategies for self-care into counseling curriculum (Brownlee, 2016; Fulton, 2016; Nelson et al., 2017). The current study examined the experiences of CITs who participated in self-compassion training during a required supervision course. A structure of nine constituent elements was identified to describe the experience of CITs. The results of the study adds to the literature regarding self-compassion training, specifically by providing insight about what it is like for CITs who engaged in such training, which is an important first step in understanding the possible role of self-compassion training as a means of enhancing self-care among counselors-in-training.

References

Ackerman, S. J., & Hillsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting therapeutic alliance. *Clinical Psychology Review, 23*, 1–33. doi:10.1037/0033-3204.38.2.171

Awa, W. L., Plaumann, M., & Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education & Counseling*, *78*, 184-190. doi:10.1016/j.pec.2009.04.008

Barnard, L. K., & Curry, J. F. (2011). The relationship of clergy burnout to self-compassion and other personality dimensions. *Pastoral Psychology, 61,* 149-163. doi:10.1007/s11089-011-0377-0

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 behavioral psychotherapists: A quantitative survey. *Counselling and Psychotherapy Research, 16*, 15-23. doi:10.1002/capr.12054

Beaumont, E., & Martin, C. H. (2016). Heightening levels of compassion towards self and others through use of compassionate mind training. *British Journal of Midwifery*, *24*, 777-786.

Breines, J. G., & Chen, S. (2012). Self-compassion increases self-improvement motivation. *Personality and Social Psychology Bulletin, 38,* 1133-1143. doi:10.1177/0146167212445599

Brownlee, E. (2016). How do counsellors view and practice self-care? *Healthcare Counselling & Psychotherapy Journal, 16,* 15-17.

Campion, M., & Glover, L. (2017). A qualitative exploration of responses to self-compassion in a non-clinical sample. *Health & Social Care in the Community, 25,* 1100-1108. doi:10.1111/hsc.12408

Christopher, J. C., & Maris, J. (2010). Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling and Psychotherapy Research, 10,* 114–125. doi:10.1080/14733141003750285

Coates, D., & Howe, D. (2015). Combatting staff burnout in mental health: Key managerial and leadership tasks that are fundamental to staff wellbeing and retention. *Asia Pacific Journal of Health Management*, *10*, 24-32.

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*. Retrieved from http://www.cacrep.org/wpcontent/uploads/2012/10/2016-CACREP-Standards.pdf

Desmond, T. (2017). *The self-compassion skills workbook: A 14-day plan to transform your relationship with yourself*. New York, NY: W.W. Norton & Company, Inc.

Desmond, T. (2016). *Self-compassion in Psychotherapy*. New York, NY: W.W. Norton & Company, Inc.

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, 37*, 155–163. doi:10.1080/02703149.2014.850345

Figley, C.R., (2002). *Treating Compassion Fatigue*. Brunner/Mazel, New York.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19,* 583-590. doi:10.1080/10503300902798375

Fulton, C. L. (2016). Mindfulness, self-compassion, and counselor characteristics and session variables. *Journal of Mental Health Counseling, 38*, 360-374. doi:10.17744/mehc.38.4.06

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

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, 13*, 353–379. doi: 10.1002/cpp.507

Giorgi, A. (2009) *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburg, PA: Duquesne University Press.

Hamill, C. (2010). Bracketing-practical considerations in Husserlian phenomenological research. *Nurse Researcher, 17*, 16.

Hofmann, S. G., Grossman, P., & Hinton, D. E. (2011). Loving-kindness and compassion meditation: Potential for psychological interventions. *Clinical Psychology Review, 31*, 1126–1132. doi:10.1016/j.cpr.2011.07.003.

Hunt, B. (2011). Publishing qualitative research in counseling journals. *Journal of Counseling and Development, 89,* 296-300. doi: doi:10.1002/j.1556- 6678.2011.tb00092.x

Husserl, E. (1983). Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. *Book 1*. Translated by F. Kersten. The Hague: Martinus Nijhoff. (Orig. pub. German, 1952).

Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and

preliminary results. *General Hospital Psychiatry, 4,* 33-47. doi:10.1016/0163-8343(82)90026-3

Kret, D. D. (2011). The qualities of a compassionate nurse according to the perceptions of medical-surgical patients. *Medsurg Nursing, 20*, 29–36.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lopez Angarita, A., Sanderman, R., Smink, A., Zhang, Y., van Sonderer, E., Ranchor, A., & Schroevers, M. J. (2015). A reconsideration of the self-compassion scale's total score: Self-compassion versus self-criticism. *Plos One, 10,*1-12. doi:10.1371/journal.pone.0132940

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*, 545-552. doi:10.1016/j.cpr.2012.06.003

Melnick, J., & Fall, M. (2008). A gestalt approach to group supervision. *Counselor Education and Supervision, 48*, 48-60. doi:10.1002/j.1556-6978.2008.tb00061.x

Neff, K. D. (2003a). Development and validation of a scale to measure self- compassion. *Self and Identity, 2,* 223-250. doi: 10.1080/15298860390209035

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*, 85–102. doi:10.1080/15298860390129863

Neff, K. D. and Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*, 28–44. doi:10.1002/jclp.21923

Neff, K. D., Hseih, Y., & Dejitthirat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity, 4,* 263–287. doi:10.1080/13576500444000317

Neff, K. D., Kirkpatrick, K., & Rude, S. S. (2007). Self-compassion and its link to adaptive psychological functioning. *Journal of Research in Personality, 41*, 139-154. doi: 10.1016/j.jrp.2006.03.004

Neff, K. D., & Pommier, E. (2013). The relationship between self-compassion and other-focused concern among college undergraduates, community adults, and practicing meditators. *Self and Identity, 12,* 160-176. doi:10.1080/15298868.2011.649546

Nelson, J. R., Hall, B. S., Anderson, J. L., Birtles, C., & Hemming, L. (2017). Self-compassion as self-care: a simple and effective tool for counselor educators and counseling students. *Journal of Creativity in Mental Health. 12,* 1-13. doi:10.1080/15401383.2017.1328292

Newsome, S. Waldo, M. & Gruszka, C. (2012). Mindfulness group work: Preventing stress and increasing self-compassion among helping professionals in training. *The Journal for Specialists in Group Work, 37,* 297-311. doi:10.1080/01933922.2012.690832

Norcross, J. C. (Ed.). (2002). Psychotherapy relationships that work: Therapist contributions and responsiveness to patients. New York, NY: Oxford University Press.

Ohrt, J. H., Prosek, E. A., Ener, E., & Lindo, N. (2015). The effects of a group supervision intervention to promote wellness and prevent burnout. *The Journal of Humanistic Counseling, 54,* 41-58. doi:10.1002/j.2161-1939.2015.00063.x

Pace, T. W., Negi, L., Sivilli, T. I., Issa, M. J., Cole, S. P., Adame, D.D., & Raison, C. L. (2010). Innate immune, neuroendocrine, and behavioral responses to psychosocial stress do not predict subsequent compassion meditation practice time. *Psychoneuroendocrinology, 35,* 310–315. doi:10.1016/j.psyneuen.2009.06.008

Porges, S. W. (2007). The polyvagal perspective. *Biological Psychology, 74*, 116-143. doi: 10.1016/j.biopsycho.2006.06.009

Raab, K. (2014). Mindfulness, self-compassion, and empathy among health care professionals: A review of the literature. *Journal of Health Care Chaplaincy, 20,* 95-108. doi:10.1080/08854726.2014.913876

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the self-compassion scale. *Clinical Psychology & Psychotherapy*. *18*, 250-255. doi: 10.1002/cpp.702

Reyes, D. (2012). Self-compassion: A concept analysis. *Journal of Holistic Nursing, 30,* 81-89. doi:10.1177/0898010111423421

Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education and Supervision, 47*, 29–45. doi:10.1002/j.1556-6978.2007. tb00036.x

Rockcliff, H., Gilbert, P., McEwan, K., Lightman, S., & Glover, D. (2008). A pilot exploration of heart rate variability and salivary cortisol responses to compassion focused imagery. *Clinical Neuropsychiatry 5,* 132-139.

Salzberg, S. (2002). *Lovingkindness: The Revolutionary Art of Happiness*. Boston, MA: Shambhala Publications, Inc.

Shosa, G.A. (2012). Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. *European Scientific Journal, 8*, 31-43.

Shuler, M., & Keller-Dupree, E. (2015). The impact of transformational learning experiences on personal and professional counselor-in-training identity development. *The Professional Counselor, 5,* 152-162. doi:10.15241/mks.5.1.152

Sinclair, S., Kondejewski, J., Raffin-Bouchal, S., King-Shier, K. M., & Singh, P. (2017). Can self-compassion promote healthcare provider well-being and compassionate care to others?: Results of a systematic review. *Applied Psychology: Health and Well-Being, 9,* 168-206. doi:10.1111/aphw.12086

Thompson, E. H., Frick, M.H., & Trice-Black, S. (2011). Counselor-in-training perceptions of supervision related to self-care and burnout. *The Professional Counselor, 1,* 152-162. doi: 10.15241/eht.1.3.152

Wardle, E. A., & Mayorga, M.G. (2016). Burnout among the counseling profession: A survey of future professional counselors. *Journal on Educational Psychology, 10*, 9-15.

Willard, C., Abblett, M. & Desmond, T. (2017). *The self-compassion deck: 50 mindfulness-based practices*. United States. PESI Publishing & Media.

Wilson, A. (2015). A guide to phenomenological research. *Nursing Standard, 29*, 38-43. doi:10.7748/ns.29.34.38.e8821

Zeng, X., Wei., J., Oei, T. P., & Liu, X. (2016). The self-compassion scale is not validated in a Buddhist sample. *Journal of Religion and Health, 55,* 1996-2009. doi:10.1007/s10943-016-0205-z

Zessin, U., Dickhäuser, O., & Garbade, S. (2015). The relationship between self-compassion and well-being: A meta-analysis. *Applied Psychology: Health and Well-Being, 7,* 340-364. doi:10.1111/aphw.12051

TABLE 1.

Table 1. *Self-Compassion Based Interventions*

Week	Content	Intervention Title	Resources
1	Introduce self-compassion Content (5 min): Describe what self-compassion is, and how it relates to mindfulness practice	Loving Kindness Meditation (2-3 min) guided meditation; (7 min) to process experiences as a group	(Desmond, 2016, p. 1-19; (Salzberg, 2002)
2	Self-compassion as a skill Content (5 min): Describe self-compassion as a skill and practice; describe basic neuroscience that describes how self-compassion strengthens the care circuit in the brain.	A Friend Indeed (2-3 min) guided meditation (7 min) to process experiences as a group	(Desmond, 2017, p. 13-15; Willard et al., 2017)
3	Mindfulness of Thoughts Content (5 min): Explain how compassion is cultivated through mindfulness practice over time (Tolerate, Accept, Welcome, Embrace with Compassion) when we develop mindfulness of the body	Present Moment (2-3 min) guided meditation (7 min) to process experiences as a group	(Desmond, 2017, p. 52; Willard et al., 2017)
4	When self-compassion is difficult Content (3 min): Explain how embracing the obstacle with compassion and understanding help when self-compassion is difficult. Describe briefly two main obstacles: being overwhelmed and competing commitments	Working with Difficult Clients, adapted (5-7 min) guided meditation; (3 min) to process experiences as a group	(Desmond, 2016, p. 191- 192; 2017, p. 87-89)
5	Prioritizing self-care through self-compassion Content (5 min): Identify briefly common obstacles to self-care for mental health professionals and how self-compassion may allow professionals to increase personal care	The Sweet Spot, adapted (5 min) guided meditation; (5 min) to process experiences as a group	(Desmond, 2016, p. 189- 193; Willard et al., 2017)

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APPENDIX A: Institution Review Board Approval Letter

OFFICE OF RESEARCH COMPLIANCE
Division of Research, Commercialization and Outreach

6300 OCEAN DRIVE, UNIT 5844
CORPUS CHRISTI, TEXAS 78412
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Human Subjects Protection Program	Institutional Review Board

APPROVAL DATE:	November 17, 2017
TO:	Caroline Norris
CC:	Dr. Marvarene Oliver
FROM:	Office of Research Compliance Institutional Review Board
SUBJECT:	Initial Approval
Protocol Number:	IRB # 123-17
Title:	Counselor In Training Experiences of Self-Compassion Training in Group Supervision
Review Category:	Expedited 6
Expiration Date:	November 16, 2018

Approval determination was based on the following Code of Federal Regulations:

Eligible for Expedited Approval (45 CFR 46.110):Research presents no more than minimal risks.

Expedited 6: Research involves only the use of educational tests, survey procedures, interview procedures, or observation of public behavior. Identification of the subjects or their responses (or the remaining procedures involving identification of subjects or their responses) will NOT reasonably place them at risk of criminal or civil liability or be damaging to their financial standing, employability, insurability, reputation, or be stigmatizing [45 CFR 46.101(b)(2).

Criteria for Approval has been met (45 CFR 46.111) - The criteria for approval listed in 45 CFR 46.111 have been met.

Provisions:	
Comments:	The TAMUCC Human Subjects Protections Program has implemented a post-approval monitoring program. All protocols are subject to selection for post-approval monitoring.

1. Informed Consent: Information must be presented to enable persons to voluntarily decide whether or not to participate in the research project unless otherwise waived.
2. Amendments: Changes to the protocol must be requested by submitting an Amendment Application to the Research Compliance Office for review. The Amendment must be approved by the IRB before being implemented.
3. Continuing Review: The protocol must be renewed each year in order to continue with the research project. A Continuing Review Application, along with required documents must be submitted 45 days before the end of the approval period, to the Research Compliance Office. Failure to do so may result in processing delays and/or non-renewal.

4. Completion Report: Upon completion of the research project (including data analysis and final written papers), a Completion Report must be submitted to the Research Compliance Office.
5. Records Retention: All research related records must be retained for three years beyond the completion date of the study in a secure location. At a minimum these documents include: the research protocol, all questionnaires, survey instruments, interview questions and/or data collection instruments associated with this research protocol, recruiting or advertising materials, any consent forms or information sheets given to participants, all correspondence to or from the IRB or Office of Research Compliance, and any other pertinent documents.
6. Adverse Events: Adverse events must be reported to the Research Compliance Office immediately.
7. Post-approval monitoring: Requested materials for post-approval monitoring must be provided by dates requested.

APPENDIX B: Clinic Support Letter

Texas A&M University-Corpus Christi
Department of Counseling and Educational Psychology
Counseling and Training Clinic
Natural Resources Center, Suite 2700 Corpus Christi, TX 78412
6300 Ocean Drive, Unit 5855 (361) 825-3988

October, 17, 2017

Institution Review Board
Texas A&M University- Corpus Christi

Dear IRB Committee:

I am excited about the research that Caroline Norris will be conducting as part of the Internship group supervision courses. I fully support and give her access to the use of the audio recording equipment and physical space of the Counseling and Training Clinic to assist her with her study, "*Counselor in Training Experiences of Self-Compassion Training in Group Supervision.*"

The clinic's recording equipment utilizes Logitech software, which is uploaded to computers that do not have access to the internet. The recording equipment, encrypted with Bitlocker to ensure confidentiality, is set-up and managed to ensure supervisors have real-time access to counselors'-in-training (CIT) performance. This method of monitoring by supervisors and peers ensures quality care and client safety, while keeping client's physical identity confidential. The use of this software will ensure Caroline can record and store data from individual interviews and a focus group in a dependable and secure way as she seeks to understand CIT's experiences, as part of her study.

The Counseling and Training Clinic at Texas A&M University- Corpus Christi is an excellent place to offer technological support and access to confidential physical space for data collection in Caroline's study. We welcome the opportunity to help with this however we can.

Sincerely,

Dr. Yvonne Castillo
Yvonne Castillo, Ph.D., LPC Approved Supervisor
Director, Counseling and Training Clinic
Texas A&M University-Corpus Christi
361-825-3995
yvonne.castillo@tamucc.edu

APPENDIX C: Brief Demographic Survey

My Pseudonym is: _____

Age: _____

Ethnicity: _____

Gender: _____

Circle only one:
My current level in Internship is:

Internship I Internship II

Circle only one:

Clinical Mental Health Counseling

Marriage and Family Counseling

Addictions Counseling

School Counseling

APPENDIX D: Self-Compassion Scale- Short Form

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale – Short Form in your research (12 items instead of 26 items). The short scale has a near perfect correlation with the long scale when examining total scores. We do not recommend using the short form if you are interested in subscale scores, since they're less reliable with the short form. You can e-mail me with any questions you may have. The appropriate reference is listed below.

Best wishes,

Kristin Neff, Ph. D.

e-mail: kristin.neff@mail.utexas.edu

Reference:

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy. 18*, 250-255.

Coding Key:

Self-Kindness Items: 2, 6

Self-Judgment Items: 11, 12

Common Humanity Items: 5, 10

Isolation Items: 4, 8

Mindfulness Items: 3, 7

Over-identified Items: 1, 9

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1) - then compute a total mean.

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

APPENDIX E: Self-Compassion Interventions

Week	*Intervention Title*	*Description*
1	Content: Introduce self-compassion Activity: Loving Kindness Meditation "May I be safe…May I be happy…May I be healthy…May I dwell in peace…" Next, the mantra will be repeated towards an imagined neutral party, and then to a person with whom the student is in conflict.	Content (5 min): Describe what self-compassion is, and how it relates to mindfulness practice Activity (10 min): 2-3 minutes of guided meditation extending kindness towards self **includes brief time to process the experience as desired by students and participants* Resources*:* Desmond, 2016, p. 1-19; Salzberg, 2002
2	Content: Self-Compassion as a Skill Activity: *"A FRIEND INDEED":* What would you offer a friend at the end of a hard day that can offer yourself now? Reflect on this thought as you continue to breathe.	Content (5 min): Describe self-compassion as a skill and practice; describe basic neuroscience that describes how self-compassion strengthens the care circuit in the brain. Activity (10 min): 2-3 minutes of guided meditation **includes brief time to process the experience as desired by students and participants* Resources: Desmond, 2017, p. 13-15; Willard et al., 2017
3	Content: Mindfulness of Thoughts Activity: "*PRESENT MOMENT*": We all think happiness is something that will come later when conditions in our lives are better. For just a few breaths, let go of any thought about the future and see if there is peace, contentment, or perhaps a place of calm to be found in the present.	Content (5 min): Explain how compassion is cultivated through mindfulness practice over time (Tolerate, Accept, Welcome, Embrace with Compassion) when we develop mindfulness of the body Activity (10 min): 2-3 minutes of guided meditation **includes brief time to process the experience as desired by students and participants* Resources: Desmond, 2017, p. 52-57; Willard et al., 2017

4	Content: When Self-Compassion is Difficult Activity: Working with Difficult Clients	Content (3 min): Explain how embracing the obstacle with compassion and understanding help when self-compassion is difficult. Describe briefly two main obstacles: being overwhelmed and competing commitments Activity (10 min): 5-7 minutes guided meditation focused on thinking about a client who is difficult to work with, and tolerating the physical and emotional experience of working with this client and sending compassion towards self in this moment. **includes brief time to process the experience as desired by students and participants* Resources: Desmond, 2016, p. 191- 192; 2017, p. 87-89
5	Content: Prioritizing Self-Care through Self-Compassion Activity: The Sweet Spot	Content (5 min): Identify briefly common obstacles to self-care for mental health professionals and how self-compassion may allow professionals to increase personal care Activity (10 min): Using a guided meditation, time in class will be allotted for students to privately self-select an activity they can realistically engage in that involves both self-compassion and self-care and will be given time to plan what they will do. **includes brief time to ask questions, share ideas, and process the experience as desired by students and participants* Resources: Desmond, 2016, p. 189- 193; Willard et al., 2017

APPENDIX F: Journal Prompts

Week 1 & 2: What was it like to participate in the self-compassion intervention?

Week 3: When I think about self-compassion…

Week 4 & 5: Self-compassion interventions have…

APPENDIX G: Semi-Structured Interview Guide

1. Describe your experience participating in self-compassion interventions during group supervision.

   Sample follow-up question: Tell me more about _____.

2. Tell me about ways, if any, in which participating in self-compassion interventions may have impacted your self-care.

   Sample follow-up question: What do you mean by ____?

3. Tell me about ways, if any, in which participating in self-compassion interventions may have impacted your work with clients.

   Sample follow up question: What do you mean by ____?

4. Tell me about any emotions you were aware of related to your participation in self-compassion interventions.

   Sample follow-up question: What other emotions came up for you during the interventions, if any?

5. Tell me about any learning you may have experienced as part your participation in the self-compassion interventions.

   Sample follow-up question: What do you think facilitated this learning?

6. Please describe ways, if any, you were positively impacted by participating in self-compassion interventions during group supervision.

   Sample follow-up question: You said ____. Tell me more about what you mean by that.

7. Please describe ways, if any, you were negatively impacted by participating in self-compassion interventions during group supervision.

   Sample follow up question: You said ____. Tell me more about what you mean by that.