Supervising Role-Related Self-Compassion
A Qualitative Study of the Experiences of Clinical Supervisors

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Abstract

This project addresses the promotion of role-related self-compassion (SC) in psychotherapists as part of their professional development and maintenance. There is evidence that therapists who are more self-compassionate are better-protected from emotional burnout (Beaumont et al., 2016), suggesting that self-compassion become part of therapist education (Nelson et al., 2018), but there is a lack of research regarding how this role-related self-compassion is addressed by supervisors. Semi-structured interviews were conducted with 6 clinical supervisors in Ontario and Quebec, Canada. Thematic analysis (TA) derived 5 main themes, including *Participants' Definitions of SC, Supervisee struggles leading participants to address SC in supervision Participants' approaches to addressing SC with supervisees, Institutional structures addressing self-care, self-compassion,* and *Challenges associated with addressing SC in supervision.* Results suggest that participants viewed self-compassion as an important component of therapist self-care, and employed a number of direct and indirect methods to address and encourage it with supervisees. Implications for practice and training are included.

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Chapter I

Introduction

This project encapsulates three separate areas of research in psychotherapy/supervision literature: role-related distress, self-care/self-compassion, and clinical supervision. In the following pages, a separate overview of each of these topics will be provided, before tying them together to form the main research question and sub-questions. Due to the nature of their work, therapists are at risk of experiencing burnout, vicarious trauma, and compassion fatigue (Farber & Heifetz, 1982; Killian, 2008; Simionato & Simpson, 2018), potentially rendering clinicians impaired (Zerubavel & O'Dougherty-Wright, 2012) and less capable of providing clients with effective and helpful services. Self-compassion is the extent to which individuals view their failures and limitations in an open and accepting manner, are kind to themselves, and view their experiences as part of the larger human experience (Neff, 2003). Self-compassion has been found to be inversely related to burnout and compassion fatigue in student-therapists (Beaumont et al., 2016), and therapist self-care has been related to better client outcomes (Pereira et al., 2017). Self-compassion has also been found to have utility against symptoms associated with maladaptive perfectionism (Fletcher et al., 2019; Ong et al., 2019), and student-therapists who are more self-compassionate tend to also be less harsh in their self-criticism (Beaumont et al., 2016).

Despite literature suggesting that supervisors be actively involved in the self-care-management strategies of supervisees (Knight, 2013; Merriman, 2015), and that the supervisory relationship may provide fertile ground to address supervisee-self-compassion as part of therapist self-care (Nelson et al., 2018), there is a lack of research focusing on *how* self-compassion is actually addressed in supervision. Supervision is the process through which issues related to the

wellbeing of the client and the therapeutic relationship are discussed between practitioner and supervisor (ACA, 2014; CCPA, 2015; Wheeler, 2007), a relationship of crucial importance to the optimal functioning of therapists and counsellors (Zerubavel, O'Dougherty-Wright, 2012).

Therapist difficulties that are considered 'personal' are, however, considered by some supervisors to be difficult to address in supervision (Grant et al., 2012), as supervisors have an ethical mandate not to engage in therapy with their supervisees (CCPA, 2015). Many supervisors feel unprepared to address such issues (Knight, 2012) and, as such, they are often neglected in supervision (Hoffman, Hill, Holmes, 2004). Given the evidence relating therapist self-compassion to client outcomes, there is a need for more research into whether and how self-compassion is handled by supervisors. Improving our knowledge of self-compassion in supervision can contribute to the development of more effective supervisory strategies that will benefit both practitioners and their clients.

Research into the utility of self-compassion as a tool promoting well-being and distress-management for individuals in the "helping" professions is somewhat nascent (Beaumont, 2016; Nelson, 2018; Norris, 2018). The current author is aware of only one study examining self-compassion within the context of supervision, the focus of which was the implementation of self-compassion-related exercise into the group supervision component of a graduate-level counselling program (Norris, 2018). To the author's knowledge, there have been no studies into the experiences of clinical supervisors addressing self-compassion with their supervisees. Because clinical supervisors play a role in both the education and professional development of their supervisees, it is important for us to understand how they define and relate to the construct of self-compassion. It is equally important that we understand the ways in which clinical supervisors address self-compassion with their supervisees, and any potential problems or pitfalls

that they see in doing so. Thus, the aim of the current study was to begin to look at some of these questions; to begin to examine how self-compassion can be leveraged by supervisors when confronted with acute distress in their supervisees. In so doing, it is the hope of the current author that future studies can use the provisional framework established by this research to provide clinical supervisors with more tools with which to guide the professional development of their supervisees. It is also my hope that future studies will be able to use the recommendations of this study and others like it to better-educate counsellors-in-training about the importance of self-care – and the usefulness of self-compassion in that regard.

Chapter II

Literature Review

Supervision

Clinical supervision is a process through which more experienced therapists and counsellors guide the professional development of their colleagues, teach and refine counselling skills, and encourage insight into professional issues encountered (CCPA, 2015; Merriman, 2015). Supervision allows counsellors the space to raise issues and concerns related to the therapeutic alliance (Wheeler, 2007) and is predicated on a strong working alliance between supervisor and supervisee, and on supervisees' willingness to disclose problems encountered in their work (Bernard & Goodyear, 2019; Nelson & Friedlander, 2001). One of the primary mandates of clinical supervisors is to ensure that the welfare of supervisees' clients is maintained via systematic, competent handling of the supervisees' practice of therapy. Clinical supervisors are also responsible for fostering the professional growth and development of supervisees, while acting as professional gatekeepers in instances where supervisee challenges indicate that remediation or reconsideration of a career in counselling or psychotherapy. Supervisors are also charged with upholding the law, professional codes of ethics, and standards of practice. (CCPA, 2015; Robinson & Landine, 2016).

One of the main functions of supervision is to safeguard the wellbeing of clients by overseeing professional standards and ensuring that therapists are practicing safely and effectively (CRPO; 2018; Goldberg, Dixon, & Wolf, 2012). Supervisors work to ensure that interns and counsellors experiencing *impairment* are not at risk of causing harm to clients (Merriman, 2015). Impairment consists of a practitioner's "…significantly diminished capacity to perform professional functions" (ACA, 2014), can occur at any stage of a clinician's career,

from graduate students/novices, to experienced therapists, and may result from cognitive decline, mental illness, psychological distress, physical injury/illness, substance abuse, burnout, or any combination thereof (Robinson & Landine, 2016). Supervisors dealing with an impaired supervisee may recommend personal therapy or increased supervision, as well as leaves of absence or withdrawal from the profession (Robinson & Landine, 2016).

Supervisors, however, are not meant to serve as therapists for their supervisees (ACA, 2014; CCPA, 2015), as it is not within their mandate (Robinson & Landine, 2016), and because such dual relationships have the potential to result in exploitation or biased judgement (CCPA, 2015). However, role-related distress connected to supervisees' experiences of their duties as therapists, such as burnout, secondary trauma, and compassion fatigue are not necessarily outside of the bounds of clinical supervision, particularly in light of supervisors' mandate of safeguarding the welfare of clients and guiding counsellor professional development. In fact, literature on supervision has suggested that supervisors need to be vigilant for signs of such distress, checking-in regularly with supervisees regarding their emotional responses to their work, and encouraging an egalitarian stance with supervisees in order to promote a more open and honest discussion of these issues (Knight, 2013). As such, clinical supervisors have a boundaried, but important role, to play in the maintenance of therapist self-care. With regards to self-compassion, it appears that promotion of self-compassion in supervision may present a highly effective means of combatting counsellor burnout and compassion fatigue (Nelson et al., 2018), particularly in light of evidence demonstrating the relationship between self-compassion and therapist wellbeing, and between therapist wellbeing and improved client outcomes (Beaumont et al., 2016; Pereira, 2017) – these topics will be expanded upon more-fully further in this chapter.

Compassion and Self-Compassion

To understand *self*-compassion, we must first come to an understanding of what *compassion* is. Many of us have an intuitive idea of what is meant by "compassion": the awareness of the suffering of another, and the presence of a drive to reduce that suffering ("Compassion", n.d.; Germer & Neff, 2013). Compassion also involves a kind of non-judgemental perspective on the sufferings of others, to the extent that suffering is viewed not as a personal failing, but rather as a necessary condition of life as a human being; suffering is something that we will all experience (Neff, 2003). Self-compassion is a way of being through which an individual is open to and accepting of one's own pain and shortcomings. Self-compassion incorporates three central tenets: *self-kindness*, *common humanity*, and *mindfulness* (Neff, 2003). Self-kindness involves extending the same kind of understanding and empathy to ourselves as we commonly extend to others (Germer & Neff, 2003). We often are our own harshest critics, passing judgement freely on ourselves and our actions, in ways that would be considered irrational, extreme, or cruel if we were to extend them to other human beings. To be kind to ourselves it to suspend our harsh self-evaluations. Common humanity is a crucial aspect of self-compassion, as it is for compassion in the general sense, and consists of individuals' viewing their *own* pain and failures not as something that is happening to themselves alone, but rather as a part of a broader set of human experiencing (Van Dam, Sheppard, Forsyth, & Earleywine, 2011). The final component of self-compassion is mindfulness. Generally speaking, mindfulness is an attitude that comprises both present-moment awareness and an open, accepting stance maintained by the practitioner towards whatever experiences may within the context of this awareness (Bishop et al, 2004). Mindfulness, as it relates to self-compassion, involves holding an objective stance towards one's painful feelings and thoughts; a certain mental

distance that prevents over-identification with one's pain (Germer & Neff, 2013). To be human is – in part – to experience failure and pain, and it is in one's best interests to view these aspects of life in a non-judgemental and accepting fashion. These three principles do not exist in isolation, but rather, they feed into and mutually-reinforce each other (Germer & Neff, 2013). In short, to be self-compassionate is to be connected to one's own suffering as part of being alive, while being mindful of over-identification and extending kindness and empathy to oneself.

Much research focus has been given to self-compassion in recent years, in particular to its influence on personal wellbeing and improving relationships. Self-compassion has been demonstrated to be negatively correlated with overall emotional distress and anxiety symptoms (Mackintosh et al., 2018). Self-compassion has also been linked to improvements in overall happiness and decreases in depressive symptomology, increases in motivation towards self-improvement, increased satisfaction in interpersonal conflict resolution, improvements in low mood, and reduction in body-dissatisfaction (Albertson et al, 2015; Breines & Chen, 2012; Odou & Brinker, 2015; Shapira & Mongrain, 2010; Yarnell & Neff, 2013). Additional studies demonstrate that self-compassion can positively impact restrictive eating behaviours, contributes to improved recovery from social stressors in individuals dealing with social anxiety disorder, as well as moderating the link between self-criticism and depression (Arch et al., 2018; Beekman et al, 2017; Kaurin et al., 2018).

Self-compassion in Psychotherapy

Given the research currently underway investigating the influence of self-compassion on a number of wellbeing and psychopathology-related constructs, it should come as no surprise that there is emerging research regarding the utility of self-compassion in psychotherapy. Several authors have suggested that, because of self-compassion's well-documented influence on

wellbeing, interventions which might enhance self-compassion (e.g. mindfulness-based stress reduction therapy, compassionate mind training) would make effective tools in psychotherapy by decreasing negative affect and self-criticism, while encouraging a more supportive, adaptive internal dialogue (Barnard & Curry, 2011; Germer & Neff, 2013). The majority of research regarding self-compassion in the psychotherapeutic context has, however, been conducted on small, self-compassion-focused pilot projects. Direct tests of self-compassion pre-and-post therapy, as well as between-sessions, has stalled behind the rest of self-compassion research (Galili-Weinstock et al., 2018). Galili-Weinstock et al. (2018) studied n=112 undergraduate students seeking therapy for diverse issues, including anxiety and affective disorders, obsessive-compulsive disorder, and PTSD. It was found that increases in clients' self-compassion tended to be associated with lower post-treatment depression, overall symptomology, and emotional difficulties (Galili-Weinstock et al., 2018). At the between-session level, increases in self-compassion predicted decreased levels of symptomology in the following session (Galili-Weinstock et al., 2018). Additionally, the positive outcome results were obtained after controlling for the effects of the therapeutic alliance, and for the inherent effects of treatment progress, suggesting that treatment-related increases in self-compassion are indeed connected to positive psychotherapy outcomes (Galili-Weinstock, 2018). Preliminary research on the psychotherapeutic outcome effects of increased self-compassion is, thus, promising. Further outcome studies are required, particularly involving non-student-therapist populations, but the work of Galili-Weinstock (2018) seem to fall into line with what the general trend in the literature: self-compassion is a beneficial, practical, and multi-faceted tool towards increased wellbeing. Given this trend in the literature, it is likely only a matter of time before researchers begin to investigate whether the benefits of self-compassion extend to individuals working in

professions with high rates of occupational distress, such as nursing, medicine, and the mental health professions.

Self-Care

Professional psychologists, counsellors, and psychotherapists are at risk of a unique set of professional hazards in their role. In addition to the risk of encountering burnout and compassion fatigue (Figley, 2002; Collins & Long, 2003; Knight, 2013) Mahoney (1997) reported that one third of psychologists surveyed had experienced depression or anxiety in the previous year, and upwards of 40% had experienced incidents of emotional exhaustion during the same time period. Research has also shown that clinicians report higher levels of depression, anxiety, and emotional exhaustion than do research psychologists (Radeke & Mahoney, 2000). Many clinicians also carry personal wounds from their past lives, in some cases including traumatic events of their own (Hesse, 2002; Wheeler, 2007; Admundson & Ross, 2016). Novice clinicians and interns are particularly effected by stress, anxiety, and self-doubt (Hesse, 2002; Merriman, 2015; Parent et al., 2016; Pearlman and MacIan, 1995; Shapiro et al., 2007), and research has shown that such role-related distress is associated with higher rates of burnout and compassion fatigue, as well as decreased compassion satisfaction (Thomas, 2013).

The risks to clients stemming from clinicians experiencing burnout, compassion fatigue, and unaddressed personal wounds or mental health issues are stark and include therapists' lack of empathy and emotional withdrawal, boundary crossings and other ethical violations, re-traumatization, and premature exit from counseling (Pearlman & Saakvitne, 1995; Hesse, 2002' Neslon et al., 2018). Given the professional hazards associated with a career as a clinician, and the subsequent need to protect clients from therapists who are experiencing such difficulties, it should come as no surprise that therapist self-care has received considerable attention in the

literature. Self-care methods recommended for clinicians are varied. Work-life balance is often mentioned in the literature, with many authors suggesting that a rewarding and fulfilling personal life is an important component of therapist self-care, as is maintaining a balanced physical health that includes enough sleep, regular exercise, and healthy diet, spirituality, and spending enough time with family (Figley, 2002; Hesse, 2002; Killian, 2008; Zebruvel & O'Dougherty-Wright, 2012; Knight, 2013).

It follows, given the fact that research into the benefits of self-compassion for increasing wellbeing and reducing psychopathology is growing every day (Albertson et al, 2015; Arch et al., 2018; Beekman et al, 2017; Breines & Chen, 2012; Kaurin et al., 2018; Mackintosh et al., 2018; Odou & Brinker, 2015; Shapira & Mongrain, 2010; Yarnell & Neff, 2013), that researchers have begun to turn their attention towards self-compassion as a tool for improving therapist self-care. It has been suggest that self-compassion might play an important role in increasing therapists' job satisfaction and limiting their risk of burnout and other occupational stress (Nelson et al., 2018; Pastiopoulos & Buchanan, 2011) however, to the best of the author's knowledge, there has been only one study to date investigating the relationship between self-compassion, burnout, and compassion fatigue as they apply to therapist self-care. Beaumont et al. (2016) employed a mixed sample of n = 54 student cognitive-behavioural and person-centred psychotherapists in their final year of graduate school, and demonstrated a significant negative correlation (r = -0.486) between scores on measures for self-compassion and burnout, as well as a significant negative correlation (r = -0.350) between scores on self-compassion and compassion fatigue. Additionally, analysis revealed a significant positive correlation between self-compassion and wellbeing (r = .439) (Beaumont et al., 2016). Other findings of note included positive correlations between self-kindness and wellbeing (r = .352), and self-

judgement and compassion fatigue (r = .511), as well as negative correlations between self-kindness and burnout (r = -.442) and self-judgement and wellbeing (r = -.364) (Beaumont, et al. 2016). In other words, the findings of Beaumont et al. (2016) suggest that student-therapists who are more self-compassionate and self-kind (itself a dimension of self-compassion; see Neff, 2003) are less likely to experience burnout and compassion fatigue than those who are more self-critical and less self-compassionate. These findings correspond to additional research suggesting that self-compassion may be a key protective factor against burnout in medical residents (Olson et al., 2015). Thus, preliminary research into self-compassion as a form of therapist self-care is promising in its capacity to mediate the professional hazards of being a therapist. Given the mounting evidence regarding self-compassion's wide-ranging benefits (see above), as well as research that associates therapist wellbeing with better client outcomes (Pereira et al., 2017), further research on the topic is needed to assess the utility of self-compassion in enhancing therapist well-being.

Occupational Distress

Burnout and Compassion Fatigue

There is considerable evidence indicating that therapists often neglect their own self-care, something that, when combined with personality factors (Zeidner, Hadar, Matthews & Roberts, 2013) and personal distress (Thomas, 2013) can result in therapist burnout and compassion fatigue, rendering clinicians impaired (Zerubavel, O'Dougherty-Wright, 2012) and less capable of providing clients with effective and helpful services.

Burnout.

Burnout has been described in health-care literature for decades (Farber, 1982; Freudenberger, 1976). Pines and Aronson (1988, p.9; cited in Collins and Long, 2003) define

burnout as a state of physical and emotional exhaustion, brought on by gradual, long-term exposure to emotionally-demanding situations. Burnout involves a gradual onset of symptoms relating to specific areas of function in the workplace; individuals experiencing burnout do not typically experience significant impairment in their social lives (Trippany et al., 2004; van der Klink & van der Klink, 2003). Estimates on the prevalence of burnout among counsellors and therapists vary, and can range from as low as 2-6% to as high as 40% (Simionato & Simpson, 2018, citing Farber, 1990; Hannigan, Edwards, & Burnard, 2004). Many workplace factors can contribute to burnout, including task overload, value conflict, perceptions of unfairness, insufficient rewards, and lack of control, and burnout may include *physical* (e.g. fatigue, colds and flues), *emotional* (e.g. anxiety, depression), *behavioural* (e.g. pessimism, substance abuse), *work-related* (e.g. poor performance, absenteeism), and *interpersonal* (e.g. withdrawal from coworkers and clients) symptoms (Kahill, 1988; Maslach & Leiper, 1997). The most commonly-used and psychometrically-supported inventory to measure burnout is the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) which, after years of use in the human services fields has yielded a conceptually clear description of burnout. Maslach et al (2001) describes three dimensions of burnout as:

- *Exhaustion* – the most widely-reported aspect of burnout; the feeling of being emotionally and physically drained.
- *Depersonalization* – attempting to cope with the emotional demands of the work by rendering those with whom they work (i.e. clients) as “impersonal objects” (Maslach et al, 2001).
- *Reduced Personal Accomplishment* (Inefficiency) – a sense of decreased role satisfaction as a result of constant exhaustion and depersonalization.

The MBI has been used has been used in discriminant validity studies to establish that burnout, as a construct, differs from the seemingly-related construct of depression (Maslach et al, 2001, citing Bakker et al, 2000; Glass & McKnight,1996; Leiter & Durup, 1994) – symptoms of burnout are specific to an individual's work-life, whereas depression is typically more globally affecting. Maslach et al (2001) illustrate that the provider-client relationship is not the only factor contributing to burnout, but that organizational features such as excessive caseload, preponderance of negative feedback, insufficient workplace resources, as well as interactions with co-workers and even family members all contribute to the gradual onset of burnout. Additionally, employees suffering from burnout can exert a negative influence on the coworkers, contributing to increased personal conflict and workplace disruption (Maslach et al, 2001).

Compassion Fatigue.

What we now know as Compassion Fatigue (CF) was originally described by Figley (1983) in his research into the ways in which families deal with a member who has experienced a catastrophic trauma. In the process of giving emotional support and companionship to a suffering family member, individuals can become "emotionally drained" (Figley, 1983). Figley called this reaction a "secondary catastrophic stress reaction", "secondary victimization", or "secondary traumatic stress" (Figley, 1983) and it results from the empathic engagement of the helper with the sufferer (Figley, 1995). The term "compassion fatigue" was coined in 1992 by Joinson, who used it to describe nurses experiencing a state of detached un-emotionality resulting from repeated contact with patients in distress (Joinson, 1992). Meanwhile, Figley (1993, 1995, 2002) continued to describe secondary traumatic stress disorder (STSD): a disorder sharing a very similar presentation of symptoms with post-traumatic stress disorder (PTSD), except that the etiology of STSD is related specifically to the knowledge of the traumatic experiences of

another. In this model, compassion fatigue refers to a particular kind of STSD reaction, wherein a caregiver/practitioner experiences a relatively sudden onset of intense preoccupation with, and re-experiencing of, the traumatic events of a patient or client, combined with feelings of anxiety relating to the patient/client, and attempts to avoid reminders of them.

According to Collins and Long (2003) compassion fatigue "develops as a result of the exposure of helpers to experiences of patients, in tandem with the empathy that they experience for their patients" (Collins and Long, 2003). Stamm (2010) concurs that compassion fatigue is a natural consequence of the helping professions, which also includes *compassion satisfaction*: the positive thoughts and feelings a practitioner has about their ability to do their work and contribute to the greater good of society through helping others. Stamm (2010) breaks down compassion fatigue into two components: burnout and secondary traumatic stress. In Stamm's (2010) model, secondary traumatic stress consists of "…a negative feeling driven by fear and work-related trauma"; the work-related trauma may be either primary (witnessed firsthand) or secondary. Stamm's "component" view of compassion fatigue is supported by Boscarino, Adams, and Figley (2010), who likewise conclude that compassion fatigue is an occupational hazard associated with numerous clinical settings, and of which burnout and "vicarious trauma" are the main contributors.

Vicarious Trauma.

Vicarious trauma is a process through which therapists working with trauma-exposed clients experience PTSD-like symptoms in response to the material presented in-session, including intrusive imagery or thoughts, painful emotional reactions, and disruptions to their schemas regarding safety and trustworthiness of others (McCann & Pearlman, 1990). At this point, the linguistic conundrum between "compassion fatigue", "vicarious trauma" and

"secondary trauma" must also be addressed. As Knight (2013) points out, it is precisely the seeming interchangeability of these terms in the literature that makes research into the hazards for practitioners providing psychological services so difficult.

Stamm (2010) answers this taxonomical dilemma by arguing that, despite volumes of research dedicated to the subject, there has never been any compelling evidence to suggest that the differences between compassion fatigue, secondary traumatic stress, and vicarious trauma amount to anything more than nuance – that no matter the label, the construct is the same: a description of the deleterious effects of providing care to traumatized individuals. Knight (2013) disagrees, arguing that the research is sufficient to consider compassion fatigue, secondary trauma, and vicarious trauma distinct from one another. Knight (2013) advocates for the use of *indirect trauma* to describe the range of symptoms and reactions possible as a result of clinicians' exposure to traumatic material through their interactions with clients. Knight's (2013) conceptualization of Indirect Trauma manifests along three dimensions: *secondary traumatic stress* (intense preoccupation with, as well as recollections and dreams regarding, the experience of clients outside of session; hypervigilance and hyperarousal), *vicarious trauma* (negative changes in the personal worldview and assumptions about society as a result of empathic connection with the client), and *compassion fatigue* (loss of empathy towards the client accompanied frustration and anger with clients at their perceived deficiencies). Another, simpler delineation of these terms indicates that, while vicarious trauma and compassion fatigue share similar symptoms, they differ in their etiology: vicarious trauma results from exposure to traumatic material of another, and compassion fatigue results from the act of empathising with the suffering of another (Hatcher and Noakes, 2010).

Although there is cloud of lexical confusion around the topic of "compassion fatigue", one thing is clear: there are certain personal hazards for the practitioner in emotionally-demanding helping professions (Knight, 2013); research estimates that 16.8% of practitioners are at high risk, and a further 57% at moderate risk (Injeyan et al., 2010). Regardless of the label applied to the construct ("secondary traumatic stress", "compassion fatigue", "vicarious trauma"), there is little negative criticism (Stamm, 2010) of the concept as a whole: that those working with clients/patients who have experienced trauma can develop symptomology resembling PTSD in response to that work, differentiated from classic burnout by both its sudden onset and demographic particularity, and by the fact that burnout and these PTSD-like symptoms can be experienced independently of one another (Trippany et al, 2004), which can impact a caregiver's ability to function in their role. To enhance conceptual clarity, we will move forward using Stamm's (2010) model: burnout and secondary traumatic stress are independent of one another, and may be experienced as such, but when they are experienced at the same time, may contribute to a specific kind of role-related distress known as Compassion Fatigue, which places into jeopardy the caregiver's ability to extend compassion – an essential tool of the helping professions and counselling/psychotherapy in particular – to those in their charge.

Perfectionism.

Research has suggested that counsellors and counsellors-in-training can be negatively impacted by perfectionism (Arkowitz, 1990; Ganske, Gnilka, Ashby, and Rice, 2015; Wittenberg, 1998). Perfectionism as a personality trait has been conceptualized as consisting of two sub-types: adaptive and maladaptive perfectionism (Rice and Ashby, 2007). Maladaptive and adaptive perfectionists have similarly high personal standards for themselves, but whereas adaptive perfectionists are able to continually strive towards their goals without being

excessively harsh or critical of themselves, maladaptive perfectionists tend to be chronically preoccupied with perceived mistakes, are harshly self-critical, and persistently perceive themselves as inadequate relative to their high personal standards (Rice and Ashby, 2007).

Research has also demonstrated that there is an association between perfectionism and negative psychological outcomes (i.e. worry, negative affect), and that this relationship is significant mediated by stress (Chang, 2000). In other words, a maladaptive perfectionist who is experience higher levels of stress may experience an exacerbation of the negative psychological outcomes associated with their perfectionism. Additionally a negative correlation between perfectionism and unconditional positive self-regard has been demonstrated, suggesting that the more perfectionistic a person is, the less-likely they are to perceive themselves in an open, non-judgemental, accepting manner (Flett et al, 2003). The same study demonstrated a correlation between lower levels of unconditional positive self-regard and scores on indexes of depression (Flett et al, 2003). These findings have an important bearing as they relate to the construct of self-compassion, which – as we will see – relies heavily upon an individual's ability to be both kind to and accepting of oneself (Neff, 2003).

Recent research also suggests that maladaptive perfectionism is positively associated with both client-and-clinician rated levels of depression, anxiety, and emotional regulation difficulties in clients with bipolar disorder (Fletcher et al, 2019). The same study demonstrated that self-compassion was a partial mediator to these symptoms (the association was not demonstrated in clinician-rated depression), suggesting that treatments aiming to foster and encourage self-compassion may be an effective means of reducing the psychological distress associated with maladaptive perfectionism in clients with bipolar disorder (Fletcher et al., 2019). Other research suggests that self-compassion may act as a mediating variable in findings that perfectionistic

clients undergoing ACT (Acceptance and Commitment Therapy) showed a decrease concern over their own mistakes (Ong et al, 2019). These findings suggest that self-compassion may have a role to play in the management of the distress experienced by individuals who are high in maladaptive perfectionism.

Perfectionism in counsellors has received surprisingly-little attention in the literature, but studies suggest that perfectionistic supervisees are likely to be more defensive to negative feedback, more inflexible, and possessing lower self-esteem than their less-perfectionistic counterparts (Ganske et al., 2015, citing Arkowitz, 1990). Additionally, supervisors high in maladaptive perfectionism may have a tendency to view their relationships with clients as weaker than their less-perfectionistic peers, undermining their own successes as therapists (Ganske et al, 2015). Supervisors responsible for supervisees who have high levels of maladaptive perfectionism tend to rate the supervisory working relationship as less-strong than with supervisees who have lower levels of maladaptive perfectionism (Ganske et al., 2015). Taken together, the research suggests that supervisees who are more perfectionistic experience more role-related distress than their less perfectionistic peers, and that supervisors may find it more difficult to form strong working relationships with these individuals. However, given the preliminary research suggesting that self-compassion may present an avenue via which to mediate the negative impact of maladaptive perfectionism, as well as research demonstrating that student-therapists who are more self-compassionate are *less* self-critical (Beaumont et al., 2016; Bell et al., 2017), it may be plausible to surmise that self-compassion may also provide a means to address the maladaptive perfectionism of counsellors and therapists.

Emergent research suggests that self-compassion has applications for the self-care and professional development of mental health professional such as counsellors and therapists. In

order to fully leverage these benefits, however, professionals need to be made aware of the research, and of how it can be applied within their self-care regimen. It is possible that some practitioners learn about self-compassion through their continued research and education as they develop in their practice of psychotherapy. Another potential avenue through which practitioners may be informed of the benefits of self-compassion for their professional development, however, is via inclusion of self-compassion as a topic in graduate-level programs, and within clinical supervision itself.

Education and Supervision

Education

Research has identified a need to impart effective self-care strategies to graduate students and trainees working in health-care-and-related fields (Beaumont et al., 2016; Knight, 2013; Lewis and King, 2019; Nelson et al., 2018; Olson et al., 2015; Senyuva et al., 2014). Despite the recognition of the need to educate future therapists and counsellors about the importance of their own self-care, relative to the occupational distress they are likely to encounter, graduate programs have lagged behind in their implementation of such modules (Knight, 2013). This lack of engagement with the topic of role-related distress, and self-care, may be due to instructors not being fully aware themselves of the importance of these topics (although this seems hard to imagine), or it may be that the classroom environment itself – competitive and impersonal – is not conducive to students' openly discussing such issues (Knight, 2013). Recent research suggests a potential framework from which to approach the topic of self-care pedagogically (Lewis & King, 2019). Students in a pilot program were given direct instruction, once per week, about occupational distress such as compassion fatigue and burnout, and about the utility of practicing mindfulness in the workplace. Students then discussed the topics in groups, developed

their own self-care plans to put into practice, and engaged in critical self-reflective journaling on the efficacy of their plans. The authors suggest that not only that students find such training to be helpful in managing stress, but recommend that a minimum of four weeks should be devoted to the topic of self-care, and that clinical supervisors be involved in supporting these learning goals (Lewis & King, 2019).

Corresponding with the growing interest in, and evidence supporting, self-compassion as a component of self-care (Beaumont et al., 2016; Bell et al., 2017; Galili-Weinstock et al., 2018), studies have begun to examine whether or not self-compassion should make its way into the classrooms and internship sites of graduate programs in counselling and psychotherapy. Nelson et al. (2018) suggest that perhaps the best way to take advantage of the beneficial effects of self-compassion may be to include learning modules that demonstrate self-compassionate exercises and writing, not just to prepare students for their demanding professional lives, but also to help ease them through the stresses and insecurities that many students face during their training. The authors point out the relative ease with which self-compassionate techniques, such as the self-compassion break, soothing touch, or self-compassionate letter writing (Neff, n.d.), can be both taught and practiced; all the more reason for educators to consider adding them to curricula (Nelson et al., 2018). Additionally, once students have learned and mastered self-compassionate practices for themselves, they have the option of teaching them to clients, so that they may reap the benefits in their own lives (Nelson et al., 2018).

A recent study highlighted the utility of teaching compassion-focused exercises and techniques to student-therapists (Bell et al., 2017). The study details the effects of a compassion-focused training (CFT) exercise used to encourage therapists-in-training to develop self-reflective practices leading to an effective “inner supervisor” to help them better-manage the

challenges of the profession. The study focused on N = 7 participants (4 males and 3 females) enrolled in a post-graduate CBT diploma, ranging in age from 27-61 (M = 40) years old. CFT training involves a 5-hour workshop followed by a CD of guided exercises and worksheets to be completed once per day for 2 weeks following the initial training. CFT centres on concepts such as soothing-rhythm breathing, creating and focusing the compassionate supervisor (imagining the compassionate qualities of the supervisor), and bringing difficulty to the compassionate supervisor. The participants then attended a group review where they shared their experiences with the training, after which they continued their daily exercises for 2 more weeks before data was collected using semi-structured interviews ranging from 25-45 minutes. Data was analyzed using an interpretive phenomenological analysis (IPA) approach by the authors to determine 6 main themes regarding the participants' experiences of the CFT training.

The themes found in the data were: (1) *the Varied Nature of the Supervisor Image* (all of the participants related that their created inner-supervisor were related to a specific person from their past, such as supervisors, lecturers etc.), with qualities such as unconditional positive regard, capacity for reflection, empathy and understanding. (2) *Blocks and their Overcoming* – participants experienced internal blocks such as difficulty in finding a stable supervisor image, feeling as though they were "forcing" a particular image, and accepting self-compassion as being anything other than self-indulgent. External blocks included time-limitations, environmental disruptions. Participants overcame blocks by remaining mindful of their experience, and developing an "observer" stance to the process. *(3) Increased Compassion and Regulation of Emotion* – participants reported an increased self-awareness around their own difficulties, and a subsequent increase in their ability to be self-compassionate. They also reported strong connections between their bodies and their burgeoning compassion, particularly through their

slow-and-soothing breathing exercises, but also through awareness of voice and facial expression. Participants also reported an increase in their empathy and connection to the difficulties of others, as well as in their abilities to manage/regulate their own emotions. *(4) Impact on Cognitive Processes* – participants reported an increased ability to process and challenge their own negative thoughts, and an increased flexibility in their attention. They also reported a reduction in rumination/worrying, as well as a subsequent increase in reflective thinking (typified by a more balanced perspective) and a reduction in self-criticism. *(5) Internalization and Integration* – every participant commented on their eventual ability to take ownership of their imagery process and relate their imagined supervisor into both their internal world and their lives in general. *(6) Professional and Personal Benefit* – participants reported an increased self-compassion in their clinical work and better self-management during and after their sessions, which they related to an increase in their ability to tolerate anxiety, frustration, and self-doubt, as well as being able to objectively reflect on sessions. Participants also reported increased feelings of focus and present-ness within sessions, increased resilience to workplace stress, increased compassion for colleagues and managers, decreased feelings of competition with other therapists, and improved personal boundaries. Participants also noted improvements in their ability to balance their work with their personal lives, as well as improved relationships with their friends and family, which they attributed to the CFT training. The authors conclude that CFT training is a viable option for improving training for therapists, and that it has the potential to improve many aspects of job-related stress and performance through improved compassion and self-reflection (Bell et al., 2017).

Although not directly-related to self-compassion, many of the exercises and techniques taught to the participants in the preceding study correspond with the types of exercises typical of

mainstream self-compassion (Self-Compassion, 2020), and the results of the program enabled the participants to experience greater self-compassion (Bell, 2017). As such, the current author sees this study as directly relevant to the topic of whether or not self-compassion can be useful for therapists and therapists-in-training. The robust set of benefits attributed to CFT training by the participants in this study, coupled with the previous research of Beaumont et al. (2016) suggest to this author that self-compassion may have a role to play in the professional development of counsellors and therapists, via affect-and-distress management, but also through more subjective aspects such as increased self-reflection and self-awareness, and improved personal boundaries.

Self-Compassion in Supervision

As mentioned earlier in this chapter, another arena through which to prevent burnout and compassion fatigue is that of supervision (Merriman, 2015; Nelson et al., 2018). The majority of self-compassion studies to date have focused on self-compassion's potential to increase wellbeing and mediate the impact of psychopathology (Albertson et al, 2015; Arch et al., 2018; Beekman et al, 2017; Breines & Chen, 2012; Kaurin et al., 2018; Mackintosh et al., 2018; Odou & Brinker, 2015; Shapira & Mongrain, 2010; Yarnell & Neff, 2013). Research has just begun to investigate its usefulness in therapist self-care (Beaumont et al., 2016), and its application as part of therapist training and education (Nelson et al., 2018). Considerably less attention has been paid to how self-compassion relating to therapists' role-related distress is promoted in clinical supervision. A recent study investigated how counsellors-in-training (CITs) experienced self-compassion interventions (SCIs) as part of their group supervision sessions (Norris, 2018). This research suggests that such interventions were associated with increased feelings of relaxation, and contributed to a heightened sense of self-awareness, as well as a more self-reflective stance

(Norris, 2018) – all potentially desirable and beneficial effects for the professional counsellor. Other authors have advocated for a balanced and compassionate supervision culture that is conducive to practitioner wellbeing (Wheeler 2007; Zerubavel & O'Dougherty-Wright, 2012). To that end, and in keeping with the evidence of self-compassion's numerous benefits, the topic of self-compassion in supervision becomes a salient one. To what extent are clinical supervisors aware of the protective influence of self-compassion, and how do they foster self-compassionate techniques in their supervisees? An extra dimension is added to these questions by the ethical admonition that supervision not veer into personal therapy from professional development (ACA, 2014; CCPA, 2015), and by research suggesting that that supervisors find issues related to more personal aspects of their supervisees' work difficult to broach, and in some cases go completely avoided (Grant, Schofield & Crawford, 2012; Hoffman et al., 2005; and Knight, 2012).

Promotion of compassionate, role-related self-care within the professional culture is crucial as it relates to public health and the extent to which counsellors are able to cope with the demands of their profession and offer the best services to clients, yet the topic remains uninvestigated within the context of clinical supervision. Research is thus required to determine how self-compassion is addressed by experienced supervisors, with the aim of informing more supervision models in the future. As such, this study will investigate whether and how supervisors encourage self-compassion with their supervisees to help protect against role-related distress, including burnout, secondary traumatic stress, and compassion fatigue, thus providing more safe and effective services to clients. This study's main research question is: How do supervisors engage with role-related self-compassion in supervision? Sub-research questions are: 1) How do supervisors understand their role in managing supervisee self-compassion? 2) How

do they address it? 3) What might encourage or discourage supervisors from pursuing this topic in supervision?

Chapter III

Method

Research Methodology

The aim of the currents study is to uncover the experiences of clinical supervisors as they relate to addressing self-compassion with their supervisees. Research into the utility of self-compassion for therapists is beginning to gain traction, but (to the author's knowledge) no studies to date have probed supervisors' experiences with, and opinions on, the subject. As such, a qualitative methodology was chosen to illuminate the subjective experiences of the participants, and to provide a backdrop which future studies into self-compassion, supervision, and therapist self-care can use to build on our understanding of these concepts. The qualitative method of data collection and interpretation selected for this study was thematic analysis.

Thematic Analysis

The current research is a qualitative study that uses Thematic Analysis (TA) to analyze and interpret the data collected. TA is a process through which data is carefully read and re-read in order to derive and describe important, recurring themes and sub-themes; a form of pattern recognition (Fereday and Muir-Cochrane, 2006). In TA, there are several categories and sub-categories of data. First, the overarching *data corpus* (all the data collected for the project), followed by the *data set* (all the data from the corpus that will be used for analysis), *data item* (each individual piece of collected data, making up the corpus and set), and *data extract* (a coded chunk of data, extracted from a data item) (Braun and Clarke, 2006). When reading about TA, one encounters recurrent mentions of *themes*, but what constitutes a theme? According to Braun

& Clarke (2006), a theme "[captures] something important about the data in relation to the research question, and [represents] some level of patterned response or meaning within the data set". In other words, a theme is some piece of information that relates to the research question in such a way as to provide insight into one or several aspects of the issue, and which is present across some or all of the data set. *Prevalence* of themes can be determined in a number of ways; by determining how often a theme is present in each data item, or at the level of the data set, by how often a theme is mentioned by each speaker, etc (Braun & Clarke, 2006). For the purposes of the current study, which is investigating the under-researched area of self-compassion as it relates to professional development under the purview of clinical supervision, themes have been coded at the level of the *data set* in order to provide a strong overview of the predominant themes and subthemes, and to illuminate paths for further research.

Inductive Thematic Analysis.

The current study uses an *inductive* approach to TA coding that allows for allows themes to emerge without interpretation from the researcher (Fereday and Muir-Cochrane, 2006); uninfluenced by the researcher's own theoretical assumptions regarding the research question (which is not to say that researcher's theoretical and personal biases are accounted for or eliminated) (Braun & Clarke, 2006). The research question posed by the current study is somewhat open-ended, and while the review of the literature is informed by popular literature on the subject of self-compassion (in particular, the work of Kristen Neff), it is the opinion of the author that a strict, theoretically-aligned approach would be of less benefit to the study, and might actually impede the research by conforming to the pre-existing biases and expectations of the researcher towards data, or by limiting opportunities for participants' interpretations of self-compassion within the context of supervision.

Latent-Level Thematic Analysis.

TA can be conducted at two levels: the *semantic* and *latent* levels. The semantic level involves identifying themes at the surface level of the data: describing/organizing the themes, and then interpreting them within the context of previous literature in an attempt to derive broader implications (Braun & Clarke, 2006). At the latent level, and attempt is made to identify the underlying assumptions and concepts that shape the semantic data (Braun & Clarke, 2006) – in essence deriving a theory about the data. For the current study, which is concerned with both the "how" and "why/why not" of supervisors' broaching the topic of self-compassion with supervisees, the latent level is of more interest. If the study were only examining the "how" part of the question, the semantic level would suffice, but because the question of "why or why not" is involved, and because one of the goals of the project is to contribute to clinical supervision knowledge, it would be useful to be able to generate a theory regarding the *underlying reasons* governing a supervisor's decision to engage with self-compassion as professional development (or not).

Implementation of TA.

TA is implemented in this project using the guidelines set out by Braun & Clarke (2006) in their work *Using Thematic Analysis in Psychology*, which describes TA as occurring in 6 phases. Braun and Clarke describe Thematic Analysis as Phase 1 "*Familiarizing yourself with the data*": reading and rereading the transcribed data (see below) while actively searching for meanings and patterns so that the "depth and breadth" (Braun & Clarke, 2006) of the data is second nature, while also taking notes of ideas for coding. Included in *Phase 1* is the subheading "*Transcription of verbal data"*: the process of transcribing data into written form. Braun & Clarke (2006) advocate for a rigorous and verbatim account of the interview, sometimes

including nonverbal utterances such as laughs and coughs. In this project, interviews consisting of approximately 60 minutes each were recorded digitally by the first author, and transcribed immediately afterwards. Due to the labour-intensive process of transcription, which involves listening and re-listening to discrete sections of the interview in a repetitious fashion to ensure accurate reflection of the conversation, the author noticed that immersion into the data was already happening. The current author found himself feeling as though he were becoming more and more acquainted with the participants and their views, and took great efforts to ensure that their grammar and mannerisms were reflected as accurately as possible. Following transcription of the interviews, the digital recordings were destroyed – as per the confidentiality agreement stipulated in the informed consent for the study (Appendix D) – and transcripts were emailed to the participants, allowing them to review the transcribed interviews and verify that they accurately reflect the conversation.

In *Phase 2* the researcher *generates initial codes*, identifying key features of the data and organizing the data into groups. Per Braun & Clarke's (2006) instruction: "Work systematically through the entire data set, giving full and equal attention to each data item, and identify interesting aspects in the data items that may form the basis of repeated patterns (themes) across the data set". Braun & Clarke (2006) advise coding for as many themes/patterns as possible, keeping some surrounding data intact to preserve context, and that any individual extract can be coded into as many themes as necessary. This part of the project was relatively straight-forward; the transcripts were read and re-read by the current, and codes pertaining to the research questions were identified. The main research questions guiding the generation of initial codes were, essentially: 1) "How do supervisors relate to self-compassion as a construct, and 2) how do clinical supervisors experience addressing self-compassion in their supervisees? Codes were

generated using pen-and-paper, with printed copies of the transcripts used, and marked-upon. Once initial codes were generated, they were submitted to the thesis supervisor for auditing. This auditing step is a modification of the TA framework, included to further increase trustworthiness by allowing the thesis supervisor to add her perspectives as an experienced qualitative researcher to the process: to test and challenge the perspectives of the first author, as well as allowing for a different theoretical and epistemological point of view to the process of deriving patterns of meaning from the interview data.

Phase 3 is "*Searching for themes*": analyzing all of the codes that have been created and examining whether or not the codes combine to form themes. This is the phase where overarching themes are generated, as well as any sub-themes, and can be represented using mind maps and other graphical means. This phase of the project comprised the creation of a list of codes for each interview, during which time the initial thematic structure began to show itself: how supervisors define self-compassion, topics of discussion with supervisees relating to self-compassion, ways (explicit and implicit) that supervisors approach self-compassion with supervisees, and challenges associated with addressing self-compassion in clinical supervision.

Phase 4: *Reviewing themes* comprises the process of refining "candidate themes", collapsing themes into each other when appropriate/necessary, or breaking themes up from one theme into separate themes. Two levels are involved in this phase: level one is the process of reading all of the data extracts for every theme, and deciding if they form a cohesive pattern; if they do, then you move on to level two (if not, the themes need to be revised/modified, etc). Level two involves looking at the individual themes as they relate to the data set, and deciding if they accurately reflect the meanings in the data set. If the generated thematic map does not match the data set, then new codes and themes need to be generated until the thematic map makes

sense. During this part of analysis, themes from the individual interviews were collapsed into one master list of themes and sub-themes using Microsoft Excel. The master list was audited by the thesis supervisor who agreed that it constituted an accurate representation of the data set. Each interview was combed-through to isolate verbatim quotes from participants which spoke to the essence of each theme and sub-theme. Care was taken not to over-represent any individual participant, in order to ensure that the voices of each were heard. Verbatim quotes were organized in Excel according to participant, and location in the transcript (page number).

In *Phase 5:* **"***Defining and naming themes"* (Braun & Clarke, 2006): the researcher determines which parts of the data best represent each theme, and produces an in-depth analysis of the individual theme. It is at this stage that the research identifies whether or not each theme has any sub-themes, and also considers how each theme fits into the data (trying to avoid overlap when/if possible). At the end of this phase, the researcher is able to succinctly describe each theme.

In *Phase 6***: "***Producing the Report"* (Braun & Clarke, 2006): the researcher produces a coherent, logical, non-repetitive, and interesting account of the data. Care must be taken to provide sufficient evidence of the themes (through data extracts), which are easily identifiable as demonstrating the theme and flow as part of the analytic narrative.

This project followed the steps outlined by Braun & Clarke (2006) to produce a thematic analysis of the experiences of clinical supervisors' promotion of self-compassionate habits and techniques as part of the professional development of their supervisees, through a critical-realist lens (Maxwell, 2012) that allows for the participant's own experiences – whatever they may be – to contribute to our understanding of the central phenomenon as part of our expanding provisional knowledge of clinical supervision.

Epistemology

Psychotherapists and counsellors have a responsibility to their clients to engage actively in their own self-care in order to protect against burnout and compassion fatigue and safeguard their own well-being while providing consistent, effective services to clients, but there is a lack of research regarding whether and how supervisors broach this professional development topic directly in supervision. Additionally, with the emergence of self-compassion as a construct demonstrating diverse and significant utility in the management of a wide range of psychological distress (Arch et al., 2018; Beekman et al, 2017; Odou & Brinker, 2015; Wong & Yeung, 2017; Yarnell & Neff, 2013)., as well as literature suggesting that clinical supervision may be a particularly useful avenue to impart the benefits of self-compassion to therapists (Merriman, 2015), there exists a gap to be addressed: do clinical supervisors address self-compassion with supervisees in distress and, if they do, what are their experiences in approaching the topic? To address these questions, this project assumes a theoretical perspective based in critical realism.

Critical realism is a conceptual framework that combines ontological realism and epistemological constructivism (Maxwell, 2012). In other words, that there exists a knowable "reality", but that there are different individual perspectives *of* that reality which are possible. It is a more thorough examination of those individual perspectives which is the goal of this research. The project uses interviews to collect data, the assumption being that each participant brings her or his own interpretive perspectives of reality to bear, contributing to our provisional understanding of the objective world. Critical realism is an alternative to a purely realistic approach (which assumes a straightforward relationship between language and meaning/experience), and strict constructivism (the notion that meaning and experience are socially produced, and do not reside within the individual) (Braun & Clarke, 2006; Burr, 1995).

Critical realism posits that neither assumption is wholly correct, and offers a nuanced approach to reconciling the differences between the two. The reconciliation provided by critical realism is crucial for this project, as the research involves investigating multiple perspectives of the same phenomenon (e.g. ways in which different clinical supervisors approach self-compassion in their work with supervisees): we can make an analogy that the central phenomenon is an artifact of the "knowable" reality, and that the individual perspectives provided by the supervisors are the constructed interpretations reflecting different aspects of that true object.

Trustworthiness

To enhance trustworthiness, or the credibility of the research, the current study includes the following measures (Guba, 1981; Lincoln & Guba, 1985):

Triangulation

The study draws on many sources of information – the participants and their interview data – each bringing their own unique perspective to the research question. As a result, the researcher's own position and opinions are tested. Additionally, the TA approach has been modified in the current study to include auditing of generated codes and themes in phases 2-4 (Braun & Clarke, 2006), allowing for the thesis supervisor to test and challenge the perspectives of the first author, as well as bringing a different theoretical and epistemological point of view to the process of deriving patterns of meaning from the interview data.

Practicing reflexivity

The researcher and the thesis supervisor met on a regular basis during the course of the study to debrief regarding the researcher's thoughts and feelings on the study itself. These conversations consisted of, but were not limited to, changes in the researcher's perspective that

occurred as the study progressed, the researcher's thoughts and feelings about the nature of the interviews, as well as how factors external to the study itself, such as relationship and financial stressors and other life events were exerting an influence on the researcher's own state of mind and, by extension, on the process and progress of the study.

Member checking

During the course of collecting data, the researcher continuously tested and verified the data given by the participants. Evidence of this member checking is preserved in the transcribed data, which shows that the researcher allowed the participants the space and opportunity to ensure that their voices were both heard and understood. This stage of the member checking took the form of paraphrasing and reflecting the content of the interviews back to the participants to ensure that they were accurately and completely understood by the researcher. Any interpretations of the data made by the researcher was offered to the participants for verification *in vivo*, and is also exemplified in the transcripts. Additionally, a second stage of member-checking comprised a review of the transcribed data by the participants upon completion of transcription by the researcher. Participants were emailed the transcripts and were given the opportunity to read and reflect on their own interviews, and to request any changes to the document in order to more accurately represent their own experiences. Finally, a third level of member-checking involved allowing participants to review the final thematic analysis, including all themes, sub-themes, and corresponding verbatim quotations, to verify that the researcher's interpretation of their data is consistent with the meaning intended by the participant.

With one exception – "John" did not respond to emails offering the opportunity to member-check – all participants agreed that the transcribed interviews accurately represented their conversations with the author. Additionally, all participants who replied to the author's

inquiries to member-check agreed that the author's analysis of the data was consistent with the meanings they intended to convey in their interviews.

Transferability

In qualitative research, *transferability* refers to the extent to which the reader of a study is able to apply the findings of the study to her or his own subjective context, and to those of others (Morrow, 2005). In this study, transferability is enhanced by a detailed description of the sampling, recruitment, and informed consent procedures (see above; Appendix), as well as detailed demographic information about the participants that still allows them to retain their anonymity (see below). Additionally, a researcher-as-instrument section is included in this document to enable the reader to assess the researcher's own unique frame of reference and account for any of the researcher's own personal biases or history in the analysis and interpretation of the data (Morrow, 2005).

Participants

Inclusion criteria

To be included in this study, participants were required to be a member in good standing of a college regulating the practice of psychotherapy, and to have had a minimum of three years in their role as clinical supervisor. The inclusion criteria for the current study was based on previous research involving clinical supervisors (Theriault & Gazzola, 2017). The minimum of three years' experience was set in order to account for any effects of novelty might have on the participants' recollection of their experiences. However, due to unforeseen circumstances resulting in difficulty recruiting participants for this study, in one case an exception was made for a participant who self-reported that they had been practicing as a clinical supervisor for two-and-a-half years, instead of three. It was felt that active supervisors would be more able to delivery

crisp and vivid recollections of their experiences than those who were not currently practicing supervision and, as such, only individuals actively practicing clinical supervision at the time of the study were recruited. Participants were required to have obtained a minimum of a Master's degree in either counselling psychology, clinical psychology, or social work, and be willing to discuss their work as a clinical supervisor addressing supervisees in distress.

Additionally, due to the non-functional bilingualism of the first author, participants were required to be comfortable conversing in English during data collection.

Sampling and Recruitment

After receiving approval to commence data collection from the Research and Ethics Board of the University of Ottawa, participants were recruited using purposeful, criterion-based sampling from various counselling and mental-health agencies in Ontario and Quebec, Canada. Emails were sent to clinical directors of said agencies detailing the nature of the study, and included letters to the directors, recruitment documents which explained the study in greater detail, and informed consent documents (Appendix). Clinical directors who were interested in distributing the recruitment material to supervisors working under their direction were encouraged to do so, and respondents were asked to contact the researcher directly, for the sake of their confidentiality, in order to schedule a time and place to sit down for a forty-five-to-sixty-minute interview. Prior to commencement of the interview, participants were again informed of the nature of the study, and given explanations regarding how their confidentiality and anonymity would be protected, and the researcher and participant both signed informed consent documents indicating that the researcher had provided the participant with a complete explanation of the study, the risks involved, and how their identity would be protected.

Sample Characteristics

Table 1

Participant Pseudonyms and Demographic Data.

Pseudonym	Theoretical orientation	Age	Years of experience as supervisor	Current level of education
Joan	Systems/Psychodynamic	60 -69	10	M.A.
Liz	Humanistic/Existential	40 -49	5	M.A.
John	Psychodynamic	50 -59	25	M.S.W.
Paul	Psychodynamic/Humanistic	40 -49	2.5	M.Ed.
Tanya	Feminist/DBT	50-59	4	M.S.W.
Annie	Psychodynamic/Attachment Theory	30-39	3	Ph.D.

Participants in this study included four individuals self-identifying as female and two self-identifying as male. Participants ranged in age from their early-thirties to their mid-sixties (M = 50, SD = 10.2). Participants' time spent in their role as supervisor ranged from 2.5 years to 25 years (M = 8.25, SD = 8.64). Participants identified a variety of theoretical orientations when prompted, and were often nuanced and eclectic in their descriptions (as might be expected). Broadly speaking, three participants aligned themselves with a psychodynamic theoretical orientation, one identified as humanistic or client-centered, one as feminist, and one as systems-based. Five of the six participants held master's degrees in counselling or related fields, and one participant had obtained a doctoral degree in counselling psychology. All participants were practicing clinical supervision in agencies associated with postsecondary institutions in Ontario and Quebec, Canada, at the time of the study.

Data collection and interview procedure

Data collection for this study took the form of an approximately forty-five-to-sixty-minute semi-structured interview, recorded digitally by the researcher. Data collection took place in the offices of the participants, at varying times of day according to the participants' schedules. Prior to the interview, informed consent was granted by the participants, with the main author reading the informed consent document to them word-for-word. Participants were then asked to complete a short demographic questionnaire. The demographic questionnaire included information such as: age, gender, years spent in role of supervisor, current level of education, and job title. After completing the demographic form, the semi-structured interview commenced. The recording apparatus used during interviews was the voice recording program on the researcher's Samsung Galaxy S7. After completing the interview, the researcher used a set of common earbuds, in conjunction with the Samsung S7 device, to transcribe the interviews into Microsoft Word. Transcription generally occurred the day after an interview, except in one instance when a migraine headache prevented such activity. As previously mentioned, care was taken by the interviewer to include the participants' own unique grammar, syntax, contractions, as well as any laughter, coughing, or other non-verbal vocalisations. All recordings were deleted after the interviews had been successfully transcribed by the researcher and member-checked by the participants. The first four interviews included opening questions regarding the nature of supervision, and how the participants came into their current role, that were judged to be extraneous to the research questions, and later interviews (from interview 5 onward) omitted these questions in order to focus on concepts more central to the topic of self-compassion and role-related distress. In this way, the design of the study itself was shaped by the data as it was being collected (Morrow, 2005).

Researcher as Instrument

I am a graduate student in counselling psychology and novice counsellor. I am not a member of a visible minority group, and have never experienced discrimination that I am aware of based on my ethnicity, gender, or sexual orientation. I have had some experience with psychological distress and mental illness, as I have been diagnosed with persistent depressive disorder and anxiety and have lived with it for the last 18 years. Additionally, my younger sister Erin was struck and killed by a drunk driver as she walked home in March 2012, and while I never received a formal diagnosis of any stressor or trauma-related psychological disorder subsequent to that event, I can say that her death profoundly changed the way I viewed myself, the world, and others, as well as being the single event that I consider to have led me to study psychology in the first place – to better understand my experiences and to potentially help others who are experiencing similar distress. It would be difficult to overstate her influence on my trajectory.

The frame of reference I bring to this work – the motivation, and the lens through which I will inevitably be gazing as I analyze and present the data – is thus one that is informed by personal experience with both mental health and trauma. On the other hand, as a beginner counsellor, I have done some reading on what constitutes safe and unsafe use of self in-session with clients, uncovering a pocket of literature regarding distress in therapists such as burnout, secondary trauma, and compassion fatigue, as well as therapist mental health, experience with trauma, etc. Simultaneously, I began to read more and more about self-compassion, and the ever-increasing body of empirical evidence extolling its benefits. I have experienced some of these benefits in my own life: developing understanding, patience, and kindness towards myself as been integral in my continued navigation of the challenges that life has presented. My work is conceived to contribute to our understanding of therapist distress, and ways in which we might

assist practitioners in the helping professions better educate and protect themselves from these issues in their roles as caregivers. In this sense, my interpretation and subsequent organization of the collected data, as presented in Chapter IV, is inextricably linked to my experiences and worldview – in particular by the last ten years of my life. In other words: a different researcher may have examined the same corpus and derived a completely different thematic structure. What follows is my own unique view of the data.

Chapter IV

Results

This chapter describes the results of the thematic analysis outlined in Chapter II. Thematic analysis revealed 5 main themes and 14 sub-themes. The main themes consisted of: (1) *Participants' Definitions of SC,* (2) *Supervisee Struggles Leading Participants to Address SC,* (3) *Supervisor Approaches to Addressing SC with Supervisees,* (4) *Institutional Structures Addressing SC and Self-Care,* and (5) *Challenges Associated with Addressing SC in Supervision.* All themes, sub-themes are listed (Table 2); for a more fulsome description, including dimensions and verbatim examples of each, see Appendix A.

Table 2

Supervision of Self-Compassion Thematic Structure

Main Themes	Subthemes
Participants' Definitions of SC	• Self-care • Staying humble • A skill (vs. state-of-being)

Supervisee struggles leading participants to address SC in supervision	• Perfectionism • Feelings of incompetence • Personal distress entering workplace
Participants' approaches to addressing SC with supervisees	• Direct approaches • Indirect approaches • Outcomes (after addressing SC)
Institutional structures addressing self-care, self-compassion	• Deliberate measures in internship program to avoid role-related distress • Creating comfortable and open work spaces • Therapist education
Challenges associated with addressing SC in supervision	• SC as inappropriate intervention • If SC does not feel congruent for the supervisor

How participants define SC

This theme encapsulates the various ways in which the participants in this study give meaning to the construct of self-compassion. The supervisors interviewed for this study identified SC with an attitude of caring towards oneself which includes self-kindness, appropriate work/home boundaries, and a sense of unconditional positive self-regard. Almost all participants referenced the importance of staying grounded and humble in their attitudes: giving permission to oneself to *not* be "the expert" – to accept that knowledge is provisional and evolving – and to allow others to provide assistance when overwhelmed. As reflected in the third sub-theme, several participants explained that, for them, SC is not a destination or a state-of-

being, but rather a skill that one acquires through practice – similar, perhaps, to mindfulness from a certain perspective. Additionally, two participants drew a distinction between self-compassion and self-indulgence, or stagnation – that SC is well-and-good, but not at the expense of forward momentum in a person's life trajectory.

This theme is divided into 3 sub-themes: *Extending the Same Care to Self as to Others (Self-Care)*, *Staying Grounded/Humble*, and *Practice (Vs. State of Being).*

Extending the Same Care to Self as to Others

The participants in this study, almost uniformly, included in their definitions of self-compassion the ability to treat oneself with the same level of consideration that is more-easily shown to others, but which participants described as being more difficult to practice in relation to oneself, as exemplified by Paul:

> …Because [caring for others is] so much easier for you to do for someone else than for ourselves. So, I think that's the element of self-compassion: including yourself in the same amount of care that you give to others.

Included in this sub-theme are the dimensions of: Healthy Work/Home Balance, Unconditional Positive Self-Regard, and Self-Kindness.

Healthy Work/Home Balance. Regarding the prevention of burnout and other role-related distress, participants frequently cautioned against overemphasis on work over more personal or domestic aspects of life, in some cases explicitly reminding supervisees who are experiencing distress of this particular piece of wisdom (Appendix A).

Unconditional Positive Self-Regard. Participants also made frequent reference to the notion that recognition of one's own value as a person, regardless of any external rewards or validations, as being germane to self-compassion. For Paul, this idea seemed to provide a means of putting one's work into perspective by not applying performance-based conditions to one's deservedness of self-respect or compassion:

> [Your value as a person] is intrinsic to you; it's not about something you've accomplished and then [you] have self-worth or self-compassion.

Self-Kindness. Finally, the third dimension of this theme comprises self-kindness. Participants spoke about the importance of one's ability to relate to oneself with tenderness and understanding in moments of distress or strain, as opposed to berating or flagellating oneself in response to perceived mistakes, as Liz explains:

> …Self-compassion, for me, means having the ability to... be gentle, kind... and understanding with ourselves as we move through life, and the inherent learning that is a part of it as well... there is an open, non-judgemental, kind approach to that journey, and all aspects of it.

Staying Humble

In their descriptions of what SC, many participants highlighted the importance of maintaining a balanced and forgiving attitude towards oneself regarding the (perhaps, self-originating) pressures to always be seen by clients and colleagues as a master, expert therapist. The majority of participants reported that staying humble in one's work, in addition to relieving unnecessary pressures and expectations, would have the knock-on effect of creating more effective therapeutic relationships, as related by Annie:

> …the idea of not being an expert, and going easy on ourselves, and being more genuine and humble, and human with clients, and how that's important to our work... so yeah, if we talk about it in different language, [self-compassion] is always there.

Permission-Giving. This sub-theme contains a dimension of *permission-giving* in relation to one's own self, mentioned by all participants either directly or indirectly. Participants frequently spoke to the value of supervisees' learning to accept their own fallibility as practitioners, and of their allowance for a certain degree of latitude with themselves after having made a mistake in-session. Paul regarded this concept as essential to a self-compassionate attitude:

> …common humanity. It's actually being able to see yourself, as human as everyone else is. Give yourself that allowance.

Paul spoke of the importance of acknowledging the challenges that come with doing the work of a counsellor while honouring one's particular developmental stage, particularly for novices and interns:

> …for me the self-compassion is just recognizing that you're in a really difficult place where you're learning these skills, and you have a huge responsibility as you're learning them, and you're gonna screw up … and recognizing that's part of the process, and the learning of it, and not being afraid of it.

Many participants spoke of the benefit for supervisees in granting permission to themselves not to be "the expert", alleviating unnecessary pressure to perform in certain ways, or exhibit certain traits, and contributing to a more grounded view of themselves in their roles:

> And that maybe goes back to the common humanity element, right? ...That idea of not being the expert and sometimes embracing the humility and humanity of doing what we do. That, I'm very all-about and that, I think, is a way of communicating self-compassion. (Annie)

A skill (vs. a state-of-being)

Several participants pointed out that SC was not a destination in-and-of-itself, but rather, something that must be attended to and practiced, in a fashion not-dissimilar to mediation or mindfulness. As illustrated by Annie:

> Maybe [self-compassion is] a practice, more than just a state of being. Like, practicing going easy on yourself, practicing the more positive self-talk, and, um, being OK with where you're at even if it's in a place of personal struggle, um, and maybe you can do that with also trying to move, and be in flux around being a better version of yourself.

There are two dimensions to this sub-theme: Mindful Self-Awareness, and Personal Approaches.

Mindful self-awareness. Mindful self-awareness reflects one's ability to tune into one's own subjective experience: to notice distress, feelings of anxiety, and countertransference from a place of detached observation (Appendix A). Concurrent to this stance of observation is the ability to respond to oneself in a compassionate way, as explained by Joan:

> [Self-compassion comprises the ability to] observe oneself; be aware of one's own experiencing, and then respond compassionately to that. Right? So… sometimes we use that 'inner-child' language, or something like that, but, you know: "I am feeling overwhelmed. I am feeling... sad".

Personal Approaches. The second dimension of this sub-theme, Personal Approaches, describes how therapists develop SC as a function of their own personal way-of-being and accumulated knowledge, in response to the particular stresses encountered in the work environment:

> …it's a matter of style, and experience, and what you've learned over the years, to work through [role-related distress] (John)

Supervisee struggles leading participants to address SC

Participants eluded to a number of issues brought to supervision by their supervisees which led them to address SC as part of their intervention. On the whole, participants described problems with supervisees' perceptions of themselves, which led them to be harshly self-critical and to question their own competence. Participants also frequently described supervisee's tendencies to push themselves harder than necessary, or to take on inappropriate levels of responsibility for their clients.

This theme includes four sub-themes: *Perfectionism, Feelings of Incompetence*, and *Lack of Boundaries.*

Perfectionism

Chief among the struggles addressed in supervision were those relating to supervisees having an overly negative bias towards their work and possessing a harsh inner-critic. Participants reported supervisees' frequently overestimating the impact of perceived errors, making unhelpful comparisons between themselves and other therapists, and having difficulty extending empathy to themselves. This sub-theme contains three dimensions: High neuroticism coupled with a harsh internal critic, Attribution of responsibility for client change, and

Supervisees pushing themselves harder than necessary (Appendix A). Paul, who also supervised a number of intern counsellors, mentioned coming across issues related to perfectionism in his supervision practice:

> But I find that a lot of the time, we have this feeling as graduate students, who are just neurotic to begin with, and then as psychologists even more so-
>
> (Interviewer):Yeah, even more so (Both laughing)

Liz concurred, noting that, for in her experience, the problem manifested as an irrational belief around academic achievement:

> And then on top of it all, like, “I need to be high-achieving”, which is part of the neurosis, right? Like “I have to be top in my grade or something”, and I'm like… hmmm; not everybody who's top in their grade is good at what they do.

Consequently, number of participants spoke of the tendency for supervisees, driven by high levels of neuroticism and perfectionism, to enact a harshly self-critical inner-voice in response to role-related distress. As Paul related:

> And so, the self-compassion element in working with new counsellors… I think that's why it's so important, because otherwise you're gonna be so hard on yourself. You'll always be looking at what's not working… and there's going to be a lot that you can interpret as 'what's not working', versus just normalizing things.

Joan added additional context to the factors driving the harsh inner-critic of her supervisees:

> Like, you have a difficult session… like, something is revealed in-session and there's a big countertransference, or a client is mad at you or something like, or you go to supervision and something happened, you know, you're confronted with something. And first, probably for all of us, the critic flares up.

Joan also speculated as to what might be at the root of her supervisees' intense self-criticism:

> I'm kind of creating a hypothesis here, but I'd say that generally, the distress is probably a disconnect from one's self-compassion, right?

Another manifestation of supervisees' perfectionism was their tendency to make unhelpful comparisons between themselves and others, be they peers at the same developmental level or more experienced counsellors. Participants reported that such comparisons were a major pitfall in supervisees' abilities to be compassionate with themselves in their work, as Liz explains:

> …There's a lot of, you know, "who has the most files" ... You know, "You've got, like, five files and you're seeing everybody, and I've only managed to get in contact with one person." ... I remember a supervisee who really struggled, like "is something wrong with me?" Right? And "what am I doing wrong?"... Came in crying at one point, because [the supervisee] was so distressed, right?

Feelings of incompetence

Subsequent (and, indeed, perhaps parallel) to encounters with supervisees' perfectionism, participants frequently reported issues relating to supervisees' perceptions of themselves as unskilled and unprepared to do the work of psychotherapy. This sub-theme contains two

dimensions: Self-doubt, and Image management (Appendix A). Many participants described supervisees' tendencies to question their own knowledge and technique, especially when faced with clients whose presenting issues were perceived by the supervisee to be highly complicated. Tanya reported:

> There's a lot of second-guessing that happens, that imposter-syndrome kind of stuff, right … I remember my own experience of this and I always think of it when I'm supporting counsellors now. I would frequently feel that way... of, "I don't know what I'm doing and I'm in over my head. This person has really complex problems and I feel like someone else could probably help them better because I am, like, screwed here."

Participants frequently reported encounters with supervisees' image-management – the tendency to maintain an overly "professional" veneer with both clients and the supervisor. These tendencies resulted in some interns having trouble relating to clients, as related by Paul:

> …the reality was the intern came across uncomfortable, 'cause they were really working hard… to…"
>
> (Interviewer) To not seem uncomfortable!
>
> To not seem uncomfortable! And to give this image.

Paul provides further context by explaining how his supervisee's attachment to her own curated simulacrum of a "professional" therapist resulted in the perception that the supervisee was closed-off, or lacking in warmth:

> …She was doing it to appear more professional, but I said, "We have to feel like we have access to you", and even I didn't feel like I had that with her.

A number of participants reported that, in-line with the desire to appear as professionally competent and capable as possible, their supervisees often felt as though they had to agree to everything asked of them by their superiors, as John reported:

> …I think what happens often with staff, is they feel, sometimes they can't say no, or they don't want to say no, or they want to take on everything. Especially newer staff.

Annie reflected on her own experience as a supervisee wanting to prove her mettle, and the value of her supervisor stepping in and inserting boundaries for her around a particular client, when it became clear that she was not going to do so herself:

> And I've had a supervisor do that to me, where, as I'm always like… "I'm a tough cookie, I can handle anything", and there was clearly a client I had in my internship… when I first started, that they said 'this is an unsafe relationship we're stopping the person." And in retrospect I was very glad... they were like "Annie's not going to tap-out any time soon, so we're going to do it for her."

Personal distress entering workplace

Participants also reported encountering issues in supervision relating to the private lives of their supervisees. In these cases, participants described supervisees who were going through difficult moments in their lives – for example, family crises or relationship troubles – and the effect that those problems could have on the supervisees' ability to perform in their roles as they otherwise may have. As John described:

> I'm going to come back to the staff member who, hypothetically, has a kid, an adolescent who has an eating disorder; they have, you know, a few children. And… he or she was

> clearly distressed, the distress was spilling over into work…. Um, they were very open with sharing with their colleagues and with myself what was going on

Participants related that these problems could result in supervisees missing appointments, using up sick days or vacation time, or being unable to stay present in-session with clients. John continues:

> …clients were complaining… that "this person is always cancelling appointments, and it's been two months since I've had an appointment with a counsellor".

Supervisor approaches to addressing SC with supervisees

This theme describes the methods by which participants in this study, having determined that intervention is appropriate and necessary, address self-compassion with supervisees experiencing role-related distress. There are two sub-themes: Direct approaches and indirect approaches. Most supervisors reported use of direct approaches in response to specific instances of distress – for example, inquiring about the source of the distress, and collaborating with the supervisee to come up with a plan to resolve the issue via addressing self-compassion. Indirect approaches, however, make up the vast majority of participants' strategies for encouraging or addressing SC. The indirect approaches reported by participants were generally aimed at encouraging SC, self-awareness, and humanistic principles to prepare supervisees for the inevitable instances of distress of confusion that they would face in their roles.

Direct Approaches

In instances where supervisees presented with specific or acute distress, participants near-uniformly reported dealing with the situation then-and-there. In cases where it was determined that SC should be addressed, participants generally described a similar approach, illuminated by

the three dimensions of this sub-theme: *Check-in Directly, Collaborate on Solutions, and Encourage Self-Kindness (*Appendix A). For John, the direct approach was predicated upon his awareness of his supervisees' behaviour, and typically follows repeated observations of a perceived struggle (in this case, repeated tardiness on a certain day of the week):

> I would go back and say, "Hey, I just wanted to let you know that I'm noticing a pattern here … and I'm concerned."

Joan also spoke about the importance of vigilance to indirect signs of a conflict or struggle in a supervisee's behaviour, such as the language they use during supervision:

> ...It might be that, I'll notice their language, you know. And often it is around a piece of countertransference, so they're kind of... they kind of know it's there, but they're kind of trying to... keep it away... and sometimes it will abate by itself, but often it's like, "Hmmm, let's just bring that out now and look at it."

In both cases, the intended effect of directly addressing the issue seems to be twofold: it ensures that the supervisor and supervisee are on the same page regarding the supervisee's ability to look after themselves and their clients, while simultaneously removing the stigma around the supervisees' struggles by communicating in a frank and straightforward manner. As Paul summarizes:

> Like I said before, graduate students and psychologists are more neurotic, so that's already there, so let's put it into the room and talk about it ... normalize it, so you don't have to hide from it and we can just bring it into the room and talk about it together.

Liz also saw value in directly addressing and quickly normalizing problems with her supervisees , while simultaneously reinforcing her humanistic perspective on supervision:

> I like to put things on the table. And again, as always, striving for: let's put it on the table in a meaningful way. In an open, non-judgemental way. “OK, so this is something that we all face.”

For Tanya, the opportunity to directly address her supervisee’s struggles came in response to a tragic event on the global stage that caused her supervisee significant distress. The supervisee notified Tanya via email, but Tanya chose to respond in-person, and relate to the supervisee in-person:

> Because she at least opened the door a crack and said, “I'm upset about this, I don't know if I can stay.” I mean, my choice was to go in person and go to her office, and be in a room, the two of us... Because it was on an email that she sent it, I could have just said “Oh yeah, go home if you need to. Tell the front desk.” Right?

Tanya also commented on the ways in which her relationship with the supervisee changed, directly following their conversation:

> And then this person that I have the least-easy-and-open relationship with… I think that self-compassion and recognizing her own human response to a tragedy in the world, by acknowledging and relating to her around that, that actually helped build the relationship and... encourage[d] her own personal response and compassion to that.

After checking-in, participants would often report engaging with supervisees to explore and process the source of distress as well as details such as duration and intensity, as exemplified by John:

> So, I like to ask them, when did this start? When did they start noticing that they were experiencing this distress, is it just starting now? Or has it been going on for months and it just got to the breaking point, and I didn't notice it.

Collaborate on solutions. Participants reported collaborating with supervisees to generate options that were protective of the supervisee, often creating space for supervisees to make adjustments and tend to their self-care, or to set more adaptive boundaries. For John, responding to a supervisee who was using up vacation and sick days to take care of an ill child, collaboration provided a means to both ensure the supervisee's continued productivity at work, but also to help the supervisee balance their home priorities:

> Is there something we can do, schedule-wise, because you're eating up your vacation days and your personal hours … if you do it this way, the time you need for vacation, when your family's going to take time off, you're not going to have anything left. So, let's just look at the big picture.

Indirect Approaches

The vast majority of participants reported addressing SC with their supervisees using implicit or indirect approaches. These methods were intended to help the supervisees embody and enact self-compassion for *themselves* in moments of distress, as opposed to the supervisor needing to step in and address them directly. In this way, the indirect approaches can perhaps be seen as techniques demonstrated by the supervisor with the hopes that supervisees would incorporate them into their very way-of-being as therapists. There are five dimensions to this sub-theme, including *Modelling, Normalizing, Promoting Humility, Encouraging Self-Awareness and Self-Reflection,* and *Preventative Measures* (Appendix A).

Modelling. By far the most standard method of indirectly promoting SC in supervisees was participants' modelling of compassion when supervisees were experiencing distress, with the aim of teaching supervisees that it is permissible and helpful to take such an attitude with themselves. Annie illustrates the impact that this kind of modelling had on her own development as therapist and supervisor:

> I think having good models and mentors was really important for me, so having... people who I admired and thought they were brilliant, but I also saw their moments where they were a little off today, and they admitted to it, and the humility in that was big for me, and then I try to be a good model myself.

Many participants spoke about modelling the humanistic principles of client-centred therapy: unconditional positive (self) regard, genuineness, and congruency. Joan spoke of the importance of modelling both genuineness and congruency with her supervisees:

> ...You know, I'm pretty imperfect, and I allow myself to be so they can see me just being me.

Paul reflected on the importance of showing compassion towards his supervisees, so that they might internalize that attitude for themselves and activate it in response to distress:

> … the counselling aspect, or the caring relationship aspect, is important in the supervisory relationship, to be able to give that experience, and… as a supervisor, give compassion to the intern … so that they can recognize that "I'm allowed to internalize this as well."
>
> (Interviewer) Like modelling, almost.

Definitely.

Normalizing. The second dimension of this sub-theme is *Normalizing.* Participants frequently reported that they made use of self-disclosure around the common experience of distress while learning the craft of psychotherapy, including their own experiences as a beginner, admitting their own mistakes, sharing amusing stories, and embracing the process of learning. Additionally, most participants who reported instances of this type of normalizing were in charge of supervising graduate-level interns. For Paul, these kinds of frank discussions about the challenges of internship provided a means to pre-emptively enhance his supervisee's SC by undercutting some potential fodder for harsh self-evaluation:

> If we can just humanize it, and break it down, like, "you are learning, and this is a hard thing to do, in front of someone who is emoting, and whose problems might be bigger than you know what to do with, and then to stay present for" … just to normalize that.

Liz reported normalizing making mistakes in-session with her supervisees, in order to keep them from unnecessarily flagellating themselves in response to a slip-up with a client; demonstrate that most in-session mistakes are quite fixable while highlighting the common experience of making them:

> ...my hope is that modelling of mistakes also in-session, like, mistakes are fine. Like, I will make a mistake. And if I make a mistake, am I, you know, modelling that I apologize if there's something to apologize for. And that it's OK - there's no need to be defensive about that, it is a part of our journey.

Annie reported using humour with supervisees to soften supervisees' self-criticism and normalize their difficult moments in-session:

> Some interns will have a great sense of humour and will use a lot of - we'll laugh a lot in our supervision sessions… Even take comedic breaks or just, you know, self-disclose more in terms of comedic flub-ups that I've done…because I have a few.

Promoting Humility. The third dimension of this sub-theme is *Promoting Humility.* Participants frequently reported placing emphasis on their supervisees' embracing personal limits and lack of presence in-session. Participants generally reported that these instances could be harnessed as powerful learning moments, if approached with a self-kindness as opposed to self-flagellation. Many participants made reference to the notion of "common humanity" while describing this process of normalization and validation. Annie reported that supervision provides her with the opportunity to help break down some her supervisees' unhelpful, preconceived notions about being "experts":

> …We have to find ways to, like, [embrace] that you're not going to be always-on, and it's not true that you're always going to be engrossed in what the person is saying, and listening … It's very difficult for people to just sit in this chair, you know? You squirm, you fidget, you tune-out, your mind wanders... and part of self-compassion is appreciating that: we're humans. We will...be off-the-mark, or we'll miss what the person said, but as long as you try to notice and come back to it, I think that could be an even more powerful experience than not missing, you know, getting it right the first time.

For Tanya, supervision also provided a chance to encourage supervisee's SC by softening their expectations that they need to be omniscient, "expert" practitioners at all time, and drew parallels between the work of supervision, and the work done between therapists and counsellors:

> The goal of [supervision] a lot of the time [is] about validating, and permission to set boundaries, and permission to make mistakes, and permission to ask questions. Which is a big piece of how I always worked with clients, too, right? And that openness, and that, "I'm not the expert here."

Encouraging Self-Awareness and Self-Reflection. The fourth dimension of the Indirect Approaches sub-theme is *Encouraging Self-Awareness and Self-Reflection.* Many participants reported feedback loops between supervisees' ability to look inward, and their ability to be self-compassionate. Participants reported that self-reflection is a useful tool for learning, but becomes more powerful when it can be approached from a place of self-compassion, safeguarding honest self-reflection from harsh self-judgement. Joan illustrates this concept:

> (Interviewer) If you're not able to self-reflect in a gentle, and maybe, like, self-compassionate way, then you won't be able to go as deep, because you'll run into your own defenses over and over again.
>
> Yep, right. That's right. Or you'll injure yourself in a sense, kind of beating yourself up all the time.

Liz reported a similar stance:

> I have a deep concern about cheerleading versus developing deeper abilities to self-reflect in effective ways. And a key component has to be self-compassion; if we're hard on ourselves we're not going to look as deeply… I want to support the ability to self-reflect in order to be able to have self-compassion, right?

Participants also reported encouraging self-awareness, in the form of mindfulness, to supervisees experiencing distress. For John, this takes the form of encouraging present-moment-awareness in supervisees, allowing them to focus on their immediate priorities:

> If I notice that they're anxious, if I feel that they're talking to me and they're telling me: they have so much on their plate and it's hard … to understand how we're going to get everything done… I would try to slow them down. I would try to tell them to, kind of, just be in the moment ... let's not worry about the future and all the things that you need to do, let's see how can we break this down best, how can we make this work for you, what do we have to look at, to take off your plate, to change what's on your plate.

Paul also reported encouraging supervisees to slow down, and to view themselves from a different perspective, something akin to an "observer" stance, which could also serve to encourage supervisees' sense of humour about themselves, thereby connecting with humility and grounded-ness:

> In being self-compassionate, your use of humour, being able to zoom out and actually look at yourself from this different perspective, so actually seeing yourself… from an outsider's perspective, to see, to what extent we're kind of, just being… so neurotic (chuckling) about things.

Preventative Measures. The fifth and final dimension of the Indirect Approaches sub-theme is *Preventative Measures.* This dimension comprises steps taken by participants in order to proactively protect supervisees who may not recognize their own limits from burnout and other forms of role-related distress. In many cases this took the form of inserting boundaries which allowed the supervisee to focus on their own self-care, as opposed to being solely focused

on work and performance. John spoke pragmatically about the usefulness of such vigilance, not only to the supervisee but to the clients, and the agency as a whole:

> If you need to take a few days or weeks and get what is going on in your life under control, then go do that! Because it's more disruptive to your clients and to us, not knowing if you're coming in day-to-day.

Annie agreed, recalling cases where supervisees were taking on too much of their clients' problems, or were dealing with difficult countertransference:

> [Erecting appropriate boundaries] might actually look like reassigning the client, in the worst-case, and we've had to do that before. Um, 'cause I think supervisors, we have to encourage supervisees to know their own limits, but I think sometimes we'll see the limits when they don't, and we'll have to.... we'll insert ourselves a bit more... And that's my job as supervisor is to get to know the people, and get to know whether they're good at recognizing their limits... or not.

Outcomes (after addressing SC in supervision)

This sub-theme encapsulates the changes in supervisee attitude or behaviour after interventions in supervision that focused on encouraging and fostering self-compassion in supervisees. No participants in this study reported outcomes that might be considered negative or adverse in response to addressing SC with supervisees experiencing distress, after determining that such an intervention is indeed appropriate. This sub-theme includes two dimensions: *Trust in self, Increased-openness with supervisor*.

Trust in self. Participants reported that addressing SC-related topics with their supervisees led to increases in supervisees' self-confidence, and in their ability to engage more

with the process of psychotherapy. For Paul's supervisee, giving herself permission to be more authentic and less-guarded with her clients created a feedback loop, wherein her increased confidence led to more fruitful and genuine sessions, which further served to increase her confidence:

> And as time goes on, and we're … just noticing how things are shifting, and how she's giving herself more permission to be more human with the person, and not, like, throwing handouts on CBT skills to them after the first five minutes, right? … We started to change that, and recognize that she didn't need to be working so hard … and so that self-compassion aspect of being able to be with them, and not push so hard … allowed her to be much more human in-session, and things just started flowing, and you could just see her demeanor was actually starting to change.

For Liz, addressing her supervisee's self-doubt, which led to constant comparisons to others and anxiety about her suitability as a therapist, also led to increases in her supervisee's sense of confidence in-session:

> (Interviewer) 'What was the result of that conversation? How did it turn out for them?'
>
> 'Ah, self-confidence grew, in time. It also helped us to come back to the same topic later on... So confidence grew, and the ability to be kind to the self, grew. I'm trying to remember, what were the concrete signals of that? But one of them, I think, was a more confident stance in-session, but without being stilted or cold.'

Increased openness with supervisor. Tanya was unequivocal in her opinion that addressing supervisees' distress in ways that allowed for self-compassion to be addressed, and to emerge, led to a positive change in the supervisory relationship. Tanya went into detail

describing how, prior to her intervention (in which she took the time to directly-address a supervisee in distress, and encouraged her to take the time to look after herself), the relationship between them became more trusting and transparent:

> I think that's a conversation where I was definitely encouraging self-compassion... as a human being, not necessarily as a boss, but also in the essence that, 'if you need to go home or whatever, I'll check in with you again at lunchtime... And that felt like kind of a breakthrough in our relationship, whereas before this person had been quite closed and did not disclose anything personal to me. And then, since then, has actually been more forthcoming with me and things feel more open and easy between us.

Tanya also reflected on the bi-directional nature of addressing self-compassion with supervisees: that when employed carefully and judiciously, encouraging SC with supervisees can create the conditions for a stronger relationship, which, in turn can make more personal topics like SC and self-care easier to address in the future:

> I don't think anything would really stop me [from addressing SC in supervision]. Again, I think I'm able to have more open conversations that taken in an element of kind, a bit more personal, self-awareness stuff... if the relationship is stronger ... You know, encouraging this self-compassion doesn't necessarily emerge from a strong relationship - although it certainly can - but [it also] is one of the things that helps build one.

Addressing SC at the Institutional/Organizational Level

This theme describes the ways in which the participants interviewed for this study view the promotion of self-compassion and self-care at the agency-level. In other words: how structures within the participants' workplace help therapists connect with their self-compassion

and prevent against burnout, compassion fatigue, and other forms of role-related distress. Additionally, this theme also describes possible paths that educational institutions (i.e., graduate programs which train psychotherapists) may take in order to promote SC as part of professional development for therapists. Included in this theme are four sub-themes: Deliberate orchestration in internship programs, Scaffolding challenging cases, Creating comfortable/open work spaces, and Education.

Deliberate orchestration in internship programs

Several participants spoke of the importance of maintaining institutional policies conducive to encouraging SC in supervisees. Paul reported that he was personally involved in the deliberate orchestration of the internship program, to focus on the personal aspects of counselling as well as professional development:

> Myself and my colleague who put together the internship program, were really conscious about - from the get-go - instilling this sort of way of working … 'we are also helping you, want to be accompanying you in your journey as becoming a professional, and on a personal level' ... So we spell it out; it's in our manual that we send to them.

Paul also spoke about the deliberate early focus on encouraging self-awareness (which participants uniformly reported being instrumental to self-compassion) in supervisees, via personal inventories, in order to facilitate self-reflective practice:

> What are your top 3 [personality] strengths, how can these be of service to you as you through this internship year, right? How might they get in the way? Because every strength can be a weakness, you know? So we work with that as well in the beginning, too, just to get them, again, to have a bit more of the self-awareness.

Finally, Paul reported that his internship program has a direct and explicit approach for helping supervisees develop effective self-care strategies:

> We operationalize it [self-care]. We show them how to do it, we talk about how we do it in our own personal lives, give examples … mindfulness meditations that we'll do with them as well. But we don't just talk to them about it, we have them do it. Because I think that's the big piece too; the experiential part. Because yes, we can read about it in a book, and yeah, 'I'll get to it when I have time...

Scaffolding challenging cases

In addition to acknowledging the personal aspects of counselling, and proactively approaching self-care, participants reported scaffolding challenging cases and projects which may lead inexperienced supervisees to harsh self-criticism or feelings of incompetence, or which may result in supervisees feeling over-burdened, and at risk of burnout. These approaches often involved active collaboration with the supervisee, as John explains:

> …if I'm going to assign [a] project to [a supervisee], I need to get a sense from them as: how comfortable do they feel, how confident do they feel that this would be successful … you know is that something you feel like you can do in the time you have, and let's look at that together.

Paul also spoke to the importance of ensuring that interns were well-prepared to handle challenging cases, and included in his description many of the explicit and implicit methods of addressing SC described previously, such as giving permission, and normalizing:

If, you know, we've had cases where you've had to see… you know, this past year, we had rape cases but we… some of the interns and myself, we had to see the individual who perpetrated it.

(Interviewer): (short pause) Wow…

So there's work to do before you're even ready to take the person into the room.

(Interviewer): Yeah…

And we have to have discussions around that, and normalize that, you know, and allow for it. As opposed to just expecting (snaps fingers) 'Yes, you should be able to do this.'

(Interviewer): Can I ask how those discussions went, or, what was the content of those discussions, or…?

(Participant exhales)

(Interviewer): How do you prepare for that?

Ahh, lots of venting. Lots of just allowing, and normalizing; 'You might not want to do this, but let's get through these preconceived notions, let's see what's going on inside of you. If you can come to a place to hear where this person is, and… um, go through the preconceived notions that you might have.

Creating comfortable and open work spaces

The majority of participants reported intentionally fostering work environments wherein supervisees would feel comfortable and confident in approaching their supervisors with any issue, which participants almost uniformly described as a primary building block to addressing or encouraging self-compassion. As Liz describes, her open stance allows her not only to help her

supervisees work through problems, or blocks, but also gives her the opportunity to encourage self-compassion:

> So also, “what do you think is getting in the way?” But I'm asking this in a warm, open, non-judgemental way. So those are like, the ground for me to help encourage that. 'You can do something about this. Good on you that you came to me; you could have just not come to me'. So, you know, I try to... I see that as a victory; I see that as taking courage. You know, “please be kind to yourself.”

Paul also reported that his open approach to supervision gives him the space as a supervisor to demonstrate to his supervisees the importance of a self-compassionate attitude towards their work:

> We're also responsive, that you can come and talk to us about, you might be feeling a limit, or not be able to manage certain things, and we will be responsive to that as opposed to "No, we expect you to be on all the time.

John reported encouraging self-compassion via proxy, by using his authority to help a supervisee struggling with issues in their home-life. John and the supervisee collaborated on a more adaptive and balanced work-schedule, allowing the supervisee to focus on their self-care:

> So it worked out well, because… they have said to me that I removed that barrier of their being concerned about work … the other stuff, I can't control or change … but they were very… it gave a sense of relief that work was not another obstacle they had to worry about, or failure at work, or worry about their future working here. So that... they've told me that helped them.

Many participants reported attempting to make the supervisor/supervisee relationship as egalitarian as possible. Joan spoke of the importance of acknowledging the inherent power imbalances of the supervisor/supervisee relationship, and encouraging discussion with her supervisees on the subject:

> OK, all the power dynamics. I'm white, I'm older than you, I'm in the captain's seat because maybe I'm evaluating you… English is my first language, I have two master's degrees… these are all my advantages. And we need to talk about that - how are you feeling about that?

For Liz, the supervisory relationship provides an opportunity to emphasise the common humanity aspect of self-compassion by demonstrating to her supervisees that, despite her knowledge and authority, she is as much a learner as they are:

> One of my goals, always, with supervision is to take away this sense of… this sense of 'otherness' - for either party. And particularly for my supervisees, towards me. Like, "here's this person who has it all figured out… and I need to be like this person who has it all figured out" … So, if we take that construct of common humanity, I am, we are... I am a learner. I'm on the path joining you on this path of learning. I've not stopped learning, first of all, and I won't.

Annie highlighted the importance of maintaining a trusting and open relationship with her supervisees regardless of her feelings about self-compassion, reporting that the level of trust in the relationship is a significant factor in her ability to properly discharge her oversight duties as supervisor:

> The relationship itself is really what makes it so that my interns will feel more comfortable coming, and kind of... admitting to some of the things that they did that they think were... faux pas, or whatever, a bit riskier. Um, and I think that's really important because otherwise, so much of what we do is behind closed doors, right?

Education

Participants in this study generally agreed that supervision, as part of counsellor education, was an appropriate forum to address SC – this was true for participants who supervised interns, fully-licensed practitioners, or a mixture of both. According to John:

> (Interviewer) "What do you think of the suggestion that supervision … is a good place to promote the benefits of self-compassion to therapists and counsellors?"
>
> "Without question … you know, if you can't take care of yourself, how are you going to take care of somebody else?"

Annie emphasised that, because self-compassion in some form or another is an important topic to cover in therapy with many clients, it follows that supervision is an appropriate forum to teach counsellors about its utility not just for their own well-being, but for their clients:

> [Self-compassion is] also a topic that is so needed within the therapy, so of course talking about it in supervision is going to be beneficial to the clients, and also the idea of like, not needing to be the expert, and going easy on yourself, practicing self-care, compartmentalizing, all of that stuff is important too... so that we're not bringing things home at the end of the day - too much...

Tanya pointed out that, because of the hectic pace that work as a therapist can sometimes take, supervision is not just an appropriate forum to educate counsellors about the value of SC, but that it may be the *only* reasonable forum:

> [Supervision] is a good place [to learn about self-compassion]. Well... I think, again, in the regular day to day of anybody's practice, and again I'm speaking from my own experience of working in an organization... as a therapist... I think [therapists] don't have a lot of time to talk to each other, they don't have a lot of time to read articles, they... I mean, unless they are, unless they're devoting time outside of work to do that stuff, it's not happening, right?

For Liz, SC was crucial in enabling the sort of self-reflection necessary for the deep learning she hoped to impart on her supervisees through her supervision, lest they be too self-critical to respond to their own countertransference, slip-ups, or lack of presence:

> (Interviewer)'Without self-compassion, it sounds like the learning is stunted.'
>
> 'Yes. I believe so. I believe the danger is there.

Participants spoke about the importance of education in providing beginning counsellors with background information on burnout and other forms of role-related distress, with several mentioning that this information was lacking in their own graduate programs, as exemplified by John:

> [Burnout, compassion fatigue were] never mentioned in [participant's graduate program] … I think it's really important to give [graduate students in counselling] the understanding or the background…

Liz held similarly strong convictions regarding the importance of providing graduate students in counselling and psychotherapy with relevant background on the types of role-related distress they may encounter in their work:

> I'm a huge believer in [topics related to burnout, compassion fatigue, etc.] being addressed in the most pedagogically sound, like, productive ways possible. And that, we need that, because burnout is a real possibility with any kind of front-line work.

However, Liz also considered that SC may be challenging to teach in a normative classroom setting, due to the highly subjective and nuanced nature of the construct itself:

> So, should [SC be taught in graduate programs]? Absolutely, there's no question. Like, a hundred percent. Um, how can it be brought in is an excellent question, and maybe not… not as easy. What is easy is talking about theories, or the DSM. Categories that are pretend-black-and-white, I'm going to say - critically. Um, however, getting to the crux of what self-compassion really is, and is not, and how to... how to develop that in oneself... there's nuances.

Finally, Joan emphasised the need for stronger supports for *supervisors* to engage in their own self-reflection and self-compassion, through formal-and-informal collegial support networks:

> We train supervisors, and we encourage them to be self-compassionate... where do they go? When they need the support... Ideally, what we do is: supervisor-mentors hang out with each other, kind of support each other, and consult with each other, and stuff. But we need that collegiality, and community...

Challenges associated with addressing SC in supervision

On the whole, participants agreed that the promotion of self-compassion in supervision, either directly or indirectly, could be useful in supervisees' management of distress. Participants did, however, reflect on instances in which self-compassion would not be their first choice for intervention with a distressed supervisee. Participants were generally wary of seeming contrived or pretentious in addressing SC, and were also conscious of ensuring that other relevant supervision topics were covered with equal weight. One participant seemed somewhat skeptical of the idea of SC in the mainstream sense and reported trepidation around the topic as a whole. The sub-themes for this section bear out the scope of their concerns: SC as Inappropriate Intervention, Inauthenticity, Supervisee Resentment, Balancing SC Content with Other Relevant Topics in Supervision, and Workplace Values.

SC as Inappropriate Intervention

When asked about times in which they *wouldn't* consider self-compassion to be an appropriate topic of discussion in supervision, participants indicated two dimensions: Red flags indicating SC is not appropriate, and Using SC only for problems affecting work being done (Appendix A).

Red flags indicating SC is not appropriate. Several participants reported that there were certain signals or signs that might indicate to them that a supervisees' issue would not be best-addressed by self-compassion. In general, these sorts of issues tended to have to do either with some sort of basic personality quality the supervisee has (or lacks), or, with issues relating to more serious lapses in performance (i.e., a supervisee failing to report a suspicion of child neglect or abuse). Annie reported that she would be unlikely to address SC with an intern who lacked warmth, or who seemed otherwise unsuited to the field:

> Hopefully I will have gotten to know the intern well enough to be able to see … whether they have what it takes… to be in this field, and that comes from some of the personal qualities I see… are they naturally warm and… eager to help, and things like that. So if I get a sense from a client – uh, supervisee – that... they may be lacking those qualities or - and you can see it even in behaviours around the office: complaining often, or not being very supportive to their colleagues, or just seeming drained and all that. Um, I would have a different conversation with them versus somebody who I see as, you know, working really hard and not complaining much...

Continuing this train of thought, Annie explained that part of her role as supervisor involves making the critical decision about whether or not a supervisee is suited to the work. If the issue boils down to a basic incompatibility with the demands of the profession, self-compassion would be forgone, and replaced with a much more pragmatic conversation:

> I want them to feel comfortable to come and kind of vent or complain - but if I have an intern who comes in week after week and says how much this takes it out of them, and how much it's hard for them to do? ...We will have the discussion already of... “It's gonna be just more of this, and then some, when you're done ... So, this is also the year to figure out: 'Can I do this?”

Tanya concurred with Annie’s view, while also adding that even if she were involved in one of these more pragmatic discussions around a supervisee’s performance, she could still see a place for SC if it led the supervisee to change their behaviour without being too hard on themselves:

> Like, the only thing I would see [in terms of not using SC in supervision] was if, the supervision, was about a complaint or something that they had... that was a performance issue, right? And I could still be compassionate about, "OK, so you made this mistake, and I encourage you to give yourself permission to learn from this and move on, but we need to change it." Right?

Potential ethical concerns in supervision. The second dimension of this sub-theme reflects participants' general belief that SC, applied in the supervisory context, could sometimes be inappropriate if the issues being discussed were more personal in nature. As is perhaps to be expected, participants reported being mindful of the boundary between therapy and supervision. Participants tended to feel that, if applied inappropriately, SC could veer from supervision into something more like therapy, resulting in a potential ethical quandary (i.e., dual role) – almost all expressed this to some degree. As Annie succinctly summarizes:

> I have to balance, as a supervisor, because sometimes with the self-compassion talk it can quickly get into 'therapist-mode' with the supervisee.

Annie later provided more context to her statement, indicating that she is comfortable discussing matters that seem to skew into the personal realm, but only as a function of the work being done by the supervisee, and only up to a certain point:

> What's coming up for you here? How do some of your life experiences inform your work, or description of suffering, or description of healing, right? I think that's very fair game to talk about. When it ends up being more, they're coming in for emotional support uniquely about their life experience... I'll do that a little bit... if it's an ongoing basis... I think at that point I would try to encourage them to bring in other people in their life too.

All participants who spoke to this dimension of practice were quite clear in their description of the boundary between the professional and personal relationship. For Joan, enforcement of the supervision/therapy boundary also seemed to provide a means for her look after *herself*, in terms of the amount of personal responsibility she felt towards her supervisees:

> I have to do the best I can. Or I expect myself to do, as much of the time as possible, the best I can. But I'm not responsible for other people, I don't have to rescue, I don't have to, you know... I do what I'm committed to doing, right?

Others were more direct and pragmatic in terms of their relationship with the personal/professional boundary, with no problem communicating it to their supervisees, as Tanya reports:

> I did have a situation once where someone started telling me a long, involved story about their relationship with their mom. I listened supportively and then, kind of said, "You know, we have an EAP program? I wonder if this is a sign that it's time to do a piece of work on that?" And "I wonder, have you looked into that? Maybe that would be a helpful thing right now, to help you do this job, that is hard if things are difficult with your mom right now"... So that's really the only time that I've kind of... diverted, and it was more just my own sense of "this is more than I... need to know right now."

Adding more context to this statement, Tanya observed that the personal/professional boundary exists for good reason; going too deeply into the personal lives of supervisees can result in an ethically fraught dual relationship that can generate complications in the workplace:

> I'm also conscious, part of [supervision] is... again, containing and setting boundaries for people sometimes... [because] I don't want you to tell me too much, and then be

> embarrassed or unable to, like, face me in other ways because suddenly I know all this weird stuff about your mom (laughing).

For Paul, the matter was similarly black-and-white:

> We can recognize it and see it, but not open it up. In the sense that, "this is something you're going to need to work on. I'm not going to be the person to do this work with you, but I can recognize it and encourage you to go do this."

Inauthenticity

Several participants mentioned that they would not address SC if it were inauthentic for them; in other words, if it were not congruent with their worldview, or with their approach to supervision, as they considered that it would be readily apparent to their supervisee, and would result in a decreased openness in supervision, as a function of diminished trust in the relationship, As Annie illustrates:

> If [self-compassion is] just being administered as a technique... then there's a chance we can't create the same level of safety, and trust in the room, which is really, really vital... for supervisees to come forth and talk about their... struggles with self-compassion, their true feelings... they're not gonna come forward... if there is a sense of inauthenticity... hypocrisy...

Liz expressed concern that over-addressing self-compassion in supervision would come off as inauthentic, resulting in some combination of resentment and/or boredom on the part of the supervisee, decreasing both the educational and personal value of supervision, as well as the perceived value of SC as a concept:

> It would be unfortunate if it was like “Wow, supervision has gotten boring because it's kind of same-old, same-old”. Or, “I'm not too sure”, questioning, ah, for example, the supervisor's… my authenticity about this topic, or my maturity around this topic if that's, a one-trick pony show and we're always just talking self-compassion, self-compassion. Like, what else? Isn't there anything else? So, like, questioning the validity of this concept or construct.

Annie was particularly ambivalent to SC in general, and expressed this ambivalence towards the language and activities associated with SC:

> I think the language [Neff] uses to self-soothe … and she does this (mimics soothing chest/heart region), right? And she's just like “it's OK darling”, or whatever. And I just have this - and I'm sure it goes back to my childhood - the major willies throughout my body just hearing that.

Annie elucidated that part of her distaste for SC comes from the connection that she sees between “going easy” on oneself and her concerns about becoming stagnant or self-accepting. Annie made frequent reference to this during her interview:

> I myself, who's more of a tough-love, like, pushing yourself and - I'm a bit of a perfectionist and I don't want to change it - so that's… kind of goes against being okay with where you're at. I'm very much about growth, constantly trying to self-improve, and grit.

For Annie, the prevalence of SC in contemporary culture seems to be a symptom of an overly sensitive and protective society, where insulation from discomfort comes at the cost of personal growth:

> There are people that I think go too easy on themselves nowadays, and we could go into a whole discussion around molly-coddling, and helicopter parenting, and kids that don't have the resiliency they used to anymore, and all that stuff. So I think that's some of the images that come up when I hear self-compassion.

Supervisee Resentment

Participants also reported that they may be less-likely to emphasise certain aspects of SC, such as common humanity, in response to supervisees' distress for fear of engendering resentment from the supervisee. For John, trivializing the seriousness of a supervisee struggling with the burden of a sick child was a concern:

> They've shared that with me, and I know that experience. I'm not going to say 'Oh, I'm so sorry to hear that, a lot of people, a lot of parents go through that and everything's going to be ok' - I think that's disrespectful because it's contrite.

Liz expressed some concern that too much SC could result in flooding the supervisee, and lessening any potentially helpful impact of SC:

> I think there is such thing as too much of a good thing, right? So… I wouldn't want to address it so much that it becomes, like, irritating, right? I think there is such a thing as being a broken record, bringing up the same, like, I guess I'll use the expression 'flogging a dead horse'. There can be overkill. And I don't think that's helpful.

Later in the interview Liz expanded on the notion, reporting that over-reliance on SC in supervision may also confuse the supervisee, who might perceive the supervisor as preachy:

> I don’t want anybody to feel like “maybe she's pushing this particular agenda and I don't know why”, or, like, “what's this about” type-of-thing.

Additionally, Paul reported that the saturation of SC and self-care in the current culture may result in supervisees resenting and dismissing the topic out-of-hand:

> I think as soon as you say 'compassion', but you put the 'self' in front of it, and it's like (makes exasperated sound), “yeah, well…” (Interviewer and participant both laughing)

Balancing SC content with other relevant topics in supervision

Participants also reported that they felt it necessary to balance addressing SC in supervision with other relevant topics and issues. Almost all supervisors reported feeling mindful of the fact that they needed to balance their compassion and understanding for their supervisees with the need to have their authority and wisdom acknowledged. John explains:

> I have to be respectful of the role of supervisor, and as much as possible I don't want the lines to get blurred. Because I also have to be able to say "no" to people, and put the brakes on for people, and be the disciplinarian sometimes for people. So I don't want to be, you know, necessarily "XXXXX the Person Who is Liked"; I don't want everyone to like me, but I want them to understand that I respect where they're coming from, and sometimes I'll say “yes”, but sometimes I'll have to say “no”.

Joan expressed similar sentiments in her interview, describing the process of balancing her duties of clinical oversight with promoting self-compassion in her supervisees:

> They will know that I'm concerned, or even a little bit angry, um, and I will say why, and this is my concern, and what was going on there? And then I might say, “You can see that

> I'm concerned about this, right? This is really important; this is really serious." And so I kind of use myself there... this is one of my favorite questions: "What's getting in the way of you proceeding with what we talked about?"... So, I try to still be accepting and curious... But kind of saying at some point, you know, there's a line here and we have to honour that.

Liz reported seeing her responsibility as supervisor from an educational standpoint; that it was part of her job to ensure that supervision was as comprehensive and complete as possible and, as such, there were times when SC would not be appropriate to address:

> (Interviewer) I'm thinking how, maybe there's some kind of responsibility there to make sure… that the learning they're receiving is, itself, quite holistic and quite well-rounded, right?
>
> (Participant) Mhm! For sure.
>
> (Interviewer) And that, perhaps, if you're addressing self-compassion too much, or addressing any one thing too much, that learning is going to stagnate.
>
> (Participant) Yeah, for sure. It will stagnate in one way or the other. I agree with that.

Summary

Summary of Findings

Thematic Analysis of participants' interview transcripts revealed five main themes relating to self-compassion in supervision: (1) *Participants' Definitions of SC*, (2) *Supervisee Struggles Leading Participants to Address SC,* (3) *Supervisor Approaches to Addressing SC with Supervisees,* (4) *Institutional Structures Addressing SC and Self-Care,* and (5) *Challenges*

Associated with Addressing SC in Supervision. In sum, participants were able to define SC as it related to their work as clinical supervisors, as well as detailing the moments in their practice with supervisees during which they found it helpful to address SC. Participants described the ways in which they approach SC with supervisees in distress, with the majority of experiences reported via modelling or other indirect methods, though directly addressing SC with supervisees was noted in incidents of acute work-related distress. Participants also shared their thoughts and experiences regarding how SC can be implemented into both the workplace and educational culture of psychotherapy, to better-protect supervisees from distress in a proactive manner. Finally, participants delineated several challenges associated with addressing SC within the context of clinical supervision, including supervisee-centric factors (i.e., contextual red flags indicating that SC is not an appropriate intervention) as well as supervisor-centric factors (such as SC not feeling genuine/congruent for the supervisor) contributing to their decision-making. However, on the whole, the participants interviewed for this study seemed to find considerable utility in SC as an intervention within clinical supervision, and most seemed quite eager to promote its usefulness to their practice. These findings will be discussed in more detail in Chapter V.

Chapter V

Discussion

The results described in Chapter IV of this study provide the beginnings of a description of how clinical supervisors relate to the construct of self-compassion in their work with their supervisees. This section will summarize the findings of the current study, drawing parallels from-and-between previous literature on the subject, and explore the implications for practice.

Limitations of the current study will be described, and possible directions for future research will be discussed.

Comparisons with Literature

Definitions of Self-Compassion

Self-kindness.

As highlighted in Chapter I, the three dimensions of mainstream SC include self-kindness, common humanity, and mindfulness (Neff, 2003). Participants in this study described SC in ways that both converged with, and diverged from, the typical definition of the construct. In contrast to Neff (2003), participants in this study did not identify self-kindness as a principle component of SC in-and-of-itself but, rather, included it as part of a broader picture of self-care. All participants, to some degree or another, agreed that SC encompassed an attitude of extending the same sort of care to oneself as one might extend to another, and it is within this context that most made mention of self-kindness. However, this description of SC also included a *pragmatic* element that was focused on ensuring an appropriate, healthy boundary between therapists' work-life and home-life. The self-compassion by participants also included a *humanistic* element, as many reflected on the importance of recognizing one's own value outside of any achievements or competence related to one's work as a therapist. This unconditional positive self-regard is somewhat related to the self-kindness described by Neff (2003), but differs insofar as it has less to do with suspending our typically harsh self-evaluations and more to do with recognizing that our value as human beings is not dependent on how often we "get it right", or are otherwise successful in our work. In this sense, the definition of SC provided by participants in this study takes on a humanistic (Rogers, 1961) bent that is, perhaps, unsurprising given how

elemental the client-centered philosophy is considered to be by many counsellors and psychotherapists.

Common Humanity.

The second tenet of SC according to Neff is common humanity (Neff, 2003). In the mainstream notion of SC, common humanity refers to the recognition that one is not alone in one's suffering but, rather, is connected through the common experience of pain and hardship to every other human being. Although some participants made reference to the term "common humanity" in their interviews, it was always after the traditional definition of SC had been provided to them – none mentioned it spontaneously when asked to define SC for themselves. In this sense, participants in this study diverged broadly from the standard definition of SC. In place of "common humanity", all participants in this study made reference to an attitude of humility in relation to the work of psychotherapy. This attitude of humility manifested principally as a stance of "permission-giving" in relation to oneself: that it is OK to make mistakes, to feel overwhelmed, to have negative thoughts or feelings towards a client, and to ask others for help when needed.

The humbleness mentioned by participants, thus, seems distinct from what Neff means when she refers to common humanity. It has less to do with viewing one's own suffering in the context of *the* suffering endured by all people, and more to do with recognizing the inherent fallibility associated with being a human being working to help others – and the itinerant acceptance of that fallibility. The author speculates that perhaps this is what "common humanity" looks like, applied to mental health professionals and practitioners: a sense that none of us are perfect, machine-like entities who never make mistakes or experience difficult emotions. One of the implications of this dimension of SC reported by participants seems to be that the acceptance

of these imperfections – and the ability to treat them with understanding – is a factor that strengthens a practitioner's ability to connect with clients in a genuine and authentic way, without relying on posturing or the maintenance of an ineffective "professional" veneer.

Mindfulness.

The third element of SC mentioned in Chapter I is that of mindfulness. In this context, mindfulness comprises the ability to observe one's own suffering from an objective headspace, with the goal of avoiding over-identification with one's own pain (Neff, 2003). In other words, to be aware of and notice one's own suffering, but not to be defined by it. Several participants mentioned this sort of awareness in their descriptions of SC, referencing the value of being generally aware of one's own state of mind, and also to reflect on any impact that one's work as a therapist may be having on one's well-being.

All participants, in one way or another, mentioned the importance of developing mindful self-awareness as it relates to SC (see "Indirect Methods", below). This type of self-awareness seems closely related to the concept of mindfulness, and its prevalence in the data collected speaks to the value that the participants ascribe to it. Several participants directly referenced the link between self-awareness and SC, with some reporting that self-awareness is a necessary precondition to SC. Others indicated that SC and this type of mindful self-awareness would reinforce each other in a feedback loop. This feedback loop would be one in which one's ability to self-reflect on various aspects of one's practice as a therapist would be hampered if one were constantly flagellating oneself over perceived failures and mistakes, and enhanced if one were able to view one's practice with an attitude of objective self-compassion. This concept seems particularly important in light of the high rates of self-criticism reported by the participants in

this study, which has been linked in previous research to higher rates of compassion fatigue and burnout in graduate-level therapists (Beaumont et al., 2016).

The feedback loop that participants reported between self-awareness and SC highlights the generally interactive and self-reinforcing nature of the various elements of SC described by participants in their personal definitions of the construct, which is in-line with the model of SC given by Neff (2003). Put differently, each aspect of SC described by the participants in this study reinforces and feeds into the others. For example, the ability to observe one's own internal state, and be aware of the impact of the work on one's own self (mindfulness) is supported and enhanced by one's ability to accept the inherent imperfections of practicing as a therapist (humility), and by the extent to which one can extend the same sort of kindness to oneself as to others (compassionate self-care). Likewise, one's ability to extend compassionate care to oneself would be enhanced and supported by one's ability to be humble about one's practice, and to self-reflect from a more neutral and mindful point-of-view. In this way, we can hypothesize that there might exist a bidirectional model of SC for therapists and counsellors, in much the same way that Neff's (2003) description of general SC seems to suggest a mutually reinforcing relationship between the constructs of self-kindness, common humanity, and mindfulness.

Many forms.

Additionally, several participants in this study made reference to the highly individualistic nature of self-care, and what that might mean for SC. Several participants spoke of their distaste for, and skepticism surrounding, the language used in some mainstream SC literature, which they perceived as being "flowery" or inauthentic. Annie in particular was highly resistant to the idea of SC, which is actually in-line with some research suggesting that some counsellors may interpret SC as being self-indulgent (Bell, Dixon, and Kolts, 2017). Several

participants pointed out that SC can take many forms, and that simply engaging in self-care, whatever it might look like for the individual, could be considered a form of SC, which corresponds with research suggesting that the terms are often used interchangeably by practitioners in the helping professions (Norris, 2018). To this particular end, participants hypothesised that SC (that is: "self-compassion") need-not take the form of the sorts of exercises typically promoted as being self-compassionate in nature, but that anything which helps the individual feel grounded, peaceful, or otherwise imparts a sense of meaning to the person, would be considered practicing SC. This perspective on SC seems to suggest that some of the participants in this study view enacting one's own self-care and SC as one and the same. Participants mentioned the many forms that SC, in this sense, could take, including regular exercise, social connection, eating well, focusing on achieving a healthy work-home balance, listening to music, etc. This corresponds to well-established self-care methods for the helping professions (Figley, 2002; Hesse, 2002; Killian, 2008; Zebruvel & O'Dougherty-Wright, 2012; Knight, 2013), and demonstrates the importance of a holistic and individualized approach to self-care.

Supervision and Education

Supervision.

The clinical supervisors interviewed for this study all mentioned the need to be mindful of the boundary between therapy and supervision in one way or another, which is in-line with literature suggesting precisely that clinical supervisors tend to be careful not to veer into the more-personal subject matter typically associated with therapy (Hoffman et al., 2005; Ladany & Walker, 2004). Participants reported *some* willingness to address personal issues with supervisees, but were unanimous in their consensus that doing so would only be appropriate in

the sparest of circumstances before recommending to the supervisee that they seek outside consultation in the form of their own therapy, or collegial/peer support. However, participants tended to agree that issues relating to their supervisees' feelings about their role were within the acceptable bounds of supervision.

Issues Encountered in Supervision.

The problems that participants reported their supervisees as dealing with tended to manifest as issues related to: heightened self-criticism, feelings of incompetence, and personal distress entering the workplace. Given the prevalence of research suggesting that counsellors, psychotherapists, and others in the helping professions are at risk of burnout and compassion fatigue (Hesse, 2002; Injeyan et al., 2010; Knight, 2013; Maslach et al, 2001; Nelson et al., 2018; Pearlman & Saakvitne, 1995), it was somewhat surprising to learn that these types of occupational distress were essentially unreported by the participants in this study. It is important to remember when interpreting the results of this study, however, that while some participants in this study worked with experienced therapists well-established in their careers, most participants were involved in the supervision of novice or intern therapists on postsecondary campuses. It is possible that occupational distress such as burnout and compassion fatigue are not encountered as often with this population of therapists. The fact that most participants in this study reported encountering a high preponderance of issues relating to harsh self-criticism, maladaptive perfectionism, and feelings of incompetence does seem to correspond with literature indicating that these sorts of issues tend to be experienced particularly strongly by novice and intern counsellors and therapists (Hesse, 2002; Merriman, 2015; Parent et al., 2016; Pearlman and MacIan, 1995; Shapiro et al., 2007),

Indirect Methods of Addressing SC

Most participants reported employing indirect methods to deal with their supervisees' distress in a preventative manner. Participants commonly mentioned modelling compassion to the supervisee in the hopes that they would internalize and enact SC during moments of distress – a method which would also have a knock-on effect wherein the supervisee may model such an attitude to their clients, similar to that proposed by Nelson et al (2018). The approach of modelling SC as an important aspect of self-care seems to correspond with literature suggesting that direct-modelling of self-care is an effective means of teaching it to students (Lewis & King, 2019). As mentioned in Chapter II, a recent study suggests that the use of compassion-focused training (CFT) in the form of a five-hour workshop can aid therapists in developing a compassionate "inner-supervisor" (Bell et al., 2017). The development of this compassionate inner-supervisor was related to increases in participants' abilities to self-regulate their emotions, experience self-compassion, and to self-reflect, and associated with reductions in self-criticism and rumination (Bell et al., 2017). I mention this study because I see a parallel between the goals of the pilot program, and of the supervisors in this study employing indirect methods of encouraging SC: to help therapists internalize helpful elements of SC and enact them during moments of distress.

Many participants also reported self-disclosing their own struggles or gaffs as students and therapists to indirectly encourage supervisees' SC in response to supervisees' distress. Participants felt that this would have the effect of illustrating to their supervisees that such adversities are within the normal bounds of experience for practitioners – in particular those who are interns or novices. This approach of self-disclosure and normalization is in-line with research suggesting that, if the relationship between the supervisor and supervisee is strong, such disclosures can have precisely this effect of normalizing – and diminishing the impact of –

stressful experiences on supervisees (Knox et al., 2011). Participants in this study highlighted that, in so doing, they hoped to mitigate some of the intensity of their supervisees' self-criticism and, in turn, increase supervisees' propensity to be self-compassionate during times of distress. This perspective seems to be well-founded in logic, as research suggests that student-therapists' ability to be self-compassionate is negatively correlated with their tendency to be intensely self-critical (Beaumont et al., 2016).

Finally, participants in this study highlighted the importance of encouraging self-reflection and self-awareness in their supervisees, relative to SC. Self-awareness, and appropriate use-of-self, are already known to be of great importance to the practice of psychotherapy (Bell et al., 2017; CRPO, 2018; Knight, 2012; Stella, 2016; Thériault, Gazzola, Isenor, & Pascal, 2015). Participants in this study saw a synergistic effect between SC and self-awareness, wherein the ability to self-reflect – deemed elemental to deep learning by several participants – would be hampered if it were to occur without some amount of SC. In other words, supervisees who are less self-compassionate would be more-likely to denigrate themselves unnecessarily, or attend only to elements of their practice they perceived as flawed. By encouraging self-awareness *in concert* with the other indirect methods described in this section, participants hoped that they would help their supervisees to become more *compassionately* self-reflective. Several participants were adamant on this topic, stressing that if supervisees did not possess the capacity to self-reflect compassionately, they may be less-likely to self-reflect *deeply*, and as such may not develop the necessary self-awareness for effective, safe practice.

Direct Methods of Addressing SC.

Participants' use of direct measures were less-frequently reported. On occasions when participants reported directly checking in with supervisees, it was typically in response to

specific instances of distress, or to the participant's inquiring about specific patterns of behaviour. For example, one participant reported noticing that a supervisee was repeatedly cancelling appointments, and appeared to be exhibiting signs of stress, which led the participant to raise the issue with the supervisee. Checking in directly allowed the supervisee to share that there was a serious illness in their family which was causing the supervisee to miss and cancel appointments, which led the participant to encourage self-kindness with the supervisee, and to collaborate on solutions. Participants who described such instances frequently reported collaborating with the supervisee to generate solutions which would enable supervisees to focus on their self-care – in this case, allowing the supervisee to make up the time during other days in the week. The process of remaining vigilant to symptoms of distress, performing direct check-ins, and collaborating on solutions, are in-line with literature recommending that supervisors comport themselves in just such a manner when dealing with supervisees experiencing occupational distress (Knight, 2013).

Participants in this study who reported directly checking-in with supervisees in response to occupational distress typically also encouraged the supervisee to be self-compassionate in the moment. These instances of directly encouraging self-compassion almost always took the form of encouraging the supervisee to engage in self-kindness, typically through the act of giving themselves permission to "go easy" on themselves. In other words, for supervisees to extend the same sort of understanding to themselves that they would to a peer or colleague; to allow themselves to ask for help, or to refer certain clients, or to experience difficult countertransference, without unfairly judging themselves for doing so.

Outcomes

It deserves mention that, due to the qualitative nature of the current study, no inferences can be made regarding a cause-and-effect relationship between the participants' addressing SC with supervisees and any outcome reported of said intervention reported by participants. That said, participants reported positive outcomes in supervisees with whom they had addressed SC. There were generally two types of outcomes reported by participants in this study: improvements in supervisees' *intra*personal function (i.e. sense of confidence, self-perceptions), and improvements in supervisees' *inter*personal function (typically an improvement in some aspect of the supervisory relationship). Participants reported that, in cases where supervisees' perfectionism and feelings of incompetence were a chief concern, addressing SC contributed to supervisees' ability to be more "human" with their clients, and to learn to trust in themselves and the process of psychotherapy more readily. The issue with these supervisees seemed to be an attachment to an overly-rigid clinical agenda that was based in insecurity regarding their skills as a practitioner. By engaging the supervisee's self-compassion, participants reported that the supervisees were able to see themselves in a more open and accepting light, which led to their ability to be more present with their clients, which in turn led to increases in the supervisees' feelings of self-efficacy and trust in themselves.

Participants also reported that addressing SC with a supervisee could lead to increased openness and trust within the supervisory relationship. Tanya reported that after she directly addressed SC with a previously-closed-off supervisee, the relationship began to change – something she referred to as a "breakthrough". In this case, Tanya reported that the supervisee became increasingly warm and forthright with her, enhancing the supervisory relationship between the two of them by allowing Tanya more access to the "behind closed-doors" content of the supervisee's sessions with clients. All participants in this study, at some point or another,

spoke of the importance of maintaining an open channel with their supervisees in order to better-facilitate their oversight of client care. As a function of the maintenance of such a dynamic, encouraging or addressing SC with supervisees provided participants with a means by which to build a more authentic and human relationship with their charges, leading to further trust and disclosure in supervision. The fact that no participants in this study reported anything that might be considered a "negative" outcome as a result of addressing SC with their supervisee corresponds with other examples of research into the benefits of SC for counsellors (Beaumont et al., 2016; Lewis & King, 2019; Norris, 2018).

Whether they were describing the implicit promotion of self-compassion through indirect methods, or through directly approaching the topic with supervisees, all participants agreed – some more enthusiastically than others (see below) – that SC is useful for the management of occupational distress. Some participants suggested that clinical supervision may even be the *best* means of teaching supervisees about the value of SC in relation to their work. Tanya was emphatic about this, suggesting that supervision be used to promote SC because many therapists – be they interns or more-experienced professionals – simply don't have the time to keep up with emerging research in self-care while managing their other responsibilities. Tanya's view was that supervision offered a pragmatic solution to this problem, given that proper attention be paid to the boundary between supervision and therapy. The participants' agreement that supervision represents a valid forum to discuss the benefits of role-related SC corresponds with some recent research which also suggests that clinical supervision is well-suited to discuss the topic (Nelson et al., 2018; Norris, 2018).

Education.

Several participants reported that in their own graduate-level training, there was precious little space given to the subject of role-related distress or self-care, such as burnout and compassion fatigue, despite literature indicating its importance to students and novice practitioners (Beaumont et al., 2016; Nelson et al., 2018; Olson et al., 2015; Senyuva et al., 2014). At a glance, it may be tempting to suggest that this discrepancy be related to the fact that several participants in this study would have completed their graduate degrees two-to-three decades previous to their interview. However, relatively-recent research made note of the lack of coverage given to occupational distress, self-care, and related topics in graduate programs for counsellors and psychotherapists, and pilot programs aiming to bring these topics to the forefront of education for front-line professions have only recently begun to emerge (Knight, 2013; Lewis & King, 2019). The emphasis placed on the importance of self-care – and SC in particular – by most of the participants suggests that there is still a need to see these topics covered in the training of counsellors and psychotherapists, which is in accordance with research into the matter (Beaumont et al., 2016; Knight, 2013; Lewis and King, 2019; Nelson et al., 2018; Olson et al., 2015; Senyuva et al., 2014).

Liz was particularly interested in the idea of SC entering the classroom, and speculated that it may be rendered challenging due to the subjective and individualistic nature of the subject. It has, however, been suggested by recent research that SC could be taught by providing students with writing exercises meant to demonstrate the core tenets of SC, which would not only benefit the students' self-care strategies, but would also give them a more-solid understanding of the construct for use with their future clients (Nelson et al., 2018). Although presumably (and in some cases, explicitly) unfamiliar with the literature in question, the views of the participants in this study correspond with this literature. Several participants reflected that because teaching

clients to be self-compassionate is so germane to the work of therapy, it would follow logically to ensure that interns are at least familiar with it as they learn their craft. Additionally, recent research has demonstrated that student-therapists are receptive to SC-related exercises as part of their graduate-level group supervision course (Norris, 2018) that employed similar exercises to those suggested by Nelson el al (2018).

Implications

Ethics

An interesting aspect of the current study concerns the tension between supervisors' mandate not to engage in personal therapy with their supervisees (ACA, 2014) and the seemingly personal nature of *self*-compassion. Many SC-related techniques have found their way into the clinical practice of psychotherapy (Germer, 2012; Gilbert, 2009; Yadavaia et al., 2014). Online SC resources are publicly available – at this point ubiquitous – and have no doubt been recommended to clients by countless counsellors and therapists. At the same time, provisions within professional organizations regarding *the self* of the therapist are becoming more common, with some jurisdictions making therapeutic use-of-self a legislated competency (CRPO, 2018) and others using more broad language relating the importance of "self-knowledge" (European Association for Psychotherapy, 2020). By attending to the self of the therapist – as addressing SC in supervision does– are supervisors placing themselves in a bind? It would appear at a glance that supervisors attempting to address SC in response to the distress of their supervisees would be simultaneously upholding one aspect of their mandate – to ensure the well-being of their supervisees and their continued safe, effective practice – while being potentially in breach of their mandate to avoid doing therapy with supervisees. These ethical issues may have something to do with why participants in this study reported the vast majority of their promotion

of SC with supervisees was done via implied methods which allowed them to either model or otherwise demonstrate self-compassionate attitudes without directly addressing the construct. In this way, participants could facilitate the supervisees' self-compassion without placing themselves into uncertain ethical territory.

There were instances where participants reported *directly* addressing or encouraging SC with supervisees, which seems to present a clearer ethical issue, and yet very few participants reported feeling wary of ethics in these circumstances. The supervisors in this study had no problem describing experiences wherein they felt like the boundary between therapy and supervision was being infringed upon. Likewise, participants reported having no qualms with enforcing the said boundary – typically by collaborating with supervisees to determine a better forum to discuss more personal matters (for example, the supervisee's own therapy, peers, etc.). Somewhat paradoxically, most participants indicated a willingness to discuss personal issues with supervisees, but all seemed to have developed a clear sense for when the discussion had gone too far into the personal realm and, in those instances, would recommend the supervisee speak to someone else in their life. When asked about instances wherein they felt that the boundary between therapy and supervision had become blurry, no participants related incidents of addressing SC in response to their supervisees' distress, instead describing situations wherein supervisees discussed deeply-personal relationship or family issues with them.

This finding implies that the participants in this study did not see addressing SC in supervision to be particularly fraught, ethically-speaking. Some participants spoke to this, indicating that if addressing SC in supervision was directly related to the work being done by the supervisee, they were likely to consider it an appropriate intervention. Several participants expressed that, as long as the topic addressed was related to the supervisee's work (i.e. stress

caused by heavy caseloads or challenging cases, anxiety and perfectionism, feelings of incompetence, stress brought on by difficult countertransference, etc.), one could not "go wrong" by encouraging SC. The intentionality of addressing SC with supervisees therefore deserves mention, as participants seem to be saying that, provided the appropriate conditions for use in supervision are met, there is no real ethical problem with encouraging supervisees to be more self-compassionate. That is: to be more understanding with themselves, to actively participate in their own self-care, to treat themselves with kindness, and to maintain a healthy work/home balance.

Implications for Supervisors

Participants reported that addressing SC with their supervisees was generally associated with positive outcomes, such as supervisees' increased self-confidence in their practice, ability to self-regulate distress, and cope with feelings of incompetence and self-doubt. Participants also reported that addressing SC with their supervisees could help to strengthen their relationship with the supervisee. Several participants referred to instances where they felt that directly encouraging SC with a supervisee in distress contributed to a more open and trusting interaction. Participants reported that a strong supervisory relationship could be conducive to addressing and encouraging SC with supervisees, but also that the inverse could be true: addressing and encouraging SC with supervisees could contribute to the strengthening of a previously cold or weak relationship. These outcomes were highlighted by participants as having multiple benefits. First, supervisees benefitted in their work with their clients by becoming more trusting of themselves and the process of psychotherapy. Second, the participants themselves benefitted from improvements in their relationships with their supervisees, which better-facilitated their oversight supervisees' practice.

Some supervisors may feel uncomfortable addressing SC with their supervisees, for concern of veering into territory see as too-personal. In these cases, a recommendation – based on the experiences of the participants in this study – could be made to reflect on the *intentionality* of their impulse to encourage SC. If it is in response to an issue raised that is not central to the supervisee's work as a therapist, it may be less-appropriate for the supervisor to encourage SC. If it is, however, in response to distress that is either caused by, or otherwise directly-related to the work that is being overseen by the supervisor, the participants in this study did not indicate that they saw any ethical problem. Some even reported that they thought clinical supervision would be an ideal forum to teach the benefits of a self-compassionate attitude relative to one's work.

The majority of participants reported addressing SC with their supervisees *indirectly*, via modelling compassionate attitudes, encouraging supervisees' humility, normalizing mistakes and gaffs, and encouraging self-reflection. Supervisors who feel as though SC compassion is too-personal a topic to bring up with a supervisee – for example, if the supervisory relationship is not strong enough for such a discussion to be fruitful – may consider addressing or promoting SC via these indirect methods.

Although the results of the current study are based on a small number of participants, there are possible implications for training of supervisors. More research is needed, but training modules for supervisors might focus on the distinction between direct and indirect methods of addressing SC with supervisees. As reported in this study, direct methods were used by participants in response to acute instances of distress in supervisees, and typically involved connecting with the supervisees through empathy, followed by encouraging the supervisee to engage in self-kindness and, in some cases, to take the time needed to deal with the source of

their distress. Indirect methods involved such tactics as modelling compassionate attitudes, encouraging humility, normalizing distress, and encouraging self-reflection. These indirect methods represent a more-nuanced approach to addressing SC, and were enacted by participants as a preventative measure to buttress supervisees' self-care regimens in the face of eventual occupational distress. By understanding the distinction between the two, supervisors interested in addressing SC with supervisees can choose which method is most appropriate to both the situation and the supervisee. Likewise, future supervisors would also need to be familiar with cases wherein SC would not be the most appropriate intervention in order to effectively address the construct with supervisees.

When Not to Address SC.

Participants in this study also reported several instances wherein they might consider SC to be an inappropriate intervention, aside from those already mentioned (i.e. instances wherein the topic being broached is clearly better-suited to a forum other than supervision). Participants described certain "red flags" that would indicate to them that SC was not an appropriate intervention, such as feeling as though the relationship with the supervisee was not yet trusting or open enough to address more personal topics. Another "red flag" mentioned by participants were instances wherein the issue(s) being addressed by the supervisor had more to do with whether or not a supervisee was well-suited to the work of a professional therapist; for example, a supervisee who presents as persistently emotionally-drained, or who has continual difficulty coalescing with the rest of the team (i.e. frequent complaining, non-supportive of other staff, etc.). In these cases, the participants' duties as gate-keepers to the profession would kick in to gear, leading to more pragmatic discussions geared towards determining how best to resolve these more-basic issues of suitability.

Participants also reported that they would be less likely to address SC if it were not congruent with their personal style. One participant in particular (Annie) reported that addressing SC did not always feel authentic for her. Annie described herself as being highly goal-oriented, with a mind towards continual self-improvement. Annie did not mince words in her evaluation of SC as a construct that could lead to laziness or stagnation, and the topic came up frequently during her interview (see p. 75-76).

Annie was the only participant so vocal in her skepticism of the usefulness of SC (although she did advocate for an active approach to self-care in general), but this may be an artifact of the relatively few participants recruited for this study. If we were to assume for the sake of discussion that Annie's aversion to SC might also be shared by some supervisees, it is possible to surmise that for these types of individuals, encouraging their self-compassion may not be the optimal choice for responding to instances of distress presented in supervision.

Supervisors may wish to reflect on the distinction between self-compassion and self-indulgence. Although Annie was the most vocal, several other participants spoke about the need to balance self-compassion and self-kindness with pragmatism. In other words: some participants felt that if an individual is "too" compassionate with themselves, they may sacrifice forward momentum in their professional and personal development, becoming complacent and stagnant. Based on the experiences of the participants in this study, the line between self-compassion and self-indulgence can be determined by looking at the bigger-picture of the supervisee's performance in their role. If the supervisee is someone who is generally able to be an effective, self-reflective, autonomous practitioner, participants in this study reported that they would have a much easier time addressing SC with them than with a supervisee who is frequently distressed in their role, has problems working within a team, or fails to complete basic tasks associated with

counselling (such as reporting suspected child abuse, for example). For the participants in this study, the distinction between the two is that, with the former, they are dealing with an otherwise capable supervisee who is experiencing "normal" distress, self-criticism, or doubt. With the latter, they may be dealing with someone who is not well-suited for work as a counsellor or psychotherapist at a fundamental level, and encouraging self-compassion cannot take the place of more serious ethical or gatekeeping duties.

An Individualized Approach.

The idea of tailoring the approach to the supervisee, or the problem being presented, was represented in several participants' experiences. The supervisors in this study spoke of the risks of potentially trivializing supervisees' problems via over-reliance on SC-related concepts – in particular that of "common humanity". The concern here seems to be that, by implying that a supervisee's distress should be viewed simply as part of the larger experience of "distress" shared by all humans throughout history, the supervisee may feel invalidated, and the relationship might be harmed. Likewise, participants reported that they needed to be mindful of over-reliance on SC lest supervisees begin to question their authenticity in the relationship. In other words, participants were concerned that if they simply jumped to SC every time a supervisee presented with distress, they might be viewed as trying to push a particular agenda in supervision, or simply as uncaring or uninterested.

Holistic Supervision.

Participants in charge of interns also reflected on their responsibility as educators – that if they were to promote SC at the expense of other relevant topics in supervision, they might become derelict in their duty to ensure that their supervisees were receiving a comprehensive,

relevant education. To this end, there was another worry expressed by some participants that, were they to over-privilege SC-related concepts in supervision, supervisees might become resentful or suspicious out of sheer boredom with the process of supervision. Finally, many participants reflected on the need to balance discipline and authority with compassion. Participants reported that, in order to properly execute their duties, they needed to be seen as authority figures in addition to compassionate, egalitarian co-learners. Participants were cognizant of this balancing act wherein leaning too-heavily in one direction may result in a cold, un-trusting relationship with the supervisee, but leaning too heavily in the other direction would present obvious ethical and legal concerns regarding the supervisor's oversight of their supervisees' safe-and-effective practice.

Any implications for practice based on the experiences of the participants in this study must be considered provisional, due in part to the limited number of supervisors recruited for this research. The participants in this study all spoke of the need to remain mindful of the boundary between supervision and therapy when encouraging supervisees to engage in SC. Pursuant to this recommendation, supervisors would be advised to address SC in response to distress resulting from the work being done by the supervisee. Participants in this study were equivocal in this regard, indicating that, for instances where personal distress was entering the workplace, the issue would ultimately be more appropriate for supervisees' personal therapy, or peer consultation/debrief. Participants also spoke of the importance of ensuring that any intervention chosen in response to supervisees presenting with distress be appropriate for both the situation being addressed, and the supervisee themselves. Participants in this study expressed that, while useful and adaptable, SC was not a "one size fits all" solution for supervisees presenting in

distress, and that treating it as such may result in sacrificing some measure of trust or authenticity in the supervisory relationship.

Finally, participants spoke of the need to remain mindful of over-reliance on SC at the expense of other relevant topics in supervision, or of the supervisor's ability to exercise their authority clearly when necessary. Participants related that supervisors responsible for interns should ensure that their supervisees are being exposed to other topics important for their professional development, such as case conceptualization, exploration of various theoretical perspectives, time management, processing of countertransference, and so on. On balance, participants also reported that even moments where disciplinary action is required could be used to promote SC (i.e. encouraging a supervisee to embrace humility), provided the relationship were trusting enough.

Implications for Related Fields

Research suggests that SC has a role to play in the maintenance of therapist wellbeing, which has been shown to be related to a therapist's ability to practice safely and effectively (Beaumont et al., 2016; Periera et al., 2017.) As such, improving our knowledge of how clinical supervisors address SC with their supervisees can contribute to more nuanced supervisory models that will benefit both practitioners and their clients. Miller and Sprang (2017) argue for a *balanced supervision* that "offer[s] support in the development of affect management skills … as a specialized form of knowledge necessary to trauma work". I would argue that the promotion of role-related self-compassionate techniques fall under the "affect management" skills argued for by Miller & Sprang (2017), and that those skills should be part of supervision for *all* counsellors and psychotherapists – not just those working in trauma fields. Understanding how clinical supervisors encourage role-related self-compassion in response to the various forms of

occupational distress encountered by their supervisees (and the extent to which their supervisees respond to these interventions) will contribute to the growing body of literature relating to self-compassion in the "helping" professions, and may even contribute to the development of new supervisory models in counselling and psychotherapy, or to the development of supervisor training modules that address the value of addressing role-related self-compassion. Additionally, since self-compassion in therapists has been linked to improved wellbeing, and improved wellbeing to improved client outcomes (Beaumont et al., 2016, Pereira et al., 2017), the findings of this study – as they pertain to the promotion of self-compassion in therapists – may contribute to improving services offered to the public, and thus to public health in general.

Chapter XI

Conclusion

This chapter discusses the methodological limitations of the current study, as well as future directions that researchers interested in investigating self-compassion as an aspect of supervision may take as we continue to expand our base of knowledge in this emergent branch of literature.

Limitations

The current study describes how clinical supervisors address or encourage SC in supervisees experiencing distress in their roles as psychotherapists, according to 6 supervisors working in Ontario and Quebec, Canada. Although data collection took place in more than one city, the current study is still limited insofar as representing the experiencing of a relatively small number of individuals in a relatively homogeneous group of environments. Data collection for this study was limited by a small number of responses despite the researcher's best efforts (initial

inclusion criteria were relaxed for one participant, who had been a supervisor for 2.5 years as opposed to 3, as a result of the small number of responses). Indeed, all respondents were associated in some way with supervising the practice of psychotherapy on postsecondary campuses, including (but not exclusively), intern counsellors. Thus, it is unclear whether clinical supervisors responsible for practitioners in the private sector, or in community-based agencies, or those supervising more experienced therapists, would have the same relationship to the construct of SC as described by the participants in this study. In fact, due to the small sample size of this study, no generalizations can be made to the any population beyond the individuals interviewed.

This study employed semi-structured interviews for the purposes of data collection. Semi-structured interviews allow for the complexities of a topic to be explored deeply, but they have several limitations. Firstly, because of the interpersonal nature of the method, it is possible for the interviewer's own points-of-view to influence the interview process. The researcher was responsible for determining which questions were important to ask, and how to phrase them. Any personal inflections or timing on the part of the researcher during the interview would not have been uniform between participants, potentially biasing results from one participant to another. Indeed, in some interviews certain questions may have been omitted, or asked in slightly different orders relative to other interviews, depending on where the flow of conversation took the interview. Furthermore, the resultant thematic analysis represents the researcher's own subjective interpretation and structuring of the data – another individual may have had a different interpretation of the data and produced a different set of codes, themes, and sub-themes. On the other hand, the use of a semi-structured interview schedule with predetermined questions may have resulted in the thematic structure being inadvertently decided in advance.

Finally, the nature of the semi-structured approach, and qualitative research in general, dictates that no cause-and-effect relationship can be established for the results described (i.e. in cases where participants reported positive outcomes after their interventions). There is also the matter of the participants' own biased recollections: it may be the case that participants are not recalling events exactly as they occurred. Despite these limitations, the current study describes a rich and varied relationship between its participants and SC, and implies several directions for future research.

Future Research

Subsequent studies aiming to examine SC from the perspectives of clinical supervisors might focus on supervisors who work with more-experienced therapists. As previously mentioned, all of the participants in this study were involved with supervising intern-level therapists and, as such, the issues described by the participants in this study may be very different from those encountered by supervisors working with more-experienced professionals. For example, many of the participants in this study described addressing SC within the context of problems relating to both intense perfectionism, and fears of incompetence. One participant (Paul) even went so far as to speculate the neuroticism displayed by some of his supervisees was directly related to their status as graduate students. It follows, then, that therapists who have been practicing for some time may not relate to SC in the same way. Another participant in this study (Annie) described several other factors contributing to decreases in occupational distress, such the increases in self-efficacy and decreases in anxiety that come along with maturity. It may be the case that more-experienced therapists – and clinical supervisors who work with them – are biased by their experience and view role-related SC as frivolous or self-indulgent.

Future studies may wish to focus on supervisors and therapists working in community-based agencies or private practice to investigate their relationships with role-related SC. The population of supervisors and clinicians represented by the current study is limited to the postsecondary environment. Similar to supervisors working with more-experienced therapists (see above), it is possible that supervisors and therapists working in different environments, such as community-based agencies or private practice, may relate to SC in different ways. Supervisors practicing in such environments may encounter a correspondingly different set of problems than those practicing on postsecondary campuses and, as such, may have different approaches to the promotion of role-related SC. To extend this idea further, future studies may also wish to focus on specific subsets of supervisors and therapists. Examples such as those who work primarily with children, or those who work with trauma or grief (to name two examples of many), to give voice to a more fulsome range of experiences of role-related SC.

Additionally, future research may focus more on *supervisee* experiences of role-related SC as promoted in supervision. Indeed, some already are (Norris, 2018). It would be interesting to conduct a comparative study to examine whether or not differences exist between supervisee and supervisor perceptions of the importance and/or usefulness of promoting role-related self-compassion as part of supervision. Perhaps most importantly, the topic of role-related self-compassion – specifically its promotion in professional culture as part of models of professional development – could be extended to other fields with high rates of occupational stress and burnout. There are high rates of occupational stress among teachers (Gluschkoff, Elovainio, Kinnunen, Mullola, Hintsanen, Keltikangas-Järvinen and Hintsa, 2016), police officers (Nelson and Smith, 2016), athletes (Gustafsson, Hill, Stenling and Wagnsson, 2016), and especially physicians (Eckleberry-Hunt, Kirkpatrick, Hunt, 2017; Myers, 2017). The outward expansion of

the study of role-related self-compassion to other professions could contribute to more sustainable models of professional development in fields far beyond counselling and psychotherapy, perhaps even reducing the ill-effects of stress on physical health, which are potentially serious (Segerstrom, Miller, 2004; Romeo, 2017). Given the amount of literature that is being devoted to addressing the importance of self-care and compassion among professionals (Alkema, Linton, and Davies, 2008; Beaumont et al., 2016; Dorian & Killebrew, 2014), it is imperative that we begin to conduct research that will contribute to the planning and staging of interventions in professional development that help address burnout, fatigue, and occupational stress in ways that are safe and sustainable. I see the current project as a stepping stone towards being able to ask some of these questions, and make a contribution towards improving public health.

References

American Counselling Association (2014). *ACA code of ethics*. Alexandria, VA: American Counseling Association.

Albertson, E. R., Neff, K. D., & Dill-Shackleford, K. E. (2015). Self-Compassion and Body Dissatisfaction in Women: A Randomized Controlled Trial of a Brief Meditation Intervention. *Mindfulness*, *6*(3), 444–454. https://doi.org/10.1007/s12671-014-0277-3

Alkema, K., Linton, J. M., & Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *Journal of Social Work in End-of-Life & Palliative Care*, *4*(2), 101-119.

Arch, J. J., Landy, L. N., Schneider, R. L., Koban, L., & Andrews-Hanna, J. R. (2018). Self-compassion induction enhances recovery from social stressors: Comparing adults with social anxiety disorder and healthy controls. *Anxiety, Stress, & Coping*, *31*(5), 594–609. https://doi.org/10.1080/10615806.2018.1504033

Arkowitz, S.W. (1990). Perfectionism in the supervisee. *Psychoanalysis & Psychotherapy, 8*, 51-68.

Baer, R. A., Lykins, E. L. B., & Peters, J. R. (2012). Mindfulness and self-compassion as predictors of psychological wellbeing in long-term meditators and matched nonmeditators. *The Journal of Positive Psychology*, *7*(3), 230–238. https://doi.org/10.1080/17439760.2012.674548

Barnard, L. K., & Curry, J. F. (2011). Self-compassion: Conceptualizations, correlates, & interventions. *Review of General Psychology*, *15*(4), 289–303. http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/a0025754

Bartoskova, L. (2017). How do trauma therapists experience the effects of their trauma work, and are there common factors leading to post-traumatic growth? *Counselling Psychology Review*, *32*(2), 30–45.

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: a quantitative survey. *Counselling & Psychotherapy Research*, *16*(1), 15–23. https://doi.org/10.1002/capr.12054

Beekman, J. B., Stock, M. L., & Howe, G. W. (2017). Stomaching rejection: Self-compassion and self-esteem moderate the impact of daily social rejection on restrictive eating behaviours among college women. *Psychology & Health*, *32*(11), 1348–1370. https://doi.org/10.1080/08870446.2017.1324972

Bell, T., Dixon, A., & Kolts, R. (2017). Developing a Compassionate Internal Supervisor: Compassion-Focused Therapy for Trainee Therapists. *Clinical Psychology & Psychotherapy*, *24*(3), 632–648. https://doi.org/10.1002/cpp.2031

Bernard, J.M, Goodyear, R.K. (2019). *Fundamentals of Clinical Supervision, 6th Edition.* Pearson.

Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., Segal, Z. V., Abbey, S., Speca, M., Velting, D., & Devins, G. (2004). Mindfulness: A Proposed Operational Definition. *Clinical Psychology: Science and Practice*, *11*(3), 230–241. https://doi.org/10.1093/clipsy.bph077

Boscarino, J. A., Adams, R. E., & Figley, C. R. (2010). Secondary Trauma Issues for Psychiatrists. *The Psychiatric Times*, *27*(11), 24–26.

Bowlin, S. L., & Baer, R. A. (2012). Relationships between mindfulness, self-control, and psychological functioning. *Personality and Individual Differences*, *52*(3), 411–415. https://doi.org/10.1016/j.paid.2011.10.050

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Breines, J. G., & Chen, S. (2012). Self-Compassion Increases Self-Improvement Motivation. *Personality and Social Psychology Bulletin*, *38*(9), 1133–1143. https://doi.org/10.1177/0146167212445599

Canadian Counselling and Psychotherapy Association (2015). *Standards of practice, 5th edition*. Ottawa, ON. Canadian Counselling and Psychotherapy Association.

Chang, E. C. (2000). Perfectionism as a predictor of positive and negative psychological outcomes: Examining a mediation model in younger and older adults. *Journal of Counseling Psychology*, *47*(1), 18–26. http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/0022-0167.47.1.18

College of Registered Psychotherapists of Ontario – Definitions. (n.d.). Retrieved October 17, 2017, from https://www.crpo.ca/definitions/

College of Registered Psychotherapists of Ontario – Supervision. (n.d.). Retrieved December 4, 2017, from https://www.crpo.ca/supervision/#qualifications_to_serve_as_a_CS

College of Registered Psychotherapists of Ontario – Entry to Practice Competency Profile for Registered Psychothereapists (n.d.). Retrieved December 5, 2017, from https://www.crpo.ca/wp-content/uploads/2017/08/RP-Competency-Profile.pdf

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: consequences for mental health-care workers – a literature review. *Journal of Psychiatric and Mental Health Nursing*, *10*(4), 417–424. https://doi.org/10.1046/j.1365-2850.2003.00620.x

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*(1–2), 155–163. https://doi.org/10.1080/02703149.2014.850345

Eckleberry-Hunt, J., Kirkpatrick, H., & Hunt, R. B. (2017). Physician Burnout and Wellness. In *Physician Mental Health and Well-Being* (pp. 3–32). Springer, Cham. https://doi.org/10.1007/978-3-319-55583-6_1

European Association for Psychotherapy – Strasbourg Declaration on Psychotherapy (n.d.). Retrieved February 24, 2020, from https://www.europsyche.org/about-eap/documents-activities/strasbourg-declaration-on-psychotherapy/

Farber, B. A., & Heifetz, L. J. (1982). The process and dimensions of burnout in psychotherapists. *Professional Psychology*, *13*(2), 293–301. http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/0735-7028.13.2.293

Farber, B. A. (1990). Burnout in psychotherapists: Incidence, types, and trends. *Psychotherapy in Private Practice*, *8*(1), 35-44.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods*, *5*(1), 80–92. https://doi.org/10.1177/160940690600500107

Figley, C. R. (1983). Catastrophes: An overview of family reactions. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and the family:Vol. 2. Coping with catastrophe* (pp. 3–20). New York: Brunner.

Figley, C.R. (1993). Compassion stress and the family therapist. Family Therapy News, pp. 1-8.

Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In Figley, C.R. (Ed.), Compassion fatigue. New York: Brunner/Mazel.

Figley, C. R. (2002). Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care[SUP 1]. *Journal of Clinical Psychology*, *58*(11), 1433–1441.

Flanagan, S., Patterson, T. G., Hume, I. R., & Joseph, S. (2015). A longitudinal investigation of the relationship between unconditional positive self-regard and posttraumatic growth. *Person-Centered & Experiential Psychotherapies, 14*(3), 191-200. doi:10.1080/14779757.2015.1047960.

Fletcher, K., Yang, Y., Johnson, S. L., Berk, M., Perich, T., Cotton, S., Jones, S., Lapsley, S., Michalak, E., & Murray, G. (2019). Buffering against maladaptive perfectionism in bipolar disorder: The role of self-compassion. *Journal of Affective Disorders*, *250*, 132–139. https://doi.org/10.1016/j.jad.2019.03.003

Flett, G. L., Besser, A., Davis, R. A., & Hewitt, P. L. (2003). Dimensions of Perfectionism, Unconditional Self-Acceptance, and Depression. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, *21*(2), 119–138. https://doi.org/10.1023/A:1025051431957

Freudenberger on Staff Burnout. (1976). *The American Journal of Drug and Alcohol Abuse*, *3*(1), 49.

Galili-Weinstock, L., Chen, R., Atzil-Slonim, D., Bar-Kalifa, E., Peri, T., & Rafaeli, E. (2018). The association between self-compassion and treatment outcomes: Session-level and treatment-level effects. *Journal of Clinical Psychology, 74*(6), 849–866. https://doi.org/10.1002/jclp.22569

Ganske, K. H., Gnilka, P. B., Ashby, J. S., & Rice, K. G. (2015). The Relationship Between Counseling Trainee Perfectionism and the Working Alliance With Supervisor and Client. *Journal of Counseling & Development*, *93*(1), 14–24. https://doi.org/10.1002/j.1556-6676.2015.00177.x

Germer, C. K., & Neff, K. D. (2013). Self-Compassion in Clinical Practice. *Journal of Clinical Psychology*, *69*(8), 856–867. https://doi.org/10.1002/jclp.22021

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, *15*(3), 199-208.

Gluschkoff, K., Elovainio, M., Kinnunen, U., Mullola, S., Hintsanen, M., Keltikangas-Järvinen, L., & Hintsa, T. (2016). Work stress, poor recovery and burnout in teachers. *Occupational Medicine*, *66*(7), 564–570. https://doi.org/10.1093/occmed/kqw086

Grant, J., Schofield, M. J., & Crawford, S. (2012). Managing difficulties in supervision: Supervisors' perspectives. *Journal of Counseling Psychology*, *59*(4), 528.

Guba, E. G. (1981). ERIC/ECTJ Annual Review Paper: Criteria for Assessing the Trustworthiness of Naturalistic Inquiries. *Educational Communication and Technology*, *29*(2), 75–91.

Gustafsson, H., Hill, A. P., Stenling, A., & Wagnsson, S. (2016). Profiles of perfectionism, parental climate, and burnout among competitive junior athletes. *Scandinavian Journal of Medicine & Science in Sports*, *26*(10), 1256–1264. https://doi.org/10.1111/sms.12553

Goldberg, R., Dixon, A., & Wolf, C. P. (2012). Facilitating effective triadic counseling supervision: An adapted model for an underutilized supervision approach. *The Clinical Supervisor*, *31*, 42–60. doi:10.1080/07325223.2012.670077

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health*, *13*(3), 235-245.

Hatcher, R., & Noakes, S. (2010). Working with sex offenders: the impact on Australian treatment providers. *Psychology, Crime & Law*, *16*(1–2), 145–167. https://doi.org/10.1080/10683160802622030

Hoffman, M. A., Hill, C. E., Holmes, S. E., & Freitas, G. F. (2005). Supervisor Perspective on the Process and Outcome of Giving Easy, Difficult, or No Feedback to Supervisees. *Journal of Counseling Psychology*, *52*(1), 3.

Injeyan, M. C., Shuman, C., Shugar, A., Chitayat, D., Atenafu, E. G., & Kaiser, A. (2011). Personality Traits Associated with Genetic Counsellor Compassion Fatigue: The Roles of Dispositional Optimism and Locus of Control. *Journal of Genetic Counseling*, *20*(5), 526–540. https://doi.org/10.1007/s10897-011-9379-4

Kaurin, A., Schönfelder, S., & Wessa, M. (2018). Self-compassion buffers the link between self-criticism and depression in trauma-exposed firefighters. *Journal of Counseling Psychology*, *65*(4), 453–462. https://doi.org/10.1037/cou0000275

Klingle, K., Russell-Mayhew, S., Kassan, A., & Moules, N. (2018). By the Water's Edge: a Hermeneutic Look at Suffering and Self-Compassion in Counselling Psychology. *International Journal for the Advancement of Counselling*, *40*(3), 227–236. https://doi.org/10.1007/s10447-018-9322-6

Knight, C. (2012). Therapeutic Use of Self: Theoretical and Evidence-Based Considerations for Clinical Practice and Supervision. The Clinical Supervisor, 31(1), 1–24. https://doi.org/10.1080/07325223.2012.676370

Knight, C. (2013). Indirect Trauma: Implications for Self-Care, Supervision, the Organization, and the Academic Institution. *The Clinical Supervisor*, *32*(2), 224–243. https://doi.org/10.1080/07325223.2013.850139

Knox, S., & Hill, C. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, *59*, 529–539.

Ladany, N., & Walker, J. A. (2003). Supervisor self-disclosure: Balancing the uncontrollable narcissist with the indomitable altruist. *Journal of Clinical Psychology*, *59*(5), 611–621. https://doi.org/10.1002/jclp.10164

Lewis, M. L., & King, D. M. (2019). Teaching self-care: The utilization of self-care in social work practicum to prevent compassion fatigue, burnout, and vicarious trauma. *Journal of Human Behavior in the Social Environment*, *29*(1), 96–106. https://doi.org/10.1080/10911359.2018.1482482

Lincoln, Y., & Egon, G. Guba. (1985). *Naturalistic inquiry*

Mahoney, M. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28*, 14–16. doi:10.1037/0735-7028.28.1.14

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job Burnout. *Annual Review of Psychology*, *52*(1), 397–422. https://doi.org/10.1146/annurev.psych.52.1.397

Maxwell, J. A. (2012). *A realist approach for qualitative research*. Sage.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims, 19.

Merriman, J. (2015). Enhancing Counsellor Supervision Through Compassion Fatigue Education. *Journal of Counseling & Development*, *93*(3), 370–378. https://doi.org/10.1002/jcad.12035

Miller, B., & Sprang, G. (2017). A components-based practice and supervision model for reducing compassion fatigue by affecting clinician experience. *Traumatology: An International Journal*, *23*(2), 153–164. https://doi.org/http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/trm0000058

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 250–260. https://doi.org/10.1037/0022-0167.52.2.250

Myers, M. F. (2017). Suicidal Behaviors in Physicians. In *Physician Mental Health and Well-Being* (pp. 87–106). Springer, Cham. https://doi.org/10.1007/978-3-319-55583-6_4

Neff, K. D. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*, 85–101.

Nelson, K. V., & Smith, A. P. (2016). Occupational stress, coping and mental health in Jamaican police officers. *Occupational Medicine*, *66*(6), 488–491. https://doi.org/10.1093/occmed/kqw055

Nelson, J. R., Hall, B. S., Anderson, J. L., Birtles, C., & Hemming, L. (2018). Self–Compassion as Self-Care: A Simple and Effective Tool for Counsellor Educators and Counseling Students. *Journal of Creativity in Mental Health*, *13*(1), 121–133. https://doi.org/10.1080/15401383.2017.1328292

Norris, C. A. (2018). *Counsellor-in-training experiences of self-compassion training in group supervision* (Doctoral dissertation).

Odou, N., & Brinker, J. (2015). Self-compassion, a better alternative to rumination than distraction as a response to negative mood. *The Journal of Positive Psychology*, *10*(5), 447–457. https://doi.org/10.1080/17439760.2014.967800

Olson, K., Kemper, K. J., & Mahan, J. D. (2015). What Factors Promote Resilience and Protect Against Burnout in First-Year Pediatric and Medicine-Pediatric Residents? *Journal of Evidence-Based Complementary & Alternative Medicine*, *20*(3), 192–198. https://doi.org/10.1177/2156587214568894

Ong, C. W., Barney, J. L., Barrett, T. S., Lee, E. B., Levin, M. E., & Twohig, M. P. (2019). The role of psychological inflexibility and self-compassion in acceptance and commitment therapy for clinical perfectionism. *Journal of Contextual Behavioral Science*, *13*, 7–16. https://doi.org/10.1016/j.jcbs.2019.06.005

Parent, M. C., Bradstreet, T. C., Wood, M., Ameen, E., & Callahan, J. L. (2016). "The Worst Experience of My Life": The Internship Crisis and Its Impact on Students. *Journal of Clinical Psychology*, *72*(7), 714–742. https://doi.org/10.1002/jclp.22290

Patsiopoulos, A.T., Buchanan, M.J. (2011). The Practice of Self-Compassion in Counselling: A Narrative Inquiry. *Professional Psychology: Research and Practice, 42*(4), 301–307. https://doi.org/ 10.1037/a0024482

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, *26*(6), 558–565. http://dx.doi.org/10.1037/0735-7028.26.6.558

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. WW Norton & Co.

Pereira, J.-A., Barkham, M., Kellett, S., & Saxon, D. (2017). The Role of Practitioner Resilience and Mindfulness in Effective Practice: A Practice-Based Feasibility Study. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(5), 691–704. https://doi.org/10.1007/s10488-016-0747-0

Radeke, J. T., & Mahoney, M. J. (2000). Comparing the personal lives of psychotherapists and research psychologists. *Professional Psychology: Research and Practice, 31*, 82–84. doi:10.1037/0735-7028.31.1.82

Pines, A., & Aronson, E. (1988). *Career burnout: Causes and cures*. Free press.

Rice, K. G., & Ashby, J. S. (2007). An efficient method for classifying perfectionists. *Journal of Counseling Psychology*, *54*(1), 72-85. doi:http://dx.doi.org.proxy.bib.uottawa.ca/10.1037/0022-0167.54.1.72

Robinson, B., & Landine, J. (2016). Ethical and legal considerations and practices in clinical supervision. In B. Shepard, L. Martin, & B. Robinson (Eds.), *Clinical supervision of the*

Canadian counselling and psychotherapy profession (pp. 65 – 99). Ottawa, ON: Canadian Counselling and Psychotherapy Association.

Rogers, C. (1961). *On becoming a person*. London: Constable.

Rogers, C. (1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology*, *60*, 827–832.

Romeo, R. D. (2017). The impact of stress on the structure of the adolescent brain: Implications for adolescent mental health. *Brain Research*, *1654*(Part B), 185–191. https://doi.org/10.1016/j.brainres.2016.03.021

Segerstrom, S. C., & Miller, G. E. (2004). Psychological Stress and the Human Immune System: A Meta-Analytic Study of 30 Years of Inquiry. *Psychological Bulletin*, *130*(4), 601–630. https://doi.org/10.1037/0033-2909.130.4.601

College of Registered Psychotherapists of Ontario – Supervision. (n.d.). Retrieved December 4, 2017, from https://www.crpo.ca/supervision/#qualifications_to_serve_as_a_CS

Self-Compassion.org – Guided Meditations and Exercises (n.d.) – Retrieved February 27, 2020 from https://self-compassion.org/category/exercises/

Şenyuva, E., Kaya, H., Işik, B., & Bodur, G. (2014). Relationship between self-compassion and emotional intelligence in nursing students: Self-compassion and emotional intelligence. *International Journal of Nursing Practice*, *20*(6), 588–596. https://doi.org/10.1111/ijn.12204

Simionato, G. K., & Simpson, S. (2018). Personal risk factors associated with burnout among psychotherapists: A systematic review of the literature. *Journal of Clinical Psychology*, *74*(9), 1431–1456. https://doi.org/10.1002/jclp.22615

Shapira, L. B., & Mongrain, M. (2010). The benefits of self-compassion and optimism exercises for individuals vulnerable to depression. *The Journal of Positive Psychology*, *5*(5), 377–389. https://doi.org/10.1080/17439760.2010.516763

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Retrieved from http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf

Stella, M. (2016). Befriending death: A mindfulness-based approach to cultivating self-awareness in counselling students. *Death Studies*, *40*(1), 32–39. https://doi.org/10.1080/07481187.2015.1056566

Thériault, A., Gazzola, N., Isenor, J., & Pascal, L. (2015). Imparting Self-Care Practices to Therapists: What the Experts Recommend. *Entrainer Des Pratiques cTautosoin Chez Les Thérapeutes : Recommandations Des Experts.*, *49*(4), 379–400.

Thériault, A., & Gazzola, N. (2018). Dilemmas that undermine supervisor confidence. *Counselling and Psychotherapy Research*, *18*(1), 14–25. https://doi.org/10.1002/capr.12153

Thomas, J. (2013). Association of Personal Distress With Burnout, Compassion Fatigue, and Compassion Satisfaction Among Clinical Social Workers. *Journal of Social Service Research*, *39*(3), 365–379. https://doi.org/10.1080/01488376.2013.771596

Trippany, R. L., Kress, V. E. W., & Wilcoxon, S. A. (2004). Preventing Vicarious Trauma: What Counsellors Should Know When Working With Trauma Survivors. *Journal of Counseling & Development*, *82*(1), 31–37. https://doi.org/10.1002/j.1556-6678.2004.tb00283.x

Van Dam, N. T., Sheppard, S. C., Forsyth, J. P., & Earleywine, M. (2011). Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of anxiety disorders*, *25*(1), 123-130.

van der Klink, J. J., & van Dijk, F. J. (2003). Dutch practice guidelines for managing adjustment disorders in occupational and primary health care. *Scandinavian Journal of Work, Environment & Health*, *29*(6), 478–487.

Wheeler, S. (2007). What shall we do with the wounded healer? The supervisor's dilemma. *Psychodynamic Practice*, *13*(3), 245–256. https://doi.org/10.1080/14753630701455838

Wittenberg, K. J. (1998). *The relationship between psychotherapists' perfectionism and tolerance of ambiguity and their enjoyment of conducting psychotherapy* [Ph.D., The Chicago School of Professional Psychology]. http://search.proquest.com/docview/1518196577/citation/250FE550B2394EE5PQ/1

Wong, C. C. Y., & Yeung, N. C. Y. (2017). Self-compassion and Posttraumatic Growth: Cognitive Processes as Mediators. *Mindfulness*, *8*(4), 1078–1087. https://doi.org/10.1007/s12671-017-0683-4

Yadavaia, J. E., Hayes, S. C., & Vilardaga, R. (2014). Using Acceptance and Commitment Therapy to Increase Self-Compassion: A Randomized Controlled Trial. *Journal of Contextual Behavioral Science*, *3*(4), 248–257. https://doi.org/10.1016/j.jcbs.2014.09.002

Yarnell, L. M., & Neff, K. D. (2013). Self-compassion, Interpersonal Conflict Resolutions, and Well-being. *Self and Identity*, *12*(2), 146–159. https://doi.org/10.1080/15298868.2011.649545

Zeidner, M., Hadar, D., Matthews, G., & Roberts, R. D. (2013). Personal factors related to compassion fatigue in health professionals. *Anxiety, Stress, & Coping*, *26*(6), 595–609. https://doi.org/10.1080/10615806.2013.777045

Zerubavel, N., O'Dougherty-Wright, M. (2012). The Dilemma of the Wounded Healer. *Psychotherapy*, *49*(4), 482-491.

Ziv-Beiman, S., Keinan, G., Livneh, E., Malone, P. S., & Shahar, G. (2017). Immediate therapist self-disclosure bolsters the effect of brief integrative psychotherapy on psychiatric symptoms and the perceptions of therapists: A randomized clinical trial. *Psychotherapy Research*, *27*(5), 558–570. https://doi.org/10.1080/10503307.2016.1138334

Appendix A

Complete List of Themes, Sub-Themes, Dimensions, and Verbatim Quotes

Table 2a

Supervision of Self-Compassion Thematic Structure

Main Themes	Subthemes	Dimensions	Verbatim Examples
Participants' Definitions of SC	• Self-care	• Healthy work/home balance	• *"I like to… share with my staff that family and life comes first, and that work comes second. Um, which isn't to say that I don't have expectations from the work, but I know how… there's a life outside of the 9-to-5 here."*
		• Unconditional positive self-regard	• *It's intrinsic to you; it's not about something you've accomplished and then I have self-worth or self-compassion."*
		• Self-kindness	• *"Do we have to feel compassion for clients to behave that way? Mostly, I think we do. And then, how does that compassion balance out with permission and compassion for ourselves?"*
	• Staying humble	• Giving permission to self	• *"So, I could kind of tell them: 'You have to practice self-compassion your whole career, and sometimes that means missing things, or feeling like, 'wow, I can't get past the fact that this huge male client made me feel unsafe', and*

			that's ok, because what's important first and foremost is my own personal health and safety.'"
	• A skill (vs. state-of-being)	• Mindful self-awareness	• *'"[Self-compassion comprises the ability to] observe oneself; be aware of one's own experiencing…"*
		• Personal approaches	• *[Self-compassion is] a matter of style, and experience, and what you've learned over the years, to work through [role-related distress]."*
Supervisee struggles leading participants to address SC in supervision	• Perfectionism	• High neuroticism coupled with harsh internal critic	• *"And so the self-compassion element in working with new counsellors… I think that's why it's so important, because otherwise you're gonna be so hard on yourself. You'll always be looking at what's not working… and there's going to be a lot that you can interpret as 'what's not working', versus just normalizing things."*
		• Attribution of responsibility for client change	• *"[Self-compassion is] about boundaries and... healthy limits, and those can be... practiced, kind of, ones, but also, internal, emotional ones about 'how do we do this work and still be ourselves'... How do you care about a client or a person, how do you show concern about a person without taking on responsibility for them, and without taking on too much, and where are the lines..."*

		• Supervisee pushing self harder than necessary	• *"…And then maybe a third issue is, cultural scripts around, you know, being the best: 'you have to really push yourself forward, boot-camp, go-go-go, do not be wimpy, you've gotta be tough on yourself!"*
	• Feelings of incompetence	• Self-doubt	• *"…Like, 'I should know that', 'I feel like I should know that', or… imposter-syndrome-types-of-things, like (brief pause)… you know, 'the client is saying 'you're the expert' and inside I'm like, 'oh my God, am I?"*
		• Image management	• *"And just this perfectionism, and this fear of, 'I want to appear this certain way', and have this idealized image."*
	• Personal distress entering workplace		• *"And in some cases [distress is caused] a little bit by what's going on in other aspects of their life, so they're drained or distracted by that"*
Participants' approaches to addressing SC with supervisees	• Direct approaches	• Check in directly	• *"I would go back and say, 'Hey, I just wanted to let you know that I'm noticing a pattern here … and I'm concerned."*
		• Collaborate on solutions	• *"…is there something we can do, schedule-wise, because you're eating up your vacation days and your personal hours … if you do it this way, the time you need for vacation, when your family's going to take time off, you're not going to have anything*

		left.' So, let's just look at the big picture."
	• Encourage self-compassion	• *"I praised her a lot because I probably saw a little bit of myself in her… I think with her I tried to push a little bit more of the going easy on herself, whatever that would look like for her. Like maybe cutting down somewhere."*
• Indirect approaches	• Promoting humility	• *"The goal of [supervision] a lot of the time [is] about validating, and permission to set boundaries, and permission to make mistakes, and permission to ask questions. Which is a big piece of how I always worked with clients, too, right? And that openness, and that, 'I'm not the expert here.'"*
	• Normalizing	• *"…And we just normalized that, just humanized it, but also normalized that us, as experienced counsellors in a university setting, we have lots of no-shows… so this is just something that happens; so try not to take it personally."*
	• Modelling	• *"So if I'm compassionate with you, can you be compassionate with yourself? And that can even take quite a while."*
	• Encouraging self-awareness and self-reflection	• *"I want to support the ability to self-reflect in order to be able to have self-compassion, right?"*
	• Preventative measures	• *"Sometimes, doing a little bit of therapy with them*

			on how to manage that [personal] stuff. I mean, I don't really do therapy with them, it's more like: 'How do we set a limit here? Where's the boundary… Between your personal life and what you're doing here. And what do you need to do to look after the boundary, you know, do you need to be working less?'"
	• Outcomes (after addressing SC)	• Trust in self	• *"And as time goes on, and we're … just noticing how things are shifting, and how she's giving herself more permission to be more human with the person, and not, like, throwing handouts on CBT skills to them after the first five minutes, right?"*
		• Increased openness with supervisor	• *"...You know, encouraging this self-compassion doesn't necessarily emerge from a strong relationship - although it certainly can - but [it also] is one of the things that helps build one."*
Institutional structures addressing self-care, self-compassion	• Deliberate measures in internship program to avoid role-related distress	• Emphasizing personal aspects of counselling in education and supervision	• *"…Myself and my colleague who put together the internship program, were really conscious about - from the get-go - instilling this sort of way of working … 'we are also helping you, want to be accompanying you in your journey as becoming a professional, and on a personal level' ... So we spell it out; it's in our manual that we send to them."*

	• Proactively approaching self-care	• *"We operationalize it here. We show them how to do it, we talk about how we do it in our own personal lives, give examples … mindfulness meditations that we'll do with them as well. But we don't just talk to them about it, we have them do it. Because I think that's the big piece too; the experiential part. Because yes, we can read about it in a book, and yeah, 'I'll get to it when I have time...'"*
	• Scaffolding challenging cases	• *"So we checked in with the student way beforehand, in terms of: 'What kind of cases would you be able to work with, or not ... if anybody's coming in dealing with grief or loss, we're just not going to refer them to you right now.' ... So they're not just thrown into a situation that they can't deal with."*
• Creating comfortable and open work spaces	• Fostering work/life balance	• *"So it worked out well, because… they have said to me that I removed that barrier of their being concerned about work … the [problems happening at home], I can't control or change … but they were very… it gave a sense of relief that work was not another obstacle they had to worry about, or failure at work, or worry about their future working here. So that... they've told me that helped them."*
	• Build egalitarian stance in supervision	• *"…One of my goals, always, with supervision is to take away this sense of… this*

			sense of 'otherness' - for either party. And particularly for my supervisees, towards me. Like, 'here's this person who has it all figured out… and I need to be like this person who has it all figured out.'"
		• Advocate for therapists' needs within interdisciplinary team	• *"'So that's also, I feel like I have to make, I have to advocate and make it a priority for staff to have access to that too, right?' 'To have access...' 'To supervision time... To the idea that maybe you actually do need to gather yourself and prepare in between visits, that you can't just go from one to the other all day, that kind of stuff, right?'"*
	• Therapist education	• Supervision as appropriate forum for education re: SC	• *"'What do you think of the suggestion that supervision … is a good place to promote the benefits of self-compassion to therapists and counsellors?' 'Without question … you know, if you can't take care of yourself, how are you going to take care of somebody else?'"*
		• SC in the classroom	• *"I'm a huge believer in [topics related to burnout, compassion fatigue, etc] being addressed in the most pedagogically sound, like, productive ways possible. And that, we need that, because burnout is a real possibility with any kind of front-line work."*
Challenges associated with	• SC as inappropriate intervention	• Red flags indicating SC is	• *"So I do kind of keep my eye out for - because I want them to feel comfortable to*

addressing SC in supervision		not an appropriate intervention	*come and kind of vent or complain - but if I have an intern who comes in week after week and says how much this takes it out of them, and how much it's hard for them to do? ...We will have the discussion already of... 'It's gonna be just more of this, and then some, when you're done ... So this is also the year to figure out: 'Can I do this?'"*
		• Potential ethical concerns in supervision	• *"…What's coming up for you here? How do some of your life experiences inform your work, or description of suffering, or description of healing, right? I think that's very fair game to talk about. When it ends up being more, they're coming in for emotional support uniquely about their life experience... I'll do that a little bit... if it's an ongoing basis... I think at that point I would try to encourage them to bring in other people in their life too."*
	• If SC does not feel congruent for the supervisor	• Inauthenticity	• *"It's not me. And you have to be authentic … people can feel it, they can see it, when you're using language or behaving in a way that... there's not much buy-in to it, and I'm going to communicate that in some way."*
		• Supervisor ambivalence to SC label	• *"I think I have a bit of a knee-jerk personal reaction of like... eye-rolling a little bit when I hear 'self-compassion'"*
		• Risk of harming relationship with supervisee	• *"…They've shared that with me, and I know that experience. I'm not going to*

		say 'Oh, I'm so sorry to hear that, a lot of people, a lot of parents go through that and everything's going to be ok' - I think that's disrespectful because it's contrite."
	• Balancing SC content with other relevant topics in supervision	• *"Yeah, the problems [with addressing self-compassion in supervision] would be not having the discussion at some point about how hard the work is. And managing expectations of the field. "*

Appendix B

Letter of Introduction for Clinical Directors

May 2, 2019

RE: Supervising Self-Compassion: A Qualitative Study

Greetings,

Two researchers from the Counselling Psychology department of the Faculty of Education, Alex Vance and Anne Theriault, are studying whether and how clinical supervisors promote self-compassion as part of psychotherapist professional development. The purpose of the study is to understand the usefulness and limits of self-compassion as a means of coping with role-related distress and/or burnout in counsellors and psychotherapists.

The focus of the exploration is on how supervisors view the utility of self-compassion as part of therapists' role-related self-care, whether or not they encourage self-compassion in supervisees experiencing distress, and if not, what prevents them from considering it to be an appropriate intervention?

We are writing to you in order to obtain your agency's permission to recruit participants from your institution and have attached our recruitment letter for your review. Participation will involve a one-hour interview (approximately). The interview can take place in the Supervision Training and Research (STAR) Centre located at the University of Ottawa or in the participant's office at their convenience.

If you are in agreement then we ask that you pass on our attached recruitment letter to any of your staff that engage in a counselling supervisor role and have done so for at least five years. Your interested staff can follow up with our research team directly.

If you have any questions, please contact our lead researcher, Alex Vance, at, or via email at. Participating in this research is entirely voluntary and confidential. Choosing not to participate will carry no negative consequences for either the participant or the agency.
Thank you for your time and interest,

Alex Vance Anne Theriault, PhD.

Appendix C

Participant Recruitment Letter

Greetings, Clinical Supervisors!

You are invited to participate in a research study that I am conducting as part of the requirements for completion of an M.A. degree in Counselling at the University of Ottawa.

The purpose of this study is to examine how clinical supervisors address self-compassion as part of the process of supervision. The goal of this research is to investigate if, and how, supervisors address self-compassion with distressed supervisees and the factors that might encourage or discourage supervisors from doing so. We hope that this research will further our understanding of clinician distress, supervisory models, and ultimately, lead to efficacious, safe services for clients.

Criteria for participation:

- You are a member in good standing of a college regulating the practice of psychotherapy
- You have a minimum of three years in your role as a clinical supervisor
- You are actively practicing clinical supervision at the time of the study
- You have obtained a minimum of a Master's degree in either counselling psychology, clinical psychology, or social work.
- You are willing to discuss your work as a clinical supervisor addressing supervisees in distress.
- You are able to be interviewed in English.

If you volunteer to participate in this study, I would ask you to take approximately 45 - 60 minutes in a sit-down interview with me, where I would ask you some questions on your experiences as a clinical supervisor. This will include sharing your previous or current dilemmas, challenges, and successes in supervising clinicians experiencing distress related to their role as a counsellor or psychotherapist. The interview will be audio recorded to provide an accurate record of our discussion, then later transcribed with all identifying information removed.

Participants will be selected on a first-come-first-serve basis. If you have any questions or concerns about the research, please do not hesitate to voice them to me at, or contact Dr. Anne Theriault at.

Thank you!

Alex Vance

MA Candidate, Counselling Psychology

University of Ottawa

Appendix D

Informed Consent Material

Consent Form

Supervising Role-Related Self-Compassion: A Qualitative Study.

Alex Vance; MA candidate, Counselling Psychology

University of Ottawa

Dr. Anne Thériault, associate professor, Counselling Psychology

University of Ottawa

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Alex Vance as part of his MA thesis, under the supervision of Dr. Anne Thériault, funded by the Canada Graduate Scholarships – Master's Program (CGS-M).

Purpose of the Study: The purpose of the study is to investigate the perspectives and experiences of clinical supervisors' addressing self-compassion with counsellors and psychotherapists who are experiencing distress relating to their work (role-related distress).

Participation: My participation will consist of being the subject of a digitally recorded, semi-structured interview, during which I will answer questions relating to my experiences as a clinical supervisor addressing the role-related distress of my supervisees through self-compassion. I will be asked to describe my experiences working with distressed supervisees, my opinions on and experiences with addressing role-related self-compassion in supervision, and regarding potential conflicts or tensions arising in supervision from these situations. Interviews will take place between March and May, 2019 at a time convenient for me. Interviews will last one hour and will be conducted in, the Centre for Research in Psychotherapist Development, University of Ottawa.

Risks: My participation in this study will entail that I volunteer information relating to my professional and, perhaps, personal lives, and this may cause me to feel nervous or anxious, or may cause concern that my answers to the questions could impact me professionally. I have received assurance from the researcher that every effort will be made to minimize these risks by ensuring that my personal information will be stored securely under lock and key, will be anonymized in the final report, and that my full interview transcripts will be stored securely and confidentially. Additionally, at the end of the interview, I will be provided with information for accessing psychological support services should I require them, via Ottawa Walk-In Counselling Services (https://www.walkincounselling.com) and the Distress Centre of Ottawa and Region (613-238- 3311), as well as with the space and opportunity to debrief following participation. I have also been assured by the researcher that I will have the opportunity to check and verify my transcripts before data analysis.

Benefits: My participation in this study will contribute to the empirical literature regarding therapist self-care, clinical supervision, and role-related distress, potentially benefitting future supervisors and mental health practitioners alike. By investigating new avenues through which to mitigate the role-related distress such as burnout and compassion fatigue in mental health practitioners, we hope to contribute to improvements in both the safety and efficacy of therapy services, which will be of direct benefit to overall public health. Additionally, findings from this study may help inform professional development standards in other fields with high rates of role-related distress (e.g. teachers, physicians).

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents of my interview will be used only for generating a thematic analysis and final report, and that my confidentiality will be protected by maintaining all of my personal information as well as the transcripts of my interviews in a secure location accessible only to the researchers, as well as confidentially destroying digital recordings of the interviews once they have been transcribed.

Anonymity will be protected in the following manner: by providing me with a pseudonym in the final report, ensuring that any verbatim quotes generated from my participation in the study which are used in said report cannot be attributed to me by any readers. Only general demographic data, such as my gender, level of education, and theoretical orientation regarding psychotherapy, will be used in the final report.

Conservation of data: The data collected, including digital recordings of the interviews, as well as hard copies of my transcribed interview, will be kept in a secure manner. Digital recordings of my interview, as well as hard copy interview transcripts, demographic information, and this consent form will be stored at the University of Ottawa in a secure cabinet accessible only to the researchers, for a period of five years, at which point they will be destroyed confidentially. Digital recordings of interviews will be confidentially destroyed by the researcher after transcription of the interview.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal, including any extant digital recordings of my interview, will be confidentially destroyed.

Acceptance: I, _____, agree to participate in the above research study conducted by Alex Vance of the Department of Counselling Psychology, Faculty of Education, University of Ottawa, which is under the supervision of Dr. Anne Thériault, associate professor, Department of Counselling Psychology, Faculty of Education, University of Ottawa.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: Date:

Researcher's signature: Date:

Appendix E

Interview Schedule

1) How did you become a clinical supervisor?

2) What is your understanding of self-compassion?

3) What role does self-compassion play in supervisee's management of their role-related distress in your opinion?

4) Where do you see self-compassion fitting in as part of the professional development of counsellors and psychotherapists?

- What do you think of the suggestion by Nelson et al (2018) that supervision is a good place to promote the benefits of self-compassion to therapists and counsellors?
    - What problems, if any, do you see in this idea?

5) Can you tell me about a moment when you encouraged/fostered self-compassionate attitudes or practices in a supervisee?

- If yes:
    - What challenges was the supervisee facing that led you to discuss self-compassion?
    - How did you make the determination that self-compassion should be addressed?
        - When is self-compassion appropriate to address? When is it not?
    - How did you incorporate self-compassion into your intervention?
    - How successful was your intervention?
- If no:

    - What is your preferred method of addressing role-related distress?
    - How might you consider addressing self-compassion as part of your supervision of role-related distress?
        - When is self-compassion appropriate to address? When is it not?

6) What experiences have you had with role-related distress (e.g. burnout, compassion fatigue) in your supervisees?

- Can you give me an example of a moment when you perceived a supervisee to be experiencing distress in his/her role as counsellor?
- What was happening for you in that moment?
- What were the indicators that warned you that supervisee was experiencing distress?
- How did you approach the problem as their supervisor?
    - How prepared did you feel to address the issue?
- How successful was/were your intervention(s)?
- What, if anything, would you have done differently?

7) Can you give me an example of a time when you felt that a supervisee's role-related distress impacted client well-being?

- How did you resolve this issue?

8) Can you tell me about a time when you determined that a supervisee's distress was not within the scope of the supervisory relationship?

- How did you make that determination?

- Can you tell me about a time when you determined that a supervisee's distress *was* within the scope of the supervisory relationship?
    - How did you make that determination?

9) What are the supervisor's responsibilities when it comes to supervisees' role-related self-care?

10) Can you tell me about a moment when you experienced a tension between your mandate(s) as a supervisor/the scope of supervision, and your perception of the needs of a supervisee experiencing distress?

- What was happening for you in that moment?
- How did you proceed?

Appendix F

Demographic Information Questionnaire

Name:

Gender: Female Male Other/not-specified

Current level of education:

Theoretical orientation:

Job title:

Years spent in role of supervisor: