Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. (2016)
Published online in Wiley Online Library (wileyonlinelibrary.com). **DOI:** 10.1002/cpp.2031

Developing a Compassionate Internal Supervisor: Compassion-Focused Therapy for Trainee Therapists

Tobyn Bell,[1]* Alison Dixon[2] and Russell Kolts[3]
[1] *Greater Manchester West Cognitive Behaviour Therapy Training Centre, Greater Manchester, UK*
[2] *Manchester Mental Health and Social Care Trust, Greater Manchester, UK*
[3] *Eastern Washington University, WA USA*

The concept of an 'internal supervisor' has been used in psychotherapy to describe the way in which the supervisory relationship is internalized and utilized by the supervisee. This research explores the possibility, and potential benefit, of training therapists to develop a 'compassionate internal supervisor'. A training programme was developed for trainee cognitive-behavioural therapists using adapted versions of compassion-focused therapy interventions. The training focused on guided imagery exercises and reflective practices undertaken for a 4-week period. Seven trainee cognitive-behavioural therapists were interviewed, utilizing a semi-structured format, regarding their experience of the training programme. The resulting transcriptions were analysed using Interpretative Phenomenological Analysis (IPA). The analysis identified six super-ordinate themes: (1) the varied nature of the supervisor image, (2) blocks and their overcoming, (3) increased compassion and regulation of emotion, (4) impact on cognitive processes, (5) internalization and integration, and (6) professional and personal benefit. The themes describe the varied ways in which participants created and experienced their compassionate supervisor imagery. Working with the personal blocks encountered in the process provided participants with a deeper understanding of the nature of compassion and its potential to support them in their training, practice and personal lives. The process and impact of 'internalizing' a compassionate supervisory relationship is described by participants and then discussed for potential implications for psychotherapy training and self-practice. Copyright © 2016 John Wiley & Sons, Ltd.

Key Practitioner Message

- Compassion-focused therapy, and related compassionate-mind imagery exercises, can be adapted specifically to develop compassion in trainee psychotherapists.
- Creating, and engaging with, an 'ideal compassionate supervisor' in an imaginal form can support psychotherapy trainees in their clinical practice and development, their supervision and their personal lives.
- The cultivation of therapist self-compassion can reduce unhelpful cognitive processes such as worry, rumination and self-criticism whilst increasing self-reflection, attentional flexibility and approach behaviour.
- Identifying, and working with, blocks to compassion is important when cultivating clinician self-compassion
- Therapist self-practice of compassion-focused exercises can provide important insights into the nature of compassion and its cultivation in clients

Keywords: Compassion-Focused Therapy, Psychotherapy Training, Imagery, Supervision, Cognitive-Behavioural Therapy, Interpretative Phenomenological Analysis

INTRODUCTION

Supervision and the Internal Supervisor

Clinical supervision is an integral part of professional development and practice across psychotherapy modalities and helping professions (see Watkins & Milne, 2014). Regular supervision is an essential requirement of psychotherapy training and professional regulation, and is reported to be the single most significant influence on a therapist's clinical practice (Lucock, Hall, & Noble, 2006). Supervision is essentially seen as an inter-personal process: an 'intensive relationship-based education and training, that is case-focused and which supports, directs and guides' (p440, Milne, 2007). It is also described as a

*Correspondence to: Tobyn Bell, Greater Manchester West Cognitive Behaviour Therapy Training Centre, Greater Manchester, UK.
E-mail: tobynbell@hotmail.com

Clinical Psychology & Psychotherapy

form of experiential learning: reflection in-action and reflection for-action (Carroll, 2007). Whilst the empirical base for supervision in psychotherapy remains limited (Wheeler & Richards, 2007), the function of supervision has been consistently described as relating to monitoring therapy quality, and facilitating supervisee competence and effectiveness (Bernard & Goodyear, 2004; Milne, 2007; Pretorius, 2006).

The psychoanalyst Patrick Casement (1985, 1990) created the term 'internal supervisor' to describe the way in which aspects of the supervisory process and relationship are internalized and then integrated by the supervisee as a means of self-support and self-review. The concept mirrors elements of the internal working model concept of attachment theory (e.g., Bowlby, 1973; Pietromonaco & Barrett, 2000) whilst the focus on the supervisor 'containing' and 'holding' the supervisee is an echo of Winnicott's (1965) writing on the mother's 'holding' of her child. The internal supervisor functions to facilitate hindsight, foresight and insight into the process of therapy, and acts to provide a mental space or supervisory view-point ('islands of intellectual contemplation' p31, Casement, 1985) for self-reflection, exploration and monitoring. Casement (1985) also describes the process of moving from an '*internalized* supervisor' (the dependence on the voice/prescriptions of the external supervisor) to a more autonomous '*internal* supervisor' (the development of a supervisee's own independent reflection). Whilst there is no empirical research into the 'internal supervisor' phenomenon, the concept of an internal supervisor has become influential, with its development described as 'the primary objective of the supervision process' (p22, Gilbert & Evans, 2000).

The Case for Compassion

The notion of creating a compassionate internal supervisor stemmed from the growing evidence-base for the clinical application of compassion and its reported benefits for mental well-being. Compassion is defined by the Dalai Lama as 'a sensitivity to the suffering of self and others, with a deep commitment to try and relieve it'; this emphasis on sensitive-awareness *plus* motivation has been adopted by clinical researchers and theorists on the subject (e.g., Gilbert, 2010). Compassion in individuals is associated with low levels of psychopathology, such as anxiety and depression (see MacBeth & Gumley, 2012 for meta-analysis) with even brief compassion-focused exercises resulting in reduced cortisol production and increased heart-rate variability (Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008). Compassion is also linked to lower levels of worry and rumination (Raes, 2010; Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013) whilst being positively associated with higher levels of cognitive flexibility (Martin, Staggers, & Anderson, 2011), self-reflection (Samaie & Farahani, 2011) and creativity in self-critics (Zabelina & Robinson, 2010). Whilst these findings are not specific to psychotherapy trainees and practitioners, they raise potential avenues for exploration in terms of clinician self-care and reflective-practice, and could be important in the context of therapist burnout, and the role of therapist factors in vicarious trauma (e.g., McLean, Wade, & Encel, 2003). Notably, when considering the potential benefit for psychotherapy trainees, self-compassion has been shown to enhance empathic accuracy, moderate negative emotions after ambivalent feedback and increase individuals' acknowledgement of their role in negative events without feeling overwhelmed (Leary, Tate, Adams, Batts, & Hancock, 2007; Mascaro, Rilling, Negi, & Raison, 2013).

The cultivation of compassion and affiliative relating (to self and others) has also been associated with the regulation and reduction of inner and external shame (see Gilbert, 2005a). Shame has been found to have a particularly toxic impact on personal relationships (Covert, Tangney, Maddux, & Heleno, 2003) with evidence that shame-proneness increases unhelpful coping styles such as avoidance (Chao, Cheng, & Chiou, 2011). Shame is also linked to increased self-criticism and blame (Lutwack, Panish, & Ferrari, 2003) and has an important mediating role in various mental health disorders (e.g., Gilbert, 2000). The impact and potential clinical benefit for therapists to acknowledge, share and work with their own shame-based experiences is well discussed by Ladany, Klinger, and Kulp (2011). Whilst shame in the supervisory relationship has received limited empirical attention, it has been linked to trainee non-disclosure of clinical and personal difficulties, as well as a reduced perception of the supervisory working alliance (Bilodeau, Savard, & Lecomte, 2012; Ladany, Hill, Corbett, & Nut, 1996; Yourman & Farber, 1996). This is of particular importance when many of the suggestions to manage therapist shame focus on the use of supervision. To manage shame in the supervisor relationship, commentators have repeatedly recommended factors that can be seen as 'compassionate' or affiliative: the creation of safe and trusting relationship ('a safe base') or the creation of an emotional bond (referencing Bordin, 1994) to foster curiosity and disclosure, increased sensitivity and reflexivity and an enhanced working alliance (Beinart, 2012; Bilodeau, Savard, & Lecomte, 2010).

Compassion-Focused Therapy and Compassionate Imagery

Compassion-focused therapy (CFT) is an integrative, multi-modal, psychotherapy created by Paul Gilbert

(2010). The approach was originally designed for clients with experiences of self-criticism and shame, factors associated with poor outcomes in traditional therapeutic approaches (Rector, Bagby, Segal, Joffe, & Levitt, 2000). It draws upon evolutionary, social and developmental psychology, and incorporates aspects of cognitive-behavioural psychotherapy. CFT involves the cultivation of compassion for self and others, via a scientific synthesis of Eastern and Western approaches. Various aspects of compassion (such as empathy, distress tolerance and non-judgement) are developed during the therapy and then utilized to develop self-soothing capacities and inner-warmth, which allow for compassionate engagement with difficult life-experiences, emotions and memories (Gilbert & Irons, 2005). The therapy has a burgeoning evidence base and is now applied within a range of National Health Service contexts for various psychological difficulties (for review see Leaviss & Uttley, 2014).

Within CFT, many psychological difficulties are deemed to be rooted in social–relational problems, including the ability to bring a caring orientation to oneself (Gilbert, 2010). Gilbert has also suggested that self-evaluative systems utilize the same processing systems that are used when evaluating external interpersonal and social information (see discussion of 'social mentalities': Gilbert, 1989, 2005b). In this way, being self-critical, or self-compassionate, stimulates similar brain processes when compared to how we experience criticism or compassion from others. CFT has therefore developed a mental training programme (compassionate mind training) that includes various mental imagery practices focused on giving and receiving compassion to generate experiences of affiliation and a caring mentality (see Gilbert & Irons, 2004). One such practice involves picturing a 'perfect nurturer' as a means to 'harness the experience of a nurturing relationship that becomes internalised' (p326, Lee, 2005). Lee (2005) has also utilized the nurturing image to reframe threat-focused thinking, in a way that adds compassionate-relating to the traditional cognitive therapy exercise of thought-challenging (Beck, 1976). The current project employs both aspects of the exercise described by Lee: adapting the perfect nurturer script to the clinical focus of a compassionate supervisor and then utilizing the image to reframe unhelpful thoughts relating to the trainee's practice and development.

Therapist Self-Practice

The current research has parallels with self-practice programmes for cognitive-behavioural therapists. The self-practice/self-reflection model of James Bennett-Levy (Bennett-Levy & Lee, 2014) is particularly notable for synthesizing both reflective and experiential practices in a systematic programme in which CBT trainees practice the techniques of the therapy on themselves. Self-practice has provided participants with deeper insights into the process and practice of their therapy, whilst enhancing their therapeutic relationship with clients and improving technical ability (for overview see Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015). Such a programme has the potential to rectify gaps in training programmes which do not require personal therapy (Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003) and can improve trainees' ongoing self-reflection: a metacognitive competency that can power 'the engine of lifelong learning' (Bennett-Levy, Thwaites, Chaddock, & Davis, 2009). The exercises developed for the current study can be seen as the initial steps in integrating the self-practice/self-reflective model within CFT. In this way, the exercises are grounded in experiential learning, consistent with Kolb (1984), which has been found to be a key mechanism of effective supervision across therapy modalities (Milne, Aylott, & Fitzpatrick, 2008).

One area of the extant literature that has implications for the current study involves investigations of therapist mindfulness practice. In a review of the literature on the impacts of mindfulness training in therapists and trainees, Davis and Hayes (2011) note a number of potential benefits of therapist meditation, including higher self-reported empathy, self-compassion in health-care professionals, self-reported improvements in counselling skills, and decreased depression and anxiety.

A Qualitative Approach

The research adopts an exploratory, qualitative approach, due to the novelty of the research subject and the focus on individual experience and meaning-making. Interpretative Phenomenological Analysis (IPA) methodology (Smith, Flowers, & Larkin, 2009) was utilized to analyse the transcribed interviews of seven CBT trainees following the self-practice programme. IPA was chosen for the focus on the quality and essence of a participants' 'lived' experience of a given phenomenon, and the emphasis on perspectival and contextual factors (Larkin & Thompson, 2012). The approach is also deemed particularly suited to exploring 'complexity, process and novelty' (p55), whilst focusing on the active role participants play in the construction and meaning of their experiences (Smith & Osborne, 2003).

IPA offers a structured methodology that seeks to balance phenomenological description with interpretative insight via an inductive 'double hermeneutic' process (Smith *et al*., 2009). This process of negotiating a shared understanding of subjective, and inter-subjective, meaning-making matches the aims of the current project:

i.e., to understand the personal experience of trainees as they engage in mental imagery of a relational nature, within the context of their role as a therapist. There is precedence of using IPA to explore CBT therapists' experience of using imagery (Bell, Mackie, & Bennett-Levy, 2015) and the development of self-compassion in clients (e.g., Pauley & McPherson, 2010).

The Research Aims

The current study utilizes the concept of the internal supervisor as inspiration and seeks to explore the potential of intentionally creating an internal supervisor with compassionate qualities. The creation of a compassionate internal supervisor was facilitated by adapting an existing exercise from CFT into a month long self-practice programme. The original CFT exercise uses mental imagery to create, and interact with, a 'perfect nurturer' or 'ideal' compassionate other as a means to generate experiences of compassion and compassionate self-relating. In the current research, we adapted this protocol in order to examine the experience of psychotherapist trainees who engaged in an imagery-based self-practice programme that involved systematically cultivating and applying an internalized compassionate relationship in the role of a supervisor. On an experiential and idiographic level, we sought to explore the process of 'internalization' and 'integration' of a compassionate supervisory relationship and if aspects (and benefits) from a live supervisory interaction are accessible in image-based form. We also sought to consider the influence of the exercises on trainees' experience of compassion and the impact this has on their clinical practice and self-care.

METHOD

Recruitment and Participant Information

Participants were recruited with a 'purposive' rationale, consistent with the idiographic methodology of IPA. Such sampling involves the selection of participants to 'represent' a particular phenomenon in a particular context (Smith *et al*., 2009). The current study therefore focused on gaining a homogenous sample of participants from a single cohort of CBT trainees, all of whom had no experience of CFT prior to the study. The sample size of the study was limited to students able to attend the training and interviews ($n = 7$). This sample size falls within the suggested scale for IPA studies (Smith *et al*., 2009). The initial voluntary training took place in the student holiday period and was open to course students and supervisors (10 students attended). Following the training an open invitation was made to course students to volunteer for the research study: a four week practice and a 1-h review. All seven students who completed the four week practice and review were interviewed.

Clinicians were recruited via information-sheets provided to a cohort of students on a post-graduate diploma in CBT at Bolton University. The diploma is accredited by the British Association of Cognitive and Behavioural Psychotherapists (BABCP). Participation in the research was entirely optional and gained no additional credits. Students were not approached personally and were able to attend training without participating in the research. No students were excluded from the study.

The sample contained four males and three females and the age of the participants ranged from 27 to 61 (mean age = 40). The participants' clinical roles included: mental health support worker ($n = 2$), pastoral care officer within secondary education ($n = 1$), child/adolescent mental health worker ($n = 2$), self-employed counsellor ($n = 1$) and primary-care mental health practitioner within the National Health Service ($n = 1$). At the time of the study, all students were enrolled on the diploma. The ethnicity of the participants included: 'White–British' ($n = 6$) and 'British–Bangladeshi' ($n = 1$).

Procedure and Training

Participants initially attended a 5-h workshop introducing CFT. The training included an outline of the basic CFT model and practices, with experiential and reflective exercises amended specifically for therapists. Such amendments involved formulating 'key threats and fears' in the participant's role as a therapist in addition to an imagery exercise in which compassion was focused on an existing client.

The participants were provided with a CD of guided practices and related worksheets. The CD contained a recording of three practices:

1 **Soothing-rhythm breathing**. This exercise replicates the script by Gilbert (2009). The exercise involves slowing and focusing on the breath, in a mindful manner, to aid parasympathetic activation and heart-rate coherence and is utilized before imagery development (Gilbert, 2010). The recorded exercise lasts approximately 10 min.
2 **Creating and focusing the compassionate supervisor (imagery)**. This exercise is an adapted version of the 'perfect nurturer' script by Lee (2012) and 'ideal and perfect' compassionate image by Gilbert (2010). The recording guides participants to create and imagine a supervisor that is 'ideal' for them. The exercise includes a meditation on the compassionate qualities

of the supervisor and then imagines compassion flowing from the supervisor to the participant. The recorded exercise lasts approximately 24 min.

3 **Bringing difficulty to the compassionate supervisor (imagery)**. This exercise adapts the 'using my perfect nurturer to help me' script in Lee (2012). The adaptation involves imagining the compassionate supervisor providing support for a specific therapy difficulty. The recorded exercise lasts approximately 28 min.

Please contact the main author for copies and transcripts of the recordings.

The worksheets included a template to document the practices and a sheet for working with difficulty adapted from Lee (2005) (appendix 1). Participants were given a practice schedule for 2 weeks following the initial training. The schedule included: 1× daily practice of soothing-rhythm breathing (using the CD); 1× daily practice of a compassionate supervisor exercise (50/50 split, using the CD); the completion of the 'working with difficulty' worksheet (daily if applicable).

After 2 weeks of practice, participants attended a 1-h group review. The review focused on evaluating progress and encouraged participants to discuss, and mutually support one another, in working with any difficulties they had encountered when undertaking the imagery exercises (e.g., in being able to imagine an ideal supervisor or establish a regular practice). Participants were instructed to continue the daily practice of the exercises (using either the CD or self-guidance) and to complete the 'working with difficulty' worksheet for a further 2 weeks. The interviews took place 2–3 weeks following the review session.

Table 1. Interview schedule and examples of questions used

1. Experience:
What was your experience of developing a compassionate supervisor?
2. Imagery:
Describe any details about the personal image of the supervisor that you created
3. Benefits:
If you found the exercises helpful, how were they helpful?
4. Obstacles:
What obstacles or difficulties, if any, did you encounter with the practice?
5. Working with difficulty:
What was your experience of taking a difficulty to your compassionate supervisor (during and after the imagery exercise)?
6. Impact:
Has the compassionate supervisor practice had any influence on your therapy or use of supervision? If so, please give examples
7. Understanding of compassion:
Did the exercise influence how you understand, or think about, compassion? If so, how?
8. Self-care:
Has the exercise changed the way you support yourself as a therapist? If so, how?
9. Open exploration:
Do you have any other experiences related to the exercise that were important to you?

Data Collection

Data was collected via semi-structured one-to-one interviews, the preferred means of data collection in IPA (see Reid, Flowers, & Larkin, 2005 for review). An interview schedule was informed by a review of relevant literature (see schedule summary in Table 1). All components of the schedule were applied at each interview but the interview was conducted in a flexible and responsive manner to allow for reflection and deeper probing as suggested by Smith (1995).

The interviews were conducted by the second author in a university setting. The interviews varied in duration from 25 to 45 min and were recorded digitally for verbatim transcription. The participants had not previously met the interviewer and the resulting transcripts were anonymized before analysis to ensure that individual students were not identifiable.

Analysis: Interpretative Phenomenological Analysis

The transcribed data was analysed using the IPA methodology described by Smith and Osborne (2003). IPA utilizes an iterative, systemized, process that begins with repeated close reading of individual cases, before an interpretative coding of the data into emergent themes. Such themes were connected and clustered into superordinate themes on a case-by-case basis: this analytic process was achieved by means of abstraction, subsumption, contextualization and emphasis (as suggested by Smith *et al*., 2009). Patterns of super-ordinate themes were then reconfigured and refined across cases and collated in a master table, evidenced by textual extracts from the raw data. The master table was then transformed into a narrative account for presentation.

The primary analysis was undertaken by the lead and second author. Both authors independently coded each case before cross-validation. Any discrepancies in analysis prompted a collaborative return to the raw data. Early transcriptions were monitored for researcher bias regarding interview technique. The third author conducted independent audits of the analysis process, ensuring that each stage of coding and interpretation was grounded in the raw data. An independent researcher matched text extracts, written on cards, to the theme headings created by the analysis of the first two authors. A 96% level of agreement was achieved when comparing the matched outcomes.

Table 2. Summary of themes

Super-ordinate theme	Sub-themes	No. of participants associated with theme
The varied nature of the supervisor image	-Influence of memory and past experience of supervision on the image created	7/7
	-Varied positive qualities of 'supervisor image'	7/7
	-Differences in modality of imagery	7/7
Blocks and their overcoming	-Internal blocks	6/7
	-External factors	5/7
	-Overcoming blocks: persistence, trust and patience	7/7
Increased self-compassion and regulation of emotions	a) Increased compassion	7/7
	-Self-compassion	7/7
	-Embodiment of compassion	6/7
	-Compassionate behaviour	7/7
	-Compassion as flow (for self and others)	5/7
	b) Emotional regulation	7/7
Impact on cognitive processes	-Disputing and reframing the content of thoughts	7/7
	-Positive focus of attention	5/7
	-Reduced worry and rumination	7/7
	-Increased reflective ability and de-centring	7/7
	-Reduced self-criticism	7/7
Internalization and integration	-Integration and internalization of process	7/7
Professional and personal benefit	a) Benefit for clinical work, training and supervision	7/7
	-Positive impact on clinical work and management of working relationships	7/7
	-Positive impact on training and study	5/7
	-Improved use of supervision	4/7
	b) Wider personal benefit	5/7

IPA acknowledges the impact of the researchers' own beliefs in their 'interpretative' turn of the hermeneutic cycle. To aid reflexive clarity it is acknowledged that the research was analysed and undertaken by a team of clinicians who predominantly practice cognitive-behavioural therapy and have advanced training in CFT. The analysis and discussion of data was undertaken from within this paradigm. The lead author also acknowledges an expectation that participants would benefit from the 'compassionate internal supervisor' exercise, based on his own experience of developing and practising the exercise.

Ethics

The study was approved by Bolton University Ethics Committee and was conducted in accordance with British Psychological Society standards (Ethics Committee of the British Psychological Society, 2009).

RESULTS

IPA analysis of the data identified six superordinate themes across cases. The themes are summarized in Table 2. If such themes were integrated further, themes 1, 2 and 5 could be subsumed under a master theme of 'process and self-practice' and themes 3, 4 and 6 could be integrated under the theme of 'impact'.

Theme 1: The Varied Nature of the Supervisor Image

Influence of Memory and Past Experience of Supervision on the Image Created

All of the participants' 'compassionate supervisor' imagery had links to a recognizable person, with three participants reporting an association with specific memories or interactions. This occurred in the context of guidance that the image be created from fantasy to embody ideal qualities of compassion. Six of the participants associated their ideal image with previous supervisors, tutors or lecturers, resulting in contrasting consequences. Five out of the seven participants focused on a positive past relationships with a fellow professional:

P4. 'I pictured a supervisor who came up straight away, when we did the initial training. She's the person I just kept in mind…because I had such a positive experience with this person in supervision that I could very easily think of her'

A single participant (P3.) experienced the opposite effect and found their image was attached to negative memories of supervision and a sense of distrust and aversion (see discussion below in theme 2).

Participants' imagery involved a combination of past relationships, passing through a number of characters or incarnations (*P7. 'It morphed and changed'*). One participant's imagery vacillated between two past supervisors depending on the positive qualities or nature of support required. Two participants' related aspects of their image to their own mothers, whilst others identified incarnations of their compassionate supervisor as a religious icon (Buddha) or a film character (Robin Williams' portrayal of a therapist in the film 'Good Will Hunting'). Two participants also mentioned the importance of memory in imagining a context or environment in which to meet their compassionate supervisor:

P1. 'In terms of environment I was thinking of my grandparents' house because I kind of associate that with somewhere of warmth, love and compassion from being quite young.'

Varied Positive Qualities of 'Supervisor Image'

All of the participants ultimately identified positive qualities inherent in, or demonstrated by, their compassionate supervisor. Many of these qualities arose independently from the instructions of the exercise (which focused on the qualities of wisdom, strength, warmth and commitment). The most frequently stated qualities, characteristics and capacities of the supervisor image were: empathy and understanding; non-judgement and unconditional positive regard; the capacity for reflection; and a sense of being comforting, soothing and calm. Various facets and dimensions of compassionate attributes were emphasized by individual participants; this varied from: assertiveness and willingness to be challenging; stability, constancy and 'unchanging essence'; and a felt sense of connectedness. A common theme was a sense of attentive, active listening and a willingness for their supervisor to be open and vulnerable in the relating:

P6. '{The supervisor} comes across as a human being who cares for people, who is vulnerable at times as well.'

Differences in Modality of Imagery

There were notable differences in the sensory modality with which the supervisor was accessed and associated. The auditory modality was prominent for four participants, whilst three participants reported visual stimuli as the salient mode of experience. One modality of imagery was frequently reported as exclusive:

P4. 'It is very visual, yes it's not sort of tone of voice as such but just visual. So I sort of see her face and the room we used to have supervision in, so that's very clear in my mind.'

P2. 'I don't get any other sense apart from auditory really.'

Participants, who experienced auditory imagery, were particularly specific about the nature of the voice tone of their imagery, referencing 'soft', 'calm' and 'warm' qualities in contrast to the 'booming' tone of an unwanted supervisor image (identified by participant 3.). Visually, there was also a particular focus on the face and smile of the supervisor. The tactile quality and sense of presence of the supervisor was also identified and linked to emotional connection:

P6. 'I feel them stood there in my vision, they don't have their hand on my shoulder but it feels like they've got their hand on my shoulder.'

Theme 2: Blocks and their Overcoming

Internal Blocks

The participants identified a number of internal blocks and resistances to creating, practising and applying the supervisor imagery. Four participants had difficulty in finding and selecting a 'reliable' or stable image, or found imagined supervisors 'competing':

P6. 'Initially it was very difficult, it was, for starters, when imaging a compassionate supervisor I had 4 or 5 different, because I could get faces or people that I've met in the past who sort of interchanged. So it was quite difficult to stay focused on one sort of person initially.'

Two participants found that their sense of 'forcing' (for detail, clarity or for a particular modality of imagery) inhibited the creation process. Similarly, participants' prior expectations (e.g., that the supervisor would be female when it appeared as a male) or their self-criticism at difficulties encountered during the process (such as problems concentrating) became counter-productive and distracting:

P1. 'I found it quite hard to visualise at times and sometimes I think I got into a bit of a battle with myself because I was focussing more on visualising rather than just relaxing and getting the overall feeling of compassion.'

A common block was accepting compassion for self, with three participants voicing beliefs that compassion was self-indulgent or solely 'for others'.

P5. 'this was completely focused towards me and my well-being and I found that difficult to get used to, to start with because I was wanting to put out {compassion} but it's drawing it in really and accepting that it's for me.'

Compassion was also initially experienced as strange

and uncomfortable on a 'felt' level, or, in turn, was 'intellectualized' without emotional connection.

The most prominent internal blocks were experienced by participant 3 and related to negative associations with the notion of supervision. The participant reported the word 'supervisor' acted as 'red light' to progress, a reaction he related to negative personal experiences:

P3. 'For me the connotation of a supervisor puts me off. Everything to do with authority, only in my experience.'

P3. 'That was my barrier, I don't like the term, I'd rather it be something like helper or something, you know not a term that's got authority written all over it.'

The participant associated the supervisor role with power imbalance and perceived dominance, questioning the 'agenda' of his supervisor as representing 'a critical top-down model of things'. A sense of distrust in the supervisor's intentions was matched with an expectation of the supervisor's inefficiency and disinterest. Such associations created a sense of frustration that was evident during the participant's recollection at interview.

External Factors

Five participants also identified external blocks relating, predominantly, to time-limitations on their ability to practice on a regular basis. This related to occupational pressures in addition to the requirements of university study and personal/family demands. Additional external blocks to practice related to disruption (e.g., noise) in the workplace environment and limited access to equipment to play the recordings.

Overcoming Blocks: Persistence, Trust and Patience

Whilst all participants initially described blocks in relation to the exercises, all participants were able to engage in personal practice and offered various means by which they overcame their initial difficulties. For many, acknowledging and working with such blocks became the gateway to developing self-compassion and identifying areas requiring reflection and self-care (see Themes 4 and 6).

The most prominent way in which participants managed internal blocks was the development of an open, mindful orientation to internal experience (a sense of making 'space' for difficulty). Participants described the adoption of an 'accepting' stance and 'observer' perspective with regard to their mental and emotional blocks:

P4. 'I just allowed it to happen really and became more of an observer of it rather than getting immersed within it in a sense really.'

In this way, participants described the imagery exercises as a form of 'process' during which blocks were acknowledged and then worked with by various means. Such means included allowing the supervisor image to evolve and transform without expectation, and focusing on the 'felt' sense of the experience (rather than the verbal elements involved). Participants also reported reducing the 'battle' with distractions and discomfort, whilst also decreasing their over-striving for detail, clarity or immediate impact.

P5. 'I was trying to re-engineer an outcome which seemed self-defeating. So I stopped.'

P1. 'I was really trying to get this descriptive kind of picture in my head and I think that's where I had a bit of difficulty at first. The more I kind of just tried to relax with it, I think them things started to come through a little bit easier.'

The very process of working with blocks became, in itself, a valued and integral aspect of the overall exercise and a means to develop trust in the practice:

P3. 'You have got to go through the process to trust what you're coming out with.'

The sense of trusting one's own voice, of identifying the compassionate voice as one's own, was of particular importance to participant 3 and is discussed below (theme 5).

All participants emphasized the importance of repetition and practice, but there was variance in how individuals maintained their own motivation. For some this included the development of a set schedule with phone-alarms to prompt practice, whilst others, who were often more stringent in their initial routine, became more flexible in their practice times and frequency:

P4. 'I just actually made space for it at different times in the day, so rather than thinking I have to do it at a certain point, I felt like I'll do it when I can, so that's what I did.'

Theme 3: Increased Compassion and Regulation of Emotion

Increased Compassion

Self-compassion. All participants reported an increased ability to be self-compassionate, both during and beyond the imagery exercises. This was initially evident in an increased awareness and sensitivity to one's own difficulties. Such sensitivity was present in all participants' reflections and was associated in the interview with expressions of care, empathy and support. Participants unanimously

reported a difference in their self-talk that was 'affirming', 'reassuring' and encouraging:

P2. 'After session I try and get that little voice in my head telling me "yeah that's ok and you're not going to have all the answers and you tried your best". I just give myself a little bit more reassurance and I'm a bit more, easier on myself.'

The change in internal dialogue was identified as a change in mind-set rather than solely an alteration to the verbal content of cognitions. Participants reported changes in perspective, emotional tone, access to memory, sensory experience and attention (see below) which resulted in a global shift in the participant's thinking and feeling:

P3. 'You think from a different place in your head don't you? There rather than here and here, you know I feel like I'm rising above it'

All participant's identified a change in their self-to-self relationship and an increased ability to provide, and be open to, self-care (characterized as 'kind' and 'warm'):

P4. 'Because I think it's just brought a real softness to the experience that I'm having. So to do that it just makes it that little bit more—it brings an element of kindness to it I think is how I'm trying to describe it, it sort of taking the rough edges off it. I can feel an immediate sort of lift in my heart, generally.'

Embodiment of compassion. A prominent theme in participant's accounts was their ability to embody and connect to compassion on a physiological level. This had a number of emotional regulating consequences (see below) but also involved the use of the body to activate, maintain and deepen the connection to compassion. Four participants utilized the slowing of the breath or the soothing voice-tone as a means to connect with their compassionate image outside of the practice and to access 'feelings' associated with compassion. For others the change in body posture (e.g., 'head up') linked to sensations of psychological and emotional solidity, strength and expansion (*P3. 'I feel taller'*). One participant identified the shift in facial expression as a key factor in accessing and embodying compassion:

P4. 'I think it was definitely the smiling inwardly, I think that's really useful to do.'

Compassionate behaviour. Compassion was linked with behavioural change and increased self-care behaviour (the positive impact of which is discussed below in theme 6). Such changes included taking breaks from work, increasing social contact and re-prioritizing personal time (linked to personal values). Such self-care behaviours were undertaken in a deliberate and conscious manner, directly linked to a compassionate intention:

P5. 'I just think it makes me a lot more aware of taking care of myself and the need for that, and I think it isn't something that maybe a long ago I might not have done but now I do take a lot of care to make sure that I make choices about things that I need to do.'

When encountering problems or difficulties, clinically or personally, participants reported a focus on their behaviours rather than on the global sense of 'self' as being at fault or to blame. This, in turn, allowed a focus on the potential for behaviour change and rectification, supported by compassionate self-talk and perspective-taking:

P4. 'And thought well I can just sort of look at it the next day and see if I need to change it or whatever but I think rather than sitting there frozen thinking I just can't do this, this is really difficult to its ok, just sort of try it and it doesn't matter because you can have another look at it.'

Participants reported to have used compassion to maintain their commitment to particular tasks and goals, reversing behavioural avoidance and increasing resilience to '*stick to the plan*' and '*stay with the process*' (participant 5).

Compassion as flow (to self and others). All participants reported an increase in compassion for others. This was articulated in the form of increased empathy and understanding of others' difficulty and an improved ability to remain connected and present with others' distress (see theme 6 for the impact on clinical work). There was also a reduction of globalized blame (to both self and others) and an increased ability to consider context (*P3. 'A lot of things aren't your fault are they?'*). Participants identified an increased willingness to demonstrate compassion for others whilst also improving their means to do so in terms practical skills, competencies and confidence:

P2. ' I wouldn't say I'm not a compassionate person, I think I am, I just think I struggle to convey it and it's kind of given me the knowledge and a bit of the tools to kind of like learn to be a bit more compassionate.'

Five participants also referenced an expansion in their understanding of compassion to incorporate both self and other: as a universal stance or orientation that was mutually beneficial. Often participants were able to practice and conceptualize self-compassion in terms of how they would treat others:

P3. 'a good example is you wouldn't be beating a kid up if they'd done something wrong, you would be encouraging them, nurturing them, giving those options and describing maybe a different way of doing things you'd be educating them wouldn't you?'

As the self-practice deepened this process reversed, with participant's translating insights from their own lives into how and where compassion might be applied to others (e.g., to clients, discussed below). There was an increased emphasis on how the practice of compassion becomes a two-way process, with self-compassion deepening one's capacity to be compassionate with others:

P4. 'I do think it's helped to have a deeper level of compassion towards other people and I think there's no doubt about that really, I think it's been there but I think it's more so because I think the more you are compassionate with yourself the more you feel able to be that way with other people.'

Emotional Regulation

The various factors and elements of compassion, discussed in the sub-themes above, were reported to influence the participant's ability to regulate and manage their emotions. All participants reported the imagery exercises had a direct and often 'automatic' effect in reducing autonomic arousal. One participant, when practising at work, measured the objective changes in physiology:

P6. 'I've got a heart rate monitor as well, I measured my heart rate and it went down a lot. So, rather than just feeling, it was actually doing something, it was actually lowering my heart'

All participants identified the use of the imagery exercises to increase their tolerance of threat-focused experiences and emotions.

P4. 'It just makes me feel far less anxious about somethings and far more like this is something I can tolerate, and get through it really

For some this was identified as 'acceptance' of the presence of the unwanted emotional experience without being 'swallowed up'. This was often linked to the reflective observer-perspective described above:

P5. 'I've just thought "do you know it's so funny watching this going on" and it's like I'm impervious to it'

For others it involved the down-regulation of such experiences by increasing warmth, 'positive' feelings and the embodiment of compassionate qualities (as described above). Such positive feelings were commonly described as 'soothing', 'calming' and 'relaxing' in nature and related to a general sense of 'slowing down'. The 'positive' experiences also extended to shifts in mood and high-energy feelings: e.g., *'really positive and uplifting'* (*P.7*) and *'very happy'* (*P.6*). Participants also identified that the 'felt' sense of their imagery allowed them to manage difficult experiences by being more emotionally stable, as if on 'firmer ground':

P5. 'It's that reassurance; it's that solidity just to kind of balance you back up again'

Theme 4: Impact on Cognitive Processes

A prominent, but overlapping, theme, was the impact of the exercises on the participants' cognitive processes.

Disputing and Reframing Content of Thoughts from a Different Mind-Set

All participants reported an increased ability to challenge the content of their negative or unhelpful cognitions. Such 'challenging' largely focused on reviewing critical or negative appraisals in a compassionate manner:

P1. 'Trying to kind of dispute any negatives that I might have been feeling from that day, from a day of work or Uni. Just kind of going through them in a nice calm empathetic way.'

P7. 'The compassionate supervisor would pop up speak to my kind of negative thoughts and ease them better.'

Positive Focus of Attention

Similarly, five participants reported an increased ability to refocus their attention in a flexible way. This allowed participants to disengage their attention from unwanted subjects whilst deliberately shifting their awareness to positive aspects of their experience:

P7. 'I'm kind of more freely available or positive. I can be able to draw out more positives from situations, where as in the past I think I would have been primarily focused on the negatives.'

Reduced Worry and Rumination

All participants identified a reduction in rumination and worry. Participants reported an increased ability to recognize the occurrence of such perseverative thinking (*P.4. 'catching that early rather than getting maybe a bit more drawn into it'*) whilst also managing such processes in a 'helpful' manner. This was predominantly achieved by: a focus on

future possibility and behaviour change; a slowing down of automatic reactivity; and the adoption of a compassionate perspective

P5. 'It is good because you don't ruminate so much. It puts it into context and you move onto the next thing and make a better job of that'

Increased Reflective Ability and De-Centring

Participants also reported a relationship between the reduction of rumination and worry and an increase in reflective thinking. Reflective thought was identified by the ability to create a 'window' for consideration: a 'wider', 'balanced', perspective on the situation. This was coupled with a willingness to reflect upon areas of difficulty, both personal and clinical, from an equanimous 'stance':

P6. 'I'm adopting a sort of stance where I will step back and stop and look at the problems…I'm stepping back and looking at it more naturally at the minute.'

P4. 'I could see things from a wider perspective it wasn't just focused or tinged with, this is something I'm struggling with and I'm always struggling with it, it's a bit more like it is what it is and that's okay, and there are things that I can do next time I don't need to be critical of myself for it.'

Similarly, participants reported a process of 'de-centring' from threat-based thoughts and experiences (which were often labelled as such). This was described as developing an 'observer' perspective or mindful ability to notice difficult experiences without personal enmeshment (*P5. 'observe the chaos'*). Such 'de-centring' supported participants in working with blocks to the imagery development (see above), but also created wider changes to the way they related to their thoughts and emotions:

P2. 'Just letting the thoughts, let them just pass and don't engage in them and if you focus on other senses within your body and you know, just observe them.'

Reduced Self-Criticism

All participants also reported a reduction in self-criticism (which they associated with increased self-compassion). This included a reduction in the processes of self-blame and negative self-monitoring. As with the reduction in worry and rumination, participants identified that the reduction in self-criticism increased their ability to think 'freely' and flexibly. Participants referred to the change as a shift in internal self-to-self dialogue:

P3. 'Reflect on things slow it down a little bit, take the emotion out of it and just don't beat yourself up you know, level the playing field and I'm not the victim all the time. Then you're in a better dialogue…'

The reduction in self-criticism and unhelpful self-monitoring was also evident in the way in which participants articulated their experiences during the interview:

P6. 'Even putting the words across to you now I'm thinking about my words rather than criticism.'

Theme 5: Internalization and Integration

Integration and Internalization of Process

All participants reported a process of integrating the compassionate voice and relating of their imagined supervisor into their own minds and lives.

There was a unanimous theme of taking ownership of the imagery practice, with a movement from listening to the guided exercises in a formal way (e.g., via CD), to being able to self-guide the practice internally:

P4. '…it's something that I can quite easily tap in to. I can think about a specific supervisor and that then just immediately has an effect on the way I feel, and I can either do that for—I was doing the CDs or I can just do that now without the CD's really I don't actually need it'.

A similar process was reported in terms of moving from set worksheets to being able to work with difficulty autonomously.

All participants reported that the image of the supervisor, and the caring relationship it offered, could be brought to mind as required (*P5.'it's a point of reference that's there'*). Participants noted the practice had become an 'embedded' part of their daily thinking and responding. For three participants the supervisor's voice began to be melded and 'integrated' with the participant's own inner dialogue (like a *'script in my head', P2*).

For participant 3 this integration became the prime means to overcome his initial blocks (see above). This participant's breakthrough occurred when he identified that the compassion generated from the supervisor was self-created:

P3. 'They've come from me not a third party because I think that's the key, it's coming back from me and so I believe in it. That's the believability of yourself that's the thing.'

The participant's changing imagery matched this shift in focus. After the initial image of a past supervisor was rejected, it was replaced by the booming voice of a powerful deity, before the voice became his own and the focus shifted to inner-dialogue and feeling. The participant

reported moving from the role of 'victim' to a sense of self-authority.

P3. 'I wouldn't take it to my supervisor I'd take it to me, after I'd been through this sort of training process, now it's taking it to myself.'

Five participants reported that the exercise allowed them to become more genuine and 'true' to themselves and their values *(P5. 'Like a little liberation')*. They identified self 'trust' and 'respect' and an ability to be more 'intuitive'. For one participant this involved a rejection of the internalized voice of a critical other:

P5. 'I was quite critical but I'm not now. I'm not a performer and I don't want to live somebody else's script.'

Another participant reported a shift in their sense of self and role as a therapist:

P7. 'I think it's altered the way I think about myself as a therapist compassionately.'

Theme 6: Professional and personal Benefit

Benefit for Clinical Work, Training and Supervision

Positive impact on clinical work and management of working relationships. The experiences described in the themes above were reported to have a significant impact on the participants' clinical practice, training and working life.

The predominant sub-theme related directly to therapist factors during treatment. This was articulated as a change in self-management during and after therapy sessions with reduced reactivity and increased self-compassion when difficulties arose. All participants linked this to an increase in the in-session tolerance of anxiety, frustration and self-doubt, and an ability to engage in objective reflection after the session.

P3. 'I do have a rethink about things. I suppose after each session or looking at what somebody's going through. A lot of things are not your own fault are they? They're not all the time, they're not really. Like institutions or families, or variables within the community you can make it worse by beating yourself up because you will just think worse about yourself and it will piss you won't it off ultimately. I'm definitely giving it a few extra seconds of thought about not being on the defensive, looking at how I am an alright person and what skills I have, and what people have said about.'

Sub-themes also included an increased acknowledgement of therapeutic progress coupled with an ability to focus on the potential for future change (in both client and therapist). Improvements in self-confidence, and a sense of stability (*P5. 'firm ground'*), were also linked with increased responsibility-taking of problems arising in clinical treatment.

A key sub-theme involved the ability to remain present and mentally focused during therapy, and the capacity to shift focus from one task to another without rumination. Participants were also able to activate compassion in-session to regulate their own drive to 'fix' their clients problems; instead, participants were able to remain sensitive to the needs and pace of their clients:

P4. 'I was very conscious I was working really hard with this person and I thought no I need to just sit back and start trying to work more collaborative with them I think. So by using the breath and then thinking of my supervisor, and I suppose in a sense what she would say which is you know if you're sat forward it means you're working too hard, sit back. So it tapped into that I guess'

Such therapist factors were, in turn, seen to impact the participants' relationship with clients. This included the perceived improvement, and valuing, of empathy, transparency and collaboration. Having encountered, and worked with, blocks of their own during the imagery practice, participants reported an increased understanding of the kind of barriers that clients encounter during treatment:

P2. 'And it makes me think, I keep saying certain things when I'm in the session to the clients like "do this" and sometimes I think I actually struggled with it myself so it makes me reflect that you know I need to be more, not open-minded but more understanding when they turn round and say they struggle'

The imagery training also had an impact on clinician's perception of the importance and utility of compassion for their clients. Participants particularly valued experiential learning methods as a means of training in a new therapeutic model (i.e., compassion focused therapy):

P4. 'I feel like now that I've put that into practice by thinking about a supervisor, I think it would help me when I might need to work with somebody in a sort of compassionate mind way in having a more thorough, more depth of understanding of maybe how to do that because of my own experiences'.

There was also a wider impact on the participants' relationship with colleagues and management of workplace pressures. Sub-themes included an increased resilience to workplace stress, which was linked to reduced personalization of service difficulties and an increased sense of personal empowerment. Two participants identified an increase in compassion for colleagues and managers resulting in reduced conflict and blame, whilst increasing empathy.

P3. 'It's just a different style isn't it? I suppose in the long run it's going to be better because you cannot fight fire with fire all the time can you. So there is time for me to have a think about my better qualities and stop beating myself up about it, it's not necessarily anyone's fault really it could be an oversight'.

Participants also reported a reduction in unhelpful comparisons with other therapists and an improvement in personal boundaries and time-management. The workplace themes are best articulated by Participant 3 who utilized the exercises to manage the regular conflict he experienced at work. Notably, this was achieved in a manner that maintained his values and willingness to advocate on the behalf of his clients, but reduced counterproductive confrontation:

P3. 'Step back take it for what it is which I know what it is, instead of getting roped in to their mess it's not going to help anybody, stick to what I am good at, stick to what I know what I think is the right course of action. Reflecting on what could make matters worse by kicking off with some other worker.'

Impact on training and study. Five participants reported the imagery practice had a positive influence on their training and university study. The main factor related to the management of procrastination and perfectionism, including 'writer's block'.

P4. 'It has in that I've definitely not got as critical of myself still, it's something I've been able to let go of. So I'm not keep going over it in my mind and it's made me go back to reading about it, reading about how I can do this rather than just thinking I can't actually do it and I'm not going to try it. I thought I need to just have a read, when I read about what the technique was, it made me think yeah I can do this, I just need to try this next time.'

Participants also reported an increased willingness to approach essay writing, reading and clinical skills practice whilst feeling more able to ask for support. The supervisor imagery was also utilized to down-regulate stress at university, allowing for the completion of academic tasks.

Improved use of supervision. Four participants also identified their use of the 'internal supervisor' imagery had an influence on their use of clinical supervision. Participants reported to be slower and calmer in supervision with a greater ability to maintain mental focus, openness and flexibility when discussing clients. Themes included an increased willingness to 'access support', to bring cases that were problematic for the therapist, and a capacity to experience feedback as guidance rather than criticism. Such factors resulted in a more efficacious use of supervision: prioritizing important cases and in reducing avoidance of difficult topics:

P1. 'I suppose in supervision I wouldn't be ruminating about the mistakes I've done and more being able then to focus on clients…I'd then feel I'm delivering a better service to the clients because I'm using the time and supervision a bit more effectively.'

Participants were also able to self-direct their awareness to positive aspects of treatment and progress, relying less on the supervisor for reassurance.

Wider Personal Benefit

Whilst the imagery practice had a clinical focus, five participants emphasized an improvement in their 'work-life balance'. This was linked with an ability to 'cut off' from work, again emphasizing a re-focusing away from unhelpful rumination. Participants reported this occurred in a conscious and deliberate manner to allow connection to personal interests and priorities outside of work, motivated by self-care and compassion:

P1. 'I'd have just continually kept working until I had to do something like going making my tea or something like that, something that I felt I had to do. Whereas this has definitely helped me just be a little bit more compassionate to myself in terms of my time management and put a few more boundaries in places….just looking after myself a bit more.'

A similar theme was the impact of the imagery practice on personal relationships. Five participants identified an improved quality of relationships with friends and family members which they attributed, primarily, to an increased capacity to be present and an improved mind-set for relating. There was a theme of enhanced experiences of connectedness and responsiveness, as well as an increased prioritization of relationships (resulting in a perception of more frequent social interactions with friends). Notably, there was a global reduction in experiences of interpersonal threat for these participants:

P4. 'I think my relationships with the people, with clients and with friends, and family is closer because I think I'm less anxious maybe, less afraid of doing things wrong and more allowing and accepting yourself really.'

DISCUSSION

As therapists strive to better care for their clients whilst taking care of themselves in the process, a growing case is being made for the importance of therapist self-practice and self-reflection (Bennett-Levy, 2003; Bennett-Levy *et al.*,

2009, 2015), with some regarding self-practice and experiential work as essential to clinicians (McCown, Reibel, & Micozzi, 2011). The current investigation sought to extend this self-practice and self-reflection work to CFT, reasoning that this experience might be an even more valuable experience for a therapy model such as CFT which so heavily emphasizes experiential work (Gilbert, 2010). This is the first study to adapt CFT practices to support therapists' work and self-care.

In considering which of the broad range of interventions included in CFT that we should utilize, we sought an intervention that mapped onto the everyday lives of working therapists. As all therapists will have experiences with supervisors—experiences which can impact both their therapy and their experience of themselves as therapists—we chose to adapt Deborah Lee's (2005) 'perfect nurturer' imagery practice to the process of supervision. Participants created an image of a nurturing supervisor, ideally matched to their needs, who could offer them compassion and support as they face common therapeutic challenges.

Our qualitative IPA analysis of participant interviews revealed both that the CFT intervention was acceptable and viable for use with therapists, and that the compassionate imagery practice appeared to have several benefits for participants. Further, participant's reflections on their practice provided insights into the challenges and dynamics to be considered when using compassion-based imagery interventions.

Overall, it appeared that imagining a compassionate supervisor- including their qualities, posture and interpersonal manner- was helpful to participants both in soothing themselves and in being able to gradually internalize and embody these qualities in themselves. The results support CFT's understanding of compassion not simply as different cognitive content, but as an alternative mind-set, affective orientation, motivation and facilitator of behaviour change. Imagining (and in some cases, imaginably embodying) the compassionate supervisor led to self-reported reductions in self-criticism, shame and feelings of threat, as well as perceived increases in resilience and positive capabilities.

The current research exemplifies key CFT processes and theory, some of which have not previously been evidenced in the extant research literature on CFT. These observations included the use of imagery both to self-soothe and to facilitate exploration and courage, the linkage of compassion to key needs, goals, and values, and the importance of embodiment and body-work to activate and deepen compassion. Participant reflections also highlighted that compassion seemed to aid their ability to mindfully observe their experience whilst increasing emotional connection (rather than detaching or inhibiting it).

In particular, the current methodology allowed insight into the various blocks that can arise with such compassionate imagery practices, and how they can be worked with. Common blocks included practical considerations such as time limitations as well as difficulty arriving at a single image/person as the supervisor, difficulty accepting and feeling compassion for the self, and working with negative associations around the notion of supervision. The IPA analysis revealed common themes across participants' ability to work effectively with such obstacles, highlighting the importance of persistent practice over time and patience and trust in the process.

Coping with blocks via the element of playfulness and exploration, which is associated with a sense of safeness and affiliation in attachment literature (e.g., Winnicott, 1971), also proved key in creatively 'trying out', and 'letting go' of particular incarnations of the supervisor as well as experimenting with different attributes of compassion (in addition to the guided instructions). Differences and contradictions in the modality of access offer insight to CFT (and imagery work in general) to encourage personalization of the imagery, focusing on the felt sense and allowing whichever mode of imagery is most potent and accessible for the individual. Such individual differences have been found in prior qualitative studies of CFT imagery (e.g., Gilbert & Irons, 2004). There were also implications with regard to the focus of attention within the imagery: e.g., visually on the face and smile; the 'soft' tone of the voice; or the sense of tactile presence. Such features are well discussed within CFT literature as a means to facilitate affective change. The focus on voice tone and facial expression finds particular resonance with poly-vagal theory in its description of how the social engagement system mediates autonomic arousal (Porges, 2011).

The experience of blocks within the process of trainee/professional development of compassionate imagery is in line with the blocks experienced by clients in clinical studies (e.g., Gilbert & Irons, 2004). Working with such blocks, fears and resistances forms a core part of CFT and can actually provide the first experiences of becoming compassionate to one's own mind, history and experiences. Working with blocks can provide a gateway to bringing a compassionate understanding and commitment to difficult aspects of the human experience, provide key insights into the nature of compassion's development in terms of resistance and fears, and potentially highlight unmet needs, emotional memories and attachment histories.

Participant 3's description of his initial block for experiencing compassion from others can be conceptualized utilizing Gilbert's (1989) social mentality theory, which proposes social mentalities as organizing social orientations which can powerfully impact one's attention, thinking, emotional reactions, motivations and behaviour. In attempting to overcome the block, Participant 3 initially generated imagery from a rank-based mentality and chose

a powerful religious figure with a 'booming voice' (to which he responded angrily), but this began to change as he identified the 'voice' as his own. As this changed, he was able to relate to the voice of the supervisor as acting from a care-based mentality with an emphasis on 'trust'. This created the desired affective and autonomic shift. This was also evident in the desire for the term to be shifted from 'supervisor' to 'helper' and from his emphasis of stepping out of the 'victim' role (rank).

Results seemed to reveal an internalization process which maps onto Casement's (1985) ideas, in which the qualities of the supervisory relationship are first incorporated through the internalization of the supervisor's voice, and are then adopted by the individual as their own. This played out in different ways for different participants. Some participants continued using the image of the compassionate supervisor figure in a formal practice but for others the supervisor became a compassionate voice, feeling and motivation that was automatic, integrated and entwined with their sense of self. Some participants reported this was felt to be a connection to their 'true self', whilst others reported their sense of self was changed. This observation demonstrates that with repeated practice, the compassionate voice can become automatic, spontaneously applied and integrated into daily living, and tapped into via the breath or voice tone. The internalization of the compassionate supervisor also appears reminiscent of Casement's (1985) 'islands of contemplation', in providing a reflective, de-centred, compassionate perspective from which to view self/other/relationship/task in a new light. This observation is also consistent with attachment theory's emphasis on a secure base as providing both a haven for safeness and a reference point for personal change and exploration (Bowlby, 1988).

The current study does involve a number of limitations that warrant reflection. One limitation is that the protocol of the study, which involved having participants engage in daily practices of soothing rhythm breathing and guided imagery of a compassionate supervisor, bears some similarity to mindfulness practices, which has been linked with experiences of increased self-compassion, and decreased stress and anxiety in therapists (Davis & Hayes, 2011). Our participants described some benefits from of their compassion practice (for example, relating to their own experience with acceptance) that would be expected from an effective mindfulness practice, and noted using a mindful orientation in working blocks to their practice when they emerged. Whilst the compassion-based imagery utilized in our study is quite different from typical mindfulness protocols, it has not yet been empirically demonstrated that the addition of specific compassion elements enhances therapist outcomes over and above that produced through mindfulness practice, and it is possible that some of the benefits reported by our participants may be due to the effects of increased mindfulness rather than the compassion-focused elements. Future research is needed to explore the relative benefits of engaging in mindfulness and compassion practices for therapists.

Despite precautions made to ensure anonymity, and the use of an interviewer not part of the university, the participants were still students of one of the researchers. This could potentially have influenced both the participant's willingness to engage in the process and their reporting of experience. We attempted to minimize biases in reporting by actively inquiring about blocks and difficulties, and informing participants that all of their experiences were of interest to the study. Additionally, selection bias may have been operating in that participants were drawn from a single setting, and all participants expressed interest in the subject, limiting the generalization of results. Additionally, due to the qualitative nature of the study, we utilized a small number of participants. Future studies could utilize quantitative methodology with larger numbers of participants in order to further explore the utility of compassion-based imagery in practicing therapists. It is also of note that the emphasis on cognitive processes, reported in the results, could be specifically related to the modality of therapy practiced by the students. Future research with students of other forms of psychotherapy would be of particular interest in exploring the potential variation in meaning-making and experience of participants when engaging in the imagery exercise.

In conclusion, whilst preliminary, our results support the use of compassionate imagery, and specifically imagining a compassionate supervisor, as a feasible and potentially useful practice for beginning therapists. The current research adds to the existing literature on therapist self-practice both in being the first study to examine the impact of incorporating compassionate-supervisor imagery into therapist self-practice, and in the suggestion that compassionate mind imagery can be successfully adapted for different groups. Of particular note, we think this study suggests that incorporating compassion-based self-practice elements into therapist training is feasible in terms of the demands on both training programme (as our initial training consisted of a single, 5-h workshop) and the trainee participants, as evidenced by our high rate of compliance with the practices. Based on our observations, programme or units seeking to incorporate such practice into therapist/trainee training would be recommended to provide trainees with very concrete instructions on how to engage in their self-practice (for example, our use of recorded CD-based practices), and offered guidance in how to work with blocks to practice as they inevitably arise. Further research could explore the utility of such interventions in groups other than clinical trainees, particularly in high-stress service fields in which

the cultivation of compassion might be specifically desirable.

REFERENCES

Beck, A. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beinart, H. (2012). Models of the supervisory relationship and their evidence base. In Fleming, I., & Steen, L. (Ed.), *Supervision and clinical psychology: Theory, practice and perspectives* (2nd ed. pp. 47–63). London: Brunner-Routledge.

Bell, T., Mackie, L., & Bennett-Levy, J. (2015). 'Venturing Towards the Dark Side': The use of imagery interventions by recently qualified cognitive-behavioural therapists. *Clinical Psychology and Psychotherapy, 22*, 591–603. DOI:10.1002/cpp.1920.

Bennett-Levy, J. (2003). Reflection: A blind spot in psychology? *Clinical Psychology, 27*, 16–19.

Bennett-Levy, J., Lee, N., Travers, K., Pohlman, S., & Hamernik (2003). Cognitive therapy from the inside: Enhancing therapist skills through practicing what we preach. *Behavioural and Cognitive Psychotherapy, 31*, 145–163. DOI:10.1017/s1352465803002029.

Bennett-Levy, J., & Lee, N. (2014). Self-practice and self-reflection in cognitive behaviour therapy training: What factors influence trainees' engagement and experience of benefit? *Behavioural and Cognitive Psychotherapy, 42*, 48–64. DOI:10.1017/S1352465812000781.

Bennett-Levy, J., Thwaites, R., Chaddock, A., & Davis, M. (2009). Reflective practice in cognitive behavioural therapy. In Stedmon, J., & Dallos, R. (Ed.), *Reflective practice in psychotherapy and counselling* (ed. pp. 115–135). Maidenhead: Open University Press.

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

Bernard, J., & Goodyear, R. (2004). *Fundamentals of clinical supervision* (3rd ed.). Boston, MA: Allyn & Bacon.

Bilodeau, C., Savard, R., & Lecomte, C. (2010). Examining supervisor and supervisee agreement on alliance: Is shame a factor? *Canadian Journal of Counselling and Psychotherapy, 44*, 272–282.

Bilodeau, C., Savard, R., & Lecomte, C. (2012). Trainee shame-proneness and the supervisory process. *The Journal of Counselor Preparation and Supervision*, *4*, 37–49. DOI:10.7729/41.0020.

Bordin, E. (1994). Theory and research on the therapeutic working alliance: New directions. In Horvath, A., & Greenberg, L. (Ed.), *The working alliance: Theory, research and practice* (ed. pp. 13–37). New York: Wiley.

Bowlby, J. (1973). *Attachment and loss, Vol. 2: Separation*. New York: Basic Books.

Bowlby, J. (1988). *A secure base: Parent–child attachment and healthy human development*. New York: Basic Books.

Carroll, M. (2007). One more time: What is supervision? *Psychotherapy in Australia*, *13*, 34–37.

Casement, P. (1985). *On learning from the patient*. London: Tavistock.

Casement, P. (1990). *Further learning from the patient: The analytic space and process*. London: Tavistock.

Chao, Y., Cheng, Y., & Chiou, W. (2011). The psychological consequence of experiencing shame: Self-sufficiency and mood-repair. *Motivation and Emotion*, *35*, 201–210. DOI:10.1007/s11031-011-9208-y.

Covert, M., Tangney, J., Maddux, J., & Heleno, N. (2003). Shame-proneness, guilt-proneness, and interpersonal problem solving: A social cognitive analysis. *Journal of Social and Clinical Psychology, 22*, 1–12. DOI:10.1521/jscp.22.1.1.22765.

Davis, D. M., & Hayes, J. A. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy, 48*, 198–208.

Ethics Committee of the British Psychological Society (2009). *Code of ethics and conduct*. Leicester: The British Psychological Society.

Gilbert, M., & Evans, K. (2000). *Psychotherapy supervision: An integrative rational approach to psychotherapy supervision*. Buckingham: Open University Press.

Gilbert, P. (1989). *Human nature and suffering*. Hove: Lawrence Erlbaum Associates.

Gilbert, P. (2000). The relationship of shame, social anxiety and depression: The role of the evaluation of social rank. *Clinical Psychology and Psychotherapy, 7*, 174–189. DOI:10.1002/1099-0879(200007)7:3<174::aid-cpp236>3.0.co;2-u.

Gilbert, P. (2005a). Compassion and cruelty: A biopsychosocial approach. In Gilbert, P. (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (ed. pp. 9–74). London: Routledge.

Gilbert, P. (2005b). Social mentalities: A biopsychosocial and evolutionary reflection on social relationships. In Baldwin, M. W. (Ed.), *Interpersonal cognition* (ed. pp. 299–335). New York: Guilford.

Gilbert, P. (2009). *The compassionate mind*. London: Constable Robinson.

Gilbert, P. (2010). *Compassion-focused therapy: Distinctive features*. London: Routledge.

Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory, 12*, 507–516. DOI:10.1080/09658210444000115.

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In Gilbert, P. (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (ed. pp. 263–325). London: Routledge.

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice-Hall.

Krieger, T., Altenstein, D., Baettig, I., Doerig, N., & Holtforth, M. (2013). Self-compassion in depression: Associations with depressive symptoms, rumination, and avoidance in depressed outpatients. *Behavior Therapy, 44*, 501–513. DOI:10.1016/j.beth.2013.04.004.

Ladany, N., Hill, C., Corbett, M., & Nut, E. (1996). Nature, extent and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*, 10–24. DOI:10.1037/0022-0167.43.1.10.

Ladany, N., Klinger, R., & Kulp, L. (2011). Therapist shame: Implications for therapy and supervision. In Dearing, R., & Tangney, J. (Ed.), *Shame in the therapy hour* (ed. pp. 307–322). Washington, DC: American Psychological Association.

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In Thompson, A., & Harper, D. (Ed.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (ed. pp. 99–116). Oxford: John Wiley.

Leary, M. R., Tate, E. B., Adams, C. E., Batts, A. A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly.

Journal of Personality and Social Psychology, 92, 887–904. DOI:10.1037/0022-3514.92.5.887.

Leaviss, J., & Uttley, L. (2014). Psychotherapeutic benefits of compassion-focused therapy: An early systematic review. *Psychological Medicine, 45*, 1–19. DOI:10.1017/s0033291714002141.

Lee, D. A. (2005). The perfect nurturer: A model to develop compassionate mind within the context of cognitive therapy. In Gilbert, P. (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (ed. pp. 236–251). Hove: Routledge.

Lee, D. A. (2012). *The compassionate mind approach to recovering from trauma using compassion focused therapy.* London: Constable & Robinson.

Lucock, M. P., Hall, P., & Noble, R. (2006). A survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. *Clinical Psychology & Psychotherapy, 13*, 123–130. DOI:10.1002/cpp.483.

Lutwack, N., Panish, J., & Ferrari, J. R. (2003). Shame and guilt: Characterological vs. behavioral self-blame and their relationship to fear of intimacy. *Personality and Individual Difference*, *35*, 909–916. DOI:10.1016/s0191-8869(02)00307-0.

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

Martin, M. M., Staggers, S. M., & Anderson, C. M. (2011). The relationships between cognitive flexibility with dogmatism, intellectual flexibility, preference for consistency, and self-compassion. *Communication Research Reports*, *28*, 275–280. DOI:10.1080/08824096.2011.587555.

Mascaro, J. S., Rilling, J. K., Negi, L. T., & Raison, C. L. (2013). Pre-existing brain function predicts subsequent practice of mindfulness and compassion meditation. *NeuroImage*, *69*, 35–42. DOI:10.1016/j.neuroimage.2012.12.021.

McCown, D., Reibel, D., & Micozzi, M. S. (2011). *Teaching mindfulness. A practical guide for clinicians and educators*. New York, NY: Springer.

McLean, S., Wade, T. D., & Encel, J. S. (2003). The contribution of therapist beliefs to psychological distress in therapists: An investigation of vicarious traumatization, burnout and symptoms of avoidance and intrusion. *Behavioural and Cognitive Psychotherapy, 31*, 417–428. DOI:10.1017/s135246580300403x.

Milne, D. (2007). An empirical definition of clinical supervision. *British Journal of Clinical Psychology, 46*, 437–447. DOI:10.1348/014466507x197415.

Milne, D., Aylott, H., Fitzpatrick, H., & Ellis, M. V. (2008). How does clinical supervision work? Using a "best evidence synthesis" approach to construct a basic model of supervision. *The Clinical Supervisor, 27*, 170–190. DOI:10.1080/07325220802487915.

Pauley, G., & McPherson, S. (2010). The experience and meaning of compassion and self-compassion for individuals with depression and anxiety. *Psychology and Psychotherapy, 83*, 129–143. DOI:10.1348/147608309x471000.

Pietromonaco, P. R., & Barrett, L. F. (2000). Internal working models: What do we really know about the self in relation to others? *Review of General Psychology, 4*, 155–175. DOI:10.1037//1089-2680.4.2.155.

Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. New York: WW Norton.

Pretorius, W. M. (2006). Cognitive behavioural therapy supervision: Recommended practice. *Behavioural and Cognitive Psychotherapy, 34*, 413–420. DOI:10.1017/s1352465806002876.

Raes, F. (2010). Ruminating and worrying as mediators of the relationship between self- compassion and anxiety and depression. *Personality and Individual Differences*, *48*, 757–761. DOI:10.1016/j.paid.2010.01.023.

Rector, N. A., Bagby, R. M., Segal, Z. V., Joffe, R. T., & Levitt, A. (2000). Self-criticism and dependency in depressed patients treated with cognitive therapy or pharmacotherapy. *Cognitive Therapy and Research*, *24*, 571–584. DOI:10.1023/a:1005566112869.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, *18*, 20–23.

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

Samaie, G., & Farahani, H. A. (2011). Self-compassion as a moderator of the relationship between rumination, self-reflection and stress. *Procedia—Social and Behavioral Sciences*, *30*, 978–982. DOI:10.1016/j.sbspro.2011.10.190.

Smith, J. (1995). Semi-structured interviewing and qualitative analysis. In Smith, J., Harré, R., & Langenhove, L. (Ed.), *Rethinking methods in psychology* (ed. pp. 10–27). London: SAGE Publications Ltd..

Smith, J. A., & Osborne, M. (2003). Interpretative phenomenological analysis. In Smith, J. A. (Ed.), *Qualitative psychology: A practical guide to research methods* (ed. pp. 51–80). New York: Guilford.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Watkins, C. E., & Milne, D. L. (2014). *The Wiley international handbook of clinical supervision*. Chichester: Wiley & Sons, Ltd..

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients: A systematic review of the literature. *Counselling and Psychotherapy Research*, *7*, 54–65. DOI:10.1080/14733140601185274.

Winnicott, D. (1965). *The maturational processes and the facilitating environment*. London: Hogarth Press.

Winnicott, D. (1971). *Playing and reality.* London: Tavistock.

Yourman, D. B., & Farber, B. A. (1996). Nondisclosure and distortion in psychotherapy supervision. *Psychotherapy, 33*, 567–575. DOI:10.1037/0033-3204.33.4.567.

Zabelina, D. L., & Robinson, M. D. (2010). Creativity as flexible cognitive control. *Psychology of Aesthetics, Creativity, and the Arts*, *4*, 136–143. DOI:10.1037/a0017379.

