

THERAPISTS IN TRAINING: BRIEF INTERVENTIONS TO EASE NEGATIVE SELF-
EVALUATIONS AND IMPROVE AFFECTIVE WELL-BEING

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Abstract

Clinical and counselling psychology trainees take on many different roles throughout the course of their graduate training, including intensive course loads, research, and clinical training. Previous research has identified significant distress and psychological symptoms reported by graduate students in clinical training. Also documented are complex barriers to receiving help for their mental health concerns. The aim of the current study was to better understand the experiences of graduate therapist trainees by tracking them over time to investigate the psychological difficulties they experience, and to examine the efficacy of brief online exercises designed to combat self-criticism and induce self-compassion. 254 clinical and counselling psychology trainees were recruited from 50 graduate programs across Canada and the United States. Participants completed baseline measures assessing self-compassion, self-criticism, positive, negative, and compassionate affect, depression, anxiety, dysfunctional attitudes, fear of negative evaluation, stress, and professional self-doubt. Participants were randomly assigned to one of three groups, a “working with self-criticism” condition, a “loving kindness meditation” condition, or a waitlist control condition. Following the baseline measures, trainees completed the online interventions for eight weeks, then completed measures at post-test and a one-month follow-up. Results indicated that the therapist trainees experienced moderate to severe levels of distress on most psychological outcome measures at baseline. However, it was found that the two active conditions were effective in reducing self-criticism and fear of negative evaluation, while increasing compassionate affect compared to the control condition. The results support the value of self-care and reflective practices among clinical and counselling trainees. Clinical implications and future directions are discussed.

Keywords: self-criticism, self-compassion, training therapist, graduate students, brief intervention

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Therapists in training: Brief interventions to ease negative self-evaluations and improve affective well-being

Graduate school across disciplines represents a particularly stressful stage of academic and career development. A large survey study from Evans et al. (2018) found that graduate students across all disciplines experienced nearly 10 times the rates of anxiety and six times the rate of depression compared to the general population. Hyun and colleagues (2006) also found that over 50% of graduate students report significant distress relating to depression, anxiety, and other emotional disturbances in relation to their graduate work. Within psychology, graduate students in clinical or counselling programs face additional, unique challenges throughout their training including heavy course loads, clinical practicums, supervision, research, and various other program demands that often exceed that of other graduate programs (Beaumont & Hollins-Martin, 2016; Hobacia et al., 2021). Graduate therapists may be particularly susceptible to higher levels of stress, anxiety, and emotional distress, which indicate a higher need for mental health services (Woolston 2019). A study by Beaumont et al. (2017) looking at therapist mental health mention the physical and psychological challenges of therapist training and assert that self-care has been shown to improve some of the additional burdens that this group of graduate students may face. Other studies (e.g., Kaeding et al., 2017; Rummell, 2015) support this and highlight how self-care strategies would seem particularly valuable and appropriate for this population of training therapists. Self-care is defined by Myers et al. (2012) as “engagement in behaviours that maintain and promote physical and emotional well-being” (p. 56). They mention strategies such as focusing on sleep, exercise, social support, mindfulness practice, and emotion regulation practices. It has been said that the importance of self-care extends beyond graduate students and becomes an ethical necessity for all mental health practitioners (Barnett et al., 2007). Marazan et

al. (2018) describes how the preventative benefits of self-care fall under the Canadian Code of Ethics under Responsible Caring, as certain aspects of psychotherapist well-being have been shown to impact the psychotherapy process (Pope & Vasquez, 2007; Theriault et al., 2009). Focus on self-care and well-being may be particularly important during the formative years of psychotherapy training. Generally, practicing self-care has been shown to enhance psychological and physical health and improve well-being (Myers et al., 2012; Williams-Nickelson, 2001) and has been linked to empathy and improved symptoms of anxiety and depression (Schure et al., 2008).

With these factors in mind, the aim of this project is to better understand the experiences of graduate therapist trainees by assessing different domains of mental health and well-being including self-criticism, depression, and positive affect. Their experiences relating to the new role of becoming a therapist will be examined following their weekly therapy sessions and the effects of Online Positive Psychology Interventions designed to reduce self-criticism and increase self-compassion will be tested over time. Previous studies (Mongrain et al., 2018; Shapira & Mongrain, 2010) have shown the efficacy of positive psychology exercises in large community samples, however, to my knowledge, no research has utilized a self-criticism and self-compassion exercise in this group of graduate therapist trainees.

Mental Health of the Training Therapist

The experiences of graduate students, and in particular, the unique challenges faced by students in clinical or counselling psychology programs, has received limited attention in the literature, particularly in Canada (Laveridere et al., 2018). Ayala et al. (2017) note the rigorous training demands of clinical psychology programs. In addition to focusing on developing all the required competencies to provide psychological services, these services expose students to

emotionally challenging clinical cases that graduate trainees in other fields do not face. For example, students at every level of clinical training may encounter clients presenting with suicidal thoughts, self-harming behaviours, complex trauma histories, and often have to navigate ethical or safety issues (De Stefano et al., 2012). The mental health profiles of clinical and counselling psychology students reflect these challenges, and often exceed the already inflated difficulties experienced by graduate students across disciplines (Beaumont & Martin, 2016; Hobacia et al., 2021).

In addition to facing complex clinical issues in therapy, students in clinical psychology programs are closely monitored by supervisors and professors, with their progress evaluated across many areas at many time points. They are faced with feedback (or criticism) that they must receive openly and integrate effectively into their practice (Bernard & Goodyear, 2009), and they must balance complex relationships with supervisors, professors, clinical staff, and clients. They also wear many hats that must be managed with care, such as fulfilling the role of student, researcher, therapist, teaching assistant, and mentor (Myers et al, 2012; Pakenham & Stafford-Brown, 2012). The impact of these varying demands is reflective in the mental health profiles of clinical and counselling psychology trainees.

Interestingly, from clinical trainees to licensed psychologists, the practice of psychotherapy itself may be accompanied with significant stress and risk for mental health problems. A review of the research from Smith and Moss (2009) found that 50% of practicing psychologists (not students) reported clinically significant levels of depression. Tay et al. (2018) found that two-thirds of practicing clinical psychologists had experienced mental health problems themselves. In line with this, Laveridere et al. (2018) conducted a survey of 240 clinical psychologists and found that over 50% reported being emotionally exhausted, with 20%

of those clinicians suffering from clinically significant psychological distress and multiple symptoms of psychopathology. The authors also found that years of experience played a protective role, with junior clinicians being at greater risk.

As part of the APA Advisory Committee on Colleague Assistance, El-Ghoroury et al. (2012) conducted a large survey of the mental health of psychology graduate students (with 68% of the sample being from clinical or counselling programs) and found that nearly 70% felt stressed with their academic work, 64% reported difficulties with their finances, with 60% experiencing anxiety, poor work life balance (58%) and nearly 40% reporting burnout and compassion fatigue. Over a third of the sample also reported being depressed and suffering from physical health concerns. A study by Hobaica et al. (2021) looking specifically at clinical psychology students found that nearly 25% reported moderate to severe levels of anxiety, and 20% of the sample reported moderate to severe levels of depression and suicidal ideation. These rates of depression and suicidal ideation are similar to other studies of clinical and counselling psychology students (e.g., 23.4% found in Rummell, 2015). Over 10% of the students reported high risk of alcohol abuse and moderate to severe drug use during the graduate program. In addition, the rates of non-suicidal self-injury, plans to attempt suicide, and suicide attempts during their clinical program exceeds rates seen in other graduate programs and the general population (Borges et al., 2010; Garcia-Williams et al., 2014). While one may expect an increased level of anxiety or stress in arduous graduate programs, these studies highlight the severity of symptoms experienced by this population and reinforce the need to examine not only what can be done to help students facing these challenges, but to reflect on how programs are structured as well.

In line with this, Rummell (2015) investigated clinical and counselling psychology graduate student workload, health (physical and mental) and program satisfaction. This study found that the students reported spending nearly 55 hours per week engaging in program related activities. This included class, assignments, clinical work, seeing clients, and attending supervision. 60% of students across all years of the program reported that the graduate program was the most significant form of stress in their lives, followed by their finances. Further, there was a significant positive relationship found between hours worked and levels of anxiety and physical symptoms. With respect to the overall health of the clinical and counselling students, 50% of the sample reported weekly physical symptoms including headaches, backpain, fatigue, and irritable bowel symptoms. The author notes that these are over double the prevalence rates from the general population. With respect to psychological symptoms, nearly 35% of the sample reported clinically significant symptoms of anxiety and depression. These rates are again considerably higher than in the general population, and even higher than that of medical students (Dahlin et al., 2005).

While there has been some comparison on levels of distress across programs and disciplines, a recent study by Victor et al. (2022) looked at differences in both diagnosed, and undiagnosed mental health difficulties in clinical graduate students, post-docs, and clinical faculty. They found that clinical graduate students accounted for the most diagnosed and undiagnosed mental disorders, making up over 36% of the sample. Of these diagnosed disorders, generalized anxiety disorder was most common in graduate students reflecting numerous and consistent worries and anxieties. Other studies (e.g., Rummell, 2015) suggest that clinical trainees and psychologists of all levels would likely benefit from interventions addressing these mental health concerns. In fact, one of the main changes graduate students wished to see from

their programs was increased recognition and importance placed on student self-care and support from faculty in these areas (Rummell, 2015).

In line with this, Pakenham and Stafford-Brown (2012) suggest that beyond incorporating self-care strategies into graduate programs, modifications should be made to the structure of clinical programs themselves to reduce the distress of trainees. These recommendations came following their study finding that high levels of stress in clinical trainees was linked to low self-esteem, anxiety, depression, and substance use. Relevant to the current study, the authors also note that at the time of their article, there had been no published intervention studies aimed at reducing clinical psychology trainee stress levels.

In reviewing the literature, it is clear that clinical and counselling psychology trainees manage workloads, clinical situations, and complex relationships (e.g., therapy patients, clinical supervisors) that differ from, and often exceed, other graduate programs, and may negatively impact well-being. Despite these programs being based on understanding and helping those suffering from mental health difficulties, accessing these services as trainees is more difficult than one may think.

Barriers to Support

While it is clear that the mental health concerns of clinical trainees *should* be addressed, therein lies another common issue: the perceived, and very real barriers to seeking mental health support as a clinical or counselling graduate student. A recent study by Klein et al. (2023) investigated the barriers that clinical psychology graduate students may face when seeking mental health treatment. Over 50% of the students surveyed reported not receiving or knowing where to turn for information about mental health treatment. They also found that 56% of students stated that seeking out care would have to be self-initiated, compared to 10% who

reported that help was offered through faculty or supervisors in their program. One of the largest barriers reported was that treatment options would not be affordable to them, even if other barriers did not exist. When asked what could assist in gaining access to treatment, students reported that program provided resources/support would be the most helpful (56%), with financial assistance and more affordable options being endorsed by 48% of the sample, and 20% stating that destigmatizing help seeking by the program would increase their willingness to seek treatment.

Several other studies report similar barriers among clinical and counselling psychology students. Hobaica et al. (2021) noted that while 82% of the clinical graduate students in their sample wanted to see a mental health professional, less than half felt able to access these services. Barriers to receiving care included having conflicts of interest within their own university counselling centers (e.g., knowing the therapists or faculty working there), two-thirds reported financial barriers, and nearly 75% reported that they do not have time given program demands. Similar to Klein et al. (2023), nearly 25% of this sample stated that possible stigma was a barrier to accessing care.

These barriers appear relevant to clinical psychologists at different levels of their training and career as well. A study from the United Kingdom found that working psychologists (non-students) reported fears of external and self-stigma (e.g., being the “patient” rather than the therapist) contributed to not seeking out mental health care. This is concerning given that two-thirds of the sample reported life-time experiences of mental health difficulties (over 20% higher than the general population). In addition, even established professional clinical psychologists had concerns about negative consequences for themselves and their career if they were to seek help for their mental health problems (Tay et al., 2018).

The aversion to help seeking seen in practicing therapists is observed at much higher rates in the student population. While one may imagine being a mental health professional would foster empathy and understanding for those suffering with mental health difficulties, Servais and Saunders (2007) found that American clinical psychologists had negative views towards those with mental health disorders, rating them as more ineffective, dangerous, unworthy, and undesirable than themselves. For students, Appleby and Appleby (2006) interviewed graduate admissions committees who stated that the disclosure of mental health difficulties by students in their psychology graduate program applications was a “kiss of death.” Even now, nearly 20 years later, is it often advised to omit any mental health related struggles in graduate school applications (Devendorf, 2022). These attitudes likely contribute to the statistics that approximately 80% of clinical psychology graduate students endorse some kind of mental health related distress, but less than 20% are currently in therapy (Rummell, 2015).

The above studies outline the troubling mental health profiles of clinical and counselling graduate students, which persist as their careers develop beyond graduate school. In addition to experiencing psychological distress, they face barriers in receiving support for various reasons. To better support these clinical trainees, potential vulnerabilities to psychological symptoms such as depression and anxiety may need to be addressed. A construct with a long history in the literature on vulnerabilities to depression, anxiety, and other mental health difficulties is self-criticism (Blatt et al., 1995; Blatt et al., 1998; Mongrain & Leather, 2006; Shahar, 2015; Zuroff et al., 2004). Upon searching PsycINFO, Google Scholar, and other popular research domains, self-criticism specifically appears to be even further understudied in the clinical and counselling graduate student population.

Self-Criticism

In object relations theory, the self-critical individual is described as one who tends to set very high, often unachievable standards for themselves and display a harsh and unforgiving self-evaluative style in the face of real or perceived failure. These individuals often strive for perfection, are highly competitive, and place high demands on themselves. Despite considerable achievements, it is never “good enough.” Self-scrutiny and the failure to live up to these high standards leads such individuals to feel unworthy, inferior, shameful, or guilty (Blatt, et al., 1976; Blatt & Zuroff, 1992).

Shahar (2015) writes that self-criticism is marked by an intense and persistent relationship with the self, characterized by high performance standards accompanied by hostility and derogation toward the self. The psychologically detrimental aspects of self-criticism involve self-directed hostility and “self-slamming” for the having made a mistake or having “failed.” This personality style is a vulnerability marker for depression as well as other types of psychopathologies (Blatt, et al., 1976; Gilbert & Proctor, 2006; Mongrain & Leather, 2006; Shahar, 2015; Zuroff et al., 2004). Self-criticism has implications for functioning in a wide variety of domains and may put individuals at risk for disturbed relationships (see Zuroff et al., 2005) and negative life events (Mongrain & Zuroff, 1994). Not surprisingly, self-criticism is associated with increased lifetime risk for depression (Gilbert & Irons, 2005; Joeng & Turner, 2015; Zuroff et al., 2005). This increased risk to depression seen in community populations is even higher among graduate students, and students who are more self-critical and have high expectations for themselves and their academic achievement are more likely to suffer from major depression (Mongrain & Leather, 2008).

As one may expect from the previous section of this paper, self-criticism also appears to be very present in clinical and counselling psychology graduate students (although there are few

studies which directly address this). A recent study by Richardson et al. (2020) investigated the role of self-critical perfectionism in doctoral clinical psychology trainees and its impacts on depression and levels of burnout. They found that those higher in self-critical perfectionism showed more severe symptoms of depression and reported higher levels of burnout. They note that self-criticism likely exacerbates the unique and challenging process of becoming a therapist. A study by Skovholt and Ronnestad (2003) describes several main domains of stress that novice therapists face including: acute performance anxiety, scrutiny of professional gatekeepers, poor emotional boundaries with clients (e.g., becoming under, or over involved with clients), beliefs about being an incompetent practitioner, having inadequate training, and holding unrealistic expectations (e.g., believing they will help all their clients in some significant way). The authors allude to the fact that as a novice, learners do not have the training, or experience to navigate these complex issues on their own and mention the importance of having positive mentors throughout training to help combat these feelings of incompetence and inadequacy.

A study by Hill et al. (2007) found similar themes in their qualitative study of a doctoral level counselling cohort in their first practicum course. This group of students received six hours of coursework and clinical training per week and completed a journaling exercise for the duration of the semester. In the journaling exercise, they described the challenges they experienced related to becoming psychotherapists. The students reported self-criticism in several areas related to training, such as feeling concerned about their therapeutic skill and performance, their ability to connect with clients, their anxiety about being a psychotherapist, and if they could manage problematic reactions from clients. Some students even reported finding it difficult to focus during therapy sessions due to intrusive self-criticism about how clients perceived them. This is in line with other research on self-criticism in therapists suggesting that it can increase

perfectionism and shame that can have a negative impact on a therapist's ability to connect with patients (Gilbert et al., 2006; Gilbert & Proctor, 2006).

Another qualitative study by Kannan and Levitt (2017) interviewed 14 therapist trainees on their experiences of self-criticism as it relates to their clinical training and therapy experiences. The authors identified several themes or situations that impacted the trainee's level of self-criticism such as feeling responsible for solving all their client's problems, feeling unsure how to direct a session, feeling self-critical or inadequate if clients terminated therapy early, or comparing their performance to that of supervisors. They also describe how self-criticism in psychotherapy trainees can impact various aspects of the therapeutic process, such as being present and attending to the emotions of clients empathetically (Myers, 2007). While the authors did not suggest a causal relationship between self-criticism and poor therapy process, given that therapist factors have been linked to therapy outcomes (Wampold & Imel, 2015), the many challenges presented to the novice therapist along with managing their own self-doubt and self-critic could likely impact therapeutic outcomes (Oliveria & Vandenberghe, 2009). The authors suggested several factors that can buffer against these harsh self-criticisms including flexible supervisory relationships, and reflective practices for students to develop healthier attitudes about their thoughts, feelings, and personal assumptions about their role as a therapist.

The literature has also identified a form of negative, and potentially destructive "self-awareness" which Theriault et al. (2009) described as "feelings of incompetence" related to one's effectiveness as a therapist. Feelings of incompetence have been linked to poor psychotherapy process (Brady et al., 1996) and negative impacts on therapists such as burnout, depression, and low self-esteem. According to Mahoney (1997) doubts about one's effectiveness as a psychotherapist are commonly endorsed across all levels of training and experience.

However, Theriault and colleagues make special mention that while feelings of incompetence are common among training therapists, most psychotherapy programs do not directly address this with their graduate trainees.

Self-criticism has been described differently by different theorists and clinicians. In addition to the direct forms of self-criticism characterized by a harsh “self-slammings” described by Blatt et al. (1976) and Shahar (2015), there are other forms of negative self-evaluation related to self-criticism. These include feelings of incompetency or inadequacy, or the fear of criticism from others that may become internalized over time. Given the different conceptualizations of negative self-beliefs, there are different treatments for self-criticism that exist, and are discussed next.

Reducing Self-Criticism

We know from the literature that graduate students are particularly at risk for depression and other mental health difficulties because of their dysfunctional beliefs. Part of this vulnerability is about “taking blame” or internalizing attributions for setbacks. Once the harsh self-criticism and self-blame is targeted, one would expect a reduction in vulnerability to dysphoric affect (Mongrain & Blackburn, 2005). While self-criticism has been previously identified in training therapists (Hill et al., 2007; Kannan & Levitt, 2017; Skovholt & Ronnestad, 2003), little has been offered on how to directly intervene and improve self-criticism among clinical and counselling psychology trainees. This is surprising given the acknowledgement of how self-criticism can impact mental health and clinical outcomes in psychotherapy (Kannan & Levitt, 2017).

Traditional psychotherapies have often focused on self-criticism given its prominence in psychopathology. Cognitive Behaviour Therapy (CBT) is a therapeutic approach that, in part,

focuses on restructuring maladaptive thoughts and beliefs. A study by Hawley et al. (2014) described self-critical perfectionism as a particular vulnerability to psychopathology, reiterating the frequent, harsh self-evaluation, the inordinate preoccupation with achievement, and fear of negative appraisal (Zuroff et al., 2004). Hawley and colleagues note that CBT is generally an effective treatment for disorders such as depression but found that those high in self-critical perfectionism experienced high stress reactivity (which can contribute to depression relapse) and note the importance of addressing self-criticism specifically in treatment. There are even self-help CBT workbooks that have entire sections on combating self-criticism through a variety of exercises such as identifying self-critical and perfectionistic thoughts, and methods to work with these core beliefs (Martin, 2019).

Similarly, a review by Kannan and Levitt (2013) looked at the theoretical and empirical understanding of how self-criticism presents in psychotherapy and offers several therapeutic approaches that have proven effective in working with self-criticism in client populations. The authors mention the role of self-criticism as a vulnerability to psychopathology, and how it can negatively impact the therapeutic alliance. In the review of effective treatment options for self-criticism, they describe cognitive approaches that focus on modifying maladaptive schemas via cognitive restructuring (e.g., challenging negative, self-critical thoughts to foster more realistic self-evaluations) and through reattribution to reduce undue self-blame.

Another common therapeutic approach for working with self-criticism is Emotion Focused Therapy (EFT; Greenberg, 2004). A study by Shahar et al. (2012) investigated the efficacy of a “two-chair dialogue” (a common intervention for self-criticism in EFT) across 10 clients who had their sessions video recorded. The sessions were then coded for the two-chair dialogue to ensure the interventions were done appropriately. They found that having clients

directly address their self-critical voice in session led to decreases in self-criticism on several measures such as the Depressive Experiences Questionnaires Self-Critical Subscale (Blatt et al., 1976) and the Forms of Self-Criticizing and Self-Reassuring scales (Gilbert et al., 2004), and several other measures of mental health difficulties such as the Beck Anxiety Inventory (Beck et al., 1988). Effect sizes were large on all measures, ranging from 0.22 to 0.45. Clients also maintained these gains at a six-month follow up period.

Self-criticism interventions have been studied and implemented for many years in client populations, yet there are very few intervention studies investigating how to reduce self-criticism in clinical and counselling trainees specifically. Addressing issues of mental health and self-criticism in clinical and counselling psychology students may still be considered “taboo” or at least has not been actively addressed in most graduate training programs. However, some studies have tested interventions for these difficulties. A study by Shapiro et al. (2007) found that therapists in training had high levels of anxiety, stress, and self-criticism, and utilized a rather intensive mindfulness-based stress reduction program to aid students in alleviating these difficulties. They found that training therapists showed lower levels of stress, anxiety, and self-criticism post intervention. While this was effective in lowering trainee distress, this intervention was time consuming (three hours per week for eight weeks) and therefore may not be realistically implementable into a clinical training program. Given that graduate students already face schedules that are very demanding of their time and energy (Rummell, 2015), they may require briefer, ongoing support throughout training.

To our knowledge, few studies have investigated the effects of brief interventions directly targeting self-criticism. Given the difficulties that novice therapists face with things like depression, anxiety, stress, feelings of incompetence, fear of negative evaluation, and other

negative self-judgements, investigating the effectiveness of interventions targeting self-criticism directly is an important gap in the literature deserving of further investigation. The current study utilized a “working with self-criticism” exercise that had clinical and counselling trainees reflect on self-critical thoughts they had during the week relating to their role as a therapist and were given a series of prompts to challenge and reframe their self-critical thoughts and beliefs.

In addition to interventions targeting self-criticism directly, the current study wanted to investigate ways of fostering *positive* feelings in this population. Recent research (Beaumont et al., 2016; Wakelin et al., 2022) has also suggested that self-compassion alone may be effective in reducing self-criticism. Therefore, we also wanted to investigate if a self-compassion intervention may be an alternative way of reducing self-criticism in clinical trainees. The ability to be self-compassionate may be an important skill when engaging in self-care and represents another way to counteract the stress faced by clinical trainees. The literature on self-compassion has gained momentum in the last 20 years particularly within clinical settings. This literature is reviewed next.

Self-Compassion

The concept of self-compassion has been long present in many Eastern literatures but emerged only recently as a discrete research topic in Western empirical psychology. Neff (2003a) is credited with the initial operationalized definition and “empirical” understanding of self-compassion. In her original 2003a article, Neff drew from Buddhist teachings on the more traditional definition of compassion, and adapted this definition to fit self-compassion, stating it “involves being touched by and open to one’s own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one’s suffering and to heal oneself with kindness” (p. 87). Her definition also includes viewing your own experiences of pain and suffering without

judgement, and as part of the human condition. Since its introduction into the literature, self-compassion has gained considerable attention from both researchers and clinicians alike.

Self-compassion has been linked to various health benefits and psychological well-being including higher levels of happiness, optimism, motivation and achievement, coping skills, and emotional intelligence (Neff, 2003a; Neff et al., 2005; Neff et al., 2007; Neff et al., 2018). This construct has gained empirical support as an important buffer against anxiety, depression, and many other mental health issues (Korner et al., 2015). Paul Gilbert (2009), in a paper on Compassion Focused Therapy, describes the neuroscience, the evolutionary, and developmental processes involved in self-compassion. He describes three affect regulation systems (drive, threat, and safety/contentment) which influence our feelings of emotional well-being. Gilbert likened the safety and contentment system to self-compassion and provides support that through compassionate mind training, an individual can learn to activate this system and obtain increased physical and psychological health. López et al. (2015) highlighted the importance of self-compassion in therapeutic interventions and assumed it to be vital for lasting improvement. A study by Segal et al. (2002) showed that, when using mindfulness based cognitive therapies, cultivating acceptance and compassion for the self may disrupt maladaptive associative networks and reduce the risk of relapse in those with at least two prior episodes of depression.

While self-compassion has been well researched now for its general benefits across community populations (Bluth & Neff, 2018; Neff, 2003b) and patients in therapy (e.g., Gilbert, 2009), its benefits for clinical and counselling psychology trainees has rarely been examined. A recent and comprehensive systematic review by Crego et al. (2022) on the benefits of self-compassion for training therapists note that little research has been done on the topic. Of the 24 articles reviewed in their study, only four of the articles used an experimental or quasi-

experimental design aiming to foster self-compassion, with the remaining articles being cross-sectional or qualitative in nature. The authors go so far to note that self-compassion and self-care “seems forgotten among therapists” (pg. 2) and describe how this was unexpected given the known benefits of self-compassion along with the difficult professional environments that training therapists face.

While few intervention studies have been done with training therapists, higher baseline levels of self-compassion among both professional and training psychologists have been associated with increased feelings of happiness, lower levels of stress, and improved emotion regulation (Finlay-Jones et al., 2017). Newsome et al. (2012) state that self-compassion is fundamental in the helping profession, and that increasing self-compassion has psychological benefits including positive affect and contentment at work (Neff et al., 2007). They also note that self-compassion is linked with more empathy and better performance therapeutically (Daniels & Larson, 2001). Raab (2014) in a review on the benefits of self-compassion in healthcare workers notes that for therapists, compassion is an essential part of the job, and that it is also fundamental in the development of healthy self-care among therapists. When one can have more self-compassion, they are then better able to show this towards the individuals they care for (Hefferman et al, 2010). In a study of clinical psychology doctoral trainees, Latorre et al. (2021) reported positive relationships between self-compassion and trainee self-efficacy and feelings of competency. Other studies have found that self-compassion is associated with greater therapeutic presence (Bourgault & Dionne, 2019) and that clinical trainees who have difficulty experiencing self-compassion have greater difficulty in connecting with others (Coaston & Lawrence, 2019).

Not only does self-compassion offer these aforementioned benefits for training therapists, but it also acts as a buffer against the negative effects that come with intensive clinical training

(Richardson et al., 2020), along with burnout and compassion fatigue (Beaumont et al., 2016; Beaumont et al., 2017; Coaston & Lawrence, 2019; Kaeding et al., 2017; O'Brien & Haaga, 2015). Similar findings indicate that self-compassion is also correlated with lower anxiety (Neff, 2003b; Neff et al., 2007), lower self-criticism (Gilbert & Proctor, 2006) and overall psychological resilience (Neff & McGehee, 2010), all of which are particularly relevant to the training therapist.

Given the benefits and protective factors of self-compassion, there has been a call throughout the literature to make self-care (and in some studies, self-compassion specifically) a mandatory part of clinical training programs (e.g., Coaston & Lawrence, 2019). One way of integrating self-care into clinical and counselling psychology programs is by introducing brief exercises in the form of self-help that can combat self-criticism and foster self-compassion.

Fostering Self-Compassion

One of the main methods used to foster self-compassion in therapy patients is Compassionate Mind training (CMT; Gilbert & Proctor, 2006). Gilbert and his team found that patients at a cognitive-behavioural-based day centre for those with chronic difficulties that engaged in 12 sessions of CMT showed reductions in depression, anxiety, self-criticism, shame, inferiority, and submissive behaviour, while also showing increased abilities to self-soothe and focus on feelings of warmth and self-assurance. Additionally, CMT has proved effective in dealing with trauma-related symptoms and was found to both reduce symptoms and increase self-compassion scores when used in conjunction with cognitive behavioural therapies (Beaumont et al., 2012). A study by Beaumont et al. (2017) used CMT with a group of post-graduate students who obtained a diploma in Cognitive Behavioural Psychotherapy. Participants took part in a three-day CMT training alongside their CBT program. There were some

limitations with this study, such as having a relatively small sample (N=21) and no control group. However, the authors reported significant increases in self-compassion, along with lowered levels of self-judgement in students by the end of the CMT program.

While CMT is effective in some populations, it was developed as a clinical treatment and is thus quite intensive (e.g., 12 one-hour sessions in individual therapy). Given the time intensive nature of these programs and additional cost barriers, they may not be ideally suited and accessible to clinical and counselling psychology graduate students (Klein et al., 2023). The current study looked for more effective ways of inducing positive changes for the well-being of clinical and counselling trainees. One type of intervention that offers brief, effective, and easy to access exercises is Online Positive Psychology Interventions (OPPI; Sergeant & Mongrain, 2015).

With the rise of the positive psychology movement (Seligman et al., 2006) there has been a focus on introducing interventions that aim to foster more adaptive thinking and constructive habits including self-compassion. Delivered online over a one-week period, Shapira and Mongrain (2010) demonstrated the effectiveness of a writing exercise involving the practice of self-compassion. When compared to control participants who wrote about an early memory, they found that the self-compassion exercise led to improvements in mood up to six-months post intervention. In a similar study, Sergeant and Mongrain (2015) found that OPPIs (including an exercise meant to foster self-compassion) were effective in increasing subjective well-being, particularly in participants who reported greater levels of distress at baseline. In line with this, Sergeant and Mongrain (2011) found that those highest in self-criticism reported the greatest increases in happiness following OPPIs. While these studies delivered OPPIs to large community

samples, this is relevant to the current study given the high levels of distress that clinical and counselling graduate students report.

One intervention effective in cultivating self-compassion is Loving Kindness Meditation (LKM). LKM is an exercise where one conjures and directs compassionate thoughts and feelings towards oneself and others. This meditative exercise has been shown to increase positive emotions (Raab, 2014), as well as compassion for others and oneself (Weibel, 2007). An LKM RCT conducted by Fredrickson et al. (2008) with a community population (N=139) had participants take part in six, one-hour LKM sessions. The follow-up results over the next nine weeks indicated increased positive emotions and personal well-being for those in the LKM condition compared to controls. While LKM has primarily been used in community populations, there have been some studies with training therapists and healthcare professionals that have shown promise.

A study by Boellinghaus et al. (2013) explored the effects of LKM on a small group (N=12) of training therapists who completed six, one-hour LKM sessions over eight weeks. They found that therapists reported greater self-awareness, compassion for self and others, and increased therapeutic presence and skill. A subsequent review paper by Boellinghaus et al. (2014) further investigated the effects of different mindfulness-based interventions and the use of LKM as ways of cultivating self-compassion in healthcare professionals. Overall, few studies have investigated the effectiveness of LKM in healthcare professionals (Bibeau et al., 2016; Crego et al., 2022) and even fewer in training therapists. The authors recognized the importance of self-compassion and called for a proper study with randomization and control groups to investigate the effects of inducing self-compassion via online interventions in training therapists.

Given this, the current study also utilized a LKM exercise that had participants cultivate compassion for themselves, for others, and then their clients each week during the eight-week exercise period. While similar to traditional LKM exercises, the instructions were adapted to have a more therapeutic/client focus. A focus on self-care and self-help has become increasingly popular over recent years and is reviewed next.

Self-Help Interventions for Trainees

Given that many interventions for both self-criticism and self-compassion are quite intensive (e.g., MBSR) and or are more suited to clinical settings (e.g., CMT/CFT), they can be time consuming and hard to access. As described earlier, clinical and counselling trainees face many barriers to accessing care, including time, finances, stigma, and concerns of dual relationships (Klein et al., 2023). A book by Norcross and VandenBos (2018) titled *“Leaving it at the office: A guide to psychotherapist self-care”* describes the importance of self-care methods for therapists at all stages. The authors offer many “self-care checklists” and encourage purposeful reflection on various topics such as developing self-empathy, scheduling enjoyable activities, filling out relevant questionnaires to your well-being (e.g., burnout measures), and to search for meaning in your own personal life outside of your role as a therapist. With this population of clinical and counselling trainees, integrating more structured “self-help” focused interventions that are brief and can be self-initiated or integrated into training programs with minimal cost and commitment is an area that needs more attention in the research. While there is some evidence for brief self-help focused interventions and their effectiveness (see Sergeant and Mongrain, 2015), little has been done to target this population of training therapists.

Effectiveness of Existing Self-Help Interventions

While LKM has shown promise as an intervention, there is some research that suggest some individuals struggle to effectively engage in the exercise (Crane et al. 2010). This was found in a study by Mongrain et al. (2018) showing that LKM does not always fare as well as other positive psychology interventions, perhaps in part due to adherence issues with a meditation exercise delivered online. In addition, there is some support that highly self-critical individuals can have negative psychological and physiological responses when trying to foster self-compassion (Longe et al., 2010). Gilbert (2009) stated that individuals with complex feelings about love and care in childhood may feel grief and guilt when fostering self-compassion as adults. While there is support for self-compassion acting as an “antidote” to self-criticism (Korner et al., 2015), there is also evidence to suggest that self-compassion and self-criticism are distinct, and that one must resolve self-criticism before moving into self-compassion (López et al., 2018; Muris et al., 2018).

Given the sparse, and inconclusive evidence on brief interventions for therapists in training, exploring the effectiveness of a novel self-criticism intervention and a self-compassion meditative intervention presented in a more “self-help” format were primary goals of this study.

Current Study

The novice therapist is tasked with easing the suffering of individuals experiencing a range of difficulties and distress levels, all the while dealing with their own performance anxiety. They must remember to manage emotional boundaries with clients and deal with potential feelings of incompetence with the real or imagined expectation that they must “cure” their clients (Skovholt & Ronnestad, 2003). Gale et al. (2017) noted that early therapists often experience high levels of stress when having deep compassion for others while lacking in compassion towards themselves. They argued that the training therapist must have access to ways of not only

showing empathy and care for their clients, but also to foster this within themselves. As mentioned above, the self-criticism and stress coupled with a lack of self-care is a recipe for distress and burnout among novice therapists. Brief positive psychology exercises have shown promise as early interventions (Seligman et al., 2006) in community populations (Sergeant & Mongrain, 2010, 2015; Shapira & Mongrain, 2010), and in some clinical settings (Gilbert & Proctor, 2006). Therefore, applying these interventions designed to increase self-compassion or reduce self-criticism in future psychologists and counsellors is of great importance. Very few studies (Beaumont et al., 2017) have looked at compassion and combatting self-criticism in a novice therapist context. No study to my knowledge has aimed at integrating brief, weekly exercises performed after a therapy session to ease self-judgments and improve self-compassion at this early stage of training.

Studying and attempting to improve the mental health and well-being of those who will go on to provide these services to people in the community is paramount. Given that this area is understudied (Marazan et al., 2018), this research looks to expand the knowledge base by exploring both the type, and severity of difficulties clinical trainees experience in their training by administering a variety of measures known to impact training therapists (e.g., self-criticism, depression, stress), and investigate the efficacy of self-help style OPPIs that are easy, safe, and accessible for busy graduate students. Of the two interventions utilized in the current study, one aimed at increasing self-compassion while the other was specifically designed to dispute self-critical beliefs. Both exercise conditions were matched in terms of attentional demands and time required to complete and were compared to a waitlist control group. Participants were recruited from graduate training programs in clinical and counselling psychology throughout Canada and the United States.

Hypotheses

1. It was predicted that the international sample of clinical and counselling graduate students would endorse clinically significant levels of depression, anxiety, self-criticism, and stress. We also predicted elevated levels for constructs related to therapist distress (e.g., fear of negative evaluation, high levels of professional self-doubt, negative affect).

2. a) The intervention addressing working with self-criticism (WSC) was hypothesized to lead to significantly greater decreases in measures directly related to self-critical beliefs and attitudes, such as self-criticism, fear of negative evaluation, dysfunctional attitudes, and negative affect compared to those in the LKM group, and waitlist control group. These effects were expected to be significant at post-test and at the one-month follow-up.

2. b) The LKM exercise designed to cultivate loving kindness towards the self and others was expected to lead to significantly greater changes in the endorsement of self-compassionate traits, as well as increases in positive and compassionate affect compared to participants in the WSC and waitlist control conditions. These effects were predicted to be significant at post-test and at the one-month follow-up.

3. Third, the previous hypotheses made specific predictions based on exercise condition and outcome, however, we also investigated outcome variables commonly related to issues among psychotherapy trainees but may not be targeted as directly by our interventions. These included professional self-doubt, stress, anxiety, and depression. It was hypothesized that scores on these measures would decrease among those in the active interventions, reflecting improvements in functioning compared to the participants in the waitlist control group. These effects were predicted to be significant at the end of the eight-week intervention period and one month later at follow-up.

4. Lastly, we administered *state measures* of psychological functioning on a weekly basis (“how you feel right now”). This was completed following the administration of the exercises for those in experimental conditions, and on a weekly basis for the waitlist controls. The measures included current fear of negative evaluation, *state* self-compassion, *state* self-criticism, and current positive, negative, and compassionate affect. It was predicted that there would be significant improvement on these measures at the weekly level over the eight-week intervention period for those in the experimental conditions compared to the waitlist controls.

Method

Participants

Two hundred and fifty-four ($N = 254$) participants between the ages of 21 and 62 years ($M=28.4$, $SD=5.17$) were recruited from 50 different clinical psychology/PsyD (81%) and counselling (19%) programs from across Canada and the United States. Of those 254, 216 completed the baseline measures and were randomly assigned into either the control condition ($n = 72$), the self-criticism exercise condition ($n = 72$) or the self-compassion exercise condition ($n = 72$), with 93 (43% retention from baseline) completing the post-test measures, and 82 (38%) completing the one-month follow-up. For the weekly exercises, 136 (63%) participants completed the first exercise week, with 118 (55%) completing week two, 100 (46%) week three, 103 (48%) week four, 87 (40%) week five, 78 (36%) week six, 75 (35%) week seven, and 79 (37%) the eighth and final exercise week. The recruitment occurred in two waves over January and February of 2021. Participants consisted of graduate student psychotherapists from all years of training with at least one client per week. In order to comply with individual university ethics boards, directors of clinical training and university psychology clinic managers were contacted directly and were responsible for circulating the advertisement to their graduate student listserv.

The ad included a brief description of the study indicating that it was investigating the experiences of training therapists and offering tools to help with some of the difficulties they may encounter in this role. 236 schools in total were contacted, 30 from Canada, and 206 from the United States with 50 programs (21%) agreeing to take part in the study.

The initial sample largely identified as female (79.5%), with 16.5% identifying as male, 3% as non-binary, and 1% as “other”. Participants were primarily White (75.6%), Asian (7.8%), Hispanic (5.1%), Black (2.8%), Indigenous (1%), with 3.7% indicating they were biracial/multicultural and 3.2% responding as “other”. The sample was fairly evenly distributed across years of training, with 26% being at the Masters’ level, and the remainder at the Ph.D. Masters 1 (12%), Masters 2 (14.3%), PhD1 (12%), PhD2 (18.4%), PhD3 (17.1%), PhD4 (10.1%), and PhD5+ (14.7%).

Measures

Baseline, Post-Test, and Follow-Up Measures.

Self-Compassion Scale-5 (SCS-5; adapted from Neff, 2003b). This five-item measure was adapted from the full version of the SCS and is comprised of the items from the “self-kindness” factor. The items include “When I’m going through a very hard time, I give myself the caring and tenderness I need,” “I’m kind to myself when I’m experiencing suffering,” “I try to be understanding and patient towards those aspects of my personality I don’t like,” “I’m tolerant of my own flaws and inadequacies,” and “I try to be loving towards myself when I’m feeling emotional pain.” This scale retains the original anchors of the SCS and are rated from 1 to 5. The SCS-5 demonstrated good internal reliability, yielding a Cronbach’s alpha of .85 in the current sample.

Depressive Experiences Questionnaire-6 (DEQ-6; Shahar, 2015). This 6-item questionnaire is designed to tap the self-criticism factor traditionally assessed in the longer, 66-item questionnaire from Blatt et al. (1976). The self-critical factor of the DEQ reflects thoughts and concerns about failure and rejection, with an intense focus on achievement and performance (Blatt et al., 1995). Participants respond to items such as, “If I fail to live up to expectations, I feel unworthy,” and “There is a considerable difference between how I am now and how I want to be.” Respondents use a 7-point Likert scale ranging from *strongly disagree* (1) to *strongly agree* (7). The DEQ-6 has a good Cronbach’s alpha of .80 in the current sample, and a five-week test-retest reliability of .83 (Zuroff et al., 1983).

Compassionate, Positive, and Negative Affect Scale (C-PNAS; Watson et al., 1988, adapted by Mongrain, 2008). The C-PNAS was created for Project Hope (Mongrain, 2008) and is based on the original Positive and Negative Affect Schedule (PANAS; Watson et al., 1988). Seven compassion adjectives (both positively and negatively valenced) were generated by the Project Hope researchers and then added to the original PANAS to assess the participants level of compassionate affect. Examples of compassionate affect include “loving” and “nurtured.” Other items for positive affect (PA) include “content” and “joyful” while negative affect (NA) has items such as “frustrated” and “unhappy.” The C-PNAS obtained a Cronbach’s alpha of .86 for the Compassionate Affect Scale, .91 for the Positive Affect Scale, and .88 for the Negative Affect Scale in the current sample.

Centre for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977). The CES-D consists of 20 items and asks about common symptoms of depression that may have been experienced over the past week (e.g., “I thought my life had been a failure”) and rate these items on a 4-point Likert scale from 0 (rarely or none of the time, less than 1 day) to 4 (most or all of

the time, 5–7 days). The CES-D demonstrated good internal consistency with a Cronbach's alpha of .85 in the current sample. Total scores range from 0 to 60, with 16 as the recommended cutoff score for clinically significant depressive symptomatology (Houston, et al., 2001; Zich, Attkisson, & Greenfield, 1990).

Anaclitic and Introjective Dysfunctional Attitudes Scales (AIDAS; Zuroff, Igeja, & Mongrain 1990). These items represent dysfunctional attitudes adopted from the Dysfunctional Attitudes Scale (Wiessman & Beck, 1978). They can be categorized along themes of dependency and self-criticism. The Introjective subscale was included in the current study as it pertains to perfectionistic beliefs in the achievement domain (e.g., “I should be upset if I make a mistake” and “if I fail partly at work, then I am a failure as a person”). Beliefs are rated on a seven-point Likert scale ranging from totally agree to totally disagree. Higher scores represent greater dysfunctionality in terms of more arbitrary, rigid, and extreme thinking patterns. Internal consistency was .89 in the current study.

Beck Anxiety Inventory (BAI; Beck et al., 1988). The BAI measures the severity of self-reported anxiety symptoms. It contains a list of 21 symptoms of anxiety experienced over the past week. Individuals are instructed to rate these symptoms on a 4-point scale ranging from 0 to 3, where 0 represents the absence of the symptom and 3 represents the symptom's presence in the severe range. Items include questions asking respondents if they have experienced things like feeling “Nervous” or being “Unable to relax.” The BAI has strong internal validity with a Cronbach's alpha of .94 in the current study.

Brief Fear of Negative Evaluation Scale (BFNE; Leary, 1983). The BFNE is comprised of 12 straightforwardly worded questions about how one feels they are perceived by others. In this study, the items were worded to reflect client concerns, such as “I am afraid

clients with not approve of me.” The BFNE has shown good internal consistency with a Cronbach’s alpha of .89 in the current sample.

Perceived Stress Scale (PSS; Cohen et al., 1983). The PSS assesses the degree to which people perceive their lives as stressful. Participants indicate on a 4-point scale how often they have found their lives unpredictable, uncontrollable, and overloaded in the last month (however, for the current study this was adopted to the last *week*). Items include questions such as, “In the last week, how often have you been upset because of something that happened unexpectedly.” The PSS had good internal consistent in the current sample with a Cronbach’s alpha of .86.

Professional Self-Doubt Scale (PSD; Nissen-Lie et al., 2010). The PSD is a nine-item scale that measures the degree of self-doubt a therapist has about their effectiveness in working with patients. Participants respond to the prompt “For the following questions, how often do you feel...” to questions such as “Unsure how to best deal effectively with a patient.” A total professional self-doubt score is obtained by averaging responses over the nine items. The PSD had a Cronbach’s alpha of .83 in the current sample.

Weekly measures.

Self-Criticizing Scale (Gilbert et al., 2004). This eight-item scale measures aspects of self-criticizing on cognitive and affective dimensions. Items include questions such as, “I had critical thoughts about myself,” “I felt ashamed of myself”, and “I kept thinking about my flaws.” Participants are instructed to respond to each item based on how they felt that day on a 6-point scale ranging from 1 “Not at all” to 6, “A great deal”. The Cronbach’s alpha for this scale was .94 in the current sample.

Self-Compassion Scale-5 State (SCS-5; adopted from Neff, 2003b). This state-version of the SCS-5 uses the same five-items described above in the baseline measure section, with a wording change to address state levels of self-compassion (rather than the trait assessed with the original measure). For example, the trait worded item “I try to be loving towards myself when I’m feeling emotional pain,” was phrased, “Today I was loving towards myself when I felt emotional pain.” The same change was implemented for all 5 items of the scale. This scale retains the original anchors of the SCS and are rated from 1, “Almost never” to 5, “Almost always.” The Cronbach’s alpha for the “state” version of the measure was .89.

Compassionate, Positive, and Negative Affect Scale (C-PNAS; adapted from Watson et al., 1988). This scale retained the same item wording as the baseline and follow up measures. The only modification to the instructions was asking participants how they feel in relation to their therapeutic work “right now.” See the description above for item examples on the negative (NA), positive (PA), and compassionate affect (CA) scales. Cronbach’s alpha for the weekly C-PNAS scores were .92 for PA, .79 for NA, and .86 for CA.

Brief Fear of Negative Evaluation Scale (BFNE; Leary, 1983). This scale retained the same item wording as the baseline and follow up measures. The only modification to the instructions was asking participants how characteristic these questions were of them “this week.” See the description above for item examples for the BFNE. The BFNE had good internal consistency with a Cronbach’s alpha of .86 in the weekly sample.

Procedure

Recruitment emails (see Appendix A) were sent to Directors of Clinical Training over January and February of 2021. If approved by directors of training or program directors, a link to the study was forwarded through their internal listserv to the graduate students within the

clinical/counselling area. Participants had to have at least one active psychotherapy client to participate in the study. Once therapist trainees were forwarded the study invitation, they were directed to an online study system, Qualtrics, where they registered for the study and completed informed consent (see Appendix B). All participants were randomly assigned to one of three conditions 1) a waitlist control group, 2) loving kindness meditation exercise, or 3) an exercise for working with self-criticism (see Appendix C for full exercise conditions).

All participants regardless of study condition completed baseline questionnaires and then several brief questionnaires (BFNE, C-PNAS, SCS-5, Self-Criticizing Scale) after each weekly psychotherapy session. Participants were sent weekly emails with a link directing them to complete the brief questionnaires, with those in the active exercise conditions receiving an additional prompt to complete the exercises. Reminder emails were sent later in the week to maximize participant retention. All exercises and data collected from participants were obtained through Qualtrics and were anonymized with a participant ID to ensure confidentiality. The baseline measures took approximately 45 minutes to complete, with the weekly exercise and brief measures taking approximately 15 minutes to complete.

Complete follow up measures for self-compassion (SCS5), self-criticism (DEQ-6), compassionate, positive, and negative affect (C-PNAS), depression (CES-D), anacritic and introjective dysfunctional attitudes (AIDAS), anxiety (BAI), fear of negative evaluation (BFNE), professional self-doubt (PSD), and stress (PSS) were collected again at post-test (10 weeks after baseline measures) and a one-month follow-up (14 weeks post baseline measures). All participants that took part in the study were entered into raffles for the chance to win one of three \$300 prizes as incentives for participation.

Study Conditions

Control Condition

Participants in the control condition completed the same baseline and weekly questionnaires administered to participants in the active conditions. Previous research examining OPPIs have utilized different writing exercises for the control group (see Seligman et al., 2005). However, more recent studies have shown that even a brief reflection exercise can have positive effects (see Mongrain et al., 2012). Given our interest in how graduate students normally navigate their role as novice psychotherapists, we decided to use a waitlist control group as the reference point for the active interventions. The control participants proceeded through the study's protocol without the active exercise components. They were offered the instructions for the exercise conditions upon completion of the study.

Loving Kindness Meditation (LKM; Active Condition 1)

This exercise first had participants settle into a mindful, meditative state by bringing attention to their breath. They were then provided a set of instructions to access feelings of kindness from their past (such as a time when they were loving and kind to others, or a time when someone showed kindness or generosity towards them) and were instructed to direct these feelings of kindness towards a close friend or loved one (e.g., "May they be happy. May they be healthy. May they be peaceful. May they be safe"). Then, they were to direct this same feeling of loving kindness to themselves (e.g., "May I be happy. May I be healthy. May I be safe, etc."). In the final parts of the exercise, the participants were to think of one, or several of their therapy clients, and cultivate a similar loving kindness (e.g., "May my client be happy. May my client be safe, etc."). Lastly, the exercise contained sets of instructions to direct the participant's thoughts to the shared space with their clients and their alliance, repeating "May we be happy. May we be

healthy. May we be safe” and so on. They were instructed to repeat these steps for 5-10 minutes once per week during the exercise.

Working with Self-Criticism (WSC; Active Condition 2)

This exercise had five brief steps guiding participants to notice, list, and reflect on specific criticisms they had towards themselves about their work as a therapist in a recent session. Step one asked them to describe a moment in their therapy session that left them feeling upset or uncomfortable. Step two asked them to list the specific criticisms they had toward themselves in that moment. Step three asked them to write down the feelings associated with these criticisms. Step four asked them to assess the validity of their judgements towards themselves, resembling the Socratic questioning used in CBT. The last step asked them to reflect on how the critical voice could be more supportive of them and were asked to write a more adaptive form of self-talk. The intention was to coach participants in a cognitive restructuring that targeted self-critical judgments about their performance as a therapist. Participants completed these steps once per week during the exercise.

Results

Data Analyses

Multilevel Modeling (MLM) in R (version 4.2.2) was utilized as the main data analytic strategy to test the hypotheses. MLM allowed us to examine changes in outcome measures over multiple time points for repeated measures nested within individuals (Singer & Willett, 2003). MLM also allows the treatment of time as a numeric, continuous variable (rather than a discrete variable), and can determine changes over time more effectively. In addition, MLM is particularly good with handling missing data points through the use of Full Information Maximum Likelihood (FIML), and utilizes all available data, even with random missing cases.

We took an intention-to-treat approach in our analyses where participants were invited to complete the exercises and measures every week, even if they did not complete the previous week. Participants who only completed the baseline measures could be included to contribute to the model parameter estimates. Given the longitudinal nature of this project, MLM was the analysis of choice that could account for attrition and missing data, and thus improves the power and accuracy of our design (Gallop & Tasca, 2009).

All MLM models were tested using random intercepts and achieved convergence with no errors. Time variables were created for the three-month longitudinal data with values obtained at baseline, post-test (10 weeks later), and at the one-month follow-up, resulting in three levels for Time. The weekly data was analyzed using Time as a factor, which allowed us to investigate changes at each week of the intervention. Variables included in each model included the outcome variable (e.g., levels of affect, professional self-doubt), Time, Condition, and a Time x Condition interaction.

In addition, to assess the degree of variability in outcome that occurred at the condition level of the analyses, intraclass correlations (ICC) were calculated for each model. ICC values help to investigate, and control for non-independence which can occur when there is a high correlation between study variables or conditions (LeBreton & Senter, 2008). When ICC values are high, traditional statistical methods become problematic as it can violate the assumption of independence, and thus bias the model estimates. Fortunately, MLM is able to handle non-independent data if this violation were to occur.

Given we were interested in assessing the effect of the exercise interventions at different time points, we conducted two sets of analyses: one with time centered at post-test (Time two) and another with time centered at follow-up (Time three). In each of the models, the control

group was used as the reference group, and we controlled for Time to investigate the effects of the exercises specifically at post-test and follow-up.

With the high attrition rate at follow-up (62%), we investigated differences between completers and non-completers on key baseline variables. Independent sample t-tests were conducted to determine if those who completed the study were any different at baseline from those who dropped out. There were no significant differences between those who completed the follow-up measures and those who did not on measures of self-compassion ($t(203) = -.25, p = .80$), self-criticism ($t(204) = .193, p = .85$), depression ($t(202) = -.18, p = .86$), or anxiety ($t(190) = .72, p = .47$).

Baseline Characteristics

Hypothesis 1: Exploratory investigation into distress levels of therapists in training.

Part of the objective for the current study was to investigate what type of mental health difficulties or distress training therapists face. Baseline scores on the following scales were examined: SCS5, DEQ-6, C-PNAS, CES-D, AIDAS, BAI, BFNE, PSS, and PSD. Data were analyzed using a sum score or average Likert response score (based on measure norms and scoring) with higher scores indicating greater symptoms. Clinical cut-off scores are provided if they exist for the given measure.

Training therapists reported self-criticism as measured by the DEQ-6 in the moderate range, with an average response of 4.36. Depressive symptomology as measured by the CES-D was 17.67 (SD = 8.81) in the current sample. 47% of participants were above the clinical cut off score of 16, indicating mild, but clinically significant depressive symptoms (Radloff, 1997). With respect to anxiety, the sample was in the mild range according to the BAI cut off scores (Rector & Arnold, 2006) at baseline (Mean = 11.49, SD = 7.43). 37% of participants endorsed

mild levels of anxiety, 18% endorsed moderate levels, and 5% endorsed severe levels of anxiety. Total mean scores on fear of negative evaluation were 36.10 (SD = 9.34) with 45% of the sample above the clinical cut off of 21+ and in the “high” range (Duke et al., 2006). Perceived stress as measured by the PSS was 28.21 (SD = 6.73) in the current sample, putting 49% of training therapists in the sample in the “high” range of perceived stress (Swaminathan et al., 2017). While professional self-doubt does not have clear clinical cut off scores, Nissen-Lie et al. (2013) found training therapists reported average Likert scale responses of 1.54, which was significantly elevated compared to licensed therapists’ average of 1.24. Average PSD scores in the current sample were even further elevated at 2.40. While Nissen-Lie et al. (2017) assert that some PSD is healthy in training therapists, it should not go so far that individuals become doubtful about themselves as people, which may be reflected in these elevated scores. Self-compassion, compassionate affect, positive affect, negative affect, and the dysfunctional attitudes scale do not have clinical norms, and thus were not interpreted here. For all correlations, means, standard deviations, and average Likert scale responses, see Table 1.

Multilevel Analyses

Hypothesis 2 a): The LKM and WSC conditions were predicted to lead to different outcomes. More specifically, the WSC exercise was expected to be more effective than LKM in reducing outcomes related to negative functioning, including the endorsement of self-critical traits, fear of negative evaluations, dysfunctional attitudes, and negative affect. The superior outcome for the WSC condition on these variables were expected to be significant at post-test and at follow-up.

Changes in Trait Self-Criticism (DEQ-6). To assess the variance in outcome that occurred at the condition level, intraclass correlations (ICC) were calculated from the two-level

unconditional model. The ICC for DEQ scores was .07, indicating that 7% of the total variance in DEQ scores was due to differences between condition levels.

A random intercepts model controlling for time was tested to examine the effect of the LKM and WSC conditions on levels of self-criticism at post-test and follow-up. At post-test, therapists experienced significant reductions in self-criticism in both the LKM condition ($B = -3.3$, $SE = 1.2$, $p = .005$) and the WSC condition ($B = -2.4$, $SE = 1.2$, $p = .048$) compared to the control condition. At follow-up, therapists in the LKM condition experienced significant reductions in self-criticism ($B = -3.4$, $SE = 1.4$, $p = .012$) compared to the control condition, while the WSC condition approached significance ($B = -2.6$, $SE = 1.4$, $p = .056$). There were no significant Time x Condition interactions found. Contrary to hypotheses, these results suggest that *both* interventions led to significant decreases in trait levels of self-criticism at post-test and at the one-month follow-up.

Changes in Fear of Negative Evaluation (BFNE). To assess the variance in outcome that occurred at the condition level, intraclass correlations (ICC) were calculated from the two-level unconditional model. The ICC for BFNE scores was .03, indicating that 3% of the total variance in BFNE scores was due to differences between condition levels.

A random intercepts model controlling for time was tested to examine the effect of the LKM and WSC conditions on levels of fear of negative evaluation at post-test and follow-up. At post-test, therapists experienced significant reductions in fear of negative evaluation in the LKM condition ($B = -3.14$, $SE = 1.6$, $p = .05$) but not the WSC ($B = -1.3$, $SE = 1.7$, $p = .45$), compared to the control condition. At follow-up, there was a trend for the LKM condition ($B = -3.3$, $SE = 1.8$, $p = .063$) but not the WSC condition ($B = -0.72$, $SE = 1.84$, $p = .69$) in reducing trainees' fear of negative evaluation compared to controls. There were no significant Time x Condition

interactions found. Contrary to predictions, the LKM but not the WSC exercise led to reduction in the BFNE in the short run with a trend towards improvement at follow-up.

Changes in Introjective Dysfunctional Attitudes (IDAS). To assess the variance in outcome that occurred at the condition level, intraclass correlations (ICC) were calculated from the two-level unconditional model. The ICC for IDAS scores was .02, indicating that 2% of the total variance in IDAS scores was due to differences between condition levels.

A random intercepts model controlling for time was tested to examine the effect of the LKM and WSC conditions on levels of IDAS at post-test and follow-up. At post-test reductions in IDAS scores in the LKM condition approached significance ($B = -3.17$, $SE = 1.7$, $p = .058$) compared to the control condition. At follow-up, a similar trend was found, with reductions in IDAS scores also approaching significance in the LKM condition ($B = -3.7$, $SE = 1.9$, $p = .056$). The WSC did not prove effective in significantly reducing IDAS scores at post-test ($B = -1.7$, $SE = 1.7$, $p = .33$) or follow-up ($B = -1.1$, $SE = 1.9$, $p = .57$), contrary to predictions. These results suggest that the LKM exercise was more effective than the WSC exercise in reducing perfectionistic beliefs.

Change in Negative Affect (NA). To assess the variance in outcome that occurred at the condition level, intraclass correlations (ICC) were calculated from the two-level unconditional model. The ICC for NA scores was .014, indicating that 1.4% of the total variance in NA scores was due to differences between condition levels.

A random intercepts model controlling for time was tested to examine the effect of the LKM and WSC conditions on levels of NA at post-test and follow-up. At post-test, there were no significant changes in NA scores in the LKM condition ($B = -0.80$, $SE = 0.55$, $p = .15$) or the WSC condition ($B = -1.09$, $SE = 1.14$, $p = .34$) compared to controls. Similarly, there were no

significant changes in PSD at follow-up in the LKM condition ($B = -1.61$, $SE = 1.29$, $p = .21$) or WSC condition ($B = -0.33$, $SE = 0.56$, $p = .55$) compared to therapists in the control condition. The hypotheses with respect to the effects of the interventions on NA were not supported. There was a significant effect of Time, however ($B = -0.11$, $SE = 0.04$, $p = .004$), indicating that negative affect did decrease for the sample as a whole over time.

Hypothesis 2b: We expected the LKM exercise to be more effective in increasing outcomes related to self-compassionate traits, and positive affect.

Changes in Trait Self-Compassion (SCS-5). To assess the variance in outcome that occurred at the condition level, intraclass correlations (ICC) were calculated from the two-level unconditional model. The ICC for SCS-5 scores was .02, indicating that 2% of the total variance in PA scores was due to differences between condition levels.

A random intercepts model controlling for time was tested to examine the effect of the LKM and WSC conditions on levels of SCS at post-test and follow-up. At post-test, there were no significant changes in SCS scores in the LKM condition ($B = 0.91$, $SE = 0.68$, $p = .18$) or the WSC condition ($B = 0.58$, $SE = 0.7$, $p = .40$) compared to controls. Similarly, there were no significant changes in trait self-compassion at follow-up in the LKM condition ($B = 0.94$, $SE = 0.78$, $p = .23$) or WSC condition ($B = 0.40$, $SE = 0.80$, $p = .62$) compared to therapists in the control condition. Contrary to predictions, the LKM intervention did not lead to changes in the endorsement of self-compassionate traits.

Changes in Compassionate Affect (CA). To assess the variance in outcome that occurred at the condition level, intraclass correlations (ICC) were calculated from the two-level unconditional model. The ICC for CA scores was .05, indicating that 5% of the total variance in CA scores was due to differences between condition levels.

A random intercepts model controlling for time was tested to examine the effect of the LKM and WSC conditions on levels of CA at post-test and follow-up. At post-test, participants in the LKM condition reported significant increases in compassionate affect ($B = 2.39$, $SE = 1.21$, $p = .049$) compared to those in the control condition. The WSC condition did not have a significant effect on CA ($B = 0.9$, $SE = 1.24$, $p = .47$). At follow-up, increase in therapists' levels of CA in the LKM condition approached significance ($B = 2.64$, $SE = 1.4$, $p = .058$) compared to the control condition, partially confirming our predictions. The WSC condition was not significantly different from controls ($B = 0.92$, $SE = 1.42$, $p = .52$).

Change in Positive Affect (PA). To assess the variance in outcome that occurred at the condition level, intraclass correlations (ICC) were calculated from the two-level unconditional model. The ICC for PA scores was .02, indicating that 2% of the total variance in PA scores was due to differences between condition levels.

A random intercepts model controlling for time was tested to examine the effect of the LKM and WSC conditions on levels of PA at post-test and follow-up. At post-test, there were no significant changes in PA scores in the LKM condition ($B = 0.63$, $SE = 0.81$, $p = .44$) or the WSC condition ($B = -0.04$, $SE = 0.83$, $p = .52$) compared to controls. Similarly, there were no significant changes in positive affect at follow-up in the LKM condition ($B = 0.89$, $SE = 0.93$, $p = .34$) or WSC condition ($B = 0.06$, $SE = 0.95$, $p = .95$) compared to participants in the control condition, contrary to predictions.

Hypothesis 3: LKM and WSC conditions were hypothesized to lead to significant increases in the overall well-being of training therapists.

We investigated changes in additional common symptoms experienced by graduate student therapists with the following measures: the CES-D, BAI, PSS, and PSD. Contrary to

predictions, there were no significant changes in these outcomes in either of the exercise condition compared to controls. There was a significant decrease in PSD over the course of the study, but the remaining variables did not significantly change over time, regardless of condition. All results for hypothesis 3 are displayed in Table 2 and 3.

Hypothesis 4: State variables of self-criticizing, self-compassion, and affect were expected to change on a weekly basis over the eight-week intervention for the experimental conditions compared to the waitlist controls.

Weekly Variables. In addition to the full set of baseline, post-test, and follow-up measures, all participants across the three study conditions were administered the BFNE, Self-Criticizing Scale, the SCS-5 State measure, and the C-PNAS every week for eight weeks. The results of these measures are provided in Table 4. However, contrary to predictions, the findings indicated that while the parameter estimates for main effects were in the expected direction, the interaction effects between Time x Condition at each of the eight weeks showed estimates in the opposite direction to the main effects. It is important to note that these counterintuitive results may be due to statistical suppression, likely due to participant attrition at the weekly level. Since this could not be ruled out, the weekly findings were not interpreted. When statistical suppressors (e.g., irrelevant variance from other variables) are not controlled, it can bias the estimates of regression models and provide inaccurate results (Martinez-Gutierrez & Cribbie, 2021).

Summary of Findings

Hypothesis 1 predicted that the international population of clinical and counselling graduate students in this study would endorse clinically significant levels of distress on various outcome measures. This was supported with the sample showing clinically elevated levels of depression, anxiety, self-criticism, fear of negative evaluation, and stress.

Hypothesis 2a predicted that the WSC condition would be more effective in reducing self-critically relevant measures, such as fear of negative evaluation and trait self-criticism, while 2b predicted that the LKM exercise condition would lead to significantly greater changes in positively valenced measures such as self-compassion, and positive and compassionate affect. This was partially supported with the WSC proving to be effective in reducing self-criticism, but contrary to hypotheses, the LKM was also effective in reducing self-criticism and fear of negative evaluation, while still significantly increasing compassionate affect.

Hypothesis 3 investigated the effectiveness of both exercises on other common difficulties that clinical trainees face such as depression, anxiety, and stress. Contrary to our hypothesis, neither condition significantly reduced these outcome variables.

Hypothesis 4 predicted that those participants in the active exercise conditions would show reductions in fear of negative evaluation, state self-criticism, state self-compassion, and compassionate, positive, and negative affect over the eight-week exercise period. These results were not interpreted due to potential statistical anomalies.

Discussion

The purpose of this research was to investigate the experiences and mental health profiles of clinical and counselling psychology trainees, and to test the efficacy of brief, online interventions designed to ease negative self-evaluations and promote self-kindness. This study is one of the first to utilize brief interventions in an experimental design with therapists in training (Crego et al., 2022) and provides preliminary evidence suggesting that these interventions are efficacious in this population.

The first aim of the study was to assess the type, and severity of distress training therapists may face. Therapists endorsed clinically significant levels of nearly all psychological

variables included in the study. They endorsed high trait self-criticism, fear of negative evaluation (in the role of therapist), high levels of stress, mild levels of anxiety, and clinically significant depressive symptoms. The level of distress found in the current study was similar, and even elevated on some measures compared to previous research in this area (El-Ghoroury et al., 2012; Hobaica et al., 2021; Rummell, 2015). The results speak to the prevalence of psychological symptoms in yet another international sample of therapist trainees. These elevated levels of distress likely reflect not only the demands that all graduate students face with heavy course loads and research (Hyun et al, 2006), but the added complexity and roles that come with clinical training (Ayala et al., 2017).

While the rigorous nature of graduate programs may contribute to these difficulties, the high prevalence of mental health difficulties compared to the general population is found in both student therapists and practicing psychologists. Victor et al. (2022) suggested that people with higher levels of mental health related distress may “self-select” into clinical and counselling programs given that these difficulties seem to continue after graduate school and into their careers, and that this may contribute to a higher baseline of psychopathology in psychologists. This points to the importance of addressing these difficulties and integrating self-care at every stage of clinical training and beyond, as a matter of ethics and responsible caring (Marazan et al., 2018). This is not only important for the clinicians, but for the population being treated as well, as earlier research reported that as many as 60% of psychologists reported working when they were “too distressed to be effective” (Pope et al., 1987).

The second aim of the study was to investigate the effectiveness of two brief interventions, a “working with self-criticism” (WSC) and a loving kindness meditation (LKM) exercise administered after the therapy sessions of novice therapists. These were designed to

reduce negative self-talk and increase self-kindness, both important for subjective well-being. There was some support for the effectiveness of these interventions. For example, it was predicted that the WSC condition would be effective in reducing negative psychological functioning. This was confirmed with participants in the WSC condition showing significant reductions in the self-critical personality style at post-test, and a trend towards significance at the one-month follow-up. Contrary to predictions, however, there were no significant changes in fear of negative evaluation or introjective dysfunctional attitudes in the WSC condition at post-test or follow-up.

Contrary to expectations, the LKM exercise was also effective in reducing self-critical traits. Participants in the LKM condition experienced significant decreases in trait self-criticism at post-test and follow-up. In addition, LKM was actually more effective compared to the WSC exercise in reducing fear of negative evaluation, showing significant reductions at post-test. Participants in the LKM condition also showed trends toward significant reductions in introjective dysfunctional attitudes at post-test and follow-up. These results are worth noting for several reasons. Trait self-criticism as measured by the DEQ-6 used in the current study is often conceptualized as a personality variable (Mongrain & Zuroff, 1995) and can be difficult to work with effectively, speaking to the effectiveness of the LKM exercise.

While the LKM proved to be effective on several outcomes, including the WSC condition was important given that no previous studies utilized a brief, online self-criticism intervention with training therapists, despite the role of self-criticism in psychopathology (Blatt et al. 1976; Shahar, 2015) and the prevalence seen in training therapists (Richardson et al., 2020). The WSC condition may have been less effective with other measures relating to self-judgement (e.g., BFNE, IDAS) given that the exercise was designed to identify, and challenge self-critical

judgements specifically. The items on the DEQ-6 are directly related to negative self-criticisms (e.g., “If I fail to live up to expectations, I feel unworthy) which were directly addressed by the WSC exercise prompts. As such, it seems like a promising tool to reduce levels of self-attacks that happen in performance situations.

Although some research indicates that LKM can be ineffective with self-criticism (Longe et al., 2010), this was not the case in the current study as participants in this exercise condition showed significant decreases in trait self-criticism, and fear of negative evaluation. Most of the research for compassion focused interventions on self-criticism are more intensive therapies like CFT and CMT (Beaumont et al., 2017; Gilbert, 2009; Gilbert & Proctor, 2006) and are often time consuming (e.g., 12 one-hour sessions) or can be costly as they often take place in the context of psychotherapy. More recent research (Vidal & Soldvilla, 2022) also indicated that CFT can be effective in reducing self-criticism, however, they note that there are very few randomized control trials comparing CFT with other therapies and that more research is needed to further understand these effects. Specific to this research, even fewer studies have investigated the effects of LKM in a training therapist population (Boellinghaus et al., 2014) and the results of the current study support the notion that negative self-evaluations and fear of external negative evaluations can be combatted with the practice of loving-kindness towards the self. This is particularly noteworthy compared to previous compassion focused interventions given the brevity and ease of the LKM intervention.

LKM was also hypothesized to be more effective than the WSC condition in increasing positively valanced variables such as positive affect and self-compassion. This hypothesis was partially supported where participants in the LKM condition showed significant increases in compassionate affect at post-test and trended towards significance at the one-month follow-up.

The compassionate affect items on the C-PNAS reflect feelings such as feeling more loved, nurtured, and comforted. Previous studies have discussed the salutary effects of compassionate affect, and compassionate feelings more generally (Mongrain, 2023). This is important given that compassionate affect/compassion for others is also linked to self-compassion and psychological well-being (Lopez et al., 2018). Increases on this particular outcome variable is congruent with the LKM task itself, as the exercise has participants foster compassion for others, for clients, and then themselves.

The LKM condition did not show significant increases on measures of self-compassion specifically. One explanation for this is the high levels of self-criticism found in study participants may have limited the potential improvements in self-compassion that could be observed. That is to say, there is some evidence that highly self-critical people may struggle with fostering self-compassion (Lopez et al, 2015; Muris et al., 2018). It is also worth noting that the reductions in self-criticism do not necessarily imply increases in self-compassion (Lopez et al., 2015). Support for this can also be found in Gilbert (2009) that describes the differing physiological systems of threat and safety that relate to self-criticism and self-compassion, respectively. Gilbert hypothesized that highly self-critical people may have “poor access” to the compassionate safety system. Therefore, participants in the current study may have been able to find some relief in their self-criticism through the exercise, but not sufficiently enough to access the self-compassionate system.

There were several outcome measures taken over the course of the participants’ semester at baseline, post-test, and follow-up that were collected to further investigate the trajectory of depression, anxiety, stress, and professional self-doubt in graduate students undergoing their clinical training. Neither of the exercise interventions produced significant changes on these

measures over the course of the semester. In hindsight, it is not so surprising in that the brief exercises in the current research were targeting a specific and narrow domain of functioning, which was the students' role as novice therapists. There are many sources of stress in a graduate student's life that may be more pivotal in increasing levels of anxiety and depression, such as the overall workload, tight deadlines, and reductions in social activities.

However, one finding from these measures was that professional self-doubt decreased over the course of the study for the sample as a whole. Given that PSD scores were elevated at baseline compared to average scores from previous studies (Nissen-Lie et al., 2013) this reduction over time may reflect a healthy "settling in" to the role of therapist over the course of the term.

Limitations

There are several limitations to this study. With respect to generalizability, a small percentage of the schools contacted responded to the study invitation. Given that the invitation was circulated by directors of clinical training and program directors, there may be differences between the programs that did or did not circulate the study, such as having existing resources for students, or perhaps not aligning with the direction or implications of the study. In addition, there was a high rate of attrition over the course of the study (38% of the sample completed the one-month follow-up measures). While this was accounted for statistically in the baseline, post-test, and follow-up analyses, we did not interpret the weekly level data due to seemingly biased estimates which can result from missing data.

Data collection also took place during the COVID-19 pandemic. This likely had an impact on the mental health of graduate students, however, it was not directly explored. In addition, the setting of therapy (virtual or in person) was not measured. In the context of a

training program, conducting therapy remotely for novice therapists may have been even more anxiety provoking without the physical support of supervisors or peers that many programs offer (e.g., direct observation). In line with this, future research may benefit from going beyond quantitative questionnaires for symptomology and incorporate qualitative data investigating the specific areas that are causing distress in this population.

Clinical Implications

The current study has several important clinical implications. While there are emerging studies suggesting the need for intervention for clinical and counselling psychology trainees (Crego et al., 2022) few studies have tested this using a randomized experimental design. This research provides tangible tools to ease the very real, and ongoing negative self-judgments of therapist trainees. We provide support that brief and easy to access online interventions are effective in reducing self-criticism and negative self-evaluation, and increasing compassionate affect related to well-being. Integrating these practices into training programs is critical (Beaumont et al., 2016; Coaston & Lawrence, 2019), not just for students, but for the clients they go on to treat as well. These brief exercises could be integrated into practicum courses at every level of clinical training and students should be explicitly encouraged and supported to be purposeful in taking the time to work directly with the harsh self-criticism that clinical trainees are often prone to, and to then cultivate self-compassion during the intensity of clinical training programs.

Previous studies have suggested that preventative self-care in training programs is crucial (Marazan et al., 2018; Pakenham & Stafford-Brown, 2012) however, recent reviews suggest that clinical and counselling students are still experiencing these difficulties, and still face barriers to accessing treatment (Hobaica et al., 2021; Klein et al., 2023). The current research offers brief,

evidence-based exercises that could counteract the lack of reflective practices and supportive mentorship that currently exist in clinical training programs.

Summary and Conclusions

In conclusion, clinical and counselling trainees in graduate training programs in both Canada and the United States endorsed moderate to severe symptomology on measures of self-criticism, stress, anxiety, and depression. Two brief online interventions administered over an eight-week period proved effective in helping reduce distress and increase measures related to well-being at post-test and one-month follow-up. These exercises have shown to be safe, effective, and time and cost efficient, all aspects that are important when integrating support for graduate therapists given the time and financial barriers that exist in this population. Overall, we hope the results of our study fall on the open and empathetic ears of program directors, clinical directors, and supervisors alike. Clinical and counselling psychology programs are intensive and difficult but needed more than ever. With the increasing demand of mental health services in recent years, improving trainees' relationship with themselves and well-being in their new role as therapists is vital. The value of these interventions for practicing psychologists may also well serve the general population struggling with distress in any professional role and is an important venue for future research.

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Table 1

Correlation matrix and descriptive statistics for baseline variables.

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
1. DEQ	1.00											
2. BFNE	0.40	1.00										
3. IDAS ¹	0.47	0.42	1.00									
4. CA ²	-0.27	-0.32	-0.15	1.00								
5. PA ²	-0.33	-0.24	-0.18	0.75	1.00							
6. SCS	-0.50	-0.39	-0.45	0.38	0.35	1.00						
7. CESD	0.48	0.28	0.43	-0.19	-0.32	-0.44	1.00					
8. PSS	0.39	0.27	0.46	-0.14	-0.26	-0.33	0.63	1.00				
9. BAI	0.24	0.24	0.32	-0.04	-0.18	-0.18	0.57	0.57	1.00			
10. NA ²	0.44	0.38	0.33	-0.42	-0.52	-0.32	0.37	0.39	0.31	1.00		
11. PSD	0.43	0.53	0.35	-0.49	-0.43	-0.26	0.24	0.19	0.16	0.60	1.00	
12. ADAS ¹	0.33	0.40	0.72	-0.08	-0.10	-0.24	0.30	0.35	0.25	0.31	0.27	1.00
Mean	26.19	36.10	19.26	33.92	14.79	15.61	17.67	28.21	11.49	9.84	21.5	19.6
Standard Deviation	6.57	9.34	10.62	6.93	4.42	3.73	8.81	6.73	7.43	2.96	6.13	9.46
Average response	4.36	3.04	3.16	3.41	3.09	3.15	0.92	2.83	1.57	1.98	2.40	3.11

As measured by the Depressive Experiences Questionnaire-6 (Shahar, 2015). Brief Fear of Negative Evaluation Scale (Leary, 1983). ¹Anaclitic and Introjective Dysfunctional Attitudes Scales (Zuroff, Igreja, & Mongrain, 1990). ²Compassionate, Positive, and Negative Affect Scale (Watson et al., 1988, adapted by Mongrain, 2008). Self-Compassion Scale-5 (Adapted from Neff, 2003). Centre for Epidemiological Studies Depression Scale (Radloff, 1977). Perceived Stress Scale (Cohen et al., 1983). Beck Anxiety Inventory (Beck et al., 1988). Professional Self-Doubt Scale (Nissen-Lie et al., 2010). *N* = 216.

Table 2*Regression of exercise condition and impact on exploratory variables at post-test*

	CESD	PSS	BAI	PSD
Fixed Effects	B (SE)	B (SE)	B (SE)	B (SE)
Mean intercept	18.11 (1.12)***	29.35 (0.84)***	10.31 (0.97)***	21.34 (0.79)***
Time	-0.07 (0.10)	0.01 (0.07)	-0.14 (0.08)	-0.15 (0.06)*
LKM	-1.16 (1.74)	-1.21 (1.2)	-0.04 (1.39)	-1.53 (1.12)
WSC	-1.4 (0.14)	-1.7 (1.22)	-1.59 (1.41)	-1.09 (1.14)
Time*LKM	0.04 (0.15)	0.9 (0.11)	0.07 (0.12)	-0.02 (0.08)
Time*WSC	-0.06 (0.15)	-0.01 (0.11)	-0.19 (0.12)	0.09 (0.09)
Random Effects	SD	SD	SD	SD
Level 2 error variance	7.57	5.14	5.95	5.26
Level 1 error variance	5.58	3.99	4.56	3.12

Note. Unstandardized regression coefficients were reported; *** $p < .001$; ** $p < .01$; * $p < .05$.

Note2. Mean intercepts represent control condition mean scores.

Table 3*Regression of exercise condition and impact on exploratory variables at follow-up*

	CESD	PSS	BAI	PSD
Fixed Effects	B (SE)	B (SE)	B (SE)	B (SE)
Mean intercept	17.82 (1.42)***	29.30 (0.99)***	9.75 (1.34)***	20.73 (0.89)***
Time	-0.07 (0.10)	0.01 (0.07)	-0.14 (0.08)	-0.15 (0.06)*
LKM	-1.0 (2.1)	-0.84 (1.44)	0.24 (1.66)	-1.61 (1.29)
WSC	-1.76 (2.1)	-1.75 (1.46)	-2.34 (1.68)	-0.75 (1.31)
Time*LKM	0.04 (0.15)	0.9 (0.11)	0.07 (0.12)	-0.02 (0.08)
Time*WSC	-0.06 (0.15)	-0.01 (0.11)	-0.19 (0.12)	0.09 (0.09)
Random Effects	SD	SD	SD	SD
Level 2 error variance	7.57	5.14	5.95	5.26
Level 1 error variance	5.58	3.99	4.56	3.12

Note. Unstandardized regression coefficients were reported; *** $p < .001$; ** $p < .01$; * $p < .05$.

Note2. Mean intercepts represent control condition mean scores.

Table 4*Regression of exercise condition and impact on weekly variables*

	SCS5	BFNE	CA	NA
Fixed Effects	B (SE)	B (SE)	B (SE)	B (SE)
Mean intercept	15.87 (0.62)***	37.77 (1.07)***	34.22 (0.91)***	10.21 (0.42)***
Time2	0.08 (0.61)	-0.65 (0.69)	0.63 (0.72)	-0.75 (0.38)
Time3	1.90 (0.65)**	-2.30 (0.74)**	1.16 (0.76)	-1.68 (0.42)***
Time4	1.30 (0.64)*	-2.68 (0.73)***	0.51 (0.76)	-1.79 (0.42)***
Time5	1.53 (0.70)*	2.90 (0.79)***	-1.39 (0.82)	-1.26 (0.47)**
Time6	1.98 (0.69)**	-3.46 (0.79)***	0.65 (0.82)	-2.08 (0.45)***
Time7	0.84 (0.74)	-3.30 (0.82)***	0.95 (0.85)	-2.21 (0.47)***
Time8	1.65 (0.71)*	-4.23 (0.81)***	1.46 (0.84)	-2.34 (0.47)***
LKM	-0.91 (0.87)	-2.23 (1.36)	0.15 (1.25)	-1.24 (0.60)*
WSC	-0.16 (0.92)	-1.55 (1.66)	-1.37 (1.38)	-0.79 (0.60)
Time2*LKM	-0.08 (0.93)	-2.03 (1.06)	0.11 (1.10)	0.63 (0.61)
Time3*LKM	-1.02 (1.02)	-0.22 (1.16)	-0.33 (1.21)	0.83 (0.67)
Time4*LKM	-0.53 (0.99)	-0.19 (1.13)	-1.56 (1.17)	2.25 (0.65)***
Time5*LKM	0.13 (1.03)	-0.24 (1.17)	1.88 (1.21)	0.67 (0.67)
Time6*LKM	-1.98 (1.08)	0.86 (1.23)	-2.93 (1.28)*	2.51 (0.71)***
Time7*LKM	0.35 (1.07)	-1.43 (1.22)	-0.17 (1.28)	1.23 (0.73)
Time8*LKM	-0.45 (1.05)	-0.54 (1.20)	-1.09 (1.24)	1.65 (0.69)*
Time2*WSC	1.20 (0.92)	-1.61 (1.04)	-0.51 (1.09)	0.37 (0.60)
Time3*WSC	-0.63 (0.94)	0.82 (1.08)	-1.06 (1.12)	1.18 (0.62)
Time4*WSC	-0.51 (0.95)	-0.47 (1.08)	-1.10 (1.13)	1.46 (0.62)*
Time5*WSC	0.21 (1.02)	0.52 (1.67)	1.40 (1.22)	0.01 (0.67)
Time6*WSC	-0.76 (1.04)	1.10 (1.18)	0.16 (1.23)	0.88 (0.68)
Time7*WSC	0.27 (1.08)	-0.37 (1.22)	-1.63 (1.27)	1.42 (0.71)*
Time8*WSC	-0.37 (1.06)	2.42 (1.22)*	-2.67 (1.26)*	1.75 (0.70)*
Random Effects	SD	SD	SD	SD

Level 2 error variance	3.43	7.80	6.03	2.39
Level 1 error variance	2.96	3.36	3.47	1.94

Note. Unstandardized regression coefficients were reported; *** $p < .001$; ** $p < .01$; * $p < .05$.

Note2. Mean intercepts represent week 1 mean scores.

Appendix A

Email Recruitment Script

Dear Director of Clinical Training, Program Director, and Administrative Staff

I am a 3rd year PhD student in the Clinical Psychology Program at York University working under the supervision of Dr. Myriam Mongrain.

Would you please consider forwarding this invitation to participate in my dissertation research to the clinical trainees at your program? Briefly, my research is geared towards documenting and offering tools to help graduate students in their burgeoning role as psychotherapists in the early stages of their training. Graduate students with at least 1 therapy client (or those who do frequent assessments) are eligible to participate.

Additionally, if you have a Counseling Center, would you consider sharing it with the Counseling Center staff for any clinical trainees to take part in as well? Only clinical trainees that are currently seeing clients (either therapy or assessment) are eligible.

Please see below for more information in the student invitation.

Thank you for considering this request! If you have a moment to let me know if you were able to share the below information, I would greatly appreciate it so I can keep track of responses.

Thank you for your time,

Davey Chafe, M.A.
Clinical Graduate Program in Psychology
York University

Myriam Mongrain, Ph.D. C.Psych.
Professor of Psychology
York University

Invitation for participants:

Are you a graduate therapist trainee currently enrolled in a clinical psychology, counselling, or social work graduate program in Canada?

If so, please consider participating in my dissertation research about the experience of graduate clinical trainees. Understanding your experiences as training therapists is extremely valuable for discovering ways to support students in the most effective way throughout your training. This study will involve self-reflection and exercises that you may find rewarding.

The study is completely online, and will take place over the next 8 consecutive weeks, with a

follow up in April, 2021. Baseline questionnaires will take approximately 20 minutes to complete, with shortened weekly questionnaires and exercises taking approximately 10 minutes. As a thank you for participating, you will be entered to win one of three raffles for a \$300 cash prize (\$900 worth of prizes).

Your participation in this study is voluntary, you are free to withdraw from the study at any time, or you may choose not to answer any specific questions.

Participation is confidential.

In addition, you must provide your email address to be entered in the raffle, but your email address will be stored in a separate database that will be connected to your data only via a participant number generated by the survey software. IP addresses will be collected to help identify fraudulent responses.

This research has received ethics approval from the York University Research Ethics Board, with REB number: e2019-422

To locate this study online, please use the following link:

https://yorkufoh.ca1.qualtrics.com/jfe/form/SV_3vAyRTjJ6uEe0PX

The Principal investigators of this study are Davey Chafe dchafe@yorku.ca and Dr. Myriam Mongrain mongrain@yorku.ca. Please email with any questions or concerns you may have.

Thank you for your time and consideration.

Davey Chafe, M.A.
Clinical Graduate Program in Psychology
York University

Myriam Mongrain, Ph.D. C.Psych.
Professor of Psychology
York University

Appendix B

Consent Form

The Benefits of Self-Compassion for Therapists in Training

Researchers: Dr. Myriam Mongrain, (mongrain@yorku.ca, BSB 132, ext: 66193, York University, Keele Campus) & Davey Chafe (dchafe@yorku.ca, BSB 122, York University, Keele Campus).

We invite you to take part in a research study in the Department of Psychology at York University. This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Purpose of the Research: The goal of this study is to better understand the stresses and difficulties of graduate students in clinical psychology. We are interested in brief interventions for therapists in training to help boost their confidence and sense of purpose in their new role.

What You Will Be Asked to Do: This study will take place completely online, and all relevant study information will be made available through emails and links to our study website. Here are the steps:

- 1) Upon entry into the study, you will be asked to fill out baseline questionnaires about your mood, personality, and your clinical training experiences (approximately 45 minutes).
- 2) You will then be randomly assigned into 1 of 3 study conditions and asked to complete brief weekly questionnaires about your experiences with clients (approximately 15 minutes). Responses to these questions will not be stored by the researchers; you will simply confirm if you completed them each week over a period of 2 months. There will be a waitlist control group to which you may be assigned. Those in the waitlist control group will be offered the exercises upon completion of the study.

You will be entered into 3 \$300 draws. All participants will be entered to win the draw, with additional entries for participants who complete the weekly testing and post study questionnaires.

Risks and Discomforts: Some people may experience mild distress while filling out the questionnaires and thinking about the work with their clients. However, these assessments are validated and widely used measures that allow for the opportunity to consolidate and reflect on clinical skill development. You may withdraw from the study at any point without any penalty. If you do experience any distress or discomfort or have questions about the study, you can contact the researchers directly.

Benefits of the Research: You may benefit from this research by gaining insight into yourself as a therapist and acquire greater ease in your new role. The exercises being tested are expected to

have lasting positive effects. In addition, the well-being of therapists in training is understudied and you will be contributing to an important area of research.

Voluntary Participation and Right to Withdraw: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, you will have the option to also withdraw your data up until the analysis is complete.

Confidentiality: All information you supply during the research will be held in confidence. Your name or other identifying information will not appear in any report or publication of the research. All data will be collected online, and upon entry to the study, you will be given a study ID and no identifies will be used. Your data will be safely stored on an encrypted server in a locked facility and only research team members will have access to this information. Confidentiality will be provided to the fullest extent possible by law.

Storage of information: All data will be collected online and stored on an encrypted server. The data collected in this research project may be used – in an anonymized form - by members of the research team in subsequent research investigations exploring similar lines of inquiry. Such projects will still undergo ethics review by the HPRC, our institutional REB. Any secondary use of anonymized data by the research team will be treated with the same degree of confidentiality and anonymity as in the original research project. The researchers acknowledge that the host of the online survey (Qualtrics) may automatically collect participant data without their knowledge (i.e., IP addresses). Although this information may be provided or made accessible to the researchers, it will not be used or saved without participant's consent on the researchers' system. Further, because this project employs e-based collection techniques, data may be subject to access by third parties because of various security legislation now in place in many countries and thus the confidentiality and privacy of data cannot be guaranteed during web-based transmission.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Dr. Myriam Mongrain either by telephone at (416) 736-2100, extension 66193 or by e-mail mongrain@yorku.ca. This research has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

☐ By checking this box, you are stating that you understand the above information and agree to participate in this study. You are not waiving any legal rights by signing this form. Your signature does not commit you to all phases of the project and you may withdraw from it at any

time.

Additional consent

☐ By checking this box, you are stating that you give the researchers permission to use this data for future analysis of similar projects. All data will remain anonymous and no identifies will be used. As well, I understand that my name and other identifying information will not appear in any report or publication of the research.

Appendix C

Loving Kindness Meditation

Becoming a clinical psychologist can be full of stress, especially around the first sessions of doing therapy. It's important to learn ways to think more positively about the process. Thankfully, there are tools in the psychological literature that can be helpful. Loving kindness meditation for example has attracted a lot attention and is gaining support in the empirical literature. Practicing loving kindness is an ability that has been associated with many mental health benefits, including reductions in depressive symptoms and pain, and more satisfaction with life. The goal of this exercise is to help you learn to generate reassurance towards yourself and your client. It may help re-focus your thoughts and feelings on being more accepting, and non-judgmental of the process.

After your session, sit in a comfortable position and begin by taking slow, deep breaths.

Bring your awareness to your heart, imagining as if each breath allows your heart to grow just a bit more. Take a moment and try to remember a time when you have been a loving and kind friend to others, or when someone has shown kindness or generosity towards you. Let the feeling of caring or love or support shown towards you sink in for a few breaths.

Start with thinking about someone you love and care about deeply. Try thinking about this special person as you extend these wishes towards them:

May they be happy.
May they be healthy.
May they be peaceful.
May they be safe.

Next, observe the following phrases with love and kindness. You may even want to try saying them out loud:

May I be happy.
May I be healthy.
May I be peaceful.
May I be safe.

You can close your eyes, breathe deeply, and take a few minutes to repeat these phrases to yourself, focusing on opening your heart and feeling loving-kindness.

Next, extend those feelings to your clients, and try repeating the following phrases:

May my client be happy.
May my client be healthy.
May my client be peaceful.
May my client be safe.

Let the feelings sink in, and perhaps try the following phrases as well since you are working as a team. With this integrated sense of the therapeutic relationships, repeat the following phrases:

May we be happy.

May we be healthy.

May we be peaceful.

May we be safe.

It's okay if your sessions feel difficult or challenging at first; cultivating warmth towards oneself and towards one's clients takes practice.

Spend 5-10 minutes after each session to practice this exercise. Notice your breath. Continue to generate these feelings of care and compassion for yourself.

Adapted from Brantley & Hanauer, 2008, Finkel, 2008, & Salzberg, 1995

Working with Yourself

- 1) Please describe a moment in your session with your client that left you uncomfortable, uneasy, or upset (e.g. “there was a moment where nobody said anything and it was super awkward”):

- 2) List the specific criticisms that you have towards yourself regarding this difficult moment (e.g. “You should have said XYZ at that moment.” “You should not have done XYZ”):

- 3) Write the feelings associated with these criticisms (e.g. I feel inferior never good enough; I feel guilty, like I should have known better; I feel anxious, like I made the client worse):

- 4) Let’s work with the criticism that sticks out the most. Just as every human being deserves a fair trial, each of your thoughts deserves a “trial” as well. How credible is this self-criticism? (e.g. It’s way too unfair.)

- 5) How could that critical part of yourself be more supportive of you in these moments? (e.g. “I’m new at this; I have what I need; I’m doing as well as anyone could expect.”)