



UMEÅ UNIVERSITET



Learning how to learn

**Psychology Trainees' Self-compassion while
implementing Deliberate Practice, with FIT at a
Psychotherapy Training Clinic**

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Abstract

The effects of clinical supervision on treatment outcome has been shown to be unclear, and this part of the education to be a challenge for trainees. This study in a naturalistic educational setting, examined how psychology trainees' ($n=12$) self-compassion (SC) develop during one year of their clinical training, and whether it covaries with the Feedback-Informed Treatment instruments Outcome Rating Scale, Session Rating Scale, and Lead Alliance Supervision Scale (LASS), with a Deliberate Practice supervision (supervisors, $n=2$) approach. Regression analysis revealed that the trainees' SC increased significantly ($\beta=.819$), interpreted helping them develop a learning stance. The covariance with supervisors' SC ($\beta=.694$), and LASS (Pearson's $r=.538$) were interpreted as the supervisors constituting good models for how to conduct assessments, and receive feedback for further self-reflection. The results suggest that this model has supported the trainees' development, and the supervisors' guidance. Further research is needed to examine causal relationships.

Keywords: Deliberate Practice, Self-Compassion, Feedback-Informed Treatment, Supervision, Education in Clinical Psychology

Abstrakt

Effekten av psykoterapihandledning på behandlingsutfall har sedan tidigare visat sig högst oklar och denna del av utbildningen är en stor utmaning för studenter. Denna studie syftar till att undersöka hur psykologstudenters ($n=12$) självmedkänsla (SC) utvecklas under ett år av deras kliniska utbildningsmoment, och hur den relaterar till skattningar med Feedback-Informed Treatment- instrumenten Outcome Rating Scale, Session Rating Scale, och Lead Alliance Supervision Scale (LASS), med en handledningspedagogik (handledare, $n=2$) i enlighet med Deliberate Practice. Regressionsanalys visade att studenternas SC ökade signifikant ($\beta=.819$), vilket antyder att metoden hjälpt dem utveckla ett lärande förhållningssätt. Samvariansen med handledarnas SC ($\beta=.694$) och LASS (Pearson's $r=.538$), indikerar att handledarna har kunnat utgöra modell för hur studenterna kan administrera mätningarna samt ta emot och diskutera feedbacken, för vidare självreflektion. Resultaten visar att denna modell har utgjort stöd för studenternas utveckling och för handledarnas vägledande arbete. Ytterligare forskning efterfrågas för att undersöka kausala förhållanden.

Nyckelord: Deliberate Practice, Self-Compassion, Feedback-Informed Treatment,Handledning, Utbildning i klinisk psykologi

List of abbreviations

DP	Deliberate Practice
FIT	Feedback- Informed Treatment
SC	Self- Compassion
LASS	Leads Alliance in Supervision Scale
ORS	Outcome Rating Scale
ROM	Routine Outcome Monitoring
SRS	Session Rating Scale

Learning how to learn: Psychology Trainees' Self-compassion while implementing Deliberate Practice, with FIT at a Psychotherapy Training Clinic

In several countries, such as the United States (Duncan, Miller, Wampold, & Hubble, 2010; Miller, Hubble, Chow, & Seidel, 2013) and Sweden (SOU 2019:15), many people in need of care due to mental illness have been noted to choose complementary and alternative care before regular healthcare. One states a feeling of being better treated, listened to and that one in said context feels more capable and healthier, rather than pathologized and helpless (SOU 2019:15). Despite psychotherapy being proven effective (American Psychological Association [APA], 2012; Beutler, 2009; Beutler et al., 2003; Chorpita et al., 2011; Cuijpers, 2017; Duncan, et al., 2010; Lambert & Ogles, 2004; Smith, Glass, & Miller, 1980; Verheul & Herbrink, 2007; Wampold & Imel, 2015), and offered within public care in many countries, those in need tend to prefer alternative help, that has been less studied. Professor Kjell Asplund, MD, by the Swedish government appointed special investigator for complementary and alternative medicine, states "...*poorly conducted psychotherapy can cause great harm*" (from Radio Sweden, *Dagens Eko*, June 5th 2019, 8.00). The statement itself points out the need to evidence- base the individual clinician, rather than different therapeutic methods, or as Miller (in Millham, 2011) phrases it: "*the most neglected variable in outcome is the therapist*" (p. 34). Many clinicians believe they improve with experience and tend to overestimate their own effectiveness (Goodyear, Wampold, Tracey, & Lichtenberg, 2017; Orlinsky & Rønnestad, 2005), while there is evidence to show that it is not the case (Erekson, Janis, Bailey, Cattani, & Pederson, 2017). Clinical abilities rather decline somewhat with time, measured in outcome of treatment (Goldberg, Rousmaniere et al., 2016). Studies show that it is instead the most self-critical, doubting and surprised clinicians that have the best treatment outcomes (Chow, 2014; Miller, Hubble, Chow, & Seidel, 2015; Najavits & Strupp, 1994; Nissen-Lie, Monsen, & Rønnestad, 2010). In other words, we need to focus more on education of, and growth in therapists in order for psychotherapy to really benefit those who are in need of it. Due to that, the ambition of this work was to study a model for psychologists' clinical education.

Unfortunately, many studies show that the effect of clinical supervision is highly unclear (Watkins, 2011) or explains less than 1 % of treatment outcome. This is due, in part, to client variables, but also to the therapist's alliance and openness in supervision as well as the pedagogy of the supervisor (Rousmaniere, Swift, Babins- Wagner, Wipple, & Berzins, 2014). Others have even shown a negative development in trainees in their clinical work (Dennhang & Ybrandt, 2013; Erekson et al., 2017). The importance of focusing on alliance over technique is emphasized (Miller et al., 2013; Ybrandt, 2018), and for trainees' natural capability of interpersonal relating not to get lost in light of learning specific therapeutic methods (Erekson et al., 2017). Traditional supervision of psychotherapy can sometimes focus too much on declarative knowledge, as opposed to procedural ability (Bennet-Levy & Haarhoff, 2019). That may possibly make it more difficult for the novice therapist to take the leap from theory to practice. This prompts the need for an examination of how supervision in clinical education can be structured in order to create the best possible learning opportunities.

In studying highly effective therapists, the single most important factor determining to what extent the clinical psychologist develop their professional ability may be *deliberate practice* (DP; Ericsson, 2006, 2016; Rousmaniere, 2017). The more time, the better the treatment outcome (Goldberg, Babins-Wagner et al., 2016; Miller et al., 2015; Chow et al., 2015). DP is outmost about individual goal-oriented repetitive training just beyond present ability, regardless of what ability one is concerned with - playing chess, piano, basketball or practicing psychotherapy (Ericsson, 2006, 2016; Rousmaniere, 2017). In a therapeutic context DP is about the time one puts into individual goal-oriented training beside the clinical practice and supervision. It is further a working method not tied to any theory or method. The definition

of DP is emphasized both due to clinical motives for creating the best learning conditions, as for research motives for being able to compare different studies, for a correct estimation of the effects on treatment outcome (Miller, Chow et al., 2018). One states that work with DP should focus on therapeutic abilities which, according to research, covaries with good treatment outcome regardless of psychotherapeutic orientation, so-called *common factors* (Duncan et al., 2010; Wampold & Imel, 2015). In a context of supervision, these are readily exemplified in "*Taxonomy of Deliberate Practice Activities in Psychotherapy - Therapist*" (Miller, Hubble, & Chow, manuscript in preparation), whereafter focus for the DP-exercise is chosen alongside the supervisor. Chow explains the importance of ONE focus at a time: "*Chase only one rabbit at a time, if you chase two, you'll miss both*" (D. Chow, personal communication, August 8, 2018). The supervisor designs the DP-exercises, which often consist of repetitive intervention-elements to the trainees' own therapy films (Chow 2018; Miller, Hubble, & Chow, 2018; Rousmaniere, 2017, 2019). The exercises should lie just beyond the trainee's current ability, in the so-called *proximal development zone* (Vygotsky, 1978), in order to challenge the trainee to a tolerable extent. This in turn is possible to control with a so-called "*difficulty-scale*" (Rousmaniere, 2019).

Through Routine Outcome Monitoring (ROM; continuous measurements of the client's well-being and of alliance in treatment) during the process (Goldberg, Babins- Wagner et al., 2016; Rousmaniere, Goodyear, Miller, & Wampold, 2017), the clinician and supervisor receives guidance regarding what area that needs focus, both concerning psychotherapeutic work and the personal development with DP. Feedback-Informed Treatment (FIT) is an example of ROM-instruments used for this purpose, such as Outcome Rating Scale (ORS) for measurement of the patients' well-being, and Session Rating Scale (SRS), for measurement of alliance in treatment (Miller & Bertolino, 2012). When FIT-assessments work as a guide for the clinician's own development and most importantly the treatments that do not develop, it is apparent that these instruments of measure have had an effect on a number of outcome measures in psychotherapy. This includes FIT doubling the effect size, cutting dropout rates in half, decreasing the risk of deterioration in therapy with 33 %, shorten length of treatment with 66 % and reducing costs for care (Brattland et al., 2019; Lambert & Shimokawa, 2011; Miller et al., 2015, 2013; Reese, Norsworthy, & Rowlands, 2009). There are further results in educational contexts, suggesting that the use of clients' feedback in supervision is related to better outcomes in treatment, as well as giving trainees a more realistic perception of their own therapeutic ability (Reese et al., 2009). Yet another study showed results not quite as good, which was explained to possibly be due to the functional level of the psychiatric patients and their reduced reflective ability during crises, or the high efficacy of the clinic at the starting point (Oenen et al., 2016). An alternative interpretation can be that the instruments potentially were not used as intended. This emphasizes the importance of careful implementation for optimal effect.

FIT has been used in psychotherapeutic education to teach trainees to evaluate their therapies, but more importantly in an educational context, to help them learn to receive and follow up on clients' views, increasing their self-reflection and eventually formulating their own goals for development and continued learning. The assessments did, however, come to be perceived as critique of their own individual therapeutic ability, something that the trainees struggled to handle. It has been proposed that implementing the FIT-instruments and their function has to be even more clear in order for it to overcome resistance in both trainees and supervisors, and thus letting the instruments have full effect (B. Elmquist, former director of studies at Scandinavian Academy for Psychotherapy Development [SAPU], personal communication, May 1, 2019). Beside a clarification of the function of the feedback-instruments at implementation, one has presently also urged working with DP as well as continually following up on the work for both trainees and supervisors (A. Törnqvist, present

director of studies at SAPU, personal communication, May 10, 2019). The need for thorough education ahead of implementation and continuous follow-up is emphasized in order to decrease resistance mainly with supervisors. This, in turn, so that the supervisors are able to engage trainees in the work (J. Svebeck, supervisor at SAPU, personal communication, May 13, 2019).

The resistance against actually letting oneself be guided by, and develop on the basis of clients' feedback is shared by many, especially professional clinicians (Miller et al., 2015; Rousmaniere et al., 2017). One worries about results being used to: "...*hire, fire, bonus, or punish.*" as Miller and colleagues phrase it (2015, p. 450). This, instead of letting results guide treatment and the own developmental work. Implementation of FIT needs to clearly explain how in psychotherapy the (1) purposeful work with DP (Chow, 2018; Rousmaniere, 2017, 2019) is guided by (2) the continuous measurements in therapy with ROM, under a (3) supervisor who carefully follows the development and (4) gradually modifies the exercises for the individual therapist. All four parts have to be present, like in a "*Cycle of Excellence*" (Rousmaniere et al., 2017), in order for the therapist to grow professionally (Figure 1; Miller, Hubble & Chow, 2017).

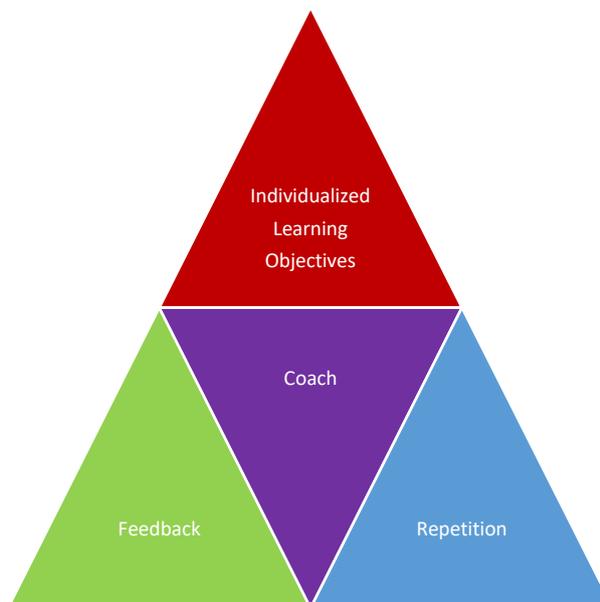


Figure 1. Illustration of the four important parts of reaching clinical excellence (Miller, Chow et al., 2018; Miller, Hubble et al., 2018; Rousmaniere et al., 2017)

An example of a DP exercise, used in this study, to orient both the supervisor and the trainee towards a baseline in the beginning of the year of supervision, was a modified version of the so-called warm-up exercise (Rousmaniere, 2017, p.135-139). The trainee attuned to his or her own reactions to a therapy film, noting: What do I see; What do I hear, and What do I feel as I watch my own therapy-film? The trainee rotated through the skills in 1-2 min segments for 15-20min, and then evaluated what skill he or she felt was easier, and what was harder. Focus for supervision was then on that particular hard part, within the zone of proximal development (Vygotsky, 1978). When it was hard for the trainee to really see or feel with the patient, it could for example be helpful to mirror the body movements of her/his patient and feel what it feels like to move like that, and then imagine what the patient might have felt. When listening was the hardest- For helping trainees learn how to listen more carefully to the patients' voice and words, the whole group could help each other to find the

emotional laden words in the therapy film, by writing them down while the film was running, and then compare with each other what words they found.

Accordingly, to DP and FIT you have to let yourself be guided by above all negative feedback in the developmental work. That can be greatly challenging and therefore require good *self-compassion* (SC; Neff, 2009, 2018). SC is described as “...*the ability to hold one’s feelings of suffering with a sense of warmth, connection and concern.*” (Raes, Pommier, Neff & Van Gucht, 2010, p.250), especially during difficult times. It has been proven important in academic environments, in order to cope with challenges in educational contexts, to be open and involved in discussions, and be able to receive both negative and positive evaluations in the educational setting (Long & Neff, 2018; Neff, Hsien, & Dejitterat, 2005). SC has also been shown to be related to a learning mind with *mastery goals*, rather than *performance goals* (Babenko & Oswald, 2018; Neff, et al., 2005). A learning and open mindset has further been identified as important for learning, especially from negative feedback (Chow, 2018; Duncan, Miller, & Hubble, 2007; Miller et al., 2013).

The pedagogical DP-model serving as a foundation for this study is in line with *the cycle of excellence* (Figure 1; Goldberg, Babins-Wagner et al., 2016; Goodyear et al., 2017; Miller, Chow et al., 2018; Rousmaniere et al., 2017), by implementing the principles of DP together with the self-assessment forms of FIT (Miller & Bertolino, 2012) in trainees’ therapies. Previous research has emphasized the need of studying how one in pedagogy might support and follow trainees’ professional development during clinical education (Dennhag & Ybrandt, 2013). Therefore, this study also accommodates parallel assessment of trainees’ alliance in supervision with the FIT-instrument *Leads Alliance in Supervision Scale (LASS)* (Wainwright, 2010), and assessment of the trainees’ SC for fostering a self-compassionate learning stance, as well as measurements of the supervisors’ SC in order to support the supervisors and to let them become a model for the trainees in question. This due to previous findings suggesting that self-compassion supports trainees’ openness in supervision (Mehr, Ladany, & Caskie, 2010).

The author did not find any studies of implementing DP with FIT (ORS, SRS, and LASS) in an educational setting that has been evaluated with assessment of SC. The present model has been examined in two separate studies: - a qualitative study focusing on trainees’ experiences of the model (Axelsson & Kihlberg, 2019) and the present quantitative study reporting results from assessments with the FIT-instruments and SC-scale. In the center of this study is the urgency to examine what this procedure brings to the trainees’ self-compassion and ability to learn how to learn. Therefore, the aim of the study was to examine how the trainees’ self-compassion covary with the different FIT-instruments throughout one year of their clinical practice with this pedagogical DP-approach.

The hypotheses to be tested were (Figure 2) that (1) the trainees’ self-compassion will be preserved or even increase over time of training, (2) the trainees’ SC will covary with the supervisors’ SC, (3) the trainees’ SC will covary with alliance in supervision (LASS) and therapy (SRS), (4) the trainees’ and supervisors’ SC will covary with patients’ well-being (ORS), and (5) these results will confirm earlier findings of alliance in therapy (SRS) covarying with treatment outcome (ORS).

The hypotheses refer to discussions of measurements in both therapy and supervision fostering a self-compassionate stance. This, since good self-compassion in academic settings might be trained by openly communicating the common humanity about fear, and “*modeling kindness in response to students’ communication attempts*” (Long & Neff, 2018, p. 229). Modeling further suggest that the supervisors’ open stance around one’s own SC will help trainees to be more self-compassionate, open, and able to ask for help when needed, as has been shown (Long & Neff, 2018). A good SC is further helpful in being able to receive both positive and negative feedback without withdrawing or getting defensive, facilitating a learning

mind in accordance with prior research (Babenko & Oswald, 2018; Neff et al., 2005). This would therefore help them create a good alliance in both supervision and therapy. A strong supervisory relationship further predicts increased supervisee disclosure and stronger supervisee-client relationships (Goodyear, 2014), and as numerous research findings show a good alliance in therapy covary with a good treatment outcome (Wampold & Imel 2015). The reasoning described above is illustrated in Figure 2, and the relationships investigated in this study are marked with double-ended arrows in the figure.

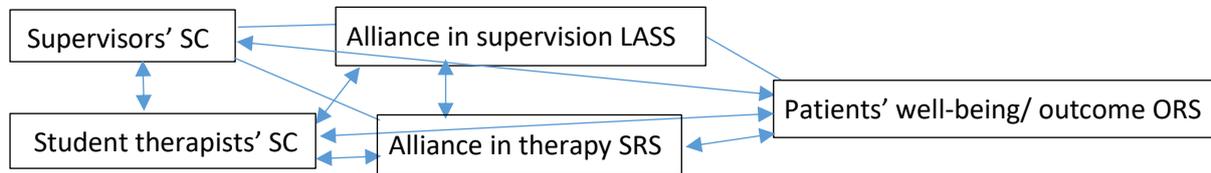


Figure 2. Illustration of hypothesized covariations in this pilot study marked with double-ended arrows.

Method

Participants

This study was conducted in a naturalistic environment, at an outpatient training clinic at a university. Psychotherapeutic practice during semester 7-10, one year Cognitive Behavioural Therapy (CBT) and one year Psychodynamic Therapy (PDT), is part of a regular clinical psychology program at the university. Two voluntary supervisors in psychotherapy (one CBT and one PDT) were, through the department's routine procedure, assigned two groups each: - one group per supervisor during semester 7-8, and one group per supervisor during semester 9-10 (n = 12, three trainees in each supervision group). Thereafter written informed consent was given by the participating trainees. None of them declined to participate in this study. Demographics upon trainees and clients are presented in Table 1.

Table 1. Age, and gender of the trainees and clients

Clients	Trainees		Men	Women
	20-29 years	30-39 years		
20-29 years	6	2	1	7
30-39 years	3	1	1	3
Men	3	1	1	3
Women	6	2	1	7

Questionnaire Instrument

Self-compassion (SC) is concerned with how we relate to ourselves when difficulties arise in life. "Theoretically self-compassion is comprised of six components that combine and mutually interact to create a self-compassionate frame of mind when faced with personal inadequacy or life difficulties: self-kindness versus self-judgement, a sense of common humanity versus isolation, and mindfulness versus overidentification" (Neff et al, 2018, p. 2). SC is preferably measured through a longer self-assessment scale with 26 items (SCS) with evidence for good internal consistency for a total SCS-score, with Cronbach's $\alpha = .92$ and test-retest reliability correlation over a three weeks' time of $r = .93$ (Neff, 2003). SC has also been measured with a shorter scale (12 items; SCS-SF) with evidence for an adequate internal

consistency with Cronbach's alpha ranging from .85 to $\geq .86$ (Hayes, Lockard, Janis, & Locke, 2016; Raes et al., 2011). SCS-SF also shows a strong correlation with the long form SCS, estimated to $r \geq .97$ and a test-retest reliability over five months of $r = .71$ (Raes et al., 2011). One can therefore regard the shorter instrument of measure (SCS-SF) an adequate alternative to the longer (SCS). Studies have indicated SC being a joint trait, consisting of the six different traits, and that none of these qualities on their own or parts of them alone correctly reflect self-compassion. All of them should instead be examined either by using all six sub-scales of the instrument together, alternatively be rated as one whole joint unit (Neff et al., 2018).

For that reason, and for feasibility for multiple ratings, a one-item scale was created for this particular study. Two studies in Swedish samples, with a Swedish translation of the tests have been found, but neither of them: SCS-Swe22 (Andersson, 2015), and SCS-SF (Bratt, & Fagerström, 2019) had however translated the different factors, only the items. For the ultra-brief assessment, here used, the wording of the factors was simplified and translated into Swedish, gathered on a scale from an un-compassionate stance (self-critical, lonely and worthless), to a self-compassionate stance (self-caring, valuable and self-accepting), based on (Andersson, 2015; Hayes et al., 2016; McCullough & Thornes, 2007; Neff et al., 2018; Raes et al., 2011). This scale, and the translation of it into Swedish is, however, not validated.

The *FIT-instruments* (ORS, SRS, LASS) are all ultra-brief self-assessment forms, and therefore feasible as process instruments for continuous measurements in developmental work in both treatment and supervision, but also in their evaluation.

ORS has been used to follow the development of the clients' well-being from session to session (Miller & Bertolino, 2012; Miller & Duncan, 2000; Miller, Duncan, Brown, Sparks, & Claud, 2003). This instrument was developed from the longer self-assessment form *The Outcome Questionnaire-45.2* (OQ-45.2; Lambert et al., 1996). ORS, consists of four questions about the clients' well-being: Individually, Interpersonally, Socially and Overall. The instrument's psychometric properties have been evaluated in a number of studies, showing good reliability with an overall internal consistency with Cronbach's alpha values ranging from .84 to .96 (Miller et al., 2003; Miller & Bertolini, 2012; Hafkenscheid, Duncan, & Miller, 2010; Moggia, Niño-Robles, Miller, & Feixas, 2018). This is comparable to the longer OQ-45.2 ($\alpha = .93 - .98$). Test-retest reliability correlation coefficient (Pearson's r) for ORS, was $r = .66$ (1st to 2nd session/one week), and $r = .49$ (1st to 4th/four weeks) for the clinical population during treatment, and for ORS for a non-clinical adult population $r = .80$ (with 1-2 weeks between measurements). This indicate that the instrument is sensitive to change in the clinical population, and discriminating well between a clinical and non-clinical population ($p < .00001$, with t-test), a form of construct validity (Miller et al., 2003). For validity, correlation between the ORS and OQ-45.2 total score ranging from $-.59$ to $-.74$ revealed a good concurrent validity (Miller, & Bertolino, 2012). Correlating ORS with distress and symptoms measures further revealed a good convergent validity from $-.32$ to $-.76$ (Moggia et al., 2018). The brevity of ORS has also been shown making it much more feasible than the longer instrument OQ-45.2. The compliance rate of ORS was 86 % at the end of one year's use, compared to 25 % use after 6 months with the OQ-45.2 (Miller et al., 2003).

SRS is the instrument of measurement used here to follow the development of alliance in treatment (Duncan et al., 2003; Duncan & Miller, 2008; Miller & Bertolino, 2012). This instrument, similarly to WAI or the shorter version WAI-S (Horvath & Greenberg, 1989), mirrors Bordin's (1979) concepts Task, Bond & Goal used for defining the working alliance in psychotherapeutic treatment. SRS does also consist of four questions: Relationship to the therapist, Goals and topics in therapy, Approach or method in therapy and Overall. The psychometric properties of SRS have shown a good internal consistency reliability, with Cronbach's alpha ranging from $\alpha = .83$ to $\alpha = .94$ (Campell & Hemsley, 2009; Duncan et al., 2003; Hafkenscheid et al., 2010; Moggia, Niño-Robles, Feixas, & Miller, 2017). Compared to

the longer *Helping Alliance Questionnaire-II* (HAQ-II; Luborsky et al., 1996), $\alpha=.90$ (Duncan et al., 2003), or WAI, $\alpha=.91$ (Campell & Hemsley, 2009), this indicates that SRS, as short as it is, is a reliable instrument for measuring alliance. Test-retest reliability with Pearson's r correlation showed an overall correlation for SRS $r=.64$ compared to HAQ-II $r=.63$ ($p<.01$, Duncan et al., 2003). Yet other studies have found the test-retest correlations for SRS ranging from $r=.49$ to $r=.81$ for a clinical sample, the lower scores earlier in treatment (Hafkenscheid et al., 2010; Moggia et al., 2017). The SRS showed a good concurrent validity, measured with Pearson's r correlation with WAI, $r=.63$ (Campell & Hemsley, 2009), and with HAQ-II, $r=.48$ (Duncan et al., 2003). SRS has also shown a predictive validity of $r=.29$ ($p<.01$) measured between the second or third session SRS scores and the final session ORS scores (Duncan et al., 2003). The compliance using SRS was 96 % compared to the usage of the WAI, 29 % during the same period, indicating a very good feasibility for the SRS-instrument (Duncan et al., 2003).

Alliance in supervision has been measured with LASS, also an instrument based on Bordin's concept of alliance (Tangen & Borders, 2016; Wainwright, 2010). LASS consists of three questions: Approach in supervision, Relationship with the supervisor and Meeting my needs in supervision. The instrument is recommended especially for clinical work with multiple assessments, to examine feedback in supervision, due to its brevity, and therefore feasibility (Tangen & Borders, 2016). Because of the same reason LASS is also limited, in being unable to capture the whole process of supervision. LASS showed a moderate overall reliability with Cronbach's alpha ($\alpha=.71$), and test-retest reliability of $r=.63$ (Tangen & Borders, 2016), which demonstrates the instrument's sensitivity to change (Wainwright, 2010). Correlations between LASS and other previously validated measurements for alliance in supervision, showed a concurrent validity ranging from $r=.52$ to $r=.71$ (Ladany et al., 1996; Tangen & Borders, 2016). Tangen and Borders (2016) state that the test needs to be evaluated further, including examination of construct- and predictive validity.

The questions of all scales are presented on a 10 cm continuous line, on which the client rates well-being (ORS) and alliance in treatment (SRS). The trainee rates alliance in supervision (LASS), and the trainee and supervisor rate self-compassion (SC) individually in supervision. All scales are rated through providing a mark on the line (poor - good) for each question, on each instrument. The length is measured from 0 to the mark, and results from the different questions are added together for each scale separately. This gives a max value of 40 for ORS and SRS, 30 for LASS, and 10 for SC.

Procedure

The quantitative instruments continuously measured the trainees' and supervisors' self-compassion (SC), alliance in treatment (SRS) and supervision (LASS) as well as the patients' well-being (ORS) during one year (divided into two semesters) of their clinical practice. The instruments constituted a basis for discussion in both supervision and treatment. The measurement of LASS and SC in supervision aimed to let the supervisor act as a model (Bandura, 1977) for the trainee regarding administering assessments, giving and receiving feedback as well as reflecting openly on measurements, rather than simply telling the trainees how they should do it. Thus, supervisors prepared the trainees for similar reflections around the assessments of ORS and SRS in therapy in cooperation with their patient. The importance of the modeling feedback loop has further been pointed out by others (Chow, 2017).

ORS, SRS, LASS and SC were all used at every psychotherapy and supervision session, throughout the whole assessment period of the study. The trainees' and supervisors' self-compassion (SC) was assessed at the end of each supervision session, and the trainees assessed the alliance in supervision (LASS) at the same occasions. The results were then discussed in the supervision group by both supervisor and trainees. The clients' well-being (ORS) was

assessed by the client and discussed together with the trainee at the beginning of each psychotherapy session. The alliance in psychotherapy (SRS) was assessed by the client and discussed together with the trainee at the end of each psychotherapy session. Changes in the clients' well-being (ORS) and alliance (SRS) from one session to the following were continuously evaluated in supervision by looking at the clients' measures and from them generated graphs for discussing the progression over time of treatment (Bargmann, 2017).

The trainees administered ORS and SRS assessments in treatments, and the supervisor was responsible for administering the assessments of LASS as well as the trainees' and supervisor's SC in supervision. The purpose of multiple assessments was pedagogical, in order to continuously adjust focus for supervision, individualized DP-exercises and clinical practice. The aim of this procedure was to create the best possible conditions for the trainees' learning, learning how to learn, and by extension a good treatment as well as treatment outcome.

Ethical considerations

An ethical consideration in this study was the always present power imbalance which prevails between trainee and supervisor. This could have impacted the trainees' choice to participate, despite them all signing a written consent to participate in the study including a clear statement that their anonymity would be preserved, with the possibility to end their participation at any moment of their own choice without any negative consequences. This is in line with the Swedish Research Council on ethics considerations and guidelines (2017).

Statistical Analyses

Missing values have been replaced with the mean value of other participants with the same instrument (SC, LASS, SRS, ORS) at the same point in time. One week has been removed entirely, when no SC-measurements were available due to a public holiday (May 1st). Since the supervisors had not synchronized their planning before the summer and winter break, these weeks were combined in order to avoid an inadequate interpretation of missing values. Simple linear regression analysis based on means across participants was conducted to examine how the trainees' SC changed during the studied period (hypothesis 1). Linear regression analysis was further used to examine changes in standard deviations among trainees' SC over the same period, and for studying the relationship between the trainees' and supervisors' SC (hypothesis 2).

Pearson correlation analysis was used to test the relationships between trainees' SC and LASS, LASS and SRS, SRS and trainees' SC (hypothesis 3); the relationship between trainees' SC and patients' well-being (ORS), supervisors' SC and patients' ORS (hypothesis 4); as well as the relationship between the patients' ORS and alliance in treatment (SRS) (hypothesis 5). Number of measuring points for trainees' SC and LASS was 28; for clients on SRS and ORS 26, and for supervisors' SC 21. The analyses were performed with IBM SPSS Statistics 25 (IBM Corporation, New York), and the α -level was set at .05

Results

The Linear regression analysis revealed significant relationships between trainees' SC and the time studied (hypothesis 1), $r^2=.670$, $\beta=.819$, $p<.001$, with a statistically significant decrease in SD over time, $r^2=.269$, $\beta=-.519$, $p=.005$ (Figure 3) and a significant correlation between trainees' SC and supervisors' SC (hypothesis 2), $r^2=.482$, $\beta=.694$, $p<.001$.

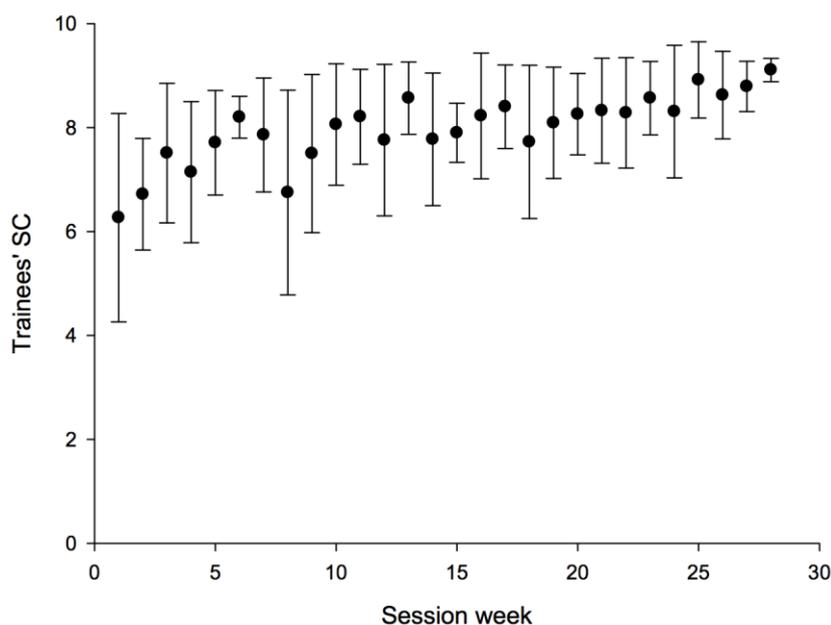


Figure 3. Means across the trainees' SC with standard deviations for each week.

The Pearson's r correlation analyses showed significant correlations between trainees' SC and LASS (hypothesis 3), $r(26)=.538, p=.003$; between trainees' SC and clients' wellbeing (ORS) (hypothesis 4), $r(24)=.391, p=.048$; between clients' self-reported alliance in treatment (SRS) and ORS (hypothesis 5), $r(24)=.642, p<.001$. Neither of the following correlations were significant: correlation between trainees' SC and SRS (hypothesis 3), $r(24)=.377, p=.058$; relationship between supervisors' SC and ORS (hypothesis 4), $r(19)=.411, p=.072$; and between LASS and SRS (hypothesis 3) the correlation was: $r(24)=.284, p=.16$.

Discussion

The aim of this study was to examine how trainees' SC changed throughout one year of their clinical practice, as well as how their SC was related to the different assessments in treatment (ORS and SRS) and supervision (LASS and supervisor's SC). Through discussion of these in supervision, the supervisor acts as a model for how trainees can integrate the instruments in treatment. The assessments have further guided the supervisor's focus on DP-exercises, and thus also the trainee's own development into a clinical psychologist, simultaneously. That includes students receiving training in letting their own clinical and professional development be guided by both clients' feedback and reflection on LASS and SC assessments. The approach intended to foster a *learning mind* with *mastery goals* (Neff et al., 2005; Chow, 2018), thus creating optimal conditions for the trainees to learn how to learn psychotherapeutic work and to stimulate continued development after the end of their formal education.

None of the tested hypotheses in the study could be falsified, but some of the supposed relationships were confirmed to a significant extent. Results show how trainees' self-compassion significantly increased during the studied period, confirming hypothesis 1. A total of 67 % of the variance in their SC could be explained by length of assessment. A higher degree of self-compassion has previously been showed to covary with higher openness, curiosity and innate motivation, with "*mastery goals*" rather than "*performance goals*" (Long & Neff, 2018; Neff et al., 2005). The latter is driven by a fear of failure and explained as "*mastery*

avoidance”: fear of trying new things, making mistakes or doing worse than before, as well as fear of asking for help when one needs it or being seen as less smart (Babenko & Oswald, 2018). The repeated measures of SC are in this case regarded (similarly to FIT-measurements) mainly as a base for, and practice in, open reflection. The fact that the spread in SC-measurements decreased significantly throughout the study was an incidental finding, showing an increased coherence among trainees. This could be seen as a desirable learning effect, when repeated measurements aimed to increase trainees’ awareness of being a part of humanity that sometimes comes across problems, helping them approach their self-evaluation in a more balanced way as well as being more self-caring. This means being overall more self-compassionate, in fostering a learning stance (Babenko & Oswald, 2018), and thus the procedure itself having increased their SC. In Axelsson and Kihlberg (2019) it also becomes clear how assessments of SC contributed to security and openness in supervision groups, and helped trainees to handle difficulties throughout the process.

The significant relationship between supervisors’ SC and trainees’ SC confirmed hypothesis 2: the probability of it not being a relationship in the population of trainees’ and supervisors’ SC in supervision was calculated to be less than 0.1 %. The results further showed that 48 % of the variance in the trainee’s SC could be explained by the supervisors’ SC. All assessments covaried, and the fact that students grew more self-compassionate during the year seems to support the principles of modeling (Bandura, 1977). Through the supervisor themselves being open in reflections on their own SC-assessments (and trainees’ LASS-assessments), they have demonstrated a learning approach. This, in turn, was related to trainees’ ability to relate self-compassionately and openly with a *learning mind*. In Axelsson and Kihlberg (2019), trainees also emphasized their supervisors’ own assessments and part-taking in roleplay as educational. This is in agreement with how other researchers have pointed out the importance of a supportive environment, in order for critical feedback to be seen as an opportunity for learning (Miller, 2007; Miller et al., 2013).

This study could only partly confirm the expected covariance between the involved parties (supervisor, trainee and client) in ability to relate interpersonally (hypothesis 3). The relationship between trainees’ SC and alliance in supervision (LASS) was significant in line with an earlier study (Mehr et al., 2010). However previous research findings showing a significant relationship between trainees’ alliance in supervision and clients’ alliance in treatment (Neff et al., 2005; Babenko & Oswald, 2018; Goodyear, 2014) could in this study not be verified, and neither could findings showing how trainees’ SC was related to clients’ SRS. A question that arose in this context was whether SC could be considered a condition for alliance, meaning that one needs to be able to feel like a part of humanity, be mindful about one’s shortcomings and be kind to oneself, in order for one to be able to appreciate others fully, with a *learning mind*. This could possibly explain, in part, why a relationship between LASS and SRS as well as SRS and trainees’ SC was not found, when it except for the alliance itself would require a good SC in all involved parties: supervisor, trainee and client.

The supposed relationship between the different parties’ well-being (ORS and SC for trainees and supervisors; hypothesis 4) could also only in part be confirmed. In addition to the already reported relationship between SC assessments for trainees and supervisors (hypothesis 1), results showed a significant relationship between the trainees’ SC and clients’ ORS. The relationship between supervisors’ SC and ORS was, however, not significant. Well-being in the direct contact between supervisor and trainee, as well as trainee and client, were significantly related, but the relation in well-being in the indirect contact between supervisor and client, was not significant, and could therefore not be confirmed, maybe due to the small number of participants in this study. At the same time, this is in line with the unclear image of the importance of supervision in treatment outcome, which has been shown in previous research, but where supervision has simultaneously been emphasized as support for the

therapist in developing their professional identity (Watkins, 2011). The trainees' SC and patients' well-being covarying could possibly also be interpreted as a performance-based self-esteem (*performance mind*) in the trainee, meaning that they would more readily feel self-compassion in cases when they in supervision could show better results from treatment (ORS). If this is the case, assessments of SC become even more important in order to practice a *learning mind*, where inferior results could be seen as opportunities for further learning (Chow, 2018; Miller et al., 2007).

In line with a number of previous research findings (Duncan et al., 2010; Wampold & Imel, 2015; Wampold, Imel, & Miller, 2009), the relationship between alliance in treatment (SRS) and treatment outcome (ORS) was significant (hypothesis 5). This emphasizes the importance of supervision first and foremost focusing on treatment alliance, in order to increase the therapist's clinical ability and for the best possible outcome in treatment (Baldwin, Wampold, & Imel, 2007; Bambling, King, Raue, Schweitzer, & Lambert, 2006; Duncan et al., 2010; Miller et al., 2013; Ybrandt, 2018). It has further been shown that it is the client's assessment of the therapist's ability to create alliance that is most important for a good treatment outcome (Baldwin et al., 2007). Working with alliance thus becomes a treatment intervention in itself where interpersonal learning, and insight into it, can contribute to a so-called *corrective emotional experience* (Alexander & French, 1946; Brattland et al., 2019).

Strengths and Limitations of the Study

This being a correlational study, the results do not suggest anything regarding causality. A control group has not been included, in part due to the difficulty in defining "regular" supervision, while other supervisors have been inspired by DP and FIT as well. This meant that effects of the pedagogy had not been possible to compare in an adequate and correct manner.

The measurements in this study are all self-assessment instruments that always contain some form of problematic subjectivity. Miller and Bertolino (2012) emphasize the importance of a careful administration when using them, including the therapist successfully conveying interest for, and meaningfulness regarding the assessments, and allowing time for them as well as handling, above all, negative feedback and adjusting treatment accordingly. This to avoid risking the instruments' validity. The supervisors' approach to the instruments and assessments did in this case come to act as a model for the trainees' administration of instruments in treatment, which was one way of aiming to control for these possible measurement errors. The instruments further do not entirely cover the meaning of what they are meant to measure. Here one has aimed to control for this through Axelsson and Kihlbergs (2019) qualitative study. In that study, in coherence with this one, the risk of measurement errors is highlighted, as the therapist's or supervisor's reactions to assessments may have affected how free the clients and trainees respectively felt to assess honestly. This could partly be controlled for through the supervisor/trainee carefully examining positive assessments equally, in order to discriminate between compliance and honest assessments.

The modified SC-scale which had been adapted for this particular study, was based on only one overarching, two-dimensional question, on a scale from self-compassionate attitudes to un-self-compassionate attitudes. That constituted a limitation in two ways. Firstly, the translated wording of the overarching factors had not undergone a thorough scientific translating procedure. Secondly the instrument here used, had not been validated, and compared to the longer instruments: SCS (Neff, 2003) and SCS-SF (Raes et al., 2010). However, when presented for the trainees in the study, the English wording of the factors were explained, and exemplified with the Swedish translation of the different items in each factor, to secure a correct understanding.

The study's repeated measurements can be considered a strength, as it contributed many points of measurement despite the low number of participants. However, it can also be

considered a weakness as the repetition can have contributed to a regression towards the mean or a supervisor's allegiance effect where one gradually adapts to the group's assessments or what one has perceived as desirable by the supervisor/trainee or others in the supervision group. Furthermore, the analysis is built on the mean values of the group, which does not make any claims regarding the different supervision groups or the individuals studied. Previous research on trainees' development of expertise during this clinical part of the education has shown large differences between trainees, where some developed and others' abilities decreased (Dennhag & Ybrandt, 2013).

The generalizability of the results are further limited due to the sample being small, which can contribute to true findings going undiscovered. Being a naturalistic study, it does, however, carry a value in terms of external validity, as it can have significance in the context of educational development as well as psychologists continued clinical development and work. Related to the external validity is the width of the study, at the expense of the depth, due to the number of hypotheses and variables tested simultaneously. The aim of the study was, however, to orient the reader in what can be of interest to study more thoroughly in the future. Hence, this intention was to capture the width of the processes which could be present at the point of this clinical course, and what might support trainees during their education. Additionally, one should consider that the changes in the measured variables can be due to natural maturation or extraneous variables, thus being unrelated to the pedagogical approach. Perhaps their increased SC has nothing to do with DP or the other assessments, but simply the fact that they have been observed for a study by two enthusiastic supervisors or that they have a good time in life at the time of the study.

Implications

The students' SC-assessments increased throughout the study, and earlier studies have shown that SC is related to better learning opportunities (Babenko & Oswald, 2018; Neff et al., 2005). These results, thus, indicate that the DP-model may have increased the trainees' learning opportunities through higher openness in supervision and a more balanced approach to themselves in light of both positive and negative feedback as well as giving them training in a *learning mind*. Axelsson and Kihlberg (2019) also observed trainees emphasizing the importance of SC-assessments for learning and development as well as for managing the great challenges in the clinical education, including FIT and DP. The fact that the trainees' increased SC-assessments also covaried with both supervisors' SC and rating of alliance in supervision (LASS) further indicates that the supervisors may have been able to act as models for them through a nonjudgmental approach to feedback assessments. Accordingly, they seem to have been able to help trainees to reflect openly on assessment in treatment together with their client (ORS and SRS), something also confirmed by Axelsson and Kihlberg (2019). They (Axelsson & Kihlberg, 2019) further highlight LASS assessments as important in catching up on problems in the supervision group at an early stage. Brattland and colleagues (2019) also point to the meaning of repairing of ruptures in alliance as practice in interpersonal relating.

Overall, the use of assessment instruments both as evaluation and basis for discussion in supervision and treatment has further been a support for the supervisor in designing DP-exercises to allow adaptation to each individual trainee. The assessments have also drawn attention to trainees' ability to relate with advantages and flaws which could have been painful. Axelsson and Kihlberg (2019) emphasize SC-assessments as especially helpful in that regard, and the importance of being able to stay nuanced and self-caring in light of negative events is also central in self-compassion (Neff, 2009; 2018). Supervision intervention directed towards trainees' own well-being and alliance in supervision has been requested by several (Dennhag, & Ybrandt, 2013; Miller et al., 2013), and trainees' perception of alliance and cooperation in supervision as well as their disclosure in supervision has being shown to relate to their well-

being, (Mehr, Ladany & Caskie, 2010). Disclosure in supervision makes it further possible to work through ruptures in supervision, and may become good model for the trainees to work through ruptures in therapy, helping the patient to learn how to repair relationships in life (Safran & Muran, 2000).

The significance of DP (Figure 1), earlier shown to be the single most important aspect in developing clinical skill (Chow et al., 2015), has in this study only indirectly appeared through the assessments. In Axelsson and Kihlberg (2019), on the other hand, trainees point out how DP, focusing on one thing at a time right beyond their own ability and repeatedly practicing this as well as receiving feedback through both patients' assessments and the supervisor's reflections, have facilitated them getting a more realistic self-image in the developmental process. This, in turn, was thought of as having accelerated mentioned process. They further note that DP is important also for their own personal development, which appears to be especially significant when several educational institutions in Sweden recently have abandoned the previously obligatory element of personal psychotherapy in an educational context. The pan-theoretical method of DP, with common factors as its primary goal for learning, clearly aims to increase the therapist's psychological capacity for relating, as a base for further learning of methodological interventions (Rousmaniere, 2019; Chow, 2018).

Asplund's (from Radio Sweden, June 5th 2019, 8:00) previously quoted statement that "... *poorly conducted psychotherapy can cause great harm*", points to both the need for evaluation of and research on psychotherapy and the importance of psychotherapists with a good ability to self-reflect and a learning mind, regardless of method used. This means that psychologists in training, in addition to self-understanding, not only need to learn how to carry out psychotherapeutic work, but also how to evaluate the work and let the evaluative instruments act as a foundation for a continued professional development - learning how to learn.

Future Study

The importance of measuring outcome in psychotherapeutic treatment continuously throughout treatment, in order to better capture the process and concurrently having the opportunity to modify treatment for the duration of the journey, has previously been studied (Miller et al., 2013; Prescott et al., 2017; Rousmaniere et al., 2019), and is requested to a higher extent than earlier, such as in the United States (Rousmaniere et al., 2019) and Sweden (SOU, 2019:15, 28). The significance of taking both qualitative and quantitative data into consideration has also been highlighted, in part for a more fully fledged image of the client's well-being as an outcome measure for psychotherapeutic treatment, and in part for more valid measurements of treatment quality (Langkaas et al., 2018; Rousmaniere et al, 2019; Rønnestad et al., 2018).

The significance of SC in learning has already been studied (Babenko & Oswald, 2018; Long & Neff, 2018; Neff et al., 2005; Ying, 2009), and in this context SC is of both intrapersonal and interpersonal importance for all three parties: supervisor, trainee and client. From a clinical perspective it seems to be of value to, in this case also study supervisors' development and experiences of the DP-model with assessments and reflections on ORS, SRS, LASS and SC in order to train a *learning mind*. Thus, it may be that resistance can be greater from the supervisors' side rather than the trainees' (J. Svebeck, supervisor at SAPU, personal communication, May 13, 2019). Additionally, clients' SC can be of interest to study as difficulties in dealing with problems is a common reason for seeking psychotherapy, and as a continuous assessment of SC can contribute to increased reflection on approaching circumstances in life and give increased self-compassion. This, in turn, might then relieve suffering.

From a research perspective it is important to validate the ultra-short SC-scale used in this study, including a thorough translation and how it correlates with the SCS and SCS-SF scales.

It is further of interest to carry out a more extensive study with an experimental design, including control groups, for a greater statistical power and increased internal validity. This in order to, among other things, examine whether the continuous measurements of SC can have contributed to an increased SC as well as a coherence in the groups, as suggested in this study and reported by Axelsson and Kihlberg (2019). A more extensive study can also clarify relationships between the different variables through path analysis of the model (Figure 2) in its entirety.

Conclusions

The results of this study point to the fact that working with deliberate practice (DP) in combination with Feedback-Informed Treatment assessments (ORS, SRS and LASS) and assessments of self-compassion (SC) is related to trainees' personal development and learning, and has also been a support for supervisors' in adjusting supervision. Further research is needed in order to study causal effect of using said assessment instruments in an educational context and their significance to trainees' ability to learn how to learn, and developing a *learning mind*.

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