

Original Research

Enhancing Therapist Courage: Feasibility and Changes in Distress Tolerance and Equanimity Following Martial Arts-Based Radically Embodied Compassion Workshops

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Abstract

The work of psychotherapy demands much of those who engage in it. Compassion provisioned by therapists requires varying competencies, yet remains a highly embodied and enactive endeavour. Therapist skill can be cultivated in this area and enhanced through a variety of body-mind trainings, including various forms of therapist personal practice. However, much clinical training/continued professional development centres on education workshops, emphasising knowledge above skill. Given this we present feasibility data from two deliberate practice/procedural learning, martial arts-based radically embodied compassion workshops aimed at enhancing therapist courage. Our findings show that conducting such training is feasible, with those attending able to participate in each practice. Participant self-report suggests the workshops can result in significant personal benefit, are able to deepen attendee understanding of compassion focused therapy and lead to an enhanced sense of how to apply it. Via self-report pre, post and 3-month after the workshops, significant beneficial changes in



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overall total clinical distress tolerance as well as specifically in absorption (the level of attention absorbed by distressing emotions) were shown. Beneficial changes were also noted in experiential acceptance and in total general equanimity pre and post workshops. We discuss limitations of the current study and potential future work that could follow from it, before concluding that training in this way represents an important first step in delineating a novel approach to therapist self-development. Practices drawn from traditional martial arts may be well suited to providing the context, relational safety and necessary skills for therapist development, in terms of enhanced distress tolerance and management of the self, to occur.

Keywords

Martial arts; compassion; therapist courage; distress tolerance; equanimity; therapeutic presence

1. Introduction

Alleviating human suffering in psychotherapy is a complex process that demands much of those who engage in it. Compassion provisioned by therapists requires many competencies, is underpinned by and dependent upon the activation of a specific motivational system and a number of associated (neuro)physiological processes [1, 2]. It is thus a highly embodied and enactive endeavour, which can be cultivated and enhanced through a variety of body-mind trainings [3], including via various forms of therapist personal practice [4-6].

However, much clinical training and continued professional development often centres on education workshops, typically delivered in a didactic fashion, with an emphasis on knowledge above skill [7]. While training in this format can help with deepening both our understanding of theory-practice links and the nature of the psychological processes underpinning mental distress, it has been argued that any skills acquired in such workshops typically decline rapidly in the absence of continued coaching or feedback [8]. Furthermore, such skills are much more vulnerable to breaking down in real time under pressure during difficult therapeutic encounters [9-11].

For such reasons, several authors have noted that psychological therapy training generally falls short of developing well-rounded, responsive therapists with real-world skills [12-16], leading to calls to specifically develop the therapist 'self' through embodied and psychophysiological approaches [17-19]. While there seems little agreement on how to best go about this, there has recently been a movement towards improving clinical expertise across a range of psychological therapies via the process of deliberate practice.

1.1 Deliberate Practice

Deliberate practice (DP) is a well-established method of performance enhancement originally applied to a number of areas, such as chess, sports and medicine, but has only been applied to psychotherapeutic work in the last decade [20]. Ericsson [21] describes deliberate practice as the engagement in a practice-based activity, often designed by a teacher or coach, with the central aim of improving a specific element of performance. This is achieved through both repetition and successive refinement over time [22] and is differentiated from other methods of training by

featuring procedural above conceptual learning. Procedural learning in this instance takes place in the context of repeated practice of specific skills, with real-time feedback from a more knowledgeable other (MKO). Such skills are then further refined by feedback, in an iterative process. For therapists, all of this happens outside of treatment, in the same way an athlete might practice a specific skill before an event.

The emerging literature on deliberate practice research within the realm of psychological therapy provides a strong rationale for its integration into clinical training as a means to aid professional growth [23]. There are several reasons why the approach might bolster therapist efficacy and potentially client outcomes, centring mostly on the notion that deliberate practice furnishes therapists with a structured method to master intricate therapeutic skills. The systematic deconstruction of therapeutic techniques, precise goal setting, and concentrated practice supplemented by feedback that forms a part of the approach can lead to therapists achieving a higher level of proficiency across varying clinical interventions, such as motivational interviewing, person-centred therapy and problem-solving therapy approaches [23].

Specific skills such as questioning, listening, paraphrasing and reflecting feelings can be improved [24] as can alliance bond capacity, alliance rupture-repair and empathy [25-28]. Deliberate practice has been shown to afford longer-lasting skills acquisition in responding to resistance markers [7, 29] when compared to didactical learning methods, as well as facilitating improvements in important intrapersonal skills (mindfulness, experiential acceptance, emotional processing, self-compassion) that impact on interpersonal skills in therapy [30, 31].

In addition, the deliberate practice approach focuses on continuous progress, which can be considered essential given the delivery of psychological therapies requires learning and adaptation over time. It can encourage therapists to pursue ongoing personal growth by identifying particular areas requiring development, actively seeking opportunities for skill refinement, and assimilating feedback from supervisors, colleagues, and clients [23]. This iterative process encourages professional development and can help therapists/clinicians stay skillfully attuned to both changing client needs and advances in treatment.

Deliberate practice may also heighten clinical decision-making. The repeated engagement in simulated or real-life therapeutic scenarios, as part of the process, can help therapists learn to manage delicate interpersonal challenges, predict rupture events in sessions and inform related treatment decisions [7]. In this way, progress in therapy can be discussed with clients and better monitored over time.

Training in this way highlights the inevitability of challenges within therapy and provides therapists with structured means to work with such material in real-time, such as managing countertransference reactions, navigating therapeutic impasses, or grappling with ethical dilemmas [32]. By systematically working to raise self-awareness, regulate one's own state and determine clinical need as it is expressed in the therapy space, therapists cultivate enhanced conflict management [33-35], increase their personal resilience and develop skill in managing clinical events that are sometimes avoided [36, 37].

1.2 Compassion Focused Therapy: Embodied Safety, Safeness and Courage

Compassion Focused Therapy (CFT [2, 38-40]), an evolutionary-informed biopsychosocial model of body-mind and psychotherapy, stresses the importance of the dynamic flow(s) of compassion

within relationships to facilitate healing, transformational change and flourishing. Therapist training in the delivery of CFT emphasises two interconnected psychological dimensions, centred around wise and courageous engagement with suffering and correspondent action to alleviate it [40, 41]. It entails the ability to bravely face, endure, and empathetically connect with client distress without succumbing to or becoming overwhelmed by it [13]. This highlights and speaks to the central component of courage as a necessary quality of effective therapists [42].

Despite this, therapeutic courage has received relatively scant attention in the psychotherapy literature, let alone focusing on the most powerful and helpful ways to entrain this crucial attribute. Therapeutic courage has been previously defined as “a mosaic of psychological, moral, creative and embodied courage for clients and therapists, involving risk in the face of fear of the unknown, choice in the face of loss, and action in service of accomplishment” ([43]; p 78). Other eminent therapists and researchers have contended that this is a process of using oneself as a tool in therapy [30, 42, 44-46], which we have previously posited requires therapists to radically embody compassion [13]. Such compassionate courage may manifest and be represented in (greater) therapeutic presence [47-49], the internal capacity to bear challenges and tolerate difficult and overwhelming emotions [14, 50], and various forms of positive therapeutic risk-taking [51-53].

Such courage is arguably most needed when attempting to navigate ruptures in the therapeutic alliance [54]. It is well recognised that the course of therapy is often beset with relational conflict that can affect the working alliance in treatment [32, 55]. Such ruptures are collaboratively shaped occurrences that demand adept handling and a redirection toward reconnection and cooperation within the relationship [11, 56] for successful resolution. Rather than being avoided, they should be embraced where possible as opportunities for profound transformative experiences [57]. Successfully navigating these ruptures can lead to healing and growth, even though they may initially evoke discomfort and pain [58, 59]. Clients often find these experiences to be novel and therapeutic [60]. Effective repair of alliance ruptures has been linked to improved client outcomes [33], underscoring its importance as a pivotal therapeutic process.

However, the psychotherapy literature and especially training seem to offer limited guidance on how to develop and sustain such therapeutic presence [44], particularly in emotionally charged interpersonal encounters with high relational tension [10, 11, 14]. Effective therapy often depends on clients feeling safe and secure. According to polyvagal theory [61] and CFT, therapists must convey social safety and safeness [1] through verbal and non-verbal cues to facilitate co-regulation and activate the parasympathetic nervous system. The vagus nerve is believed to operate through independent ventral and dorsal vagal parasympathetic pathways [61]. The ventral vagus, which emerged in mammals, helps enables social engagement via exchange of safety and safeness cues and reduces sympathetic nervous system defense reactions. In unsafe environments the sympathetic nervous system activates a flight-or-fight response, with the dorsal vagal system initiating an immobilization shutdown response as needed. Indeed, awareness of one’s own bodily feelings and levels of vagus nerve activation have been shown to be important in the effective regulation of one’s emotional responses [62]. This underscores the importance of therapists’ self-regulation, allowing them to maintain social connection and engagement without becoming overly defensive or reactive [14, 47]. Indeed, higher therapist pre-session calmness and increases in calmness from pre to post-session have been shown to be related to better session quality and working alliance by both clients and therapists [63]. It has been argued that calm therapists may be

less reactive and more emotionally receptive in session, a quality that characterises so-called 'master' therapists [64].

In this context, it has been suggested that therapists should focus on the how they interact with clients [65], rather than simply focusing on the techniques they employ during treatment. Establishing a sufficiently supportive therapeutic presence is therefore seen as a crucial step in building a positive therapeutic alliance, where clients feel safe throughout their therapeutic journey [47]. Crucially, the experience of safety and safeness is bodily based [1, 61, 66, 67]. Embodied safety, safeness and stability can thus be more powerfully cultivated and obtained via body-based interventions [68], because they directly tap into and influence subcortical systems and physiological processes that organise the body-mind in ways that give rise to these states [69]. It has been argued that the skills honed through traditional martial arts (TMA) are directly pertinent to achieving this objective [11, 13, 56].

1.3 Martial Arts

The visionary psychiatrist Stuart Twemlow was one of the first proponents of the idea that training in the martial arts can help entrain important attributes of the 'mind' of psychotherapists, that are directly relevant to the enactment of effective psychotherapy [70, 71]. Twemlow noted that many (albeit sound) technical trainings in psychotherapy have significant limitations and in many cases are insufficient in furnishing therapists with the necessary body-mind attributes to undertake the often demanding tasks of psychotherapy. Twemlow thus argued that the embodied movement practices integral to the martial arts have the potential to help therapists become a safe(r) and containing presence, or greater psychobiological containers [72], for their clients [73]. This contention was borne out in a landmark qualitative study of psychotherapists who were also highly skilled Aikido practitioners, who were able to delineate how their martial arts training directly translated to and informed their psychotherapy practice [74]. This included feeling safe(r), more centered and present in therapy, affording increased abilities to relate and respond compassionately to clients and their distress. To do this considerable 'courage under fire' is needed, including the ability to manage one's own physiological and emotional state and accept the interpersonal patterns that unfold across therapy [75], as mirrored in the embodied experience of real-world conflicts [76] and those entrained within the dojo (training hall).

Our contention is therefore that martial arts are especially well placed to entrain the courage needed to tolerate and so respond compassionately to the conflicts and disaffiliation so common within treatment. Accordingly, we developed a training system called Fierce Compassion Martial Arts (FCMA) to cultivate and strengthen Radically Embodied (therapist) Compassion [11, 13, 14, 56]. Fierce compassion, in this sense, describes the development of distress tolerance and compassionate resilience, so as to stay fully present and emotionally available in difficult encounters. It includes the qualities of strength, courage and empowerment to confront suffering while attempting to transform it. It is fundamentally about halting suffering, not causing harm.

FCMA is a comprehensive approach that draws from traditional martial arts principles and practices. Training in traditional forms of martial arts (e.g. Karate) have been shown to lead to higher heart rate variability and greater parasympathetic nervous system recruitment, helping with stress resilience [77]. FCMA training integrates key elements from Alliance-Focused Training [54] for rupture-resolution and therapeutic modalities like CFT and Compassionate Mind Training (CMT) [56],

aimed at fostering compassionate motivation and flow. It functions as an embodied system designed to facilitate crucial co-regulatory processes necessary for successful rupture-repair and positive therapeutic outcomes. Each aspect of FCMA's training workshops is crafted to stimulate the motivational drive and associated neurophysiology of compassionate engagement and action, utilising repeated deliberate practice of separate skills with real-time feedback from a MKO.

1.4 Feasibility

Feasibility studies are typically employed to explore whether an intervention warrants further testing and resources. They inform assessments of whether it is practical to investigate a topic, if the research methods or protocols associated need modification and if so how such changes might occur [78]. Several general themes are typically addressed by feasibility studies and, for the current purposes, include acceptability (how do individuals react to the intervention), demand (is it felt necessary), implementation (how well the intervention can be implemented as planned), practicality (how well it can be delivered), adaptation (is it possible to make modifications to the intervention as needed), integration (how well it might supplement existing training) and limited-efficacy testing (the intervention can be tested in a limited way such as using a convenience sample).

The current paper considers data obtained as a result of running FCMA based workshops to help determine the feasibility of the approach.

1.5 Aims

We explore whether bringing traditional martial arts practices into training workshops for therapists is feasible. We consider whether such training is felt to be personally helpful, deepens understanding of the evolutionary and biopsychosocial model of compassion and advances clinical CFT skills.

In addition, we explore initial data on the potential for such training to enhance self-rated levels of therapist distress tolerance and mindful equanimity initially and over time.

2. Materials and Methods

2.1 Design

The study featured a repeated measures within-subjects design using evaluation feedback and self-report questionnaires, before, after and 3 months post workshop.

2.2 Participants/Sample

Two separate 2-day workshops were conducted. The first was in Bristol in September 2022 and the second in Dublin in May 2023. 15 participants attended the Bristol event and 9 attended the Dublin training. Data was combined to form a single dataset ($n = 24$). There were 19 female and 5 male participants. The average age of attendees was 36.6 years, with a range of 24 to 57 years.

Participants had between 7 and 35 years of self-rated clinical experience (mean 15.6 years) Most of those taking part were Clinical Psychologists (71%), with some Therapists (25%) and a Trainee Clinical Psychologist (4%). All had some experience of CFT. Most had none, or relatively little (i.e. no regular training of more than 6 months), experience of martial arts, although 2 had trained for 6

years and were still currently in training. All attendees were able to complete everyday physical activity (walking, sitting and raising from a chair unaided, able to raise their arms above their heads) without difficulty.

The workshop leaders (the authors) have extensive experience (20 years plus) of various traditional martial arts including Karate, Tae Kwon Do and Wing Chun, as well as with more modern developments in self defence/protection systems such as Jeet Kune Do, Defence Lab and Urban Combatives.

The initial workshop was advertised on the Compassionate Mind Foundation webpage and a dedicated CFT listserve. The second workshop was advertised solely via the CFT listserve.

The training was aimed at any CFT-interested therapist/clinician hoping to develop and enhance their abilities in compassionate engagement and action, particularly in the face of high relational threat and disaffiliation in therapeutic encounters. The workshops were described as involving a series of experiential exercises derived from a range of traditional Martial Arts (e.g. primarily Tae Kwon Do and Wing Chun), blended with practices from Compassionate Mind Training (CMT), with an explicit focus on how these relate to therapeutic process(es) and can be transferred to the therapy space.

The practices were described as designed to help therapist/clinicians develop the underlying (neuro)physiological capacities, motivational switching abilities and somatic resources to respond compassionately to challenging therapeutic encounters, particularly ruptures in the therapeutic alliance. Full details of the workshop content can be seen elsewhere [11].

2.3 Measures/Feedback Questions

Participants were invited to complete two standardised questionnaires, the Distress Tolerance Scale (DTS) and the Equanimity Scale (ES), on arrival but prior to the start of the workshop and again at the end of the second day following completion of the training. These questionnaires were selected on the basis that they can be used as proxy measures for specific components of therapist embodied compassion targeted by the training, namely distress tolerance, emotional balance/stability and courage.

They also completed three anonymous feedback questions exploring how personally helpful the workshop had been, the extent to which it deepened their understanding of the evolutionary and biopsychosocial model of compassion and how to apply it using compassionate practices and to what extent it advanced their clinical CFT skills. Each question was rated from 1 (not at all or marginally), 3 to 4 (somewhat) to 7 (very much). Following this a text space was provided inviting participants to 'write here anything you particularly liked and/or anything you think we should change.'

Attendees were invited to re-complete the two questionnaires at three month follow up, as well as completing some additional questions about their adherence to training practices in the interim (i.e whether or not they had continue to use the techniques practised at the workshop and if so which ones and how often per week).

The Distress Tolerance Scale (DTS [79]) is a 15 item self-report measure of emotional distress tolerance. It demonstrates good relations with other measures of affective functioning, as well as adequate convergent and discriminant validity. It features four factors; the perceived ability to tolerate emotional distress (tolerance), the subjective appraisal of distress pertaining to whether it

is regarded as acceptable or shameful (appraisal), the level of attention taken up by the experience of distressing emotions (absorption), and the extent of efforts taken by the individual to alleviate the distress (regulation). Each demonstrated acceptable internal reliability scores (Tolerance $\alpha = 0.72$, Appraisal $\alpha = 0.82$, Absorption $\alpha = 0.78$ and Regulation $\alpha = 0.70$). In addition, the measure can be summed to create a Total second-order general distress tolerance factor (internal reliability $\alpha = 0.82$). DTS scores have been shown to demonstrate stability over a 6-month interval.

In the current study measure instructions were modified to focus solely on Therapist/Clinician distress tolerance. The measure's original directions of 'Think of times that you feel distressed or upset. Select the item from the menu that best describes your beliefs about feeling distressed or upset', were modified to 'Think of times that you feel distressed or upset during your role as a Therapist/Clinician. Select the item from the menu that best describes your beliefs about feeling distressed or upset'. The response format remained unchanged (i.e. 1. Strongly agree, 2. Mildly agree, 3. Agree and disagree equally, 4. Mildly disagree, 5. Strongly disagree).

The Equanimity Scale 16 (ES [80]) assesses trait equanimity, conceptualised as an even minded state or disposition towards experience regardless of its affective valence (i.e. as pleasant, neutral or aversive). Factor analytic work suggests two underlying constructs, Experiential Acceptance and Non-reactivity, with good internal reliabilities ($\alpha = 0.85$ and $\alpha = 0.82$ respectively). The measure can be summed to create a Total score, which also demonstrates good internal consistency ($\alpha = 0.88$). As well as having good convergent and divergent validity, the ES also demonstrates adequate test-retest reliability ($r = 0.87$, $p < 0.001$) over 2-6 weeks.

2.4 Procedure

The workshops, entitled 'Embodied Compassion: Integrating CFT and Martial Arts to entrain therapist courage', focused on martial arts practices designed to facilitate therapy sessions in terms of pre-session, peri-session and post-session practices. Specific components are described below (see Table 1) and full details of the training can be found elsewhere [11, 56].

Table 1 Workshop martial arts-based practices.

Pre-session practices	Description
FCMA Salute	Breath in, hands over heart, step forward, hands part in an open gesture, then reverse to step back to neutral stance
Martial soothing breathing	x4 component standing breathing practice, hands rise, extend, withdraw and press down, carried out in synch with the words summon-issue-gather-contain
Static stances	Wing Chun basic stance with shield arm block (bent elbow) held in place and Tae Kwon Do Seogi horse stance with arms to the sides, fists or palms up
Stances in action	Tae Kwon Do walking stance, knife hand with step forward and backward
In-session practices	Description
Evoke-provoke drill	Partner work to embody the self-critic or criticism from a client, pushing and pulling you as you try and stabilise your therapist self (i.e. becoming strong in the body/stance to offset the critic)

Compassionate maai	Partner work drill (which can also be done solo via imagery) in which you and a partner attempt to maintain synchronous spatial/psychological closeness in the face of rupture (i.e. moving together in time and space)
Kihap/Kiai	Shouting with a compassionate spirit while moving forward and striking focus pads. Can be done as a solo drill in the air. Can be done with volume or silently. The overall aim is to enact a fierce response to the suffering of the other
Defence to punch	Wing Chun based drill to defend a straight punch, cover block and step to outside the partner's elbow, shield arm block and simultaneous cover/check their hip with the palm. Done as one smooth motion
Step and block	Tae Kwon Do knife hand step back and block twice in sequence, in response to a partner stepping in and straight punching twice (step punch, step punch), then offering a compassionate countermeasure. Can be practised as a solo drill to an imagined partner
Kihap/Kiai revisited	As above, shouting with a compassionate spirit but this time moving backward a step and striking the advancing focus pads. Can be done as a solo drill as well as in the air, can be done with volume or silently
Stepping and halting	Tae Kwon Do block to partner round punch and simultaneous step to mirror their footwork but with a halting straight arm block to their shoulder
Sisu	A practice to enact immense spirit in the face of feeling overwhelmed. Assume a squat hold, plank hold or arms out to shoulder height and hold until breaking point and then carry on for a further 5 seconds
Post-session practices	Description
Biological completion	Shake it off drill, vigorous shaking of the body with the feeling of release (to music)
Ha breath	Wing Chun stance, arms pulled back to sides hands in fists, then a rapid extension to arms out, palms facing and with a strong flicking motion, while releasing the breath with a loud Ha sound. Build up the intensity as needed
Imagery 1	Distress tolerance imagery (see Hiskey & Clapton, 2021)
Evoke-provoke drill	Partner work as above, but this time as you enact the push and pull of the internal critic, while your compassionate other/partner stays connected, helping you to stabilise and respond with strength and wisdom
Imagery 2	Standard imagery practice but to deepen, enrich and develop your ideal Compassionate Sensei as a resource
Embodied rescripting	A practice of enacting a shaming part of oneself (putting you on the floor), before stepping back mentally and bringing online one's compassionate other (see Compassionate Sensei) to support you in standing up and moving back into affiliation

Note - for each practice there was an explicit instruction to move at one's own pace, thereby gradually developing a feel for the movement pattern. The atmosphere in the workshops was aimed to be affiliative and co-operative rather than competitive.

Workshops were divided into three components: pre-session, in-session and post-session embodied enactive processes and practices. This was to help explicitly entrain the skills required for each phase of therapy sessions, including processes common and applicable across psychotherapy models. These include: therapeutic presence and pre-session centering [47, 81, 82], embedded relational mindfulness [83], kinaesthetic empathy [84], managing therapeutic distance [85, 86], interpersonal and biobehavioural synchrony [87, 88], motivational monitoring and switching [89, 90], rupture-repair/resolution [91], metatherapeutic processing [92], embodied dialogical rescripting [93] and psychophysiological resilience and recovery [94].

Participants were invited to join a dedicated workshop specific WhatsApp group to share ideas and encouragement. In addition, monthly reminders of workshop content were posted to further encourage continuation of the practices as possible.

Given the nature of the current study formal ethical approval was not necessary. Participants instead provided written consent that their data could be used for the purposes of workshop evaluation.

3. Results

All attendees completed both full days of the training. 23 of our total 24 participants completed three feedback questions at the end of the second day, exploring their experience of the workshop.

The average score for the 'extent to which the workshop was 'personally helpful' was 6.5, for the training 'deepening participant understanding of the evolutionary and biopsychosocial model of compassion and how to apply it using compassion practices' the average rating was 5.9 and for the 'extent to which it advanced participant clinical CFT skills' the average was 5.8.

3.1 Qualitative Content Analysis

Results of the qualitative data were explored via a conceptual analysis, focusing solely on the presence and frequency of concepts/themes expressed within the free text. Of the 23 participants who completed the feedback data above, 21 provided some form of handwritten comment around the two categories below.

3.1.1 Was There Anything You Particularly Liked?

The most common comment (by 52% of respondents) was that participants appreciated the workshop content, in terms of the blend of theory and experiential practices and the explicit links made between them. In addition, 43% enjoyed the sense of fun/playfulness brought to the topic, while remaining aware of the seriousness of the topics at hand. Twenty two percent made explicit reference to the safe and containing space that existed within the workshops (although this was commented on informally by many of the participants across the two days), with 10% also mentioning how the movement practices made staying engaged with the work across the two days manageable.

3.1.2 Was There Anything You Think We Should Change?

There were few suggestions for changes. Typically separate changes were mentioned by single participants (26% of those who took part) and included supplying videos of the moves trained, moving the bodywork component to earlier in the first day, training in a larger space and allowing more time for creative enquiry within each movement.

3.2 Quantitative Data Analysis

All 24 participants completed both the DTS and ES measures at Time 1, 24 completed the DTS and 23 completed the ES at Time 2. At Time 3, 15 completed the DTS and 13 completed the ES.

With regard to reported scale alphas, in general values between 0.7 to 0.8 indicate an acceptable level of reliability. However, these values vary depending on the construct being measured. In particular, alpha levels for DTS Appraisal at each time point are somewhat low in our sample, as is DTS Tolerance at time point 2 and ES Non reactivity at Time point 3.

Table 2 (below) provides data on paired samples t-tests (two-tailed) which were carried out to explore pre, immediately post and 3 months post workshop questionnaire responses. Significant increases can initially be seen in DTS Appraisal scores between Time 1 and 2 and 1 and 3, between DTS Absorption scores at Time 1 and 3, between DTS Total scores at Time 1 and 2 and 1 and 3, between ES Exp Acceptance at Time 1 and 2 and 1, between ES Non Reactivity Time 1 and 2 and between ES Total scores Time 1 and 2 and Time 1 and 3.

Table 2 Descriptives (means and standard deviations) and paired samples t-test scores for questionnaire measures at pre, post and 3 months post practice (n = 24 at Time 1, 24 for the DTS and 23 for the ES at Time 2 and 15 for the DTS and 13 for the ES at Time 3).

Measure pairs	Alpha	Mean (std dev)	t	df	p	d
DTST1Tolerance DTST2Tolerance	0.68	12.33 (2.18)	-1.87	23	0.07	-0.38
	0.44	13.17 (1.81)				
DTST1Tolerance DTST3Tolerance	0.68	12.33 (2.06)	-1.35	14	0.20	-0.34
	0.69	13.00 (1.51)				
DTST2Tolerance DTST3Tolerance	0.44	15.38 (1.23)	0.61	14	0.54	0.16
	0.69	13.00 (1.51)				
DTST1Appraisal DTST2Appraisal	0.59	21.96 (4.05)	-2.91	23	0.01	-0.59
	0.57	24.08 (3.34)				
DTST1Appraisal DTST3Appraisal	0.59	21.00 (3.52)	-3.63	14	0.003	-0.94
	0.55	23.93 (3.12)				
DTST2Appraisal DTST3Appraisal	0.57	23.00 (3.00)	-0.89	14	0.40	-0.22
	0.55	23.93 (3.12)				
DTST1Absorption DTST2Absorption	0.72	10.21 (2.45)	-1.14	23	0.26	-0.23
	0.72	10.88 (2.51)				
DTST1Absorption DTST3Absorption	0.72	9.73 (2.31)	-3.84	14	0.002*	-0.99
	0.69	11.80 (2.18)				
DTST2Absorption DTST3Absorption	0.72	11.00 (2.45)	-1.03	14	0.32	-0.27

	0.69	11.80 (2.18)				
DTST1Regulation DTST2Regulation	0.72	11.59 (2.19)	-1.12	23	0.27	-0.23
	0.57	12.21 (2.00)				
DTST1Regulation DTST3Regulation	0.72	11.93 (1.79)	-0.77	14	0.45	-0.20
	0.69	12.20 (1.90)				
DTST2Regulation DTST3Regulation	0.57	12.40 (1.84)	0.32	14	0.75	0.08
	0.69	12.20 (1.90)				
DTST1Total	0.84	56.08 (8.64)	-2.35	23	0.03	-0.48
DTST2Total	0.80	60.33 (7.36)				
DTST1Total	0.84	55.00 (7.67)	-4.42	14	<0.001*	-1.14
DTST3Total	0.83	60.93 (6.96)				
DTST2Total	0.80	59.73 (6.63)	-0.51	14	0.62	-0.13
DTST3Total	0.83	60.93 (6.96)				
ES1ExpAcceptance ES2ExpAcceptance	0.84	27.43 (5.36)	-4.78	22	<0.001*	-1.00
	0.80	31.00 (4.08)				
ES1ExpAcceptance ES3ExpAcceptance	0.84	27.23 (5.20)	-2.71	12	0.02	-0.75
	0.74	29.85 (4.49)				
ES2ExpAcceptance ES3ExpAcceptance	0.80	30.85 (4.02)	0.98	12	0.34	0.26
	0.74	29.85 (4.49)				
ES1NonReactivity	0.72	27.13 (4.93)	-2.32	22	0.03	-0.48
ES2NonReactivity	0.79	28.96 (5.24)				
ES1NonReactivity	0.72	27.62 (5.62)	-1.86	12	0.09	-0.52
ES3NonReactivity	0.74	30.38 (4.15)				
ES2NonReactivity	0.79	29.24 (5.31)	-0.73	12	0.48	-0.19
ES3NonReactivity	0.74	30.38 (4.15)				
ES1Total	0.85	54.57 (9.02)	-4.36	22	<0.001*	-0.91
ES2Total	0.88	59.96 (8.64)				
ES1Total	0.85	54.85 (9.82)	-2.99	12	0.01	-0.83
ES3Total	0.70	60.23 (6.88)				
ES2Total	0.88	60.44 (8.43)	0.09	12	0.93	0.03
ES3Total	0.70	60.23 (6.88)				

Footnote: Bonferroni Correction adjusted alpha = 0.002. * indicates a significant result (i.e. $p < 0.002$).

However, when conducting multiple tests at once to compare several means, there is a higher chance of committing a type I error and rejecting the null hypothesis when it is likely true. To control for this, we performed a Bonferroni Correction and adjusted the α level for each measure to be equal to α (adjusted = α/n where α : the original α level and n : the total number of comparisons per measure).

For an original alpha level of 0.05, with 24 t tests our adjusted alpha is 0.002. Following this, only DTS Absorption between Time 1 and 3 ($p = 0.002$), DTS Total between Time 1 and 3, ES Exp Acceptance between Time 1 and 2 and ES Total between Time point 1 and 2 reached significance (i.e. $p < 0.001$).

Finally, participants completing our three month post-training follow up were asked about the nature of their ongoing practice. In all 47% had kept up some form of training, which ranged from 4-5 days a week to once fortnightly. The most common frequency of practice was once a week, cited by 57% of this group (although the duration of practice was unspecified). The training practices cited varied but included *sisu*, moving breathwork, *ha* breath, compassionate sensei, *kiai/kihap*, *maai* and biological completion work.

4. Discussion

Our findings show that conducting traditional martial arts based experiential workshops to enhance psychological therapist development is feasible. Those attending were able to participate in every practice, with few if any modifications needed to ensure attendees could join in. Participant self-report suggests the training can result in significant personal benefit, was able to deepen attendee understanding of CFT and led to an enhanced sense of how to apply it.

In terms of the general areas addressed by feasibility research, we contend that the current study is acceptable as: participants reacted well to the practices; the workshops met a need/demand in that they bridge the gap between didactic and embodied distress tolerance training; they could be implemented as planned as the structure of the two days required no modification; they were felt to be practical as evidenced by attendees comments; they needed little or no adaptation (although this remained possible in terms of simplifying or adding additional complexity to the practices); they seemed to integrate well with existing training on conflict management and allowed for basic efficacy testing.

In terms of standardised measures, significant beneficial changes in absorption (the level of attention absorbed by distressing emotions), in total clinical distress tolerance, in experiential acceptance and in total general equanimity scores were also identified, with absorption and total clinical distress tolerance benefits continuing over time (i.e. between Times 1 and 3). Notably, both ES and DST scores at Time 3 suggest there was not a return to pre workshop levels and that as such, for this group, training effects do not seem to have diminished.

Whilst these are early tentative findings and to be viewed with caution, the data indicates that these workshops may be able to positively impact on therapists' distress tolerance capacities and abilities, vital components of what we conceptualise as Radically Embodied Compassion [11, 13, 56]. Being able to maintain a calm, balanced and stable body-mind state, be more open/receptive to and withstand/endure distress are all vital components of being able to courageously compassionately engage with suffering and take wise action to alleviate it [13, 41, 95]. Increases in general equanimity, experiential acceptance and reductions in being absorbed in one's own distress may be indicators of enhanced therapeutic presence, as indicated by existing research [96, 97]. These abilities and facets of therapist embodied compassion may usefully transfer to the therapy space, as highlighted by a previous qualitative study [74], via a process we have previously described as somatic metamorphism [11, 13, 56]. However, this remains to be tested and verified, which future research could also attempt to investigate through validated measures of subjective and objective therapeutic presence (Therapeutic Presence Inventories, [98]) and attunement (Patient's Experience of Attunement and Responsiveness Scale, [99]).

That changes in experiential acceptance and total equanimity scores did not change between Time points 1 and 3 is interesting. It may be that the initial significance of this findings may be a

casualty of the number of t tests carried out. Alternatively, it may be that higher scores are actually maintained but our reduced sample size ($n = 13$) simply remains too small to detect this. It could also be that improved equanimity is simply harder to maintain without consistent effort. Indeed, it has been noted [30] that deliberate practice can lead to a rapid development in skills but early progress can plateau [100], thus ongoing and committed training is likely required to ensure further development. This ethos is of course already enshrined in the TMAs.

Around half of those who completed our three month post-training follow up maintained an ongoing personal practice. Over half of this group trained once a week but we did not ask as to the length of their personal practice per session and there is likely considerable variability in engagement with such work. In addition, the range of preferred practices was wide, although we might expect this given we actively encouraged attendees to train only those movements that seemed most relevant to them. As such, *sisu*, moving breathwork, *ha breath*, *compassionate sensei*, *kiai/kihap*, *maai* and biological completion work would mean quite different things to different participants, in an embodied sense, although each is aimed at stimulating compassionate stability and courage. Overall, our intention was that some form of practice might be encouraged and for a significant minority this proved to be the case.

Our levels of follow up (circa 63%) at three months were good for a study of this type. These rates may have been enhanced by participant involvement or reminders as per our WhatsApp community, although we have no way of knowing.

Training via deliberate practice, as outlined in our workshop, has the potential to offer a cost-efficient and effective means of ongoing skill development and refinement. By focusing on specific skills and integrating structured feedback as part of the process of initial development, therapists can tailor their specific learning needs thereby making the best use of sometimes scant available resources, including supervision, peer support, and continuing education avenues.

In addition to the finding that, compared with non-experiential workshops and training as typically delivered, deliberate practice is effective in skill acquisition [23], it has also been argued that deliberate practice can foster a culture of personal accountability and healthy introspection within the therapeutic community at large. We believe this emerged during our WhatsApp groups, as members sometimes shared thoughts on their training experiences and the martial themes we had explored at part of the workshops. Indeed, by requiring clinicians to determine specific aims within training, gauge their progress over time and consider related clinical outcomes, deliberate practice seems to nurture a sense of responsibility for personal skill refinement and quality enhancement. Overall then, deliberate practice in psychological therapies seems to offer a sound framework for therapists to systematically target and enhance their technical and interpersonal skills.

However, that the field is still in its infancy does mean that as yet there are too few studies to confidently cite the positive effects of deliberate practice on clinical outcomes. It remains the case that by incorporating this method into novel training initiatives such as our workshop, into supervision relationships, and clinical professional development endeavours, the field can continue to evolve and more effectively address the multifaceted needs of clients within a dynamic (often resources-poor and changing) mental healthcare environment.

4.1 Limitations

Our study is based on data from only two workshops and, as a result, there are relatively few participants. Our small sample size therefore means that the data we have presented are provisional. Those attending are self-selecting, will have demonstrated a particular interest in experiential training, and so may not be fully representative of the general population of clinicians delivering psychological therapies in the United Kingdom.

It is also unclear why a minority of our obtained subscale alphas were lower than reported in the related measure development literature. This could be due to misinterpretation of the questionnaires, with a small sample size meaning any such errors would be heightened. Alternatively our small sample may have amplified otherwise aberrant responses that would otherwise become insignificant in a large sample. This is particularly likely when some of the subscales reported were comprised of only 3 items (e.g. DTS Appraisal). However, the scale alpha scores we obtained for the DTS Total and ES experiential acceptance and Total scores were acceptable, suggesting we can have some confidence in these findings.

We also note that changes experienced between Time 1 and 2 for the DTS can be considered to reflect changes in one's confidence as a therapist. A true measure of one's opinion as to level of distress tolerance in one's therapist/clinical role (and any changes as a result of training) can of course only be realised over time. We believe that the inclusion of Time 1 and 2 DTS data nonetheless remains important here, given it speaks to an increase in the perception of resilience.

Deliberate practice can often require homework to be completed in solitude and without ongoing immediate feedback, as was the case in the interval between the end of our workshop and our three month follow up assessment. It can also be seen as time-consuming and challenging [26, 27]. Such factors could serve as a barrier to the uptake of deliberate practice methods, given psychotherapy training already entails a significant level of personal commitment and energy.

Moreover, sufficient quality supervision is likely required to help practitioners identify a particular growth edge and agree on the manner in which it might be expanded. Such support may be unavailable due to local resource restrictions/limitations and a consideration of the implications of this may mean the approach is untenable in some circumstances. We also acknowledge that the authors, as workshop leaders, have high levels of subject matter expertise and so further work would need to be conducted to determine if trainers could be readily trained to deliver FCMA to a wider audience.

4.2 Future Work

Given the findings from the current research, next steps should include running a pilot study with a larger group of participants. As a part of this, further qualitative work could be undertaken to better understand the embodied experience of TMA practices for non-martial artists. It could also compare the impact of our workshop on both trainee and experienced therapists.

We might also explore the extent to which the questionnaires we have used make sense to participants, tap the constructs we are most interested in capturing and capture the addition our workshops may be making to current training efforts. We have already, above, suggested some alternative measures that could be considered. In addition, we could also consider the role of physiological measurements in training to help better conceptualise the processes underpinning our notion of courage under fire.

While not explicitly measuring calmness and interpersonal sensitivity as part of our work, future workshops could also feature specific physical sensitivity training, which has a rich heritage within the TMA. For example, there are many drills from Wing Chun (chi sau), Kali (stick flow drills) and Jeet Kune Do (trapping flows), which have the potential to help therapists feel greater embodied safety, more present, less reactive and more emotionally receptive under pressure. In this way therapists might entrain the feel of 'rolling with resistance', such as when encountering reluctance to engage in therapeutic change [7]. In a similar vein, further specific training in mushin drills, as a form of martial meditation [101] and relational mindfulness, might help with pre-session preparation and in-session management, which has been shown to enhance therapist effectiveness [82].

5. Conclusions

We believe the current study represents an important first step in delineating a novel approach to therapist self-development. It has been said [102] that deliberate practice is distinctive in that it asks us to try and do something we cannot do and that the process of this takes us out of our existing comfort zone. The challenge for psychological therapists is therefore to accept this call to growth within discomfort. As we have shown, training and practices drawn from traditional martial arts may be well suited to providing the context, relational safety and necessary skills for therapist development, in terms of enhanced distress tolerance and management of the self, to occur.

Author Contributions

Both authors contributed equally to the writing of this paper.

Competing Interests

Dr Syd Hiskey and Dr Neil Clapton are co-founders of Fierce Compassion Martial Arts (FCMA), a (currently non-profit) training organisation and system designed to cultivate Radically Embodied Compassion.

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