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## **'Self compassion is dangerous': a qualitative exploration of self compassion in an Irish primary care mental health sample**

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***'Self Compassion is Dangerous':***

**A Qualitative Exploration of Self Compassion in an  
Irish Primary Care Mental Health Sample**

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Thesis submitted to the University of Limerick in fulfillment of the  
requirements for a PhD in Clinical Psychology

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## Abstract

Empirical research has demonstrated a wide range of beneficial outcomes for cultivating self compassion in people with mental health difficulties (Gilbert et al. 2010a, Neff et al. 2003b). Emerging research also suggests people can experience a multitude of barriers when attempting to develop self compassion (Gilbert et al. 2014). This phenomenological study explored the lived experiences and barriers to cultivating self compassion in an Irish Primary Care mental health sample to expand on the predominately quantitative evidence base. The sample was derived from a GP Practice in a Southern region of Ireland. Eleven participants with a diagnosis of Depression, and/or an Anxiety disorder attended individual semi-structured interviews. The audio recorded interviews were transcribed verbatim, and analyzed using Template analysis (Crabtree et al. 1992). The emerged themes are as follows; Diverging perceptions: *'self pity'* versus *'self promotion'*, Socio-Cultural Effects, *'Emptiness'* and Mental Health difficulties, Distrust: *'It's not allowed'*, and *'Seeing the Colours'*: Recovery. The superordinate and subordinate themes are contextualised within the current literature, and the clinical implications are discussed. The strengths and limitations of the research are explored with reference to recommendations for further research.

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## **1. General Introduction**

Compassion is not religious business, it is human business, it is not luxury, it is essential for our peace and mental stability, it is essential for human survival.

(Dalai Lama XIV in Shiromany, 1995 p. 144)

Clinical Psychology is a constantly evolving field with regard to empirically based interventions for people with mental health difficulties. Indeed, the progressive nature of this field of research is evident in the recent emergence of the ‘third wave’ movement. In essence the ‘third wave’ movement - which has begun to gain momentum and credence internationally both within academic and clinical sphere - refers to a collection of theoretical and therapeutic frameworks which have been influenced by Eastern philosophies such as Buddhism. This new paradigm proposes that distress in life is caused by one’s desire to change what is beyond one’s control and, as such it seeks to empower people by altering the way people relate to themselves and by cultivating their ability to tolerate distressing thoughts and emotions. The ‘third wave’ includes therapies such as Acceptance and Commitment Therapy (Hayes et al. 2006), Dialectical Behaviour Therapy (Linehan et al. 2006) and Mindfulness Based Cognitive Therapy (Teasdale et al. 2000).

Compassion is a concept which is gaining international recognition within both general and clinical populations as a critical component within these ‘third wave’ approaches. The word ‘compassion’ originates from the Latin word ‘compatior’ which means ‘to suffer with’. Compassion has been defined as ‘a sensitivity to the suffering of self and others, with a deep commitment to try to relieve it’ (Gilbert et al. 2010a, p.3). Traditionally, compassion has been defined in external terms as a concept which is principally concerned with the distress of another. However, there has emerged in recent years a school of psychological thought

which has demonstrated the practical and clinical utility of self compassion as a tool for altering the way people relate to themselves. Self compassion consists of three main constructs which engender one another, namely, mindfulness versus over-identification, common humanity versus isolation, and self-kindness versus self judgement (Neff et al. 2003a). Epitomising, in this regard, a fundamental shift away from the problem-saturated narratives of the ‘second wave’, Compassion based approaches promote a more optimistic, validating and self-affirming approach. There has been a dramatic increase in research publications exploring self compassion in recent years with a variety of clinical populations, and across a wide spectrum of clinical settings. In particular, this research has demonstrated an array of beneficial outcomes for people with mental health difficulties. However, the provisional empirical evidence is dominated by quantitative designs in community and secondary care samples.

As a consequence, this research aimed to expand the existing literature by exploring the lived experiences of self compassion in an Irish Primary Care mental health sample. The current dissertation will be structured with regard to the following sections;

- **Literature Review;** contains a critique of the existing research
- **Methodology;** includes a review of relevant methodologies, a rationale for choosing a qualitative design, a description of the research procedure, and a discussion of the analysis process
- **Results;** depicts a presentation and interpretation of the main superordinate and subordinate themes
- **Discussion;** provides a contextualisation of the results in relation to the current empirical literature, offers recommendations for future research, discusses the

clinical implications, in addition to a critique of the strengths and limitations of the research

The following literature review provides an overview of the self compassion research currently being undertaken as part of the ‘third wave’ movement, with a particular emphasis on Clinical Psychology. To this end, this review not only explores the conceptualisation of self compassion, the relationship between self compassion and mental health difficulties, and the provisional evidence base for compassion based interventions, but it also, crucially, identifies gaps in the contemporaneous literature in this emerging field.

## **2. Literature Review**

### **2.1 Introduction**

There is a plethora of research exploring self compassion across a range of contexts and populations. This literature review aims to provide a critique of the self compassion literature that is pertinent to clinical psychology and in particular to mental health difficulties. As a consequence, this review is not an exhaustive critique of the self compassion research but includes an account of the most relevant literature in order to identify the gaps in knowledge and contextualize the current research being undertaken.

A number of systematic procedures were employed to guarantee that the literature review was conducted in a comprehensive and reliable manner, and to ensure the credibility of the findings as described in the following section.

### **2.2 Systematic Literature Review Procedure**

The most relevant peer reviewed articles were sourced by the inclusion of the following search terms; ‘Compassion’ and ‘self compassion’ independently and accompanied by ‘mental health’, ‘depression’, ‘eating disorder’, ‘anorexia’, ‘bulimia’, ‘anxiety’, ‘generalised anxiety disorder’, ‘social anxiety disorder’, ‘post traumatic stress disorder’ (and variants of these mental health difficulties), ‘self criticism’, ‘qualitative’, ‘lived experience’, ‘conceptualisation’, ‘definition’, ‘lifespan’, ‘fear of self compassion’, ‘barriers’, ‘fear’, ‘difficulty’, ‘challenges’, by employing the following databases; Academic Search Complete, Medline, PsycArticles, PsycInfo, Humanities Full Text, Social Sciences Full Text, CINAHL Plus with Full Text, General Science Full Text, Omnifile Full Text, and UK and Ireland Reference Centre.

Google Scholar was employed using the aforementioned terms to enable the detection of unpublished dissertations and service-based research. Relevant Master's and Doctoral Theses were also sourced from Irish Universities including the National University of Ireland Galway, University of Limerick, University College Cork, Trinity College Dublin and University College Dublin.

The decision making process with regard to including and excluding articles was also influenced by a number of considerations including a desire to reflect the breadth of research in relation to compassion, to provide the reader with an overview of the most trustworthy findings and to highlight the areas where further research is needed.

A variety of criteria guided the inclusion and exclusion of quantitative articles including; large international samples, explicit hypotheses, reputable journals, type of measures employed, a variety of designs (e.g. quasi-experimental versus correlational), different populations and contexts (e.g. secondary schools and inpatient services). A limited number of qualitative research studies were available in the literature. The inclusion of qualitative research was predicated on the relevance of the research in relation to self compassion and mental health difficulties.

This literature review includes a critique of the self compassion research in relation to the following areas;

- 2.3 Conceptualisation and Theoretical Models of Compassion
  - 2.3.1 Goetz: Compassion as an Emotion
  - 2.3.2 Gilbert: Compassion as Attributes and Skills
  - 2.3.3 Neff: Self Compassion
- 2.4 Self Compassion and Attachment
- 2.5 Self Compassion and Mental Health

- 2.5.1 Self Compassion and Depression
- 2.5.2 Self Compassion and Anxiety Disorders
- 2.6 Self Criticism and Shame
- 2.7 Qualitative Self Compassion Research
- 2.8 Fear of Compassion
- 2.9. Self Compassion and Positive Psychology
- 2.10 Empirical Basis for Compassion Interventions
- 2.11 Identified Gap in the Literature
- 2.12 The Current Study

This ensuing subsection inaugurates the review with the exploration of the conceptualisation of self compassion and the accompanying theoretical frameworks.

### **2.3 Conceptualisation and Theoretical Models of Compassion**

Compassion has been conceptualized in multitudinous ways from Biblical times to current leading theorists. The Buddhist tradition has an extensive history of disseminating and advocating for the diverse range of benefits of cultivating compassion towards others and the self. Buddhism defines compassion as ‘a sensitivity to the suffering of self and others, with a deep commitment to try to relieve it’ (Gilbert et al. 2010a, p.3). Until recently, compassion has generally been conceptualized in the academic literature in relation to the expression of compassion towards others rather than towards the self. This is evidenced by the array of literature exploring compassion in caring professions (Figley et al. 1995, Rossi et al. 2012).

The literature pertaining to Clinical Psychology has generally conceptualised compassion within three main strands; as an emotion (Goetz et al. 2010), as an amalgamation of attributes and skills (Gilbert, 2010a), and as a tripartite including self kindness versus self judgement, mindfulness versus over-identification, and common humanity versus isolation (Neff et al. 2003b).

### **2.3.1 Goetz: Compassion as an Emotion**

Goetz and colleagues (2010) conceptualise compassion as a distinct emotion rather than a variant of sadness or love. This diverges from other conceptualisations which propose compassion is a vicarious emotion which is only experienced through an individual's interactions with others. Goetz et al. (2010) advocates for the existence of a 'compassion related profile'. This profile consists of similar but distinguishable emotions such as pity. In evolutionary terms, compassion has also been compared with Darwin's use of the term sympathy, and is considered to contribute to the safeguarding of vulnerable offspring, for promoting inter-familial relations and as a desirable emotion in mate selection.

Goetz et al. (2010) combined their conceptual analysis of compassion with the available neuro-physiological evidence relating to different regions of the brain and postulate compassion involves the components of; detecting another person's suffering (e.g. temporal prefrontal cortex), mirroring another's emotional experiences, assessing the relevance or deservedness of the sufferer, coping with empathetic distress, feeling warmth towards others, and an overarching motivation to respond. This multi-faceted conceptualisation requires an abundance of stages which extend beyond what is typically required for an individual to experience an emotion. Compassion has also been defined similarly as a complex multidimensional construct that is comprised of four key components: (1) an awareness of

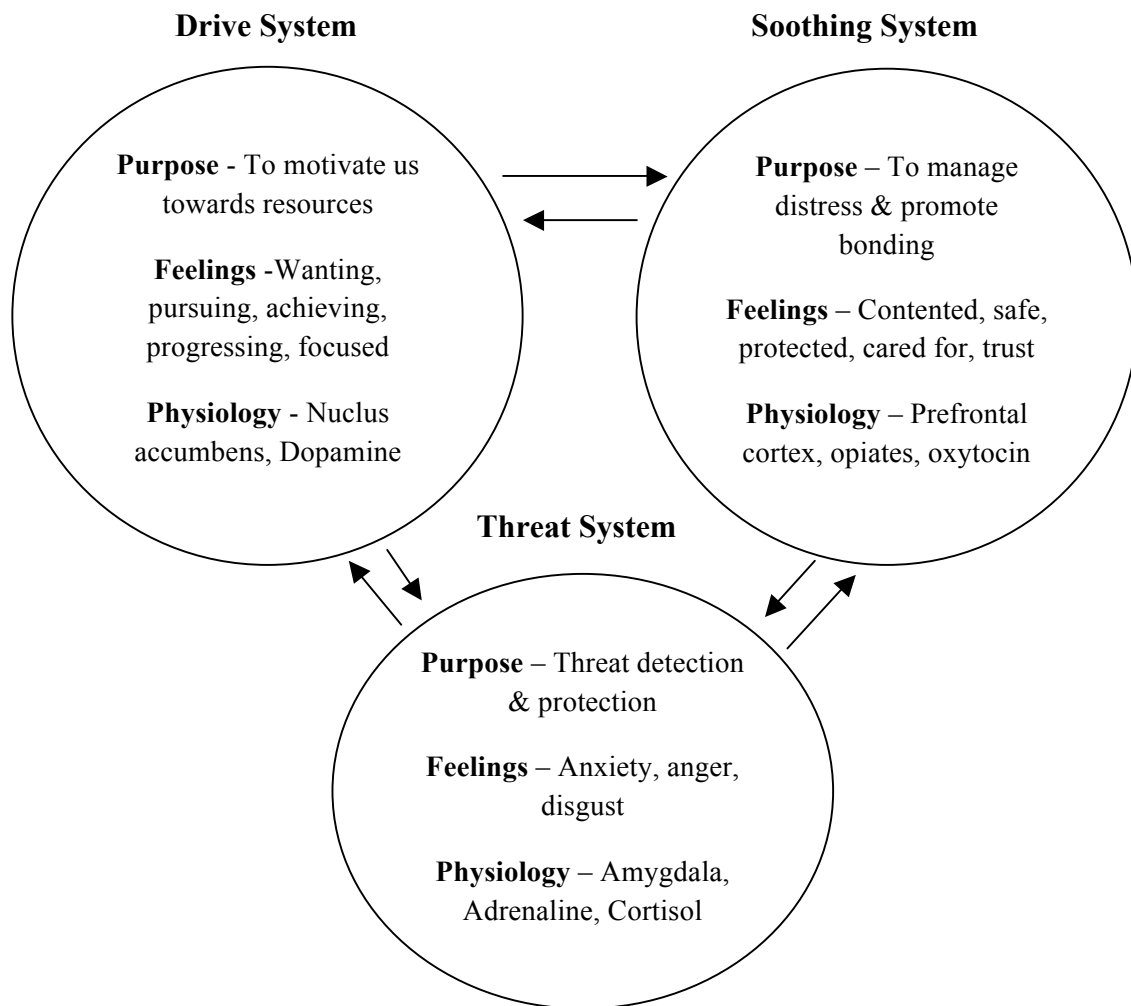
suffering (cognitive component), (2) sympathetic concern related to being emotionally moved by suffering (affective component), (3) a wish to see the relief of that suffering (intentional component), and (4) a responsiveness or readiness to help relieve that suffering (motivational component) (Jazaieira et al. 2014).

These multi-faceted conceptualisations although comprehensive detract from the validity of a singular conceptualisation of compassion as an emotion. Future research could elucidate if there are differences between these multi-faceted conceptualisations when compassion is applied to the self and to others. Moreover, if researchers conceptualise compassion as an emotion further research is required to explore its evolutionary function in cross-cultural research.

### **2.3.2 Gilbert: Compassion as Attributes and Skills**

Professor Gilbert from the United Kingdom is a leading pioneer in Clinical Psychology compassion research. Professor Gilbert propounds that research into the neurophysiology of emotion suggests humans have at least three emotion regulation systems, namely the threat and protection system, the drive, resource-seeking and excitement system, and lastly, the contentment, soothing and safeness system (Gilbert, 2009). Please see Figure 1. for a visual representation of the emotion regulation systems.

**Figure 1. Emotion Regulation Systems (Gilbert, 2005)**



Gilbert et al. (2009) argues the soothing system evolved to enable primates to form and maintain affiliative relationships, thereby ensuring their survival. Gilbert conceptualizes compassion within this evolutionary based soothing system, and in contrast to Goetz and colleagues asserts compassion is not merely an emotive response, but rather a complex combination of attributes and skills that can be nurtured and developed (Gilbert et al. 2011, Cole-King et al., 2011). Emerging research indicates the emotions associated with compassion such as contentment and safeness are more strongly associated with lower levels of depression, anxiety and stress than the emotions associated with feeling energized or excited (Gilbert et al. 2008). This evolutionary framework presupposes that compassion

should be present in this format cross-culturally. Although, there is some evidence in support of this (Neff et al. 2008) further research is needed to explore the occurrence of compassion across cultures.

### **2.3.3 Neff: Self Compassion**

Buddhist philosophy emphasizes the importance of directing compassion towards the self, as well as towards others. Notably, the Tibetan word ‘tsewa’ translated as compassion does not differentiate between compassion for others and compassion for the self (Neff, 2003b). Professor Neff conceptualises self compassion within Social Psychology and the Buddhist tradition and her pioneering work has led to a surge of research exploring self compassion across psychological disciplines.

Neff (2003b) defines self compassion as ‘being open to and moved by one’s own suffering, experiencing feelings of caring and kindness towards oneself, taking an understanding, non-judgemental attitude towards one’s inadequacies and failures, and recognising that one’s own experience is part of the common human experience’. Self compassion consists of three components each consisting of two parts namely; self kindness versus self judgement which includes ‘being kind and understanding toward oneself rather than being self critical’, common humanity versus isolation; ‘seeing one’s fallibility as part of the larger human condition and experience rather than as isolating’, and finally mindfulness versus over identification; ‘holding one’s painful thoughts and feelings in mindful awareness rather than avoiding them or over identifying with them’ (Neff et al. 2003b). Neff et al. (2003a) asserts there are individual differences in how these components are experienced and they are considered to be conceptually distinct. The components of self compassion are not, however,

mutually exclusive and can influence each other interdependently, i.e. cultivating skills in mindfulness can lead to an increase in levels of self kindness.

Researchers have questioned whether one can be self compassionate without possessing all three components of Neff's conceptualisation of self compassion. Further exploration of these three components, possibly through a factor analysis may help to decipher the degree to which each component might contribute to the higher order factor in terms of factor loadings (Barnard et al. 2011). Neff's research found support for the existence of three components. However, it is important to note these components cover a significant range of elements. One could argue, when such a variety of factors are included in one conceptualisation, in addition to components individually engendering one another, cultivation across such a breadth of components is likely to inevitably lead to an increase in well being, amongst other positive outcomes.

The literature anecdotally reports a variety of negative beliefs by clients towards compassion, such as a belief that compassion will lead to an increase in self pity, or complacency (Gilbert, 2009). Neff's conceptualisation of self compassion indicates self pity is related to the over-identification with feelings. As a result, being mindful as part of being self compassionate would lead to clients becoming more objective about the feelings they experience. In relation to the belief that self compassion could lead to complacency, high and low self esteem has been positively associated with distorted self knowledge, but only low self compassion is positively associated with distorted knowledge. Participants who were high in self compassion in fact rated their performance more accurately (Leary et al. 2007). As a result, being equipped with more accurate knowledge is likely to assist people to make positively reinforcing changes in their lives.

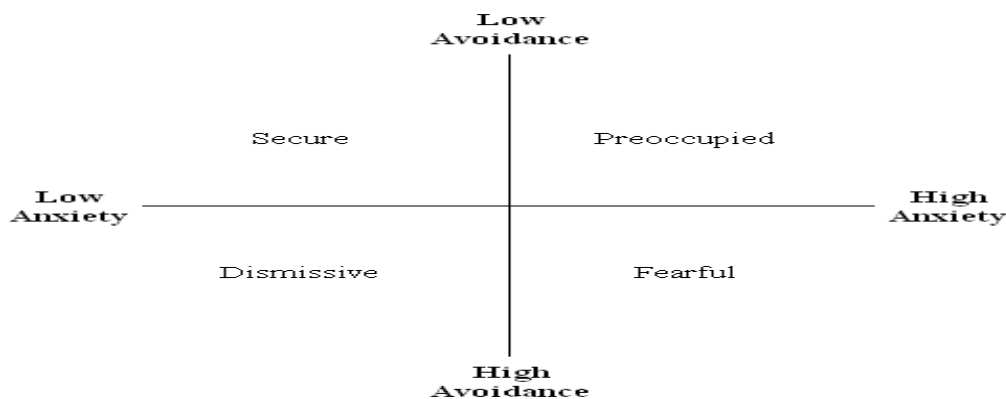
Neff has conceptualized self compassion both in terms of its constitution, as well as how it can be differentiated from seemingly similar constructs. Critics have argued the conceptualisation of self compassion bears a strong resemblance to self esteem. However empirical research has demonstrated that self compassion and self esteem are distinct constructs, and are in fact inversely related to one another (Neff et al. 2009). Self esteem is defined as the ‘degree to which the self is judged to be competent in life domains’ from both self evaluations and perceived evaluations from others (Neff et al. 2009). In contrast, self compassion does not promote or require evaluation from the self or from others, and promotes the adoption of a caring, kindly attitude towards oneself which in turn helps to induce helpful behaviours and reduce self judgement (Neff, 2003b). Moreover, self esteem has been correlated with narcissism in contrast with self compassion where no correlation has been found (Neff et al. 2009). The self kindness component of self compassion has been compared to Roger’s unconditional positive regard. However, the constructs are arguably distinguishable by the emphasis in Humanistic Psychology on the individual in contrast to the central component of common humanity within self compassion (Neff, 2003b).

The array of conceptualisations of compassion renders making comparisons across the literature challenging. However, what is evident from the literature is the recent shift from considering compassion merely as an emotion to considering the constituents of compassion to include a broader repertoire of components. As a consequence, there has been a dramatic increase in the application of these broader conceptualisations to a wide range of theories and psychological disorders. The following section explores the available literature with regard to self compassion and attachment theory.

## 2.4 Self Compassion and Attachment

Attachment refers to the affectional bond between a caregiver and an infant during the early formative years of life. This bond is internalized by the infant and shapes how they relate to others and themselves (Bowlby, 1979). Adult attachment theory has evolved from the work of Hazan & Shaver (1987), and Barthomolew & Horowitz (1991). Contemporary adult literature generally conceptualises adult attachment along a two-dimensional space, namely anxious and avoidant attachment styles as illustrated in figure 2.

**Figure 2. Adult Attachment Styles (Mikulincer et al. 2003)**



Adults with an anxious attachment style seek closeness, possess a fear of rejection, and worry about interpersonal relationships. Avoidant Attachment is characterized by a lack of attachment security, avoidance of intimacy in relationships, and a tendency to be overly self-reliant (Mikulincer et al. 2003). A secure attachment style is reflected in a positive sense of self, and being comfortable with both intimacy and independence in interpersonal relationships. Individuals who have experienced parents who are warm, sensitive and responsive are more likely to have a secure attachment style as adults. In contrast, early experiences such as abuse, neglect or certain types of parenting style have been associated with increased vulnerability to mental health difficulties (Bowlby, 2005).

Preliminary evidence is emerging with regard to a possible relationship between attachment style and self compassion (Raque-Bogden et al. 2011, Pepping et al. 2015). The preliminary research suggests a secure attachment style may provide individuals with an internalized parental template which enables individuals to self soothe, and may enhance people's ability to be self compassionate. Research has shown emotions encompassing safety, and warmth are associated with a secure attachment style (Gilbert et al. 2008), and student's ability to self-soothe and to reassure themselves in stressful or threatening situations was correlated with how affectionate their parents were (Irons et al. 2006).

Research completed in Australia with a large sample (N=329) found undergraduate students who recalled their parents as high in rejection, overprotective and low in parental warmth predicted lower levels of self compassion (Pepping et al. 2015). This prediction was mediated by attachment anxiety but importantly not attachment avoidance. Pepping et al. (2015) conducted further research with an experimental design (N=32). The findings indicated increases in state attachment security led to increases in state self compassion.

Further research in the USA with undergraduate students (N=208) found self compassion and mattering partially mediated the relationship between attachment anxiety/avoidance and mental health, with higher levels of attachment anxiety and avoidance being associated with lower levels of self compassion (Raque-Bogdan et al. 2011). Notably, although attachment avoidance was statistically significant it accounted for the least amount of variance. These findings provide provisional evidence that if a relationship between attachment style and self compassion exists it may vary according to attachment style. These findings are tentatively promising, particularly due to the large sample sizes. However, the over reliance on student samples, self report and correlational designs significantly limits the generalisability of the findings to people with mental health difficulties. Neff expanded the research base by conducting research with high school students and adults.

Neff et al. (2010) conducted correlational cross-sectional research with US high school students (N=235) finding participants with an anxious attachment style had more difficulty being kind towards themselves and approaching distressing issues mindfully. Moreover, greater perceived maternal support was associated with higher levels of self compassion, whilst maternal criticism was related to lower levels of self compassion. Adolescents with a secure attachment style possessed higher levels of self compassion, however no relationship was found between dismissive attachment style and self compassion. Neff et al. (2010) argues the way individuals relate and respond to themselves in times of distress may be modelled on familial experiences. Importantly however, the size of the effect (moderate and modest) suggested that although maternal support and family functioning may provide adolescents with the ability to be self compassionate, they do not appear to determine how self compassionate one is.

These findings were replicated in a study exploring self compassion in adult romantic relationships (N=104 couples, Neff et al. 2013a). Importantly, as per the adolescent research (Neff et al. 2010), dismissive attachment was not correlated with self compassion. This provides additional evidence that only certain attachments styles are related to an individual's ability to be self compassionate. Critically, self compassion was also found to be a stronger predictor of positive relationship behaviour than attachment style. This may have significant clinical implications for individuals with mental health difficulties if this finding is replicated with clinical populations. Furthermore, participants were able to accurately describe their partners' level of self compassion, indicating it may be an observable trait and thus may be a possible target of intervention for couples in therapy.

Research exploring self compassion and parenting style with people with complex needs or mental health difficulties is severely limited. Gilbert et al. (2013) conducted cross-sectional research with individuals with Depression. The findings indicated that a higher fear of

compassion for self and from others was associated with a lower ability to depend on others and to be emotionally close to others, in addition to a higher tendency to worry about being abandoned in adult relationships. Fear of compassion from, and for the self, was also associated with insecure attachment styles in both the depressed sample (Gilbert et al. 2014) and a student sample (Gilbert et al. 2012).

The Maltreatment and Adolescent Pathway (MAP) longitudinal Canadian study assessed 117 randomly selected adolescents receiving child protection services over a two year period (Tanaka et al. 2011). The results demonstrated that higher childhood neglect and emotional and physical abuse were associated with lower levels of self compassion. Importantly, when age and gender were controlled for emotional abuse was significantly associated with lower levels of self reported self compassion, even when the effects of emotional neglect and physical abuse were taken into account. Furthermore, young people with low self compassion were more likely to have psychological distress, problems with alcohol, and have reported a 'serious suicide attempt' than those with high self compassion. Although a relatively small sample, these findings suggest the possibility of a relationship between the impact of parenting experiences and level of compassion in adolescents with particularly complex needs.

The variety of attachment models which are employed within the research make comparisons across studies challenging. This is compounded by the disagreement in the literature with regard to what constitutes a disorganised attachment. Some theorists argue disorganised attachment overlaps considerably with other attachment styles and may not of itself be a distinct category. A major limitation of the research is the over-dependence on student samples. This limits the generalisability of the findings, particularly as the relationship between attachment style and mental health difficulties is a diverse and complex area. The over-reliance on self report measures is also of concern as the correlational nature of the

research results in a gap in empirical knowledge with regard to the causal links. More research is required with a variety of designs including experimental conditions, and with a larger variety of assessment tools, such as the adult attachment interview to explicate the relationship between self compassion and attachment style further.

The following section provides a critique of the literature with regard to self compassion and mental health difficulties.

## **2.5 Self Compassion and Mental Health**

The evidence suggests that the relationship between self compassion and mental health difficulties is transdiagnostic. A recent meta-analysis by MacBeth and Gumley (2012) found a large effect size in the relationship between compassion and psychopathology, indicating higher levels of compassion were associated with lower levels of mental health symptoms. However, it is unclear from the literature whether self compassion is related to different mental health difficulties in distinct ways.

It is important to acknowledge the preliminary but promising research with regard to a variety of presenting concerns including trauma (Beaumont et al. 2012), alcohol misuse (Brooks et al. 2012), personality disorder (Lucre et al. 2013), health promoting behaviours (Sirois et al. 2014), psychosis (Mayhew et al. 2008, Laithwaite et al. 2009), and eating disorders (Breines et al. 2013, Adams et al. 2007, Ferreira et al. 2014, Kelly et al. 2014a, Kelly et al. 2014b, Kelly et al. 2013). The following subsections specifically explore the empirical research in relation to Depression and Anxiety disorders.

### **2.5.1 Self Compassion and Depression**

Self compassion has been considered as an emotion regulation strategy in relation to its role in Depression (Diedrich et al. 2014, Ehret et al. 2014). Pervasive self criticism tends to be a major difficulty for people with depression. Consequently, developing an individuals' ability to self soothe and alter a negative and critical way of self to self relating, as is proposed in Neff and Gilbert's conceptualisations of compassion, is theoretically likely to lead to improvements in a range of outcomes. At present, the literature is emerging in support of this argument.

Self compassion has been negatively associated with components of depression including self criticism, depression, anxiety, rumination, and thought suppression (Neff et al. 2003a). The evolutionary theoretical framework of self compassion necessitates the exploration of the construct in cross cultural research. Cross-cultural research with undergraduate students from Japan and the USA (N=1200, and N=420 respectively) found self compassion was related to lower depressive symptoms (Yamaguchi et al. 2014). A large international randomized controlled trial (N=504) was conducted with a sample of people with moderate to severe depression and/or an anxiety disorder from a range of locations including Australia, Greece, the USA, and Africa amongst others (Van Dam et al. 2011). Self compassion was found to be a robust predictor of symptom severity and quality of life with self compassion accounting for 10 times the variance reported in Mindfulness research.

These findings were expanded by research exploring self compassion with a group of people with depression (N=120) and with a group who had never experienced depression (N=142, Krieger et al. 2013). Findings indicated participants with depression reported lower self compassion than the participants who had never experienced depression, even when depressive symptoms were controlled for. Importantly, symptom focused rumination and

cognitive behavioural avoidance mediated the relationship between self compassion and depressive symptoms indicating the complexity of the relationship between self compassion and depression.

Ehret et al. (2014) explored the role of self criticism and self compassion as risk and resiliency factors for developing depression with people from German outpatient services (N=101). The research expands upon the previous study by exploring self compassion with people with depression, those with a history of depression in addition to a control group. Results indicated participants with depression, as well as those with a history of depression presented with lower levels of self compassion and higher levels of self criticism than the control group. Moreover, higher and lower levels of self criticism and self compassion respectively predicted the development of a recurrent depressive episode, above other associated risk factors such as perfectionistic beliefs or rumination. Future research needs to explicate these findings further with a larger clinical sample. These important preliminary findings, if reliably replicated could indicate the role of self compassion as a preventative intervention. This is particularly relevant and pertinent to depression due to its recurring nature.

A study conducted in Germany with a small clinical sample (N=48) indicated a trend towards self compassion being more effective than cognitive reappraisal with individuals with particularly low mood (Diedrich et al. 2014). The lack of statistical significance is important to emphasize. However, the small sample size may have limited the statistical power. This finding needs to be explored further as it could have important clinical implications, such as the need to choose different therapeutic approaches depending on the severity of an individual's depression.

Research is also emerging with regard to examining the efficacy of self compassion interventions in reducing negative affect, in addition to increasing positive affect. Compassionate letter writing was completed with a non clinical sample of Australian undergraduate students (N=187, Odou et al. 2014). Writing in a compassionate way reduced artificially induced negative affect relatively quickly (within 10 minutes) compared to writing in a general expressive way which did not result in any reduction of affect. The student sample and lack of a control group significantly limits the generalisability of the findings. Moreover, artificially induced negative affect is likely to be qualitatively different from the low mood that is experienced by people with mental health difficulties. However, the provisionally promising results indicate self compassion can be cultivated relatively quickly with certain groups and in certain environments.

Shapira et al. (2010) completed an experimentally designed study exploring the efficacy of two online self help interventions with a group of people with moderate depression. The initially large sample size (N=1002) reduced drastically to a follow up sample size of N=63 for a self compassion group and N=55 for an optimism group. For the self compassion exercise participants were asked to write a compassionate letter every day for seven days. Significant increases were observed in the self compassion group. Moreover, both interventions demonstrated significant increases in happiness at 6 month follow up, and decreases in depression were sustained at 3 month follow up compared to the control group. This research also extends the current evidence base with regard to the different type of practices which can be employed to cultivate self compassion.

These studies provide preliminary evidence that it may be possible to cultivate self compassion relatively quickly in times of distress. A combination of these approaches may alleviate distress by increasing positive affect, whilst simultaneously reducing negative affect. It is critical to explore these findings with people with mental health disorders as mental

health interventions are often designed to solely alleviate negative affect and place little regard to improving an individual's overall quality of life.

The following subsection explores the limited research with regard to self compassion and Anxiety disorders.

### **2.5.2 Self Compassion and Anxiety Disorders**

The application of self compassion to anxiety disorders is an emerging field of research. As a consequence, there are relatively few publications exploring the relationship. Similar to depression there is also a strong theoretical rationale for cultivating self compassion in people with anxiety disorders to alleviate the distress caused by high levels of self criticism, and cyclical worry. Research has demonstrated lower levels of self compassion in participants with a diagnosis of Generalised Anxiety Disorder (Hoge et al. 2013) and Social Anxiety Disorder (Werner et al. 2012).

A longitudinal study with US university students explored the temporal ordering of a meditation intervention designed to effect changes in self compassion, mindfulness, and trait anxiety (Bergen-Cico et al. 2014). Significant increases in self compassion, and mindfulness were found in the intervention group (N=108) in comparison to a control group (N=94). Significant reductions in trait anxiety were mediated by increases in mindfulness. Notably, increases in mindfulness precipitated increases in self compassion. The focus on the temporal changes is a significant strength of the study. However, participants were not randomly assigned and the student sample limits the generalisability of the findings. Importantly, the findings contrasted with cross-sectional research conducted with meditators (Baer et al. 2010) and mental health samples (Van Dam et al. 2011).

Van Dam et al. (2011) demonstrated that self compassion was superior at predicting changes in anxiety than mindfulness. Moreover, self compassion accounted for a higher proportion of the variance than mindfulness. It is important to note the research conducted by Van Dam is likely to be more representative and generalisable to a mental health population as it included an international and significantly larger mental health sample (N=504). The disparity in the results may also be partially attributed to the different self report measures used. However, further research could explicate whether the temporal relationship between self compassion, mindfulness and anxiety differs between the general population and mental health samples.

International research by Kemppainen et al. (2013) explored self compassion in relation to HIV related anxiety. The cross-sectional multi-national study was conducted with a diverse sample including China, USA, Namibia and others (N= 1986). The findings indicated that HIV related anxiety was significantly and inversely related to self compassion scores across participants in all countries even when gender was controlled for.

Although the research exploring self compassion and anxiety is in its infancy, it appears overall the findings are more mixed than in relation to depression. It is important to note that there are significant differences between different anxiety disorders, such as Generalised Anxiety Disorder or Social Anxiety Disorder. As a result this may make exploring the relationship between self compassion and different anxiety disorders more challenging. However, the large scale international studies provide promising and reliable findings to guide future research in the area. As previously mentioned self criticism is often a dominant and debilitating component of both Depression and Anxiety difficulties. As a consequence, the following section explores the role of self criticism in relation to mental health difficulties and provides a critique of the available research.

## 2.6 Self Criticism and Shame

In recent decades there has been a marked increase in the research exploring the relationship between self criticism and mental health difficulties. Self criticism is a ‘conscious evaluation of oneself that can be a healthy and reflexive behaviour, but also can have harmful effects and consequences for an individual’ (Kannan et al. 2013). Self criticism can impact people differently in its severity, function and form (Gilbert et al. 2004a). It has been found to occur across cultures, ethnicity, and genders and can occur transiently or in more chronic trait like forms (Whelton et al. 2005, Kannan et al. 2013). Self criticism can become a form of self harassment for people and may exacerbate feelings of isolation (Gilbert et al. 2004b). People with high levels of self criticism also tend to experience higher levels of shame and disgust, and can feel vulnerable and unable to counter their self critical thoughts (Whelton et al. 2005). Gilbert et al. (2004a) argues self criticism can serve different functions and can include an effort to improve the self, prevent future mistakes, or may also stem from self-hatred. Research has found a significant association between students reporting their parents as rejecting and low in warmth, and their level of self criticism (Irons et al. 2006).

The role of self criticism as a predisposing and perpetuating factor is most regularly referenced within the literature with regard to Depression (Gilbert et al. 2006b, Luyten et al. 2007, Murphy et al. 2002). Importantly, research suggests that it is the individual’s inability to defend themselves from self-attacks rather than the presence of self-criticism itself that is associated with Depression (Gilbert et al., 2004b).

A study by Kopala-Sibly (2013) explored the developmental trends of self criticism and Blatt’s (1982) model of anaclitic (dependent) personality across the lifespan in a large

multicultural study (N=3586). When ‘depressive’ and ‘neurotic’ symptoms were controlled for reductions in self criticism were observed cross-culturally throughout the lifespan.

It is important to note however that there may be cross-cultural differences in the conceptualisation of self criticism and its role for both the individual and for society in general. In particular, differences in the structure and fabric of more interdependent cultures, such as in parts of Asia need to be considered. In more interdependent cultures self criticism can be perceived as a mechanism to fulfil systemic values. For example, in Japanese culture shame, harsh self-judgement and threat of isolation can be viewed as a means of self improvement, thus self criticism can be perceived as a positive phenomenon for the improvement of the individual as part of a collective society (Yamaguchi et al. 2014).

High levels of self criticism can also play a role in a number of other mental health difficulties including self harm (Gilbert et al. 2010b), social phobia (Cox et al. 2000, Cox et al. 2004), and eating disorders (Fennig et al. 2008). Indeed, there is a growing contingent of cross-cultural literature which lends support to the argument that a high level of self criticism is transdiagnostic (Schanche et al., 2013, Kannan et al. 2013).

Bordin’s (1979) definition of the therapeutic alliance is the most commonly employed conceptualisation in the literature. Bordin proposed that an alliance consists of three main components namely a positive emotional bond, an ability to agree goals for the therapy, and a mutual consensus between therapist and client with regard to tasks. The therapeutic alliance has been found to account for a significant proportion of the therapeutic outcome, and thus is a crucial aspect to any psychological intervention (Norcross, 2011). Critically, research has found that individuals with higher levels of self criticism reported poorer ratings of the therapeutic alliance (Whelton et al. 2007). Moreover, self critics were found to have a significantly poorer response to cognitive therapy (Rector et al. 2000). Gilbert (2004a)

proposes that the relationship between levels of self criticism and therapeutic outcomes may be influenced by the functions of self criticism for the individual.

Importantly, clients with high levels of shame and self criticism can find it particularly difficult to be kind towards themselves, generate healthy self-soothing or reassuring thoughts, images or indeed experience feelings of self-warmth, or self compassion (Gilbert et al. 2004b, Gilbert et al. 2006a, Gilbert et al. 2009). Gilbert (2010b) argues that the overstimulation of neural pathways in self-criticism, and the under-stimulation of neural pathways for generating self-soothing thoughts could result in the increased accessibility of self-critical and intrusive thoughts.

Self criticism can be a pervasive and destructive component of many mental health difficulties in perpetuating periods of distress by inhibiting and undermining the individuals' attempts to make positive changes in their lives. Neff and Gilbert's conceptualisations of compassion both aim to alleviate the distress caused by high levels of self criticism by modifying the way people relate to themselves.

The subsequent section explores the limited qualitative research with regard to peoples' lived experiences of self compassion.

## **2.7 Qualitative Self Compassion Research**

Focus groups were conducted with female (N=38) and male (N=30) US undergraduate students in the development and validation of the Self Compassion Self Report measure. Neff et al. (2003a) argues being self compassionate does not increase self absorption or self pity as these concepts relate to people feeling they are alone in their distress (i.e. isolation) and a sense of being overwhelmed or immersed in their personal feelings (i.e.

over-identification). However, the focus group results indicated that a considerable number of participants possessed concerns that being self compassionate was self indulgent and could lead to ‘letting yourself get away with anything’ (Neff et al. 2003a). This reflects a disparity between the aims and objectives of self compassion and people’s perceptions of the construct.

Research conducted by Berry et al. (2010) found support for Neff’s conceptualisation of self compassion in a sample of Canadian women in relation to body self compassion (N=5). However, LeClair et al. (2005) conducted a mixed methods study employing a Gestalt two chair technique with students in an intervention group (N=40), and a control group (N=40). Qualitative findings indicated there was a considerable range in participant’s conceptualisation of self compassion in contrast with Neff’s conceptualisation.

Pauley et al. (2010) conducted qualitative research within a secondary care community mental health team exploring the experiences and meaning of compassion with a UK sample diagnosed with depression or anxiety disorder (N=10). The Interpretative Phenomenological Analysis (IPA) identified three main themes as presented in Figure 3;

**Figure 3. Self Compassion in a Depression/Anxiety sample (Pauley et al. 2010)**

	<b>Superordinate Themes</b>	<b>Subordinate Themes</b>
<b>1</b>	<b>Compassion is a kind and active process</b>	i. Compassion is about being kind towards people ii. Compassion requires action
<b>2</b>	<b>Self compassion is meaningful and useful</b>	i. Self compassion feels meaningful for me ii. Self compassion might help me with my depression/anxiety
<b>3</b>	<b>Being self compassionate is difficult</b>	i. I’m not sure I can be self compassionate ii. Negative impact of depression/anxiety on my ability to be self compassionate

The identified themes reflect a divergence from the quantitative literature reflecting a broader conceptual understanding of compassion by this group of participants. The findings also illustrate the challenges of being self compassionate and the inextricable link between mental

health difficulties and compassion. Participants were recruited from one of the researcher's clinical caseloads, this is a significant limitation of the research as the therapeutic alliance is likely to have had an impact on the way participants' responded during the interviews.

An 8 week Compassion Focused Therapeutic Well Being programme was completed with individuals with a diagnosis of cancer (N=5, Boden, 2013). The main IPA findings indicated participants experienced an increased sense of well being, found compassion for others was easier than self compassion, and indicated that self compassion could be learned over time. A negative perception of compassion emerged as a theme, in that self compassion was selfish in some manner. Moreover, participants reported finding self compassion difficult, and partially attributed this difficulty to cultural influences.

Sutherland et al. (2014) conducted a qualitative study using IPA of online accounts of non-suicidal self injury. Surprisingly, the main superordinate themes corresponded directly to Neff's three components of self compassion. However, the subordinate themes demonstrated the multiplicity of participants lived experiences in the identification of multiple components of self compassion. Please see Figure 4. for the superordinate and subordinate themes.

**Figure 4. Self Compassion in People who Self Injure (Sutherland et al. 2014)**

	<b>Superordinate Themes</b>	<b>Subordinate Themes</b>
1	Self-kindness	i. Being understanding and empathic toward self
		ii. Acknowledging progress and resourcefulness
		iii. Engaging in acts of self-care and self-support
		iv. Reconstructing identity
2	Common humanity	i. Receiving compassion from others
		ii. Normalizing self-injury
		iii. Feeling compassion for others
		iv. Resisting external and internal judgment
		v. Being visible
3	Mindfulness	i. Having a balanced experience and perspective
		ii. Accepting one's experience and coping
		iii. Seeing distress as temporary and manageable
		iv. Holding onto hope

Importantly, the results do not appear to reflect the same level of difficulty practising self compassion as experienced by participants within other qualitative research. This may be due to the methodological differences between obtaining the data from online accounts rather than conducting focus groups or individual interviews.

Although, the qualitative findings are not generalisable it is interesting to observe that relatively similar themes appear to emerge with regard to self compassion being challenging despite the heterogeneity of the participant samples, such as patients with cancer and people with a diagnosis of depression and anxiety.

There is a notable preponderance of quantitative research in the literature. Although quantitative research has advanced our understanding of the conceptualisation and utility of self compassion in alleviating distress, the scarcity of qualitative research reflects a deficit in the representation of the lived experience of service users and how they perceive and experience self compassion in their everyday lives. It is critical to garner a sense of people's world view, and their lived experiences of self compassion. Obtaining individual experiences of self compassion will provide both researchers and clinicians with a comprehensive and inclusive appreciation of the complexity of people's mental health difficulties and the role self compassion may possess in alleviating people's distress.

As discussed previously, certain qualitative studies indicate that people with mental health difficulties can experience self compassion as particularly challenging. The following section explores the emerging research with regard to people's fears of cultivating compassion.

## 2.8 Fear of Compassion

Throughout the literature on compassion and self compassion there is an abundance of anecdotal reports that people with mental health difficulties can find it exceedingly difficult to be self compassionate and can experience a sense of fear towards engaging in self compassionate exercises (Gilbert et al. 2011). However, the empirical research behind why certain people can fear self compassion is in the preliminary stages.

Researchers have proposed that an expression of kindness and compassion from another person can serve to activate the individual's attachment system, and if the individual has had negative early experiences the accompanying negative emotions can come to the fore (Bowlby et al. 2005). Fear of compassion from, and for the self, has been associated with insecure attachment styles in both a student sample (Gilbert et al. 2012), and a depressed sample using the Fear of Compassion self report scale (Gilbert et al. 2014).

Gilbert (2010a) suggests that individual's fears of being compassionate can be due to a variety of factors. These factors may include conditioning, alexithymia, and dissociation from certain types of emotions driven by an over active threat system in combination with an under developed soothing system. Alexithymia refers to difficulties recognising, deciphering, and verbally labelling emotions. In addition, people with alexithymia have a tendency to attribute their emotions to external rather than internal factors (Gilbert et al. 2011). Rockcliff et al. (2008) found people with high levels of self criticism demonstrated an elevated heart rate suggesting their threat system was activated when engaging in compassionate exercises.

Research with a student sample with elevated levels of depressive symptoms indicated difficulties generating self-reassurance and compassionate images about the self (Gilbert et al. 2006b). Moreover, all participants within an IPA qualitative study reported difficulties

being self compassionate, including ‘maintaining a passionate stance’, with some participants attributing this difficulty to their mental health difficulty (Pauley et al. 2010).

Within a non clinical student sample which was predominately female (83%, N=185), fear of compassion was positively correlated with self criticism, alexithymic traits, depression, anxiety and stress (Gilbert et al. 2012). Gilbert et al. (2014) conducted research with participants with depression from Community Mental Health Teams and Self help groups (N=52) and found fear of compassion was positively correlated with alexithymic traits. Moreover, mediation analysis found alexithymia impacts on depression through its effects on compassion for the self and fear of happiness. Similar associations were found in the clinical sample as well as in the student sample, with the depressed group reporting significantly higher fears of positive emotions in comparison to the student sample. These findings are significantly limited by their correlational nature and their over reliance on small samples. However, the initial results provide preliminary support that people with mental health difficulties can experience compassion as a threatening construct.

A recent study by Kelly et al. (2013) emphasizes the necessity for future research on people’s fears of compassion with different mental health groups. Kelly et al. (2013) explored fears of compassion with inpatient and day hospital service users in an eating disorders treatment programme (N=74). Higher fears of self compassion were associated with higher shame, and more severe eating disorder pathology. Critically, clients with lower self compassion and higher fears of compassion demonstrated no significant change in their eating disorder symptomology or level of shame over the 12 week intervention period. This was in contrast with significant improvements in individuals with low fear of self compassion. Further research using a larger randomised sample and a control group is needed to explicate the reliability and validity of these findings. However, these provisional findings indicate the

combination of low self compassion and high fear of self compassion may be a significant impediment to treatment outcomes in people with eating disorders.

Kelly et al. (2014a) conducted further research with undergraduate students (N=155) and service users from an eating disorders treatment centre (N=97). The eating disorder group had lower self compassion, and higher fear of self compassion than the student group. When self esteem was controlled for high fear of self compassion was the strongest predictor of eating disorder symptoms in the eating disorder group, whilst low self compassion was the strongest predictor in the student group. The researchers assert being fearful or unwilling to be self compassionate may be more harmful than the absence of self compassion itself. Future research employing a non-correlational design with a larger cross-cultural sample is essential to elucidate these findings further.

The subsequent section explores the emerging literature in relation to the benefits of cultivating compassion.

## **2.9. Self Compassion and Positive Psychology**

There is a growing body of empirical literature in support of the range of benefits of supporting people to be more compassionate towards themselves, within the general population and with people with a variety of mental health difficulties.

A critical attribute of developing people's ability to be self compassionate relates to both the reduction of negative affect, in addition to an increase in positive affect, thus increasing an individual's well being and quality of life. These two dimensions of affect are often not simultaneously targeted in mental health interventions. A significant amount of research pertaining to the cultivation of self compassion in mental health groups predominately focus

on the reduction of negative affect. Importantly, a reduction in negative affect does not automatically presuppose an increase in positive affect.

Self compassion has been associated with psychological wellbeing across the lifespan, from adolescents to older adults (Neff et al. 2010, Yarnell et al. 2013, Allen et al. 2012), and across cultures (Neff et al. 2008). Research has also demonstrated the role of compassion in physical wellbeing (Hall et al. 2013), life satisfaction (Neff et al. 2003a), and positive psychological functioning (Neff et al. 2007).

Research completed with undergraduate Canadian students (N=123) indicated that self compassion partially mediated the relationship between mindfulness and happiness (Hollis-Walker et al. 2011). More specifically, the components of common humanity, mindfulness and isolation (inversely) predicted happiness. Baer et al. (2010) found self compassion and mindfulness mediated the effects of meditation on well being in a non-clinical sample of meditators and non-meditators. Although these findings are correlational in nature and thus causality cannot be determined, they emphasize the need to expound the mediating and moderating factors between self compassion, well being and positive affect.

Breines et al. (2013) completed research with undergraduate students in the USA (N=63). An experimental design was employed to add to the existing literature in relation to the situational factors which may impact on people's ability to be self compassionate (N=63). The findings indicated activating support giving schemas by a group of participants thinking about giving support and a group actually giving support to others increased state self compassion. This may have important implications for how self compassion and compassion for others are interlinked. Importantly, the research did not include standardised self compassion measures, and refers to isolated incidences of giving support to others rather than

a chronic care giving role. However, the research provides tentative empirical support that compassion towards others may increase state self compassion.

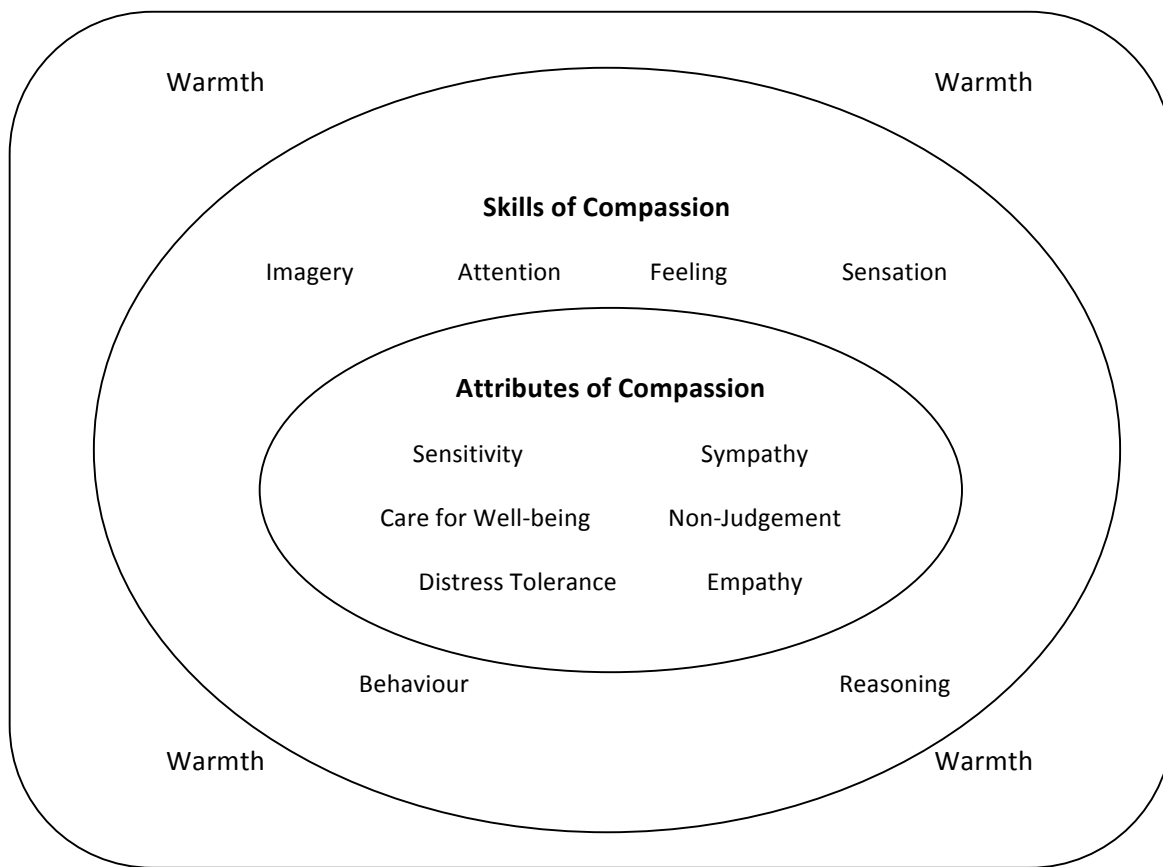
The following section explores the efficacy of Compassion Focused therapies.

## **2.10 Empirical Basis for Compassion Interventions**

As a consequence of the identified benefits of cultivating self compassion, a range of research has explored the efficacy of compassion based interventions, including Compassion Focused Therapy (CFT) in addition to integrating compassionate exercises into more established therapies such as Acceptance and Commitment Therapy and Cognitive Behavioural Therapy.

Professor Gilbert is the founder of Compassion Focused Therapy (CFT) an evolutionary based approach that assimilates the scientific study of compassion with attachment theory. CFT is an integrated therapy that encapsulates a wide range of theories including neuroscience, developmental, evolutionary, social, and Buddhist psychology. CFT arose from the notable presence of high levels of self criticism and shame in Professor Gilbert's therapeutic work with people with mental health difficulties. CFT is a multi-modal approach that draws on a range of models, please see Figure 5. for an illustration of the components of CFT.

**Figure 5. Multimodal Compassion Focused Therapy (Gilbert, 2009)**



The core attributes require individuals to be aware of, and be sensitive to suffering. They include care for well-being, sensitivity, distress tolerance, motivation, sympathy, empathy, and non-judgement. Compassionate skills are the necessary tools required to develop these attributes and includes attention, imagery, reasoning, feeling, sensations, and behaviours. Importantly, all of these skills are interlinked and in turn, engender one another.

A recent comprehensive review by Leaviss et al. (2014) incorporated recent studies of the efficacy of CFT, and recommended that the evidence demonstrates CFT is as effective as treatment as usual in psychological disorders, and CFT ‘shows promise as an intervention for individuals with high self-criticism’.

Gilbert et al. (2004b) conducted a pilot study over a 6 week period investigating the use of compassionate images in a sample of self-critical people from a Depression support group. A

significant strength of this intervention was its inclusion of participants with a history of an enduring psychological disorder for more than 10 years. Post intervention there were significant increases in the accessibility of creating compassionate images and in the ability to self-soothe in a threatening situation. Gilbert & Proctor (2006a) delivered Compassionate Mind Training (CMT, a previous version of CFT), with 6 participants with chronic mental health difficulties, with high levels of shame and self-criticism over 12 two-hour group sessions. The results found significant reductions in a number of areas including, depression, shame, submissive behaviour, self-criticism, and anxiety. Moreover, the participants' significantly increased their capacity to self-soothe, and cultivate feelings of reassurance and warmth for themselves. The small sample size, absence of randomised allocation, and lack of a control group in both studies significantly limit the reliability, validity, and generalisability of the findings. However, an empirical review by Hofmann et al. (2011) found preliminary support for the integration of compassion components into more established therapies.

Stanford University and the Centre for Compassion and Altruism Research and Education (CCARE) developed a 9 week Compassion Cultivation Training protocol designed to enhance compassion (Jazaieri et al. 2013). Participants were drawn from a community sample (N=60), and compared with a waitlist control group (N=40). Results indicated significantly higher levels of compassion for the self, from and for others in post measures. Although, the results appear to be promising, larger clinical samples are needed to generalise the findings to people with mental health difficulties.

Neff et al. (2013b) conducted a pilot group with 21 adults from the community using an 8 week Mindful Self Compassion programme. Pre and post measures indicated improvements in self compassion, mindfulness and wellbeing. However, high attrition rates for follow up data limits the interpretability of the follow up findings. An RCT was also conducted with a community sample comparing a Mindful Self Compassion intervention group (N=25) with a

waitlist control group (N=27). Significant gains and reduction in self compassion and depression levels respectively were found, with a large effect size for the intervention group compared to the control group. Moreover, increases with a medium effect size were demonstrated for mindfulness and life satisfaction. This finding was maintained at 6 month and 1 year follow up. Self compassion was also found to predict wellbeing gains. Further research with a larger secondary or tertiary care clinical sample would contribute to determining the level of efficacy and generalisability of this intervention. Importantly, self compassion in the control group also significantly increased during the 8 week period. When contacted, 77% of participants stated they had sourced self compassion materials during the RCT and had independently tried to practice self compassion in their daily lives. This provides additional support for the findings as the gains in the intervention group are likely to be even greater than represented. The research also explored changes of self compassion over time. The results indicated that self compassion developed slowly across the intervention, and that post intervention gains in self compassion remained stable over time. The maintaining of gains from a Psychological intervention is a critical aspect to empowering service users to develop skills to prevent relapse and maintain wellbeing.

Yadavaia, Hayes, and Vilaradaga (2014) conducted research with 73 undergraduate students in the USA from an initial screening group of 532. Eligibility criteria included self rated high psychological distress and low self compassion. Participants were randomly assigned to a control group or an Acceptance and Commitment Therapy workshop which was specifically adapted to focus on self compassion. The intervention led to large increases in self compassion with a large effect size compared to the control group at post-treatment and two month follow up. The intervention group also led to moderate to large reductions in general psychological distress, and significant reductions in anxiety and depression at two month follow up. The authors argue this outcome is comparable to the results of more protracted self

compassion interventions such as Neff's Mindful Self Compassion programme. However, Neff's intervention was conducted with a community clinical sample with a history of mental health difficulties. In contrast, Yadavaia et al. (2014) screened a student sample with self reported psychological distress. It is possible that these participants level of distress may be qualitatively different than the community sample, a proportion of whom, were referred from local therapists. Moreover, the integration of self compassion components into an ACT intervention obscures any ability to ascertain which components of the intervention contributed to the observed changes in self compassion.

Importantly, a mixed methods study with 'at risk adolescents' in foster care, found no significant differences between a control group and a Cognitively based Compassion Training intervention (N=70, Reddy et al. 2013). The lack of change in the measured areas, such as maladaptive behaviours, may be partly due to poor sensitivity of the quantitative measures employed. The research did not employ any specific self compassion measure, as a consequence, it is difficult to establish whether the lack of improvement indicates that developing self compassion is contextually different within this group. However, the qualitative findings reported positive experiences of the intervention with the majority of participants stating they would recommend it to a friend. This research is a crucial example of the need for the publication of alternative, unexpected or null results to facilitate a thorough understanding of the complex role of self compassion and any differences that may exist between populations.

An emerging evidence base for compassion focused interventions is developing. However, there are significant methodological and conceptual differences between studies making cross-study comparisons challenging.

The following final section identifies the current gaps in the literature with regard to self compassion and mental health difficulties.

### **2.11 Identified Gap in the Literature**

The majority of compassion research in relation to Clinical Psychology encompasses the conceptualisation of self compassion, the relationship between self compassion and mental health difficulties and the efficacy of compassion focused interventions. Although, research is beginning to advance into other methodological frameworks including qualitative and quasi-experimental designs (Berry et al. 2010, Leary et al, 2007, Breines et al. 2013) the current literature predominately employs correlational designs with non-clinical samples. This significantly hinders the application and generalisability of the findings to mental health groups. Moreover, the over-reliance within the research on quantitative designs reflects a significant gap in the literature with regard to the experiential components of self compassion. As a result, further research employing qualitative methodologies is very much needed to explicate people's lived experiences.

Furthermore, the available limited literature exploring self compassion with regard to clinical samples has tended to predominately employ community or secondary care samples from the USA and parts of Europe. Consequently, an exploration of the phenomenon of self compassion within an Irish Primary Care setting is required to expand and enhance the current knowledge base.

The limited available qualitative research suggests individuals with mental health difficulties can find self compassion particularly challenging (Pauley et al. 2010, Boden, 2013). These preliminary findings are corroborated by a range of anecdotal reports from clinicians with regard to clients possessing a multitude of negative beliefs towards compassion. Professor Gilbert (2010a, p. 204) remarks; 'Developing better understanding and further research on the

complex blocks, barriers, and resistances to developing self compassion is ... urgently required'. Elucidating the perceptions of self compassion in those with a mental health difficulty, in addition to exploring the variety of challenges individuals experience in cultivating self compassion, is best achieved through qualitatively designed research.

## **2.12 The Current Study**

The current study sought to address the aforementioned gaps in the literature with regard to self compassion. A qualitative research design aimed to explore the lived experiences of self compassion in an Irish Primary Care sample with people with mental health difficulties. The following research questions were formulated to address the identified gaps in the literature;

- How do people with a mental health difficulty perceive self compassion in an Irish Primary Care setting?
- What are people's lived experiences of self compassion?
- Are there challenges to being self compassionate? And if so what barriers have people experienced?

The Primary Care sample was sourced from a GP practice in the Southern region of Ireland. Following the application of relevant inclusion and exclusion criteria, 137 participants were invited to participate in the research. Eleven participants with a diagnosis of depression and/or anxiety disorder provided informed consent and attended semi-structured individual interviews. The exploration of the research questions during the semi-structured interviews were guided by a flexible interview protocol. The interviews were subsequently transcribed verbatim and analysed using Template Analysis (Crabtree et al. 1992).

The epistemological and methodological considerations which framed the research process are discussed in the following section. Moreover, a description and rationale for choosing a Hermeneutic Phenomenological approach to exploring the research questions is presented, in addition to the rationale for employing Template Analysis as a method of analysing the data. An explicit account of the procedures involved in the research is also provided with consideration to issues of ethics and confidentiality.

### **3. Methodology**

#### **3.1 Overview**

Research methodologies emerge from a range of epistemological and ontological frameworks, and the choice of methodology has far reaching implications for all aspects and stages of the research. The following subsections discuss the process of identifying the most appropriate methodological framework to address the research. This process involved the consideration of a variety of methodologies to enable the researcher to make an informed choice. A rationale for choosing a phenomenological framework in addition to employing Template analysis (Crabtree et al. 1992) is presented in the following subsection. Furthermore, a comprehensive description of the procedural aspects of conducting the research and the analysis process is provided with reference to ethical considerations and issues of informed consent.

#### **3.2 Epistemological and Methodological Considerations**

Epistemological and theoretical frameworks served to guide the entire research process, providing both the structure and flexibility to conduct research with integrity and vigour. Positivism refers to the assumption that there is one universal truth which is both measurable, and discoverable (Smith, 2007). Quantitative research lies within a positivist framework which aims to ascertain objective findings. In contrast, Social Constructionists propose that everyone formulates meaning from their interpersonal relationships and encounters (Willig et al. 2013). Accordingly, there is no one 'truth' as such but rather the different meanings people ascribe to their individual experiences through their interactions with others. These two streams epitomise the distinct differences between epistemological frameworks. As demonstrated in the literature review, the current research with regard to self compassion is dominated by quantitative designs, and thus lacks the breadth and depth

qualitatively designed research can offer. As a consequence, the current study focused on exploring participants' lived experiences of self compassion rather than seeking to obtain an objective 'truth'.

It is beyond the scope of this dissertation to fully explore and explicate the different qualitative methodologies. As a consequence, the following subsection provides an overview of the qualitative methodologies which are relevant to the research questions. This is followed by a more in-depth discussion of phenomenological approaches in subsection 3.1.2. A rationale is then presented in subsection 3.1.3 in relation to choosing a phenomenological approach rather than alternative methodologies to explore the research questions.

### **3.2.1 Qualitative Methodologies**

An array of qualitative methodologies are available for conducting research in the field of Clinical Psychology, including Phenomenology, Content Analysis, Grounded Theory, Discourse Analysis, Ethnography amongst a range of others. The decision making process with regard to identifying the most suitable methodology to address the research questions was conducted through the consideration and critique of different methodologies to enable the researcher to make an informed choice. A number of methodologies were deemed to be particularly pertinent to the research questions specifically Phenomenology, Discourse Analysis, and Grounded Theory. Phenomenology aims 'to produce knowledge about the subjective experience of a research participant' (Willig et al. 2013, p. 16), and provides the reader with the opportunity to obtain an alternative and rich understanding of another person's experience of a phenomenon. Grounded theory aspires to develop an explanatory theory of basic social processes studied in the environments in which they take place (Walker et al. 2006). Discourse analysis is involved with the exploration of language in use, specifically with regard to how individuals accomplish social, personal, and political

objectives through language (Starks et al. 2007). The similarities and differences between these three major qualitative approaches are depicted in Figure 6 (Starks et al. 2007).

**Figure 6. Comparison of Phenomenology, Discourse Analysis & Grounded Theory**  
(Starks et al. 2007)

	<b>Phenomenology</b>	<b>Discourse Analysis</b>	<b>Grounded Theory</b>
<b>History</b>	European Philosophy	Linguistics/Semiotics	Sociology
<b>Philosophy</b>	There exists an essential perceived reality with common features	Knowledge and meaning is produced through interaction with multiple discourses	Theory is discovered by examining concepts grounded in the data
<b>Goal</b>	Describe the meaning of the lived experience of a phenomenon	Understand how people use language to create and enact identities and activities	Develop an explanatory theory of basic social processes
<b>Methodology</b>			
Formulating a research question	"What is the lived experience of the phenomenon of interest?"	"What discourses are used and how do they shape identities, activities, and relationships?"	"How does the basic social process of X happen in the context of Y environment?"
Sampling	Those who have experienced the phenomenon of interest	Those situated in one or more of the discourses of interest	Those who have experienced the phenomenon under different conditions
Data Collection: Observations	Observe participants in the context where the phenomenon is experienced	Observe participants in conversation in their natural environment	Observe participants where the basic social process takes place
Interviewing strategy	Participant describes experience, interviewer probes for detail, clarity	Both engage in dialogue, interviewer probes for intertextual meaning	Participant describes experience, interviewer probes for detail, clarity
<b>Analytic Methods</b>			
Decontextualisation & Recontextualisation: Process of coding, sorting, identifying themes and relationships and drawing conclusions	Identify descriptions of the phenomenon; cluster into discrete categories; taken together, these describe the 'essence' or core commonality and structure of the experience	Examine how understanding is produced through a close look at the words. Interested in <i>how</i> the story is told, what identities, activities, relationships, and shared meaning are created through language	Open, axial & selective coding; examine concepts across their properties & dimensions; develop an explanatory framework that integrates the concepts into a core category
Role of Analyst's Views	Bracket views	Examine own place in the discourse(s)	Bracket views

<b>Audience</b>	Clinicians, practitioners & others who need to understand the lived experience of the phenomenon of interest	Policy makers & interventionists who need to understand the discourses in use to craft effective messages	Researchers & practitioners who seek explanatory models upon which to design interventions
<b>Product</b>	A thematic description of the pre-given 'essences' and structures of lived experiences	Description of language-in-use, identify how different discourses shape how identities, relationships, and social goods are negotiated and produced	Generate theory from the range of the participants' experience

The following subsections explore phenomenology in more detail and provide a rationale for choosing a phenomenological approach and for employing Template Analysis (Crabtree et al. 1992) as a method to explore the research questions.

### 3.2.2 Overview of Phenomenological Approaches

Knots in the webs of our experience around which certain lived experiences are  
spun and thus lived through as meaningful wholes

(Van Manen, 1990, p. 90)

Edmund Husserl is considered to be the Founding Father of Phenomenology. In the early 20<sup>th</sup> century, Husserl challenged the belief that any researcher could be fully objective. Husserl argued Scientists at the time were unaware of the degree to which their preconceptions were influencing the research process. As a result, Husserl advocated for a shift in focus towards the nature of things themselves to enable the researcher to access the essence of a phenomenon (Smith, 2007). Consequently, he proposed phenomenological research should focus on interpreting a person's lifeworld. The life-world 'comprises the world of objects around us as we perceive them and our experience of our self, body and relationships' (Finlay, 2008). He developed a paradigm of thought referred to as Transcendental Phenomenology which is based on the premise of 'reduction'. Reduction involves individuals

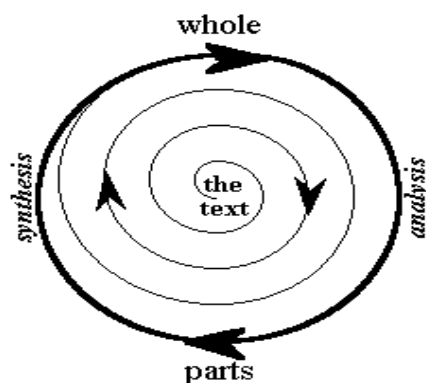
becoming aware of their own pre-conceptions when accessing the essence of a phenomenon. Husserl argued the lifeworld could be experienced through pre-reflections of a phenomenon when they are presented to individuals. He proposed that a shift was needed from intentionality to a 'God's eye view' of phenomenon. Husserl argued individuals could transcend everyday experiences by adopting this 'God's eye view'. 'Intentionality' refers to the perception that 'consciousness is always directed to an object that is not itself consciousness' (Giorgi et al. 1997). Accessing the essence of a phenomenon is made possible through techniques such as 'bracketing'. 'Bracketing' refers to the attempt to become more conscious of and thus seek and obtain a distance from preconceived ideas to enable the researcher to encounter a phenomenon (Tufford et al. 2012).

In contrast, Heidegger, a student of Husserl argued bracketing is not achievable and proposed that phenomenon cannot be understood without also considering the contextual world. As a consequence, he propounded that all individuals are meaning makers in relation to one another (Kafle et al. 2013). Heidegger's Existential Phenomenological framework consists of a number of central tenets. Specifically, these include the conceptualisation of an embodied experience (that our experiences are mediated by our physical being), temporality (our experience of time), and finally, that human beings will experience death (the awareness that our lives are finite) (van Manen, 1990).

Hermeneutic Phenomenology is arguably a more flexible and pragmatic framework than Transcendental Phenomenology and Existential Phenomenology. Van Manen (1990) differentiates between two concepts within Hermeneutic Phenomenology, namely the 'lifeworld' as it is immediately experienced, and the 'lifeworld' as it is revealed through text. Hermeneutic phenomenology in relation to the 'lifeworld' revealed through text emphasizes

that individuals, both participants' and researchers' experience phenomenon subjectively. Consequently, the interpretation of a text is an evolving process. The expression of language through speech requires an additional layer of interpretation by the researcher, and thus necessitates the researcher to maintain a reflexive stance. Reflexivity refers to 'an awareness of the researcher's contribution to the construction of meanings throughout the research process and an acknowledgement of the impossibility of remaining outside of one's subjective matter while conducting research' (Willig et al. 2013, p.5). The exploration of both the participants' experiences and the researcher's subjective interpretation of these experiences are achieved in Hermeneutic Phenomenology through a cyclical process of maintaining a critical stance. This critical stance is also commonly referred to as 'horizons' (van Manen, 1990). Please see Figure 7. For a visual presentation of this re-iterative and cyclical process of interpretation.

**Figure 7. Hermeneutic Circle: Reading, Interpretation, and Reflection**



Van Manen (1990) argues Hermeneutic Phenomenology consists of a number of additional critical principles. These principles include choosing and investigating experiences which are of particular interest to the researcher and to the world, describing the phenomenon through writing, reflecting on the essential themes, maintaining a strong orientation to the phenomenon and lastly, balancing the context by considering both the parts and the whole.

### **3.2.3 Rationale for a Hermeneutic Phenomenological Approach**

The decision as to which methodological framework was the most appropriate to explore the identified research questions was guided by both practical and theoretical considerations. The literature predominately explores self compassion from a positivist standpoint, i.e. with quantitative designs. As previously mentioned, the researcher wanted to address this gap in the research by elucidating participants' lived experiences of self compassion.

Moreover, the National policy document in relation to Mental Health Services in Ireland *A Vision for Change* (Department of Health, 2006) stipulates the necessity of empowering service users to become actively involved in all aspects of their recovery journey through mental health services. In this regard, exploring participants' lived experiences of psychological concepts and therapeutic approaches was considered to be a pragmatic method of operationalising these guidelines. As a consequence, a phenomenological framework was deemed to be the most appropriate philosophical and theoretical approach as the aim of phenomenology is to depict the lived experience of a phenomenon.

Flexibility with regard to exploring the research questions was considered to be a crucial aspect of choosing a particular methodology due to the dynamic nature of medical environments and the importance of providing participants with mental health difficulties with the optimum framework to explore their vivid and rich lived experiences. Consequently, the inherent pragmatism and flexibility of van Manen's (1990) conceptualisation of Hermeneutic Phenomenology was deemed to be the most appropriate phenomenological approach to address the research questions.

Template analysis (TA) is a technique for thematically organising and analysing qualitative data (Crabtree et al. 1992). One of the strengths of Template analysis (TA) is that it can be aligned with a range of epistemological positions, and was chosen as it is particularly suited to the phenomenological framework of this research. The utility of employing TA within a Hermeneutic Phenomenological framework has been demonstrated in applied research previously (Rodriguez et al. 2009, Rogers et al. 2010). The benefits of employing TA has also been illustrated in ‘real world’ research (Kirkby-Geddes et al. 2013, McLachlan et al. 2012), within medical settings (King et al. 2002), and with mental health groups (Lucock et al. 2007).

The researcher acknowledges that Interpretive Phenomenological Analysis (IPA) may also have been an acceptable method of analysis as it ‘seeks to understand the meaning of an account of experience by stepping outside of the account and reflecting upon its wider meanings’ (Willig et al. 2013, p.17). TA was chosen as a more suitable approach for a number of reasons. One of the foremost and pivotal reasons TA was selected to analyse the data as opposed to IPA was the option to employ ‘a priori’ themes.

In TA researchers are able to define a tentative coding template in advance of analysing data (King, 2004). These ‘a priori’ themes can identify areas which are particularly salient to the aims of the research project. The ‘a priori’ themes then undergo a reiterative process of being modified to reflect the ‘bottom-up’ themes identified in the text. The use of ‘a priori’ themes from the available literature in combination with ‘bottom up’ themes supports the phenomenological framework of the research which is aimed at exploring people’s experiences within their social, cultural and psychological contexts (Willig et al. 2013). The application of ‘a priori’ themes has been challenged by critics who argue if they are applied

too strictly it can lead to researchers overlooking important data (Reynolds et al. 2003). However, when applied in a flexible manner the ‘a priori’ themes can facilitate the elucidation and explication of the researchers’ pre-conceptions, enabling the researcher to explore alternative themes within the data in a more transparent and explicit format. This process corresponds with the principles of van Manen’s (1990) Hermeneutic Phenomenological approach particularly in relation to the importance of maintaining a critical stance in the interpretative process.

The researcher was acutely aware the research was in part fulfilment of a Doctorate in Clinical Psychology. As a result, the researcher was conscious of their own experiences of working in adult mental health services and the presence of a number of clinically derived anecdotal experiences which could have interfered or indeed served as a barrier to obtaining the ‘essence’ of participants’ lived experiences. The researcher considered the inclusion of ‘a priori’ themes to be crucial in providing a structured framework to elucidate and explicitly acknowledge the researcher’s pre-conceptions. Employing ‘a priori’ themes was deemed to enable the researcher to be more open to considering alternative viewpoints within the text, thus ensuring the trustworthiness of the data.

IPA has also been applied within compassion research previously (Pauley et al. 2010). The researcher considered employing an alternative and less well known approach to data analysis in the form of TA could add to the existing methodological literature relevant to Clinical Psychology. Moreover, employing a methodology to analyse the data which appears not to have been used previously in this area of research, could arguably illuminate participants’ experiences in a novel manner and highlight diverse findings.

Similar to the flexibility sought from van Manen's (1990) Hermeneutic Phenomenological approach, TA was also deemed to be slightly more flexible than IPA and thus more appropriate for the exploratory nature of the research. This flexibility is evident in TA allowing researchers to choose the number of hierarchical themes in the interpretation of data. In contrast to IPA, TA does not stipulate a maximum number of hierarchical themes.

TA was also considered to be more suitable than the previously mentioned methodological approaches of Grounded Theory and Discourse Analysis. Grounded theory was deemed to be inappropriate, in this specific research context, as it is an inductive approach which aims to collect and analyse data to construct a theory (Charmaz, 2014). As a result, Grounded Theory was considered to be incongruent with the principal aims of the current research to elucidate the 'essence' of people's lived experiences.

Hermeneutic Phenomenology and Discourse Analysis both acknowledge and emphasize the importance of text and language in the construction of meaning. Despite this similarity, Hermeneutic Phenomenology is distinct from Discourse Analysis as it encompasses a number of additional central principles and is not solely focused on exploring meaning through the interpretation of language construction and expression. As a consequence, Hermeneutic Phenomenology's central principles were deemed to be a useful framework to guide the exploration of the research questions rather than primarily focusing on the expression and construction of language. Moreover, TA was chosen as a pragmatic and amenable tool to operationalise all of the central principles of van Manen's (1990) Hermeneutic Phenomenological approach.

An additional final benefit of TA relates to the use of a template during the analysis process. This is a significant strength of the approach as it arguably forces the researcher to take a ‘systematic and well structured approach to data handling’ (Brooks & Nigel, 2012). This was an important aspect of employing TA, as the template provides a structured and transparent framework to the analysis process leading to the trustworthiness of the findings.

As previously discussed, TA offered a range of strengths which were aligned with the epistemological framework of the research and provided an approach to data analysis that possessed both the structure and the flexibility to comprehensively explore the research questions.

### 3.3 Research Questions

**Figure 8. Research Questions**

Identified Research Questions
<ul style="list-style-type: none"> <li>▪ How do people with a mental health difficulty perceive self compassion in an Irish Primary Care setting?</li> <li>▪ What are people’s lived experiences of self compassion?</li> <li>▪ Are there challenges to being self compassionate? And if so what barriers have people experienced?</li> </ul>

### 3.4 Research Design

A sample of patients with mental health difficulties from a General Practice in the Southern region of Ireland were invited to take part in this phenomenological research. Please note the term ‘patient’, ‘client’ and ‘participant’ will be used interchangeably. Informed consent was obtained from all participants, and confidentiality was ensured throughout. Individual one to one semi-structured interviews were held with participants to explore the aforementioned research questions. The semi-structured interviews were guided by an

interview protocol. The audio recorded interviews were transcribed verbatim, and then analyzed using Template Analysis (Crabtree et al. 1992). The participant recruitment, procedure and analysis are described in detail in the following sections.

### **3.5 Research Procedure**

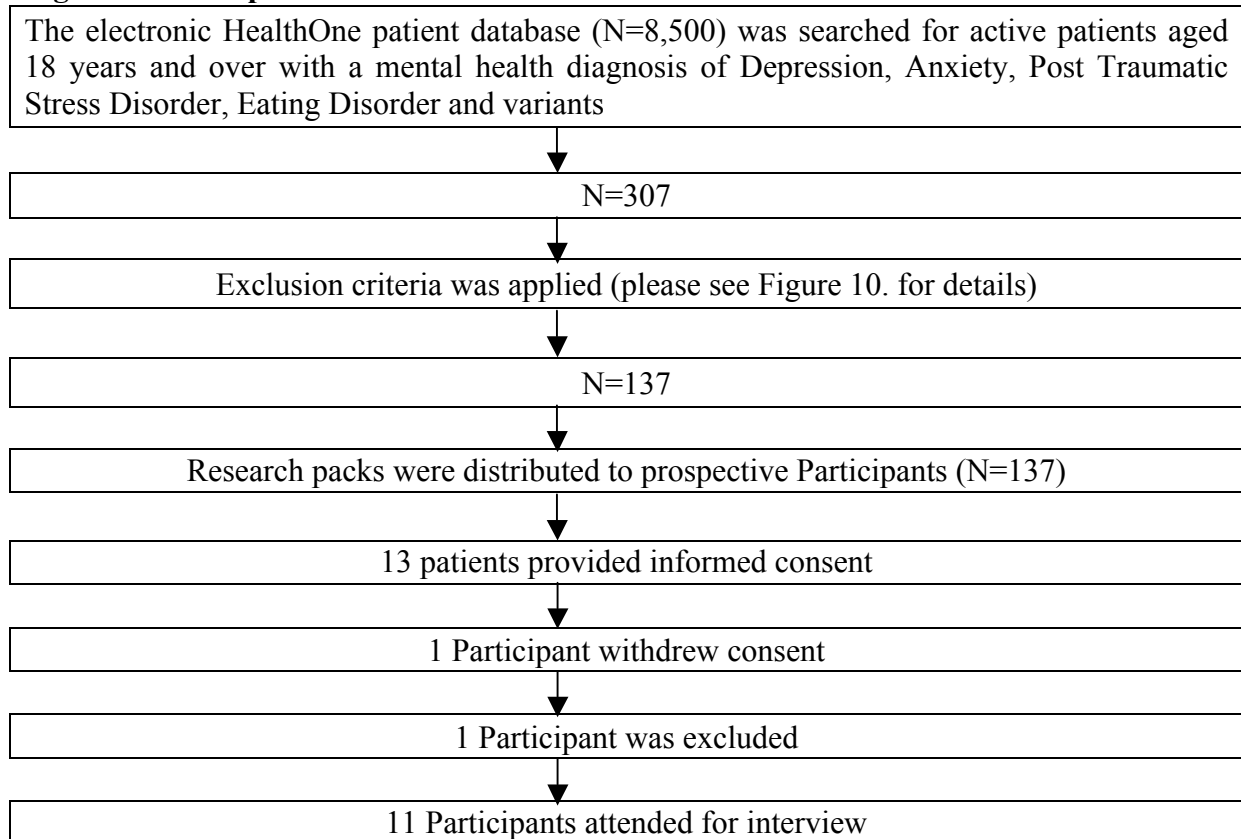
#### **3.5.1 Participant Recruitment**

The research was conducted with a large General practice in the Southern region of Ireland consisting of approximately 8,500 active patients. Active patients are defined as patients who have been seen at least once in the last three years. The GP Practice has two surgeries, one surgery is located in a town which covers an approximate population of over 11,000, and another surgery is located within a more rural area with an approximate population of 2,000. The GP practice is a teaching practice for the Department of General Practice in UCC in Undergraduate Medical training. It is also an accredited training practice for the UCC/HSE postgraduate training scheme for General Practitioners. As a result, patients are accustomed to a high staff turnover in the form of being introduced to different Students, Trainees and GP Registrars. Moreover, patients are regularly asked to participate in research being conducted in the practice.

Participants who were aged eighteen years or above were sourced from the GP practices Health One software. Patient files can be identified according to a diagnosis recorded at the front of their file. The patient files were searched by the diagnoses or mental health difficulties of ‘depression’, ‘anxiety’, ‘post traumatic stress disorder, and ‘eating disorder’, with relevant variations, e.g. ‘Generalized Anxiety Disorder’. The general terms which were

employed aimed to encapsulate a broad selection of mental health difficulties within the Primary Care setting. Please see Figure 9. for a flow diagram of the recruitment process.

**Figure 9. Participant Recruitment Process**



An initial sample of 304 participants were identified. It is important to note that 304 participants would appear to be a relatively small representation of the numbers of people with Depression, Anxiety, Post Traumatic Stress Disorder, or an Eating Disorder from a sample of 8,500. However, the policy of the practice is that a formal diagnosis is only recorded at the front of a file if the patient is reporting a moderate to severe level of distress which is impacting on their life to a significant degree, and/or they require pharmacological intervention. Otherwise, a diagnosis or description of the problem is recorded in the individual consultation record. As a result, it is likely that the sample does not reflect a significant proportion of the patient sample that may be currently experiencing mild mental health difficulties. All 304 identified participant files were screened by the Clinical

Psychologist in Training and the Field Supervisor for certain pre-established exclusion criteria. Please find the inclusion and exclusion criteria depicted in Figure 10.

**Figure 10. Inclusion and Exclusion Criteria**

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
18 years and above	Currently attending secondary care services
Diagnosis of;	Past history or presence of psychosis
Depression	Significant physical health difficulties, e.g. Cancer
Anxiety Disorder	Presence of an Intellectual Disability
Post Traumatic Stress disorder	Active medico-legal disputes
Eating Disorder	Maximum number of 2 consultations in past 3 years
	Active substance misuse
	Additional factors, e.g. Bereavement

Following the application of the exclusion criteria, 137 participants remained. Importantly, when reviewing the identified sample it was evident that there was an overlap in the criteria which would warrant a referral to secondary care services. In reality, the GP Practice were supporting people with significant mental health difficulties who for a variety of reasons were not accessing the available secondary care services. This lack of differentiation in an Irish setting is likely to have influenced the obtained sample by including participants with needs which technically might receive secondary care input in a different country. However, the exclusion criteria were maintained as no participants were attending secondary care at the time of interview.

The selected 137 participants were sent a research pack which included a letter by the Field Supervisor (Please see Appendix C) inviting the participant to take part in the research, a stamped self addressed envelope, an Information Sheet (Please see Appendix A), and a Consent form (Please see Appendix B). Participants were requested to return the Consent Form by a certain date to the Clinical Psychologist in Training if they wished to participate.

### **3.5.2 Informed Consent**

As previously mentioned participants were posted a letter from the Field Supervisor (Please see Appendix C), an Information Sheet (Please see Appendix A), and a Consent Form (Please see Appendix B). This provided participants with the opportunity to review the contents of the research pack in their own time to make an informed decision about participating in the research. The consent form explicitly stated that Participants could withdraw their consent at any time without needing to provide a reason, including following the attendance of an interview. Participants were also informed that their participation was completely voluntary, and would have no impact on their access to medical care in the future. They were explicitly informed that their participation was completely voluntary. Moreover, Participants were informed the research would be completely anonymous, and all the data that was gathered would be kept separate from their medical files. Participants were given the opportunity to seek clarity and voice any queries at every stage of the research. Finally, Participants were informed that the research was being submitted to the University of Limerick in part fulfilment of Clinical Psychology Training, and that they could request a copy of the results of the research.

### **3.5.3 Confidentiality and Ethical Issues**

Ethical approval was sought and granted from the Clinical Research Ethics Committee of the Cork Teaching Hospitals. All research was conducted in compliance with the Psychological Society of Ireland Professional Code of Ethics Guidelines (Psychological Society of Ireland, 2011). The Clinical Psychologist in Training was a temporary Voluntary Researcher with the GP Practice for the duration of the project, and therefore had to sign and adhere to the confidentiality policies and codes of conduct for the GP practice. The entire research project, including the content of the data was handled in a sensitive and professional

manner. When the consent forms were returned, all participants were assigned pseudonyms to protect their anonymity. At the time of the interviews, the signed consent forms were photocopied for the participants, and verbal consent was sought for the audio recordings of the interviews. Participants were informed that the audio recordings would be destroyed following the transcriptions of the interviews. It was envisioned before commencing the research that participants could experience a certain level of distress discussing difficult experiences. Consequently, a safety plan was agreed with the Field Supervisor. This included the following;

- At the beginning of the interview the contents of the consent form were reiterated including the limits to confidentiality with regard to disclosures
- The purposes of the research were re-explained
- Participants were provided with a debriefing sheet at the end of the interview containing contact details in the eventuality they had further questions
- Participants had access to a consultation with a medical professional free of charge if required
- The Trainee discussed any concerns which arose such as disclosures, with the field supervisor immediately after the interviews

The Clinical Psychologist in Training, Academic Supervisor, and Field Supervisor were named in the application for ethical approval. This ensured that if necessary and appropriate, both supervisors had access to the identification of the Participants. All research data, including the completed consent forms were kept separate from the participant's medical files, and were kept in a secure location in a locked cupboard. On finishing the project, the research data will be kept in a secure location in the University of Limerick for a maximum

of seven years, and will be shredded thereafter. It was not anticipated that there would be any significant risks to participants by partaking in the research. No financial remuneration was given to participants and no funding was granted to conduct the research.

### 3.5.4 Demographic Information of Participants

Thirteen consent forms from participants were returned, all of whom were invited to attend an interview. One participant withdrew consent prior to completing an interview and one interview was excluded from the analysis as the individual did not consider that they had experienced any mental health difficulties. Consequently, eleven interviews (eight female, and two male) are included in the analysis. Please see Figure 11. For a brief synopsis of participants' demographic information.

**Figure 11. Demographic Information of Participants**

Pseudonym	Gender	Age	Brief Description
<b>Florence</b>	Female	49	Florence is an English woman with a history of Postnatal Depression following the birth of her first child twenty years ago who has ADHD. She has been married for 25 years and has two boys aged 17 and 20 years. She has been with the GP practice for 23 years. She has never been prescribed medication in relation to her mental health.
<b>Stacey</b>	Female	49	Stacey is an Irish woman who has been with the GP practice for 5 years. She has been married for 19 years, and has three children aged 18, 20, and 22 years. Stacey has a diagnosis of Depression, and Generalised Anxiety Disorder. She has had a long history of trauma including both physical and sexual abuse as a child, and also has a history of agoraphobia. She is currently prescribed Venlafaxine which she has been taking intermittently for approximately 15 years.
<b>Gerry</b>	Male	48	Gerry is from Northern Ireland, he is single and has been with the practice for 15 years. Gerry has had two episodes of Depression, and took anti-depressants during these periods but is no longer prescribed anti-depressants.
<b>Vanessa</b>	Female	65	Vanessa is Irish and has three sons aged 40, 37, and 29 years, and two grandchildren. She has been married for more than 25 years, and has been with the Practice for over 10 years. Vanessa has had Depression since she was a teenager and has been on anti-depressant medication on and off for her whole life. One of her sons also suffers with Depression. At present she is prescribed Venlafaxine and Dothiepin.
<b>Alice</b>	Female	25	Alice is a single Irish woman who has been attending the practice for the last 6 to 7 years. She has a diagnosis of Depression and was first diagnosed at the age of 14 years. She is currently prescribed Celexa.

<b>Eve</b>	Female	42	Eve is an Irish woman who has been with the practice for more than 20 years. She is married and has been with her husband for 16 years. She has one son aged 15 years. Eve was in a car accident 8 years ago which has left her with chronic pain, which she states is the source of her Depression. At present she is prescribed Dothiepin.
<b>Clare</b>	Female	50	Clare is an Irish woman who is divorced and has been in a new relationship for the last 5 years. She has a 12 year old son from her first marriage and a 19 year old step-daughter. She has been with the practice for 4 years and had one mixed episode of Depression and Anxiety a few years ago. She was prescribed Venlafaxine at the time but is no longer on any anti-depressant medication.
<b>Grace</b>	Female	76	Grace is an Irish woman who has been married for 42 years and has been with the practice for 15 years. She has two daughters, aged 53 and 48 and 6 grandchildren. She had an episode of Depression two years ago in the midst of her husband's physical ill health and was prescribed an anti-depressant for the period.
<b>Ann</b>	Female	42	Ann is a single Irish woman with a long history of recurring Depression since her adolescence. There is a possible history of an eating disorder, and she has been suicidal at times in the past. She has been with the practice for 20 years. Ann has been prescribed a range of anti-depressants, and has been prescribed Fluoxetine and Quetiapine for the last year and a half.
<b>Samantha</b>	Female	47	Samantha is an Irish woman and has been with the practice for 20 years. She is divorced, and has one daughter aged 19 years from this marriage. At present, she is in a long term relationship with a new partner. She has had two episodes of depression and has never been prescribed anti-depressants.
<b>Hugh</b>	Male	42	Hugh is originally from New Zealand and has been with the practice for 5 years. He is married and has two children aged 5 and 7 years. His wife has experienced an episode of Postnatal Depression. Hugh has had recurring Depressive episodes since his early twenties, and at present he is prescribed Fluoxetine.

### 3.5.5 Generation of Data

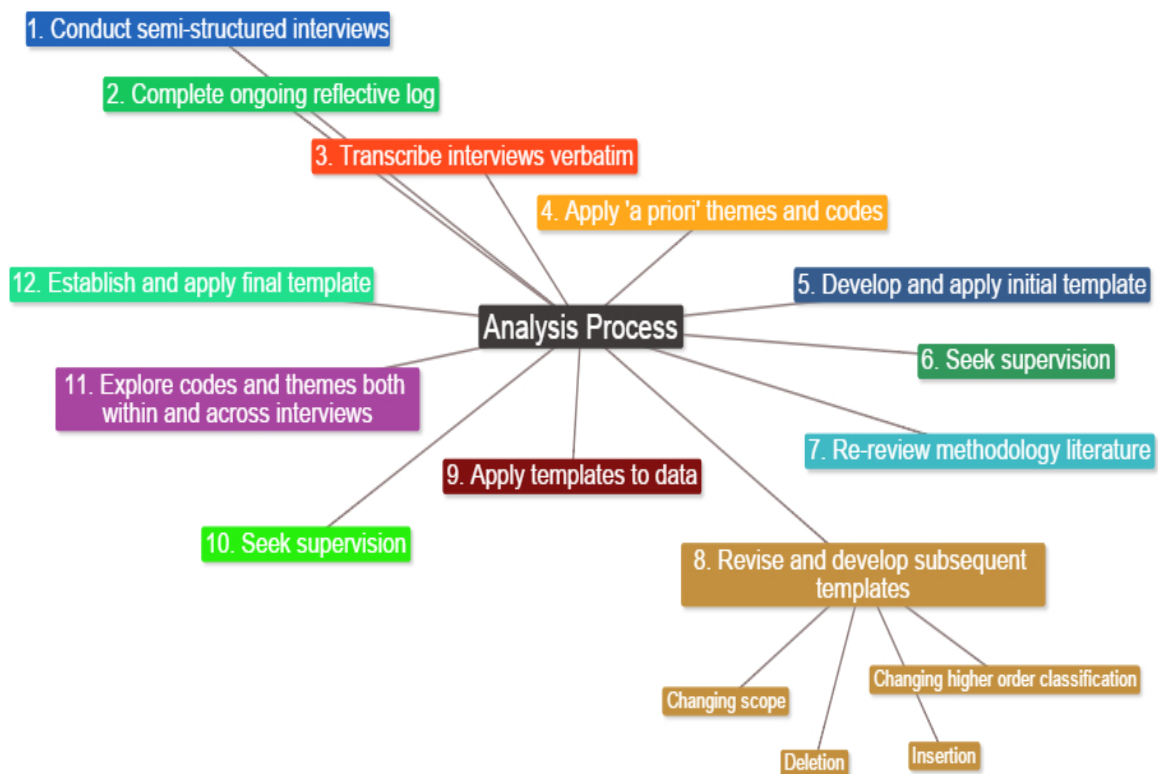
On return of the consent forms Participants were contacted to organize the individual interviews at a time and date that was mutually agreeable. The individual interview is a well established and frequently used qualitative method that can support the elicitation of the rich, in depth data of people's experiences (Howitt et al. 2010). The semi-structured interviews were held in either surgery depending on which locality was the most convenient for the participant. The 11 individual interviews lasted between 60 to 90 minutes in length. Each participant completed one interview, and all interviews were audio recorded subject to verbal consent. The Clinical Psychologist in Training facilitated the individual interviews by employing a semi-structured interview schedule (Please see Appendix D) to help guide the exploration of people's experiences. Participants were provided with a debriefing sheet

(please see Appendix E) at the end of the interview. Following the first and second pilot interviews supervision was sought and the reflective log was reviewed to identify any areas for change, such as not providing participants with enough time to consider and reflect on a question before asking an additional question. The interview schedule was revised accordingly. The audio recordings were transcribed verbatim and analysed using Template Analysis (Crabtree et al. 1992).

### 3.5.6 Analysis

The process of analysis was a gradual and reiterative one with reflexivity, and regular consideration of the methodological literature. Please see Figure 12 for a visual presentation of the central aspects of the analysis process.

**Figure 12. Analysis Process**



Following the transcribing of the interviews verbatim, all interviews were read three times. This enabled the researcher to become familiar with each interview as well as to become immersed in the data as a whole. Themes are a feature of a participant's account that characterises a particular experience that is pertinent to the research question. Coding is the process of identifying such themes in a participant's narrative account by applying codes to small units of data (King, 2014a). Prior to conducting the interviews 'a priori' themes were determined by what most frequently occurred in the relevant literature and what was most appropriate to the research questions. Please find the 'a priori' themes depicted in Figure 13.

**Figure 13 'A priori' Themes**

<b>'A priori' themes from the literature</b>
Compassion is a kind and active process
Self compassion is useful
Self compassion is difficult

These provisional and tentative themes were applied to the interview transcriptions. The research indicates that 'a priori' themes can be applied to a small sample of the data in the development of the initial template (King, 2014b). However, as the framework for the research is phenomenological the researcher believed it was important for the 'a priori' themes to be applied to all the transcripts to enable a thorough and balanced reflection of all participants' experiences. Importantly, the application of the 'a priori' themes supported the explicit acknowledgement of the researcher's assumptions of what may be likely to arise in the data. This was a strength of this method of analysis as it enabled a more open and reflective analytical process. Moreover, it provided an initial systematic approach to analysing the large quantity of data. Crucially, the application of the 'a priori' themes was applied in a 'soft' manner (Brooks & King, 2012). This type of application ensured that when the 'a priori' themes were applied to the data they were adapted, and deleted as necessary

when ‘bottom up’ themes emerged. This cultivated the development of an initial template (Please see Appendix F). The initial template was applied to the data, which involved a reiterative process where codes or themes were ‘inserted’ (added), ‘deleted’ (excluded), ‘adapted to change scope’ (a code may have been too narrow or too broad), and changed to a different ‘higher order classification’ as necessary (King, 2004, p. 261).

At this stage, the reflective log was critical for the researcher. It enabled an open dialogue with regard to the emerging codes and themes which were unexpected. It also prompted the researcher to repeatedly return to the central aim which was to obtain the participants’ lived experience. This reflexivity was an essential aspect of the analysis, as at times during the research process, it was tempting to attend in more detail to data that was more reflective of the dominant literature. Moreover, it was important for the researcher to consider the voices of all participants equally and to reflect both the similarities and differences between participants’ experiences. A balance was also attempted to be maintained between providing a depth to participants’ narratives. Coding the data in too much detail, as this could lead to a disjointed and incoherent analysis, ultimately leading to the voices of participants becoming lost.

The template was revised five more times through this reiterative process. Please see Appendices F to K for a depiction of the templates. Following these revisions the analysis shifted from focusing on the individual interviews to considering the experiences of the participants as a whole, a key aspect of the Hermeneutic Phenomenological approach. This enabled the data to be interpreted as a whole whilst simultaneously retaining the personal voice and depth of participants’ individual experiences.

The reflective log guided the researchers’ continuous questioning of the data; do these hierarchical themes reflect the depth and array of participants’ experience? Am I accidentally

placing too much emphasis on my own presuppositions? In addition, it was helpful to reorganise the data for different themes from a linear presentation to one more conducive to lateral thought, as depicted in Appendix L. This also allowed the researcher to assess if any integrative themes were not being captured in the identified interpretive themes. Integrative themes ‘permeate all other themes coded on a template’ (King et al. 2002).

As per the guidance in the literature, significant time was taken to develop a comprehensive final template as finalising the template prematurely can lead to important themes being overlooked (Brooks & King, 2012). It is always a matter of debate as to when a template can ultimately be termed a final one (King, 2004c). The researcher found revisions could continue to be made endlessly. However, the final template was decided upon when the research questions had been addressed and the themes reflected the depth of both the individual and collective lived experiences of participants.

King (2014c) has suggested a number of methods of ensuring the quality and trustworthiness of research using Template Analysis. One of these methods is to assess the inter-rater reliability. This was achieved within this research by an external coder independently coding a segment of the data. The two independently coded sections of the data were then compared for similarities and differences. The researcher also maintained a reflexive journal throughout the research to ensure the trustworthiness of the data as per the guidelines (King, 2014c).

### **3.6 Conclusion**

In summary, the following research questions were explored with an Irish Primary Care mental health sample using a Hermeneutic Phenomenological framework to address an identified gap in the literature;

- How do people with a mental health difficulty perceive self compassion in an Irish Primary Care setting?
- What are people's lived experiences of self compassion?
- Are there challenges to being self compassionate? And if so what barriers have people experienced?

Semi-structured individual interviews were conducted with participants, transcribed verbatim and analysed using Template Analysis (Crabtree et al. 1992). The following section will present the main findings and provide an interpretation of the transcribed data. Direct quotations will be employed to justify the superordinate and subordinate themes.

## 4. Results

### 4.1 Overview

This section addresses the research questions concerning the lived experiences of participants with mental health difficulties and provides a holistic interpretation of the main research findings. A brief summary of the process of generating themes is presented, this is accompanied by depictions of the initial and final templates (Figure 14 and Figure 15), and is contextualised within the Hermeneutic Phenomenology framework. The following sections present and interpret the subordinate and superordinate themes with direct quotations from participants.

### 4.2 Generation of Themes

The ‘a priori’ themes identified from the current literature were applied in a flexible manner to all eleven interview transcriptions. These ‘a priori’ themes were adapted, and deleted to enable the emergence of ‘bottom up’ themes by line by line coding. The identified codes were then grouped together to reflect subordinate themes. An initial template was developed and applied to all the transcripts. Please see Figure 14 for a presentation of the initial template.

**Figure 14. Initial Template**

Superordinate Themes	Subordinate Themes Level 1	Subordinate Themes Level 2
Barriers of being self compassion (SC)	1. need for justification to self and others	
	2. negative perception of sc	2.1 sc is dangerous/threatening
		2.2 sc quota/dichotomy
	3. perception self criticism is useful	
	4. societal pressure	4.1 negative perception of sc from society
	5. sc is difficult to practice	5.1 timing
		5.2 high self criticism
		5.3 lack of compassion from others
		5.4 mental sc is harder than practical sc

		5.5 lack of knowledge to be sc mentally
		5.6 peer pressure/societal pressure
		5.7 difficulty depends on topic
		5.8 self image/identity/self belief/ self confidence
		5.9 negative belief re sc
	6. causes of sc being difficult	6.1 perception of family history
		6.2 mental health and shame
		6.3 uncertainty
	7. guilt	
<b>Ambiguity of perception</b>	1. negative perception of sc	1.1 sc is self-indulgent
		1.2 sc is dangerous or threatening
		1.3 sc is self pity
		1.4 sc is selfishness/feeling sorry for the self
		1.5 sc is not being firm
	2. compassion is for others	
	3. approaching sc dichotomously	
	4. sc, compassion for others, and receiving compassion are distinct but interlinked	
	5. sc is multi-faceted	5.1 sc includes practical components
		5.2 sc includes mental components
		5.3 sc has to be meaningful/authentic
		5.4 sc is being kind to yourself
		5.5 sc is appreciating the small things/being mindful
		5.6 too much sc is negative
		5.7 sc is limitless
		5.8 sc is understanding yourself
		5.9 sc is acceptance of self and difficulties
		5.10 sc is minding yourself
		5.11 sc is liking/loving yourself
	6. sc is conditional	6.1 sc needs to be deserved/earned
		6.2 disparity between logical understanding of sc and emotional acceptance of benefits
<b>Clarity of definition of compassion</b>	1. compassion relates to loss/grief/bereavement	
	2. emotional and a practical component	
	3. compassion is for others	
<b>Mental health difficulties are linked with sc</b>	1. mental health difficulties eradicates sc	
	2. sc is an essential part of recovery	
	3. sc is an important part of maintaining wellness	
	4. past experiences of mh difficulties raised sc for others	
	5. isolation reduces sc	
<b>Lived experience of sc and society</b>	1. compassion towards others more practical in Ireland	
	2. more compassion towards others in rural communities	
	3. societal pressure to conform	
	4. self consciousness of the Irish	
	5. differences between societies	
	6. changes between generations	
	7. negative perception of sc by Irish	
	8. gender differences	
	9. Irish very self critical	
<b>Lack of awareness about sc</b>	1. lack of awareness of topic	
	2. triggers for awareness	
	3. lack of awareness about cultivating sc	
	4. term is not commonly used	

The template was revised and applied to the data five times in total. At each stage of revision, superordinate and subordinate themes were ‘inserted’, ‘amended’, ‘deleted’, or ‘changed scope’ as per the Template Analysis (TA) guidelines (King et al. 2004, p. 261). This reiterative analysis process involved constant revision of the templates to incorporate deeper and more representative interpretations of Participants’ experiences. Reflexivity was critical in guiding all stages of the analysis. Following this analytical process a final version of the template was settled upon and embodies a comprehensive synthesis of the most pertinent themes from Participants’ lived experiences. Please see the appendices F through K for an explicit portrayal of the rigorous and gradual process of interpreting and identifying the themes. The final form of the template is illustrated in Figure 15.

**Figure 15. Final Template**

Final Template	
<b>Diverging Perceptions: 'self pity' versus 'self promotion'</b>	1. Self pity
	2. Multi-Faceted Self Promotion
<b>Socio-Cultural Effects</b>	1. ' <i>Compassion is for Others</i> '
	2. Pressure to Conform
	3. Reciprocity
<b>Distrust: 'It's not allowed'</b>	1. Self Compassion is ' <i>Dangerous</i> '
	2. Self Compassion Quota
	3. Pervasive Self Criticism
<b>'Emptiness' and Mental Health Difficulties</b>	1. ' <i>Disappearance</i> ' of Self Compassion
	2. Self blame and Guilt
	3. Being Undeserving
	4. Need for ' <i>Permission</i> ' and Justification
<b>'Seeing the Colours': Recovery</b>	1. Determination
	1.1 Gratefulness and The Present
	1.2 Distance from Thoughts
	1.3 Acceptance
	1.4 Prevention
	1.5 Experience and Learning
	2. External Support

The identified themes reflect an extensive range of lived experiences within the sample. At the time of interview, all Participants' mental health difficulties were being managed through Primary Care services. The sample consisted of an array of people at different stages of recovery, thus enabling a breadth of experience to be elucidated.

It should be noted, the identified themes are not mutually exclusive and certain themes overlap slightly. This is evident between the superordinate themes of “*Emptiness*: Mental Health difficulties”, and “Distrust: *It's not allowed*”. Both themes reflect an expression of Participants experiencing self compassion as threatening. However, when the data was explored in detail, the themes emerged as independent of one another as they reflected in one essence, the specific experiences of the absence of self compassion in the midst of a mental health difficulty, and in the other, specific barriers to developing self compassion.

A Hermeneutic Phenomenological framework provided a structure to gathering and interpreting the data. One critical aspect of Hermeneutic Phenomenology is concerned with the interpretation of experience through language. In light of this premise, the researcher was mindful of incorporating the essence of Participants' spoken word in the analysis and reporting of the study's research findings. One of the most striking examples of the approach can be found in the research themes, whereby the researcher constructed the theme titles based upon the Participants' own words, such as “Diverging perceptions: *'self pity'* versus *'self promotion'*”, and “*Seeing the Colours*: Recovery”. Moreover, both short and long quotations were employed to justify the themes in order to allow the reader to gain a sense of the language used by different participants. A discussion of the main superordinate and subordinate themes depicted in the final template are described and interpreted in narrative form in the ensuing section.

## 4.3 Themes

### 4.3.1 Diverging Perceptions: '*self pity*' versus '*self promotion*'

This superordinate theme emerged from Participants expressing a wide range of perceptions about how they defined self compassion in addition to their attitudes and feelings towards being self compassionate. Some Participants viewed self compassion positively and stated that its cultivation would be useful as a method of self promotion. By contrast, other Participants described it in negative terms perceiving self compassion as akin to self pity.

This variation may be as a consequence of the diversity in the sample, some Participants had a history of mental health difficulties, whereas others were in a period of low mood at the time of the interview. The array of definitions of self compassion articulated by the Participants and the diversity of attitudes towards the construct may have important clinical implications.

Participants who perceived self compassion in a positive manner conceptualised the term broadly, as comprising of a plethora of components. This finding was notable as it was in contrast with the mainstream academic literature on this topic which generally depicts self compassion as a way of relating to the self rather than the pragmatic elements articulated by Participants in this study. In addition, there was a pervasive lack of awareness amongst Participants towards the term self compassion which was juxtaposed to a concrete and elaborate awareness of compassion towards others. Two of the most prominent subordinate themes identified in the responses of the Participants are justified with quotations in the following subsections;

- 4.3.1.1 Self Pity
- 4.3.1.2 Multi-Faceted Self Promotion

#### **4.3.1.1 Self Pity**

A number of Participants expressed their perception of self compassion as a negative construct, using a variety of terms such as ‘selfish’, ‘self-pitying’, ‘feeling hard done by’ amongst others.

Eve: to be honest, I feel that I’m being self indulgent and I feel that I’m being sorry for myself.

Participants equated self compassion with being overly focused on the self, and believed this would then lead to further distress. It was subjectively noted by the researcher that the individuals who perceived self compassion negatively were generally in distress or in a period of low mood at the time of interview. This subjective observation was given provisional support by Gerry’s sense of his experiences;

Gerry: that’s why I’m exciting to be asked...because if you had asked me five years [ago, in a period of low mood] I would probably be all confused, and tense, and walk out saying what was all that about.

It should be noted that this subordinate theme possesses certain similarities with the superordinate theme of Distrust: *‘It’s not allowed’* which will be discussed in more detail in section 4.3.3.

#### **4.3.1.2 Multi-Faceted Self Promotion**

In contrast to perceiving self compassion as being self indulgent or self pitying, other Participants perceived self compassion in a positive manner as being supportive towards the self or self promoting. Participants who conceptualised self compassion as useful tended to

also describe self compassion as consisting of multiple facets. These multiple facets included mental and practical components, in addition to including components of self worth.

The lived experiences for this group of Participants indicated a broader conceptualisation of self compassion than the academic literature. Notably, the responses from the Participants indicated the inclusion of more pragmatic components in their conceptualisations of self compassion, this was evident in Samantha referring to her work as a Fire-fighter, and Alice's reference to physical exercise.

Florence: self compassion is ... doing nice things for yourself as well as mentally.

Participants' multi-faceted experiences of self compassion with regard to mental strategies included focusing on the present and appreciating aspects of everyday life, self exploration, and self-kindness.

Participants' experiences that self compassion partially consists of being present and appreciating the smaller things indicates the availability of opportunities to complete self compassion practices in everyday life.

Ann: the mental self compassion, you sit down and be grateful for the good things you have, and take pleasure in the little things mentally in your life.

Alice: It's hard to be self compassionate if you're not being present in the moment because, mmm you're not kind of thinking of what you need here and now like.

An additional mental component to self compassion included exploration about the self. Participants described the benefits of this approach including cultivating a deeper level of insight in relation to their mental health difficulties.

Vanessa: It's [self compassion] a sort of a feeling, understanding yourself. Understanding the problem you have, and how you deal with it.

Importantly, Participants described the need to approach self exploration in an open and supportive manner rather than in a self critical way to facilitate the process. It appeared that when Participants' attempted self exploration in a self critical manner it led to the individual feeling under threat and resulted in a cessation of beneficial and effective self exploration.

Being kind towards the self emerged as a critical component of self compassion. This was reflected through the use of the term 'kindness' as well as through analogies;

Samantha: soft and caring ya. A hug you know?

Participants explored the need to be kind towards themselves as a useful mechanism of promoting change for the future.

Gerry: I guess it's just not being hard on yourself, being more self promoting rather than self critical. Ya, just giving yourself the benefit of the doubt a little bit. Kind of encouraging yourself ... particularly if you have done something that you know is not ... right or not good, or not one of your best tasks, or accomplishments. You can still say, look there is learning there.

An important and unexpected finding related to participants conceptualising self compassion in relation to their self worth and ability to love and believe in themselves.

Samantha: I would consider myself a good person. That to me is compassion for me. That's just my way of explaining it.

Alice: have a bit of faith in yourself so you can work things out and get through things.

This indicates the intimate and integral relationship people can have with self compassion and the possible link with a person's sense of self. Moreover, these findings may suggest an association in some form with attachment style in this group of Participants.

Participants' lived experiences reflect a diversity of negative and positive perceptions of self compassion, in addition to reflecting a broad multi-faceted conceptualisation. These findings indicate to some degree an individualised experience of self compassion. Moreover, Participants conceptualised self compassion by grounding the concept in examples from their everyday life, suggesting the ability for individuals to integrate self compassion exercises into their routines.

#### **4.3.2 Socio-Cultural Effects**

The superordinate theme of Socio-Cultural Effects refers to the intrinsic link between Participants' awareness and ability to be self compassionate and their social and cultural environment. This theme emerged from Participants' experiences that being compassionate towards others and the absence of receiving compassion from others had the effect of directly cultivating or obliterating their ability to be self compassionate. This indicates that self compassion, for this group of Participants, is in some way contingent upon their external environment. A number of subordinate themes were identified as follows;

- 4.3.2.1 '*Compassion is for Others*'
- 4.3.2.2 Pressure to Conform

- 4.3.2.3 Reciprocity

#### 4.3.2.1 '*Compassion is for Others*'

This subordinate theme refers to the tendency of Participants to consider compassion in relation to other people rather than towards the self.

Florence: We all know what compassion means, we have all heard that word but we feel it's to do with other people isn't it.

Moreover, Participants demonstrated a lack of awareness in relation to the term self compassion.

Clare: Mmm, I don't know to tell you the truth. I have never even thought about it.

Indeed, the vast majority of Participants stated they had never considered directing compassion towards the self.

Hugh: It just wouldn't even cross my mind that those same sort of feelings of compassion, would be appropriate when you are going through something yourself.

Samantha: Again that word compassion. I don't know how to be compassionate with myself, but maybe it's just the word that is throwing me.

This lack of awareness in relation to self compassion contrasted strongly with Participants' cognisance and extensive lived experiences of being compassionate towards others. Participants discussed a breadth of experiences of the structured religious and non religious

role of compassion in Irish society, particularly in relation to loss or bereavement. However, when participants were asked about being self compassionate they often responded with confusion. This subordinate theme may indicate the presence of a social and cultural norm experienced by these participants, that compassion should be directed towards others rather than towards the self. If participants consider compassion as a construct which should only be applied to others this is likely to act as a barrier for cultivating self compassion.

#### **4.3.2.2 Pressure to Conform**

One of the subthemes which emerged from the range of lived experiences shared by Participants during the course of this research was an expression of a societal pressure to avoid self compassion in order to conform to a stoic normative standard. Of the broad range of factors attributable to this sense of pressure, the input of peer groups, the values within families and the concerns of the broader social milieu were the most prominent.

Alice: I do think actually society has kind of made it [being self compassionate] very difficult for me.

Overall, Participants described Ireland as a complex social environment, being a country which is both compassionate and critical. Within this perception, participants expressed their sense that a social norm needed to be upheld. Ann describes this process as being ‘taken down’ if she was perceived to have ‘notions’.

Eve: I suppose in some ways you would be worried about what other people think about you, which is definitely an Irish thing.

This self consciousness was also reflected in Alice's account which led to a deliberate curtailing of self compassion;

Alice: Fear that people will judge me...I am really good at being self compassionate, and I kind of get very aware of other people around me seeing that, and then I might go back into my shell and go .... It's safer to just not try.

The subordinate theme is in some regard related to the previous theme of '*Compassion is for Others*'. The combination of both subordinate themes lends support for the presence of an underlying social belief or norm that compassion is generally only acceptable when directed towards others. This is evident from Participants expressing their experience of being confronted with judgemental attitudes when they attempted to engage in self compassionate practices.

#### **4.3.2.3 Reciprocity**

This theme reflects how Participants experienced an interdependence and reciprocal relationship between their external socio-cultural environment and their capacity to be self compassionate. In essence, the findings suggest the social relativity of self compassion. In particular, Participants depicted the existence of a link between the absence of compassion from others and the detrimental effect which it had on their internal self compassion. In this regard, Hugh described New Zealand as an 'austere cultural landscape' which eradicated his 'internal compassion'.

Hugh: But then when you are just in this most atomised city in the world... there's no community there's no connection with anything ... You just become this massive atomised soulless thing. And that, that has no compassion... I guess maybe it's a

reflection that internal compassion can't be found when there isn't any external compassion you know? If you are in a city like that, that's just cold, then turning inward and being kind to yourself seems mad as well. You know like, when there's no kindness in the pool anywhere and there's just survival and everybody is just surviving on their own terms.

This powerful quote highlights the difficulties one can face when disconnected from a community, and the challenges of cultivating self compassion in an uncompassionate environment. Hugh's comment with regard to 'survival' also echoes an evolutionary framework, and suggests the vital role which self compassion plays in enabling people to live a fulfilling and worthwhile life beyond merely surviving.

This sense of environmental reciprocity was also evident in the Participants descriptions that being compassionate towards others helped to cultivate their capacity to be self compassionate in times of distress.

Alice: But I think I've learned over time ... they [self compassion and compassion for others] are a quite similar thing. So I have it within myself, so I'm sure if I have it [compassion] within myself for other people, I can kind of access it [for myself].

This finding may be an important target for intervention for individuals that find self compassion particularly difficult when they are in acute distress.

Overall, the socio-cultural effects on Participants' abilities to be self compassionate were broad and complex. However, Participants' experiences indicated there is a pervasive and systemic component to cultivating and maintaining self compassion.

### **4.3.3 Distrust: *'It's not allowed'***

The vast majority of Participants expressed distrust and uncertainty with regard to cultivating self compassion. During the course of the interviews, Participants often expressed surprise at their own emotional response to the concept of self compassion. Although, in general, they acknowledged the logical usefulness of self compassion, many Participants articulated their reservations towards the concept.

As previously mentioned, the reflexive process was critical throughout the analysis stage. However, it was particularly important in the titling of themes. This subordinate theme was re-titled a number of times during the analysis process as demonstrated in the versions of the templates (Appendices K to L). Earlier provisional titles for this theme included references to the challenges of being self compassionate, a fear of being self compassionate and others. Although the theme reflects these components, distrust more accurately portrays the palpable unease experienced in the interviews when Participants considered self compassion. This was accompanied by Participants' non-verbal responses to the construct, including one Participant hunching her shoulders, turning her head away and raising her hands in defence. Importantly, these responses appeared to be subconscious for Participants as when they became aware of their negative feelings and attitudes towards self compassion they were often startled. At times, Participants were also unable to articulate the origins of their wariness.

The following subordinate themes are explored with quotations from Participants;

- 4.3.3.1 Self Compassion is *'Dangerous'*
- 4.3.3.2 Self Compassion Quota
- 4.3.3.3 Pervasive Self Criticism

#### 4.3.3.1 Self Compassion is '*Dangerous*'

Participants that conceptualised self compassion negatively as self-indulgent, as previously discussed in subsection 4.3.1.1, understandably considered self compassion to be unhelpful and experienced it as threatening.

Stacey: It's a dangerous road to go down.

However, even Participants that conceptualised self compassion in a positive manner also often articulated a distrust and nervousness with regard to being self-compassionate.

Ann: [pause] I would be afraid that I would find myself out... that I'm not as good as I think I am. That would be my fear if I was trying to be totally compassionate with myself. I wouldn't have any excuses anymore, you know.

Ann's powerful quotation emphasises the paradox of embracing a more self critical approach in order to safeguard against the unknown. A long history of being self critical although knowingly unhelpful was deemed to be safer than the unknown of being self compassionate and possibly exposing oneself to potential negative realisations about the self.

This sense of distrust of self compassion and positive affect was also evident in Hugh expressing how he previously considered the more distressing aspects of life to be in some way more authentic and thus more reliable and predictable than more positive aspects. Hugh discussed his experiences in literary terms, referencing Kerouac and Salinger.

Hugh: If you tell yourself something to explicitly interfere with how you [negatively] feel about something then you are lying to yourself ...it's not the real lived experience ... if you start to take little daisy pictures on top of it [positive emotions or attitudes]

and change it, it's just inauthentic....I mean loads of [people] have this grandiose bullshit idea that you have to live like Kerouac [with a dystopian view of the world] you know.

Participants' experiences reflect a tendency to consider negative affect to be in some way more trustworthy than positive affect. This inclination to experience positive affect or practices which cultivate positive affect such as self compassion, as threatening or dangerous may be due to the unreliability of positive affect in the midst of mental health difficulties. Moreover, it could indicate a propensity to seek out an idealised version of positive emotions. Hugh stated that it took him a considerable length of time to alter his perception that austere life, which gives extra credence to negative affect, was more authentic than experiences with positive affect. It also encompasses a perception that a rationalisation is needed to allow oneself to experience positive emotions.

Participants' experience of self compassion related to a need to place boundaries on themselves in anticipation of possible further distress or self disgust threatened by exposing themselves to the unknown. The perception of self compassion as threatening and dangerous was widespread during the interviews whether addressed explicitly, as in Ann's quotation, or implicitly, through non-verbal cues or avoidance of central questions.

#### **4.3.3.2 Self Compassion Quota**

This subordinate theme emerged from the tendency of Participants to consider self compassion in polarised terms and to believe that only a certain amount of self compassion was useful or appropriate. Framing self compassion in such polarised terms resulted in Participants conceptualising it as an ideal, thus regarding self compassion as entailing

kindness towards the self at all times. Participants subsequently and inevitably considered self compassion to then be unattainable, and thus found the concept overwhelming.

Alice: it would be like me being nice to me all the [time], probably being like the complete opposite to what I am, when I'm being really bad... I have this fairy tale idea of it.

Certain Participants also tended to view self compassion as being quantifiable, and equated large amounts of self compassion with a negative outcome.

Stacey: if I had started to go down the road of like self compassion I would have drowned in it.

Importantly, this belief with regard to an acceptable amount of self compassion cultivated a tendency amongst Participants to place restrictions upon themselves on the degree to which they were allowed to engage in self compassion practices. These restrictions ultimately and unhelpfully led to Participants being unable to explore the outcome of increasing their self compassion, and thus their confidence and belief in a limited quota of self compassion was never disproved. As a consequence, Participants' fears that only a certain quantity of self compassion was acceptable ultimately maintained their self judgement.

#### **4.3.3.3 Pervasive Self Criticism**

This theme refers to the widespread presence of self criticism in all Participants' lived experiences, and appeared to be an antagonist to developing self compassionate. All Participants articulated the prevalence and pervasiveness of self criticism. This is a relatively

unsurprising finding as self criticism is arguably a central component of many mental health difficulties particularly depression and anxiety disorders. In the case of one Participant in the midst of a period of low mood, a segment of the interview was devoted to addressing the critical thoughts that would occur following the interview when the Participant returned home. Subjectively, those Participants who were in a stage of recovery rather than in the midst of a difficult period were better able to garner distance between their emotions and their thoughts in order to allow them to assess the accuracy of their critical thoughts, and were generally more open to the construct of self compassion.

Participants' descriptions of periods of low mood were invariably dominated by an all-encompassing self critical way of relating to the self.

Hugh: And you sort of turn in on yourself as a 'you're failing this', 'you're not doing this well enough', 'you're not doing x well enough'. And then there is this knock on effect to my kids and my marriage and you sort of, you don't necessarily express compassion towards the stresses in those situations you beat yourself up over not getting it right.

Importantly, when exploring the origins of the difficulties of being self compassionate during the interviews Participants discussed the type of relationship they had with their caregivers. These Participants stated their difficulty being self compassionate, and tendency to be self critical was due to the fact that their parents were highly critical when they were growing up. In contrast, some Participants were unable to identify the source of their critical way of relating to themselves and tended to associate it with their mental health difficulty.

Although, a high prevalence of self criticism was an expected theme, an unanticipated finding of this study, has been the discovery that certain Participants found self criticism as a useful mechanism to place boundaries on their behaviour.

Ann: That maybe some of the criticism is due, is correct, is valid you know

However, Participants' experiences of self criticism, like their experiences of self compassion, were not static over time. Gerry's experience epitomises this shift from perceiving self criticism as a useful tool at one point in time to later recognising its pernicious ability to gradually erode an individual's confidence to effect change in their own lives.

Gerry: What was commonly said to me when I was much younger, you are very hard on yourself... that was my cloak... being critical kept me on my feet, you know, wishing you could do things better, wishing that you were better... That was almost something that I wanted to hear because that's the way I seemed to want it. But not realising that that has a hugely detrimental effect [on] your subconscious mind, you are basically telling yourself, that is your limit... But now I don't have any ... limits you know. My limit is limitless if you like.

Participants' distrust of self compassion was quite extensive. Their experience of perceiving self compassion as dangerous indicates the intimacy of self compassion in how we relate to ourselves and the complex range of beliefs encapsulating peoples' experiences. Moreover, the range of restrictions Participants placed upon themselves, in combination with their engrained and habitual tendencies of being self critical appears to have inhibited their ability to adopt more flexible and supportive ways of relating to themselves.

The following section explores self compassion in relation to Participants' experiences of mental health difficulties and the resulting challenges of cultivating self compassion.

#### **4.3.4 '*Emptiness*' and Mental Health Difficulties**

This superordinate theme reflects the detrimental effect of mental health difficulties on Participants' abilities to be self compassionate. Participants struggled with a sense of feeling they were undeserving of self compassion and also expressed a need to justify both to themselves and others the decision to be more self compassionate. The theme demonstrates the pivotal role of self compassion in Participant's overall well being. The subordinate themes are as follows;

- 4.3.4.1 '*Disappearance*' of Self Compassion
- 4.3.4.2 Self blame and Guilt
- 4.3.4.3 Being Undeserving
- 4.3.4.4 Need for '*Permission*' and Justification

##### **4.3.4.1 '*Disappearance*' of Self Compassion**

This subordinate theme is concerned with the formidable role which mental health difficulties can play in influencing Participants levels of self compassion. Specifically, the research identifies a trend that the presence of a mental health difficulty can have a detrimental effect on Participant's levels of self compassion when in a period of significant distress. Participants initially struggled to define the term self compassion abstractly. However, the transcriptions and the researcher's reflective log demonstrate that when participants began exploring self compassion with regard to their mental health difficulties they spoke with fluidity and provided innumerable vivid examples of their lived experiences. This reflects the importance of exploring Participants' perceptions within their lived experiences.

The '*Disappearance*' of Self Compassion was a pervasive theme in all Participants' lived experiences, and occurred in combination with a sense of hopelessness;

Gerry: it was like someone decommissioning a dog or a horse...I was like a beaten bird.

Samantha: when my mum was in hospital [psychiatric] there last year. And it was a very sad place ... they just couldn't see light at the end of the tunnel, lots and lots of people. ... They can't channel that feeling I suppose, being kind, or compassionate.

This sense of hopelessness was also accompanied by an elevation of a self critical way of relating to the self.

Alice: that would definitely be the time where it's [self compassion] the worst. Where I'm in a very low mood I find trying to do things to help myself ... They seem almost impossible... the critical side of me comes out, and I find it very very difficult.

Florence: very dark, very dark, just you know in a hole you know, trying to get out [re postnatal depression]. so I don't think I could have mentally been nice to myself.

Some Participants stated they did not feel they had the ability to be self compassionate with themselves or others at that time of low mood, and their distress resulted in a narrowing of their awareness onto their internal distress, resulting in feeling isolated from others which is likely to lead to further distress.

Ann: I would call it kind of hibernating. Very much sort of shrinking into myself.

Moreover, Hugh described a sense that a reserve of self compassion can exist. He described how mental health difficulties erode this reserve, in addition to the ability to be

compassionate towards others which can lead to isolation, exacerbating the mental health difficulty.

Hugh: if you hadn't invested enough in that bank of compassion internally you haven't got anything left...I find when I'm at my worst...I just... don't have any energy to give [to others].

Collectively, Participants' lived experiences indicate one of the central tenants of mental health difficulties appears to be the elimination of people's ability to be self compassionate. In addition, the 'disappearance' of self compassion is also likely to serve as a perpetuating factor for periods of low mood.

#### **4.3.4.2 Self Blame and Guilt**

This theme refers to the extensive self blame, shame and guilt described by Participants during periods of low mood. When Participants believed they were to blame for their low mood they deduced that they were unworthy of receiving or cultivating self compassion. This tended to culminate in a sense of guilt and acted as a barrier with regard to practicing self compassion.

Alice: I feel guilty about doing something nice for myself

The self blame and guilt was pernicious for participants and an integral component to maintaining their low mood as it appeared to feed into a cycle of self critical thoughts and negative self judgements which impacted on their sense of self.

Hugh: when you are right in the middle of some kind of difficult period or sort [of] psychological stress you tend to blame yourself for being in that position. It's

absolutely bound up in the position being as terrible as it might seem to you, it's your fault rather than external conditions being at fault.

Moreover, the guilt experienced by Participants served to deplete the energy or attention they could invest in cultivating strategies to manage their mental health difficulty in a more efficacious manner.

Ann: You know, what used to be my one worry long ago was that if I told anyone I was depressed, or if they knew I was depressed they would think that I came from a bad house, like or a bad husband and then I felt guilt. Fierce guilt.

This theme of self blame and guilt was strongly correlated with a sense of being undeserving of self compassion as explored in the following section.

#### **4.3.4.3 Being Undeserving**

This subordinate theme refers to the pervasive sense that Participants viewed themselves as unworthy of self compassion. The process notes from the interviews within the reflective log reflected multiple examples of Participants being shocked when they discovered they held this perception about themselves. The finding was unexpected and particularly striking given that the theme was equally present in Participants who were in a period of low mood as well as Participants who were currently well.

Alice: But there's just like this voice in my head saying no you don't deserve it.

This subordinate theme provides additional support for a broader conceptualisation of compassion. Participants discussed how being compassionate towards themselves in times of distress included practical tasks such as showering or eating.

Alice: It actually gets ... quite bad, quite severe. I start thinking that I don't even deserve to eat [laughs nervously], and I would completely neglect myself and I get to the stage where I wouldn't even [do] basic things like. Things like, needs like eating, showering and stuff like that just basic self compassion. I would kind of not think that I deserve any of those, that's when it gets very bad...I'm just in a different world then.

Participants expressed confusion and ambiguity with regard to the rationale behind their perception that they were unworthy or undeserving of self compassion.

Samantha: That I shouldn't you know? ... I don't deserve compassion for myself. But I do, I'm no better girl to say it you know. [Participant became tearful at this point]

Hugh: I'm one of these people that naturally feel like I deserve no compassion at all. So I've, I mean I can see the sort of craziness of that. I mean everybody is deserving of compassion, and deserving of respect and love so I know that that's just wildly inappropriate.

Participants experiences of being self compassionate highlighted a disparity between the logical argument that they deserved self compassion and the ensuing emotional response. The presence of these beliefs and these reactions in Participants who were in a period of low mood, in addition to those with a history of mental health difficulties indicates a well established and embedded belief system.

#### 4.3.4.4 Need for '*Permission*' and Justification

This theme relates to Participants expressing a perceived need to rationalise or justify being self compassionate. For certain Participants, this tendency was related to the previous subordinate theme of feeling that he/she did not deserve self compassion. This in turn appeared to lead participants to feeling a need to justify self compassion both to themselves and others. In addition, some Participants such as Florence identified needing 'permission' to engage in self compassion which reverberates with the superordinate theme of distrust, and that self compassion 'is not allowed'.

Florence: that's what I needed, sort of permission.

Other Participants engage in pragmatic rationalisation to justify being self compassionate. This is evident in Hugh's expression of his need to consider the positive impact of being self compassionate on the people in his life. This justification navigates his self blame and enables him to be more self compassionate.

Hugh: I know it will help me be a better person for the people around me ... Even if like, I had a hard time justifying it to myself... the only way for me to work over that is to see it in these utilitarian terms. You will be of much more benefit to the other people you care about if you can work that into the way that you deal with your life... If you can just let yourself off the hook and find ways to be kinder to yourself.

These findings are critical as they indicate an additional barrier for people to cultivate self compassion, and also illustrate these Participants' experiences of what is entailed in developing self compassion.

Participants' profound lived experiences demonstrate the daily challenge of living with mental health difficulties and the complex interaction with people's ability to be self-compassionate. This complexity is compounded by the individual differences in peoples' lives, and is dependent in some form on their stage of wellbeing. However, the theme provides evidence that whether related to their mental health difficulty or the wider socio-economic climate self-compassion is integral to core components of the participants self-worth.

The following final theme explores the cultivation of self-compassion in Participants' recovery journey from their mental health difficulties.

#### **4.3.5 '*Seeing the Colours*': Recovery**

This theme revolves around the pivotal role which self-compassion plays in Participants' recovery from their mental health difficulties. This superordinate theme was prevalent across the vast majority of Participants and in some respects it resembles a similar structure to the subordinate theme of 'Multi-Faceted Self Promotion' due to the presence of multiple components.

The reflective log was crucial in elucidating Participants' experiences within this theme as it entailed a constant critique of the role of the researcher in interpreting Participants' experiences. As this dissertation is focused on Participants' lived experiences of self-compassion, the data discussed below is focalised around self-compassion however it does incorporate elements of general recovery. It is important to note that Participants' recovery journeys included a broad spectrum of strategies of which self-compassion was one component. The researcher felt incorporating the breadth of Participants' responses was critical in order to encapsulate people's overall lived experiences.

The range of experiences is reflected in the multiple components of the theme structure. The following subordinate themes were identified;

- 4.3.5.1 Determination
  - 4.3.5.1.1 Gratefulness and The Present
  - 4.3.5.1.2 Distance from Thoughts
  - 4.3.5.1.3 Acceptance
  - 4.3.5.1.4 Prevention
  - 4.3.5.1.5 Experience and Learning
- 4.3.5.2 External Support

#### **4.3.5.1 Determination**

This subordinate theme relates to the prevailing sense of resilience and determination expressed by Participants' with regard to their recovery journeys. Participants' resolution was self-evident in their perseverance in cultivating their ability to be self compassionate. The recovery journey was described in an arduous manner and did not consist of one specific element but of an amalgamation of individual strategies that people had found to be the most effective.

##### **4.3.5.1.1 Gratefulness and the Present**

The present and being appreciative of everyday moments was a central aspect of self compassion for Participants in their recovery journey. Notably, the current subordinate theme is similar to Participants' conceptualisation of self compassion in the previously discussed theme 'Multi-faceted self promotion'. With regard to being present and appreciating the

smaller things in life. Participants described the benefits of using this strategy to regulate their emotions and effect change.

Alice: And I think when you are being mindful...You are more aware of yourself...I feel a bit sad about something, you can figure it out and then you can do things to help yourself. Whereas if you are not being mindful ... you won't know if you need to be self compassionate.

Florence: if things are going bad to say stop and be grateful for all the good things I have. I find it easier to have that self compassion in my mind and be nice to myself with the little things in life.

Some people's recovery journeys had cultivated a sense of appreciating the little things in life and attending to them in more detail.

Gerry: I guess I need to feel the energy fields between people a bit more. And I think a lot of people go around in the dark like this... they are walking around blindly ... Whereas I'm smelling everything, I'm seeing everything.

Attending to the present appeared to have a grounding effect on participants. This grounding effect supported Participants to address other challenges on a daily basis and prevented a cycle of self critical thoughts overwhelming them and eroding their energy levels. Moreover, attending and being grateful for smaller aspects of everyday life as described by Gerry evoked positive emotions in little bursts throughout the day. This strategy appears to be of significant utility as it is likely to also challenge the tendency to seek an idealised version of positive affect.

#### 4.3.5.1.2 Distance from Thoughts

Participants emphasized the need to be able to reflect and in some cases externalise their own thoughts, to enable them to obtain some form of emotional distance and detachment.

Hugh: not trusting your internal monologue...it's [not] Gospel, it's too random to be trustworthy. I'm a scientist ... but when it comes to listening to your own head, I'm just like a fairy tale Goblin you know, I don't carve off the purely inane thinking.

The immense power Participants gave to their thoughts is illustrated by Clare's experience;

Clare: Your own thoughts can either destroy you or lift you up... Other people can hurt you. But only you can destroy yourself.

Participants described a tendency to become over involved with their thoughts which ultimately led to a spiral of self criticism, and a sense of feeling overwhelmed. Indeed, Hugh described the importance of curtailing critical thoughts as a way of being self compassionate.

Hugh: It almost sounds like a blizzard...you just are constantly telling yourself exactly how shit it was and why you are responsible for it, and how you don't see things changing...it's a pointless and incorrect voice that you sort of overlay on top of everything else. So just shutting it off is compassionate in a lot of ways.

Learning to obtain an emotional distance from their thoughts increased their psychological flexibility and awareness of the variety of options of how they could respond to their thoughts.

Hugh: Open that little window to show yourself a little bit more, cut yourself some slack to stop focusing on quite as intently, see yourself as part of a bigger continuum ... see yourself in that context.

The role of self criticism, obtaining a distance from thoughts and responding to the self in a kinder and more supportive way interacted for Participants in a variety of ways. However, the emotional distance served as an important aspect of their recovery as it provided them with opportunities to increase their psychological flexibility and shift away from a rigid way of perceiving their difficulties.

#### **4.3.5.1.3 Acceptance**

The theme of Acceptance refers to Participants' ability to take ownership over their mental health difficulty, and as a result respond accordingly. Participants' experiences did not reflect a sense of resignation but rather an acknowledgement of the situation they found themselves in.

Vanessa: Acceptance is a very big thing in it you know... I mean if you have a lame leg like, and it's going to stay with you, you know and there's nothing you can do with it like. You can't keep pretending it's going to get better or hope it will ... You just have to learn to live with it like, and around it like ... and you would be happier for doing it like.

This acknowledgement enabled Participants to alter the way they responded to the challenges they faced. Indeed, an important shift was demonstrated from desiring the situation was different towards an acceptance of their reality, which enabled them to make changes.

Alice: the main thing is accepting...I have depression ... I might not be able to cope sometimes but just accepting it and not trying to cure it.

This subordinate theme was an important component to Participants' process of recovery. However, Participants' experiences indicated this acceptance occurred gradually over time

and was an aspect of self compassion which could only be achieved through Participants learning from their own lived experiences.

#### **4.3.5.1.4 Prevention**

This theme relates to Participants employing self compassion as a strategy to pre-empt and prevent periods of low mood. Employing self compassion as a preventative strategy was an unexpected finding in relation to people's lived experiences. Vanessa described it as an 'uphill battle every day'. Participants indicated how on account of past periods of low mood they now live their lives by proactively engaging in preventative strategies which ranged from attempting to keep a balance in their lives, to keeping healthy, sleeping well, or indeed imitating and adopting strategies from other people.

Hugh: I guess I'm trying to work out how other people manage their compassion in how she [wife] does. She seems to have a really solid baseline. She doesn't go below a certain level...That's brilliant. Having that kind of inner reserve ... I don't have that, I would like to develop that...I will just keep going down, and down and down and getting worn down by things and not sort of topping up that compassion pool.

Hugh stated believing one is being proactive in managing moods, in and of itself can be useful, as he stated if he did not believe he was taking active steps to prevent another period of low mood he began to feel guilty and a cycle of self critical thoughts would commence. Participants described a variety of strategies to proactively manage their well being, such as being kind towards themselves throughout the day.

Vanessa: I tell myself, I always remind myself that I'm a nice person like, and I'm a good person. And I'm there for my kids like.

Gerry: You actually have to say, look what I have just done. So my mindset now is particularly, when I'm doing swimming or running, I start telling myself all the [positive] things I've done, like a repeating thing, like it's all good.

All of the Participants' strategies were cultivated from their own lived experiences of what they had found to be the most effective in the past and were tailored to fit into their everyday lives. This denotes the importance of cultivating self compassion as an integral part of everyday lives.

#### **4.3.5.1.5 Experience and Learning**

Participants often used a variety of terms to describe how they have cultivated compassion in relation to supporting their recovery, these included 'maturity', 'age', and 'time'. Overall, these terms appeared to reflect a developmental process of learning from their own lived experiences and adapting to new challenges as a result.

Gerry: If someone said you are now 38. I would say no don't put me back. I don't want to lose what I've got. So, I think it's a bit like Dorothy in the Wizard of Oz, she had to go through that experience ... The good witch says you could have gone home anytime you like, you know. You had it within you all you had to do was really want it. She didn't have to click her [heels] that was the whole message of the film. The experience of going around, she ends up learning about herself.

The learning Participants garnered from their lived experiences appeared to be central to supporting them to regulate their mood and improve their quality of life. Importantly, many Participants discussed that the responsibility to make changes lay solely with themselves.

Moreover, Participants stressed the importance of needing to be at a certain stage to be open to making changes, as Clare describes; ‘You would have to break down that wall yourself.’ Other Participants also spoke about the necessity of being open to learning from experience, and how this related to self compassion.

Vanessa: the more ignorant people are the less compassionate they are, and there are no two ways about that.

This openness to experiencing life in different ways was further supported by Hugh’s expression of the role of self compassion in navigating distress in life.

Hugh: If you don’t allow compassion to mitigate this lived experience. If you don’t allow it to soften the experience, then ya, life might be brutal and real, but it’s just not a life worth living because this perception of this real life, that’s a really grim one and it doesn’t. And it’s not more authentic than the one that is mitigated by compassion to being bearable, copable you know?

The determination in Participants’ lived experiences was profound. Their narratives reflected resilience throughout their lives, and a continued search for alleviating the distress. Cultivating self kindness as a component of self compassion may be a particularly useful strategy to enable people to approach their past behaviours with openness and with a supportive attitude, as this is likely to be a conducive strategy to initiating and maintaining change.

The tendency to engage in a variety of strategies appears to have supported people in responding to a range of proximal and distal difficulties. This comprehensive and varied

approach by participants indicates the necessity within the sample to adopt individualised strategies during the recovery process.

#### **4.3.5.2 External Support**

This subordinate theme refers to the necessity of receiving support from others in order to successfully cultivate self compassion during the recovery journey.

Participants explored their personal experience of needing more acceptance and understanding from society.

Alice: I think if it was more just like acceptable [laughs]... if people started seeing it as a normal everyday thing that you do for your own mental health. Like it wasn't seen as a kind of a big deal or something it would be a lot easier...So just people saying, you know what it's okay to actually be self compassionate.

Participants discussed the role of how receiving compassion from others in developing their ability to be self compassionate when in distress, and ultimately supported them to recover.

Florence: I don't think you can really learn that [self compassion] yourself [when low in mood]... I don't think without outside influences you could just suddenly get up and say I've got to be nice to myself.

Vanessa: What I used to find brilliant long ago... I would have had maybe two of the kids at the time like. And I would feel so overwhelmed like you know ... The kitchen, I'd be exhausted. The wear would be inside in the kitchen all built up and everything like. He would come in after [work] in at half 12 like... And next thing...you would hear the water going, and you would hear the clatter and he would be washing the wear. And just because he was doing that, I would get up and help him. And that's all

it took. But I couldn't do it before that, I couldn't do it like. But once he came, and somebody was being good to you like. Somebody was thinking of you, somebody had that compassion for you like.

Participants also explored the role of attending to their environment and context to support themselves to recognize the compassion being offered by other people.

Hugh: if you can just open a crack to sort of listen to what else is going on other than that internal monologue then you are in a position to maybe hear from the external world that there is something worth being compassionate about. Because you generally get a lot of love and support from the people around you when you are in a particularly dark place.

This subordinate theme of external support interlinks with the theme of Reciprocity. Both themes reflect the Participants' experiences of the bidirectional impact of self compassion both towards others, in addition to receiving compassion from others. However, the integral aspect of recovery within the theme of external support differentiates the theme from the theme of Reciprocity. Moreover, this subordinate theme provides further evidence that the sample considers self compassion in a broader, more pragmatic sense, and is more contingent on interpersonal relationships than the literature suggests.

### **4.3 Conclusion**

The results of this research indicate that self compassion is inextricably linked with mental health difficulties, and importantly, in people's journey through their recovery. All Participants perceived self compassion as multi-faceted and significant disparity was observed in Participants' conceptualisations of the construct. Participants experienced self

compassion as threatening, and as such voiced a strong personal sense of distrust with regard to the concept. Participants who were in the midst of a period of distress as well as those who were in a period of recovery expressed a range of meta-cognitive beliefs which interfered with their ability to cultivate self compassion such as feeling undeserving of self compassion. Mental health difficulties were also found to temporarily eradicate Participants' abilities to be self compassionate. Socio-cultural factors contributed to the variety of challenges people faced when attempting to cultivate or practice self compassion. Participants lived experiences also demonstrated the powerful and intrinsic way self compassion supported their recovery, in addition to serving as a preventative strategy with regard to relapse. The following section explores these findings in relation to the current academic literature, the clinical implications and the recommendations for future research. The strengths and limitations of the research are also discussed.

## **5. Discussion**

### **5.1 Overview**

This phenomenological research was aimed at addressing a gap in the existing literature by exploring people's lived experiences of self compassion in an Irish Primary Care mental health group. The research was designed to address three main research questions, namely;

- How do people with a mental health difficulty perceive self compassion in an Irish Primary Care setting?
- What are people's lived experiences of self compassion?
- Are there challenges to being self compassionate? And if so what barriers have people experienced?

Eleven semi-structured interviews were conducted with Participants who had a diagnosis of depression and/or an anxiety disorder. The individual interviews were transcribed verbatim from audio recordings and analysed using Template Analysis (Crabtree et al. 1992).

### **5.2 Operationalisation of Hermeneutic Phenomenological Principles**

Van Manen's (1990) Hermeneutic Phenomenological principles were operationalised by a number of measures throughout this research. Firstly, research into Participants' lived experiences of self compassion addressed a gap in the literature and thus was of particular interest to both the researcher and the world. Employing Template Analysis as a method of analysing the interview transcripts enabled the researcher to explore both Participants' individual experiences, as well as the collective experiences of the sample through hierarchical themes. This served to balance the exploration of both the parts and the whole of

the phenomenon of self compassion. From a methodological perspective the integrity of this research was ensured by the researcher's extensive re-iterative engagement with the transcripts in the analysis process. A number of superordinate and subordinate themes emerged from the analysis as presented in figure 15. The essence of Participants' experiences were presented and interpreted in narrative form through the use of direct quotations in the results section. This narrative process operationalised van Manen's (1990) principle of describing the phenomenon through writing.

Importantly, reflexivity was a fundamental aspect of this research as necessitated by Hermeneutic Phenomenological research. At every stage, reflective practice maintained the researcher's critical stance during the exploration of Participants' 'lifeworlds', and enabled the researcher to consider the interpretation and meaning of the Participants' lived experiences of self compassion at exponentially deeper levels. Reflexivity was particularly important in those instances where findings emerged which were in conflict with the researcher's preconceived notions. In such circumstances, reflective practice demanded that the researcher not only consider the data which supported the preconceived notions, but also the data which challenged them, this process ultimately achieved a more comprehensive and holistic analysis. Moreover, this reflexivity enabled the researcher to continuously return to the Participants' responses from the perspective of their lived experiences, thus operationalising van Manen's (1990) principle of maintaining a strong orientation to the phenomenon.

It is important to note, that all Participants constructed their meaning of events through the interview process. As many Participants had never directly considered the term 'self-compassion' previously it was often through moment to moment reflections during the interview process that they began to explore their own understanding of their experiences. As a consequence, the results should be interpreted with an acknowledgement that Participants'

conceptualisations were being partly constructed as the interview progressed and they became more self aware with regard to how they are compassionate in their everyday lives. The researcher was conscious of this process, and made attempts to manage this meaning making process by asking open ended rather than leading questions. However, the researcher simultaneously acknowledges the active and integral role of the researcher in the emergence and interpretation of people's lived experience within qualitative research.

The following section contextualises the findings in relation to the academic literature, and discusses the clinical implications of this research. This is subsequently followed by a critique of the strengths and limitations of the research with reference to the recommendations for future research.

### **5.3 Contextualisation with the Literature and Clinical Implications**

#### **5.3.1 Perception of Self Compassion in an Irish Primary Care Sample**

The findings from this sample serve both to support and challenge aspects of existing mainstream literature on the perception of self compassion.

Notably, Participants demonstrated a lack of awareness with regard to the term, and were generally initially unsure how to conceptualise self compassion, tending to take time to reflect and consider their responses. This finding provides support for other qualitative research in the area (Pauley et al. 2010). However, during the course of the interview Participants' perceptions of the construct emerged.

The literature conceptualises compassion as an emotion (Goetz et al. 2010), as a combination of skills and attributes (Gilbert et al. 2010), and as an interdependent amalgamation of self-kindness versus self judgement, mindfulness versus over-identification, and common

humanity versus isolation (Neff et al. 2003a). Although Participants at times described their experience of self compassion in emotive terms, they generally conceptualised the construct in relation to a range of skills and approaches. This sample diverged from the literature by conceptualising self compassion in a broader and, in some ways, more pragmatic manner than Neff's conceptual framework. Although comprehensive in scope, Neff's conceptualisation tends to focus on the more cognitive dimensions of self to self relating. In contrast, Participants in this study depicted a multi-faceted structure to self compassion which included being kind towards the self but also incorporated 'basic self compassion' which included physical exercise and personal hygiene. In this regard, the current research makes a valid contribution and extends the existing literature in this field by providing evidence that individuals at times conceptualise self compassion as multi-faceted.

In addition, the findings serve to support a number of components which have previously been reported in qualitative research. Specifically, this research provides support for Sutherland et al.'s (2014) findings that acceptance, distance from thoughts/a balanced perspective, and understanding may indeed be central to Participants' experiences of self compassion.

Reflecting a further key finding of this research, Participants' experiences suggest that self compassion does not exist in isolation from being compassionate towards others, and receiving compassion from others. Indeed, the majority of the Participants initially explored their meaning making of the term self compassion in relation to their understanding of being compassionate towards others. Moreover, Participants' lived experiences illustrated the interdependent and reciprocal relationship between being self compassionate and receiving compassion from others. This finding is in line with previous qualitative research (Pauley et al. 2010) and lends support to Gilbert's conceptualisation of compassion, which proposes that

being compassionate towards others and receiving compassion from others can have a reciprocal engendering effect.

Overall, these findings lend support to a hybrid conceptualisation of self compassion which comprises an amalgamation of Neff and Gilbert's respective models of the concept. Support for this hybrid conceptualisation can be found with reference to the inclusion of the components of self kindness and mindfulness in Participants' experiences, in addition to, the inextricable link between receiving compassion from others, and being compassionate towards the self.

In addition to the above findings, the dominance of Participants' negative perception of self compassion as self indulgent or self pitying as demonstrated in this research, adds to the limited existing literature which proposes that self compassion can be interpreted by individuals as leading to the over involvement with emotions, and thus can lead to further distress. Indeed, this research also indicated Participants' perceived self compassion in a negative manner when in a period of low mood. This may highlight a possible need for Clinicians to adapt the rate and style of the introduction of the concept of self compassion in clinical practice to service users' stage of recovery. However, it is important to emphasize that a cross-cultural component of self compassion needs to be explored further. As indicated by Yamaguchi et al. (2014), self criticism and self compassion can be viewed diversely in different societies, particularly in relation to individualistic and collective societies.

The manner in which people perceive self compassion has important clinical implications. The diversity of conceptualisations raised within this sample reflects the need to be aware of the multitudinous ways individuals may perceive self compassion. As a consequence, it may be necessary for Clinicians to begin interventions with a collaborative and open dialogue with service users about their perceptions and expectations of self compassion to assist the

implementation of compassion-based interventions. If a service user's perceptions of self compassion is drastically dissimilar to those of a clinician this may negatively impact on the implementation of an intervention, or lead to the service user prematurely disengaging from a service.

### **5.3.2. Challenges and Barriers to being Self Compassionate**

#### **5.3.2.1 Mental Health**

This Primary Care sample discussed how their mental health difficulties temporarily eradicated their ability to be self compassionate. This research finding extends the existing literature which has demonstrated a significant inverse relationship between levels of distress and self compassion in Community and Secondary Care samples (Hoge et al. 2013, Neff et al. 2003a, Kelly, et al. 2014 MacBeth et al. 2012). In particular, Samantha's interpretation that people who are in psychological distress have lost their ability to 'channel' self compassion is poignant. In this regard, her observations epitomise the need for further exploration of the absence of self compassion during mental health difficulties, and how this may relate to people's ability to maintain a quality of life or sense of well being.

It is also likely that Participants' polarized conceptualisation of self compassion - namely that they consider self compassion as requiring self-kindness at all times - led Participants to feeling overwhelmed at the idea of being self compassionate. This tendency is apparent in Alice's depiction of self compassion as a 'fairy tale version' which she perceived, in her own words, to be the 'complete opposite to what I am'. This belief that there is an acceptable amount of self compassion could, in and of itself, be detrimental to Participants' attempts to cultivate self compassion. As a consequence, there is a need for further research to examine

this finding. If, as this research suggests, this polarised conceptualisation of self compassion is a frequently occurring belief, it may be useful to address it in clinical interviews as it could remain an unspoken or indeed unconscious belief which could ultimately interfere with therapeutic interventions.

### **5.3.2.2 Self Blame and Guilt**

The detrimental consequence of the absence of self compassion in the midst of a period of low mood would appear, from this research, to have been compounded by a distinct sense of shame, and self blame which Participants' experienced as a consequence of their mental health difficulty. The prevalence of self blame and shame in individuals with mental health difficulties is reflective of wider research on this issue (Kannan et al. 2013). Participants' heightened sense of responsibility for their low mood often resulted in a pervasive sense of guilt for directing any form of kindness towards themselves. As a consequence, this self blame and guilt also served as a perpetuating factor in Participants' mental health difficulties and as a challenge to developing self compassion.

### **5.3.2.3 Self Criticism**

Self criticism is a persistent factor in a range of mental health difficulties (Schanche et al. 2013). Hugh's externalisation of his self critical thoughts as a 'fairy tale Goblin' epitomizes the extent of the personal distress caused by Participants' critical thoughts. The pervasiveness of Participants' self criticism was found to be an additional barrier in cultivating self compassion. Participants' experiences notably indicated the prevalence of self criticism in their lives, and indeed some Participants' described a belief that self criticism was

a useful tool for self improvement. It is likely that a protracted critical way of relating to the self was familiar to Participants, and the introduction of an alternative method of self to self relating may have triggered fears in relation to the unknown. This indicates the need in clinical practice to explicate service users' beliefs with regard to self criticism to prevent any interference with the therapeutic process. Gerry's progressive account, of the manner by which his perception of self criticism evolved from initially perceiving it as a useful 'cloak', to subsequently, recognising it as a debilitating barrier, highlights a powerful finding within this research that Participants' attitudes towards self criticism can be altered over time. Clare's contribution on the responsibility people possess over how they engage with their thought processes is particularly relevant in this context; 'Your own thoughts can either destroy you or lift you up'.

All of the above provides support for the ecological validity of implementing self compassion-based interventions in order to specifically target critical self to self relating. Future research in this area is merited in order to qualitatively explore what people find useful about self criticism, and what contextual shift is needed to alter the way people relate to themselves.

#### **5.3.2.4 Distrust of Self Compassion**

One of the most dominant themes emerging from this research is the presence of a widespread perception amongst Participants that self compassion is in some regard dangerous or threatening. Indeed, this sense of distrust is acutely apparent in Stacey's description of self compassion as 'a dangerous road to go down'. A distrust of being self compassionate is in and of itself a barrier as it is likely to result in reluctance by Participants to cultivate self compassion. This finding extends previous literature which demonstrates preliminary

evidence that people with mental health difficulties can be fearful of self compassion (Gilbert et al. 2014). Importantly, the current research suggests a need to explore service users' meta-cognitive beliefs with regard to self compassion in clinical practice before commencing an intervention.

Significantly, the theme of Participants feeling undeserving of self compassion and expressing a need for permission to engage in self compassion practices occurred in both Participants who were in a period of low mood during the interview, and those who were in a period of recovery. The continued presence of this theme of unworthiness amongst the Participants suggests the presence of a specific set of beliefs which are quite persistent over time. Importantly, Participants were often surprised at their own response to the construct of self compassion reflecting a disparity between a logical appreciation that they deserved self compassion and an emotional reflex to reject it. As a result, significant care and consideration may need to be taken when exploring service users' conceptualisation of self compassion and self compassion practices. The therapeutic alliance is an essential component of clinical outcomes (Norcross et al. 2011), and may be particularly relevant in this context in relation to navigating these deeply held beliefs with service users.

#### **5.3.2.5 Attachment and Self Compassion**

Participants expressed their view that being self compassionate was related to their sense of worth. A number of Participants' also stated that they found self compassion difficult due to the relationship they had held with their primary caregiver during childhood. As a consequence, the challenges of being self compassionate for this group of Participants may be related to certain core beliefs or indeed, Participants' internal working models. Moreover, not only do these findings indicate the intimacy of how Participants relate to

themselves, but it also points to the intertwined relationship between self compassion and attachment style. These findings have significant clinical implications with regard to the depth of the intervention that may be required to address the difficulties service users can experience attempting to cultivate self compassion. The current research findings add to the limited existing literature with regard to self compassion and attachment.

Future qualitative research is merited in order to explore the impact which the caregiver relationship can have on people's lived experience of self compassion, and the challenges people face developing self compassion as a result.

#### **5.3.2.6 Socio-Cultural Factors**

Participants varied in their experiences of the expression of compassion within Irish society. Overall, Participants had experienced Irish society as compassionate at times whilst simultaneously being oppressive in attempting to force people to conform to the established standards. Significantly, a number of Participants discussed their awe at how compassionate Irish people could be in practical terms in times of bereavement, such as large attendances at funerals. This phenomenon is integral to Irish society, and this religious tradition is embedded in the cultural narrative of the country. However, Participants also expressed their experience of Irish people as being critical both towards themselves and others. This juxtaposition indicates the complexity of the socio-cultural attitudes towards compassion in Ireland at this time and indicates the necessity of further qualitative research to elucidate a more comprehensive understanding of these dichotomous views within an Irish context.

The findings of this study indicate the existence of an underlying pressure amongst Participants' to eschew self compassion in order to conform to a normative stoic social

standard. This reflects a pressure being exerted by the wider socio-cultural milieu and serves as an additional barrier for certain participants in developing self compassion. Importantly, this finding indicates a broader and urgent socio-cultural need to cultivate societal acceptance and knowledge with regard to self compassion. In particular, reframing the idea that distress in everyday life is to be hidden or disguised, and challenging the illusion that the sole purpose of life is to pursue an uninterrupted experience of positive emotions, is an essential prerequisite for change in this area. The pressure of pretence on both individuals with mental health difficulties, as well as the general population, is likely to be a further challenge in managing distressing experiences as part of everyday life. Moreover, this pressure simultaneously reinforces and contributes to a stigma that people should feel ashamed of mental health difficulties rather than viewing them as reflections of distress based on a continuum. It also inhibits and contorts more effective and realistic methods of regulating emotions such as more acceptance and mindfulness based approaches (Hayes et al. 2006, Teasdale et al. 2000) to manage the inevitable distress human beings experience during a lifetime. A society which approaches distress more directly in an open and supportive manner may help to alter the widespread emotional avoidance that is arguably pervasive within Irish society at present. Tackling these social norms would require a fundamental shift in societal attitudes which may be achieved through increasing awareness and engaging in a social discourse.

#### **5.3.2.7 Fear of Positive Affect**

The current research findings demonstrated Participants' in this Irish Primary Care sample were distrustful of self compassion and positive affect. These findings add to the preliminary existing literature, which suggests that people with mental health difficulties can

experience distress and fear towards more positive emotions, in addition to experiencing anhedonia (Gilbert et al. 2012, Gilbert et al. 2014). This is a critical area for further investigation as it suggests that clinicians need to adapt their interventions for service users not only to reduce instances of negative affect but also, to target the avoidance or fear of positive affect.

Anhedonia refers to the lack of enjoyment or happiness in activities which were previously enjoyable and is often a central tenet of Depression. Importantly, anhedonia does not encapsulate whether people simultaneously become reluctant to possess or cultivate more positive emotions in combination with a loss of positive affect. There is an argument that people may avoid or be disinclined to experience positive affect in circumstances where they are primarily experiencing negative affect for fear that any such positive affect would be unpredictable or transient and thus lead to further distress such as feeling disappointed when the positive affect eludes the individual. The logical and understandable response for individuals in this situation is to unconsciously or consciously avoid cultivating positive affect so as to increase their perceived sense of control over their emotions.

If a fear of positive affect is present in an individual with mental health difficulties, this fear is likely to also be compounded by social media and the wider socio-cultural milieu. Irish society promotes a myth that positive affect is an attainable goal for life. In reality, sadness, anger, embarrassment and a myriad of other emotions are a natural and inevitable aspect of daily life. Humans experience a range of emotions which serve a variety of essential evolutionary functions. It would be interesting to expound upon this finding further. Do people with mental health difficulties in primary care settings have both an elevated level of negative affect, in combination with a fear or resistance to developing positive affect?

In summary, the findings reflect the presence of a significant number of meta-cognitive beliefs which act as barriers and challenges to cultivating self compassion for these Participants. Although it is not possible to generalise the findings, future research could explore the type, presence and source of some of these meta-cognitive beliefs. This may support clinicians to target these beliefs before the introduction of self compassionate exercises, as if such beliefs are not addressed, they are likely to interfere with the implementation of any compassion focused intervention. Previous research has referenced Participants' experiences of finding compassion challenging and threatening (Gilbert et al. 2014, Rockcliff et al. 2008). However, the current study makes a key contribution to the existing literature in this field by elucidating these barriers in detail in an Irish Primary Care sample.

### **5.3.3 Recovery**

#### **5.3.3.1 Recovery and Self Compassion**

Self compassion can be employed to develop a kinder and more supportive way of relating to the self. As the research with community, and secondary care samples demonstrates being more self compassionate can enable people to increase well being, and can be an important intervention transdiagnostically (Neff et al. 2010, Shapira et al. 2010, Bergen-Cico et al. 2014).

Self compassion was an integral aspect of recovery within this sample. Participants' narratives in relation to their recovery reflected the dominant but often unacknowledged role of self compassion as a method of gradually emerging from the 'emptiness' of their mental health difficulties. The current research expands the existing evidence base on this topic by

indicating that for a group of Participants from a Primary Care setting, self compassion was pivotal to their recovery journey.

The combination of the subordinate themes of ‘Staying in the Present and Gratefulness’ and ‘Distance from Thoughts’ support the hypothesis that Participants’ experiences of self compassion are related to the components of mindfulness. These findings suggest that Participants were using different words to describe similar constructs in the literature. Participants’ inclusion of mindfulness as a central component of self compassion lends support to Neff’s conceptualisation of self compassion. The way self compassion and mindfulness are interconnected, and in particular how they engender one another needs to be explored further in future research.

The additional inclusion of the subordinate theme of acceptance highlights the need for individuals to adopt a variety of coping strategies. This finding incorporates a broader conceptualisation of self compassion on the one hand, and it epitomises the complexity of the recovery process on the other.

### **5.3.3.2 Self Compassion as a Preventative Strategy**

*A Vision for Change* (Department of Health and Children, 2006) documents the multitudinous benefits of providing early intervention in response to mental health difficulties enabling swifter recovery periods and lower incidences of relapse. Compassion-based research demonstrates the transferability of the therapeutic approach across a range of contexts and settings. As a result, the implementation of self compassion practices and literature is, in theory, particularly suited to a Primary Care environment both for cultivating and maintaining positive mental health, in addition to providing an adjunct to usual care, i.e.

pharmacological intervention whilst awaiting psychological input. The role of self compassion as a preventative strategy is a critical experiential finding. The literature predominately focuses on the impact of self compassion on well-being, or reducing psychological distress.

The Participants' preventative strategies included practices of self compassionate self talk, establishing an 'inner reserve' of self compassion, and being self compassionate by proactively maintaining a balance in their lives. These findings on the use of preventative strategies should be explored further in future research to elucidate the possible benefits of self compassion in preventing relapse. Teasdale et al.'s (2000) research offers empirical support for Mindfulness Based Cognitive Therapy in relation to the reduction of relapse by 50% in people who have experienced Depression three or more times. Future quantitative research could explore whether self compassion may also have an impact on the recurrence of depressive episodes.

Neff's (2013) research has provided initial evidence that self compassion may be an observable trait. This was reflected in Hugh's observations of his wife's 'pool of compassion' referring to her ability to be self compassionate. Participants' attempts to observe and learn from the self compassion strategies of others may also be a pragmatic method to help individuals to develop self compassion.

Self compassion aims to cultivate a more supportive and kinder way of relating to the self, this is likely to be useful not only to reduce negative affect, and increase positive affect, but also to prevent the occurrence of a spiral of negative self critical thoughts. As a consequence, it is theoretically likely to prevent the reoccurrence of a period of low mood. As previously stipulated, care and consideration needs to be taken due to the emerging relationship between self compassion and attachment style. One possible indirect psychological intervention which

would be amenable to Primary Care settings would be to provide service users who are in receipt of psychological support from their GP, with access to self compassion psycho-educational materials. This would facilitate the wider dissemination of psychological knowledge amongst other disciplines, whilst also developing services users' knowledge base with regard to self compassion and possibly cultivate their mentalizing capacities.

The ensuing section discusses the ethical considerations of the research and provides a critique of the methodological framework, and the strengths and limitations.

#### **5.4 Ethical Considerations**

A reflective log was completed throughout the research process. It contained entries in relation to the interview process including when Participants discussed emotive topics, such as the impact of the caregiving relationship on their ability to be self compassionate. The researcher was particularly mindful of maintaining a balance between obtaining rich data and being considerate of the emotional impact of the interviews on Participants. This issue arose in all the interviews, and was challenging at times particularly when Participants were in need of psychological intervention and were currently having difficulty accessing psychological support. The researcher actively managed the parameters of the interview in order to prevent the interview shifting into a therapeutic session. This was deemed to be essential to safeguarding the well-being of the Participants, as it would have been unethical to commence a therapeutic intervention without the availability of follow up sessions.

The researcher was also mindful that Participants did not feel overwhelmed during the process of recalling difficult periods in their lives which could have left them feeling uncontained upon leaving the session. This balance was achieved by cultivating a working

therapeutic alliance, adhering to the pre-established safeguarding plans and structuring the session to support the Participant to explore their lived experiences in a safe and validating environment. Participants were provided with debriefing sheets which contained the details of local services at the end of the interview. In addition, the researcher supplied Participants with tailored information with regard to specific therapies or services which were particularly relevant to Participants' lived experiences.

### **5.5 Reflexive Process**

Reflexivity is a continual process whereby a researcher repeatedly reflects on their own actions, values, and perceptions and how they impact on all aspects of the research process, such as data generation, and analysis (Lambert, 2010). Reflexivity is quintessential to conducting clinically relevant and authentic qualitative research in the field of Clinical Psychology. Incorporating and integrating reflexivity throughout the research process leads to a range of beneficial outcomes. These can include increased transparency in the researcher's subjective role in conducting the research, rigorous data analysis, in addition to ensuring the credibility of the research findings (Darawsheh, 2014). Reflective practice can be described as a reiterative process, enabling continuously deeper levels of understanding and is considered to consist of different elements, including personal reflection, and personal reflexivity. Stedman and Dallos (2009) conceptualise personal reflection within Schon's (1983) framework of 'reflection in action' which constitutes reflecting on spontaneous and immediate acts in the moment. The researcher found attending to these moments within the semi structured interview to be critical to ascertaining a deeper level of Participants' experiences, and to guide the interview process. This was evident for example, when the Researcher became aware of Participants finding it difficult to discuss the topic of self

compassion. The Researcher's recognition of this difficulty, and the subsequent empathy for the Participant, led to the adaptation of the interview process to manage the exploration of Participants experiences in a compassionate and ethical manner.

Personal reflexivity includes the act of looking back over, or reflection on action and is concerned with the application of knowledge or theory to the reflection in action moments (Stedman et al. 2009). Reflection on action enables further meaning making by exploring an individual's understanding of their own social status, such as gender or ethnicity and their own auto-biographical narratives (Stedman et al. 2009). Although, Stedman et al. (2009) incorporate Schon's work into their conceptualisation of reflexivity, they also argue for the recognition and inclusion of the researcher's own embedded personal values. The Researcher continuously attempted to be mindful throughout the research of their personal values, and attempted to operationalise certain values where appropriate in the implementation of the research. This included treating service users and Participants with dignity and respect throughout the research process and empowering service users by giving voice to their experiential knowledge. The Researcher was conscious of a power imbalance throughout the research, and undertook practical measures to manage this dynamic, such as moving the position of the chairs, and adapting the phraseology of questions.

The Researcher had previously completed a Masters on the cross-cultural risk and protective factors for suicide in young men in the United Kingdom and Ireland, which included exploring self criticism and self compassion within the sample. The research demonstrated significantly higher levels of self criticism in Irish men than young men from the UK. The role of self criticism and self compassion within mental health difficulties remained an ongoing interest for the Researcher since the Masters, and developed further during clinical placements on the Clinical Psychology Programme working with service users with mental health difficulties. The research journey has developed the Researcher's understanding of the

variety in people's life experiences and the necessity of adapting clinical styles to the individual. The importance of working alongside the service user was also highlighted and the need to repeatedly attempt to gain a sense of their perspective of their world to support them in times of distress. The research has cultivated in the Researcher a deeper level of compassion for the variety of difficulties people can experience and the fortitude and resilience individuals can employ when faced with tragedy and loss. The findings of the research have automatically informed the Researcher's clinical practice and have instilled the need to disseminate the findings to support a broader socio-cultural shift from a self critical way of relating to the self to a more self compassionate one. Further research in this area is pivotal to explore the phenomenon in more detail within an Irish setting, to ascertain the role Clinical Psychology may have in dispelling certain myths about self criticism and self compassion, and to promote positive mental health in both the general population and within mental health services.

## **5.6 Methodological Critique**

### **5.6.1 Strengths**

The current study extended the available research in the field of self compassion by elucidating the lived experiences of an Irish mental health sample using a qualitative design in a Primary Care setting. It was felt in particular, that the employment of a qualitative design was important in order to acknowledge and validate peoples' experiential knowledge and thus operationalise a central tenant of *A Vision for Change* (Department of Health and Children, 2006).

In addition, the use of a relatively unknown methodological technique in the format of Template analysis (TA) is a significant strength of this research. Template analysis was deemed to provide both the structure and flexibility to best elucidate Participants' lived experiences within a dynamic medical setting, and with a group of people with mental health difficulties. Moreover, TA not only facilitated the comprehensive exploration of the data, but it also provided a structured method of approaching a large data set.

Qualitative research has been criticised for delivering unclear and poorly articulated explanations with regard to the process of how themes emerge and how they are identified from narratives. Conscious of avoiding such analytical shortcomings the template format for this research presents the reader with a structure which explicitly demonstrates the process as to how the themes emerged, and the process of determining superordinate and subordinate themes. This provides readers with clarification as to how the final template was agreed upon, and promotes transparency and lucidity in the research process. Template analysis also enabled a comprehensive approach of explicitly acknowledging the pre-conceptions of the researcher through the 'a priori' themes, as well as, allowing for the emergence of 'bottom up' themes. This both acknowledged the inherent role of the researcher in the construction and interpretation of themes, whilst also providing a guiding framework for data analysis. Furthermore, the current research adds to the existing literature by demonstrating the utility of TA in 'real world' research with a clinical sample, and expands the limited research base for Primary Care, and Multi-Disciplinary research.

This research's exploration of self compassion with people who are currently living in Ireland adds to the literature in this field by exploring the construct within its specific socio-cultural context. Exploring self compassion within an Irish context serves to contextualise people's lived experiences of mental health difficulties within the cultural milieu in which they live, or perhaps more particularly the social environment in which the difficulties emerge and are

entrenched in. The research highlights the necessity of conducting further research in order to obtain a comprehensive and systemic representation of the phenomenon of self compassion in a distinctly Irish context. This may illuminate possible international cross-cultural similarities and differences.

An additional strength of this research is the targeting of a Primary Care sample. This addresses a significant gap in the literature which has predominately been completed with university students, community and secondary care samples. It is essential for compassion focused research to explore the phenomenon in different clinical settings as well as with different populations in order to obtain a holistic and thorough appreciation of the perpetuating and precipitating factors. This research adds to the existing literature by enunciating this Irish Primary Care sample's experiences of self compassion and how they are similar or different to other research samples.

Importantly, during the Participant recruitment stage it became evident that in an Irish setting the distinction between primary and secondary care is, in some respect, an artificial and abstract one which lacks any level of ecological validity. Participants within this sample reflect a wide range of difficulties, some with a history of disordered eating, suicide attempts, child sex abuse amongst others. Consequently, all participants reported a significant history of distress, some with significant mental health difficulties. While this pragmatic difficulty illustrates the real world challenges of conducting research within clinical settings, it also emphasises the clinical validity of the research.

The research highlights the need for improved access to psychological services and more input in relation to early intervention at a Primary Care level. The complexity of service users' difficulties denotes the challenges faced by General Practitioners attempting to manage mental health difficulties for services users with insufficient access to psychological services.

Participants explained that their desire to take part in the research stemmed both from a wish to help others in similar situations, and also in the words of one Participant to use it as an opportunity to access ‘free therapy’. This comment highlights the urgent necessity for improved access to affordable therapeutic services at a Primary Care level.

An indirect and unexpected but positive outcome of the entire research process was the promotion and dissemination of psychological knowledge in a medical environment. Increased inter-agency working is quintessential to fully address the complex needs of individuals with mental health difficulties, and to reduce the over reliance on pharmacological intervention in times of limited available psychological support.

The findings of the research were disseminated in numerous ways in a variety of settings. All outcomes of the research were sent to the Participants, as well as to the General Practice where the sample was obtained. Presentations have been organised with a HSE Psychology Primary Care service, as well as a private Psychology Service. The dissemination of the findings is inherently important for the researcher, as it is an integral aspect of the phenomenological nature of the research to provide Participants with a voice to highlight their lived experiences. The researcher has an obligation to all Participants who shared their distressing experiences to ensure that their time and goodwill as research Participants will be reflected in a wide dissemination of the research with a view to supporting other individuals who have mental health difficulties.

Finally, this research also demonstrates the necessity and importance of empowering service users so as to afford them an active role in the development of services, and in framing how services can be tailored to support individuals with mental health difficulties. Moreover, the research highlights the power of Participants’ experiential knowledge and its role in cultivating service user led services. All Participants were eager to engage in the process and

to further their understanding of their mental health difficulties. This also indicates that services need to be led in a service user friendly way to encourage the engagement process.

### **5.6.2 Limitations and Future Research**

A pertinent limitation of the research is the sourcing of Participants from one General Practice. Although, the sample was derived from two surgeries with a patient population of 8,500 from two different geographical locations the findings remain limited as the research covers a relatively small geographic region. Future research on a wider scale, involving the collection of data from a variety of GP practices across different geographical regions is required. A multi-site project for instance, could explore the experiences of self compassion with a larger population over a larger catchment area. Indeed, Template analysis would offer a pragmatic and revealing method of exploring people's experiences across different regions.

The small sample size of the research is unfortunate as it also limits the generalisability of the findings. However, a sample size of 11 is comparable with qualitative research conducted in similar clinical settings (Pauley et al. 2010). The structure and flexibility of Template analysis allows for the inclusion of larger numbers of participants in comparison to other qualitative methods. In this regard, it is suggested that future research could perhaps explore self compassion within a larger sample in addition to sourcing Participants' from different regions as previously mentioned.

The provisional title of the research; 'Are people afraid of being self compassionate? A qualitative exploration of self compassion in a primary care mental health group', was included on the consent form, debriefing and information sheet. The provisional title was included to promote transparency for participants with regard to the research topic, and to

ensure that informed consent was obtained. However, it is possible that the initial title may have inadvertently primed Participants' responses for the research. Although, it is important to recognise the possibility of such priming, the depth of the interviews, the comprehensive and reiterative analysis and the reflexive process employed throughout the research ensured that its impact on the research findings, to the extent to which it had any at all, would have been minimal.

It was unfortunate in the current research that service users with a broader array of mental health difficulties, such as people with an eating disorder and post traumatic stress disorder were not available to partake in the study. It is worth noting however, that if people with broader presenting concerns were included this may have induced a significant degree of heterogeneity within the sample which could have impinged on the identification of themes across Participants. Kelly et al.'s (2013) research provides provisionally promising findings with regard to an eating disorders sample. Self compassion may be particularly relevant with an eating disorders group and the preliminary findings in the literature warrant replication and expansion. It is suggested that future research could explore self compassion with service users with different presenting needs. This may further elucidate the similarities and differences between people's lived experiences of self compassion. Moreover, another viable and valuable future research venture would be to explore the conceptualisations of self compassion in a community sample without mental health difficulties in order to reveal the socio-cultural attitudes towards self compassion within a non-clinical population.

In addition, alternative data generation strategies might also be useful to expound upon the current literature. Although the individual interview is a well established method in qualitative research, Focus groups can offer a more pragmatic method of generating data with larger sample numbers. Furthermore, Compassionate writing letter as per previous research (Odou et al. 2014) could also be a useful alternative to interviews or focus groups. As a

result, Participants could be asked to complete letters, and simultaneously complete reflective diaries as part of a study to explore longitudinal and in-depth experiences of self compassion. This would enable a cross-cultural sample to be obtained using online services. The data could then be analysed to explore people's experiences of self compassion in relation to historic events in addition to more recent experiences.

It is arguable that a statistical calculation of inter-rater agreement may have increased the validity of the coding. However, statistical calculations presuppose that there is one inherent truth that can be objectively quantified and qualified. As a result, conducting this form of analysis would have been incongruent with the experiential nature of the current research. Moreover, King (2014c) argues that statistical calculation should be avoided in TA as qualitative data and the construction of meaning is always open to variations of interpretation.

Finally, future research could also explore people's experiences over a number of exploratory interviews. This would likely facilitate the development of a richer therapeutic alliance in addition to providing participants with more time, space and reflection in the meaning making process to explore their lived experiences and the challenges of cultivating self compassion.

## **5.7 Conclusion**

This research sought to address a gap in the existing literature on the topic of self compassion by exploring the lived experiences of an Irish Primary Care sample of people with mental health difficulties. A Hermeneutic Phenomenological approach, in conjunction with the relatively novel method of Template analysis was employed in conducting this research. These flexible methodological frameworks not only offered a comprehensive

approach to exploring Participants' lived experiences but also, importantly, facilitated an explicit and transparent portrayal of the process underpinning the emergence of the research themes.

In exploring the research questions at the centre of this study, the current findings suggest that Participants perceive self compassion in a highly varying manner, and comprising of multiple components. The findings demonstrated Participants' self compassion was eradicated in times of low mood or psychological distress. Moreover, the research highlighted a variety of barriers which were experienced by Participants in cultivating self compassion. These barriers included a number of meta-cognitive beliefs including an over-arching distrust of self compassion, a sense that self compassion was undeserved and a belief that self compassion was dangerous in some regard. Further exploration of the barriers experienced by individuals in cultivating self compassion is merited, particularly as the findings also point to a relationship between Participants' experiences of self compassion and attachment style. Furthermore, the research provides evidence of the reciprocal nature of compassion in terms of how we relate to others, and indeed, how others relate to us. The findings also suggest a link between a person's internal level of self compassion and the attitudes of the socio-cultural milieu that surrounds them.

Importantly, Participants also illustrated the integral role of self compassion as a preventative strategy, in addition to being pivotal in their recovery journey.

Future research employing a variety of methodological approaches, with a range of clinical populations, in diverse settings is essential to explore these findings further to help explicate the origins of some of these belief systems and support the implementation of compassion-based interventions in clinical practice.



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## 7. Appendices

### Appendix A



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O L L S C O I L L U I M N I G H

### Participant Information Leaflet

#### **Are people afraid of being self compassionate? A qualitative exploration of self compassion in a primary care mental health group**

**Researcher's names & titles:** \*\* - GP \*\* – Clinical Psychologist in Training

**Telephone number of researchers:** \*\*

You are being invited to take part in a research study carried out at your doctor's general practice by Dr \*\* and \*\*. We are interested in people's experiences of self compassion and the challenges people experience in being self compassionate in a group of people with mental health difficulties.

We are inviting people to come to an individual interview/discussion, at the surgery in \*\* or \*\* on a date and time that suits you. The meeting will be with \*\*, and will last for approx 60 to 90 minutes, and may involve more meetings if you wish to continue taking part.

All aspects of the study will be handled in a private and confidential manner, and every participant will be given a code so they are not identifiable. All information gathered from the study will be kept completely separate from your medical file. You do not have to take part in this study and a decision not to take part will not effect your future medical care in any way.

Before you decide whether or not you wish to take part, you should read the information carefully, and telephone \*\* if you have any questions – do not feel rushed or under pressure to make a quick decision. You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out. You do not have to give us a reason. If you do opt out, it will not affect the quality of treatment you get in the future. All Participants will have access to a copy of the outcomes of the research. The outcome of the anonymized research will be submitted to the University of Limerick in part fulfilment of the Doctorate in Clinical Psychology.

Please feel free to contact \*\* on the above number if you have any questions about the study.

**Many thanks for taking the time to read this.**

*This study has been approved by the CREC Ethics Committee on 9<sup>th</sup> June 2014  
Adapted from the ICGP recommended Information Sheet*

## Appendix B



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### Participant Consent Form

**Are people afraid of being self compassionate? A qualitative exploration of self compassion in a primary care mental health group**

<i>I have read and understood the <b>Information Leaflet</b> about this research project.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I don't have to give a reason for opting out, even if I choose to opt out after I complete an interview.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>I have been assured that information about me will be kept private and confidential, and separate from my medical records.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>I have been given a copy of the Information Leaflet and this completed consent form for my records.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>I understand that opting out won't affect my future medical care in any way.</i>		
<p style="text-align: center;"><b>Storage and future use of information:</b></p> <i>I give my permission for information collected about me to be stored or electronically processed for the purpose of scientific research and to be used in related studies or other studies in the future but only if the research is approved by a Research Ethics Committee.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Participant Name (Block Capitals): \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by the Researcher.** I the undersigned, have taken the time to fully explain to the above patient the nature and purpose of this study in a manner that they could understand. I have invited them to ask questions on any aspect of the study.

Name (Block Capitals): \_\_\_\_\_

Qualifications: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**This study has been approved by the CREC Ethics Committee on 9<sup>th</sup> June 2014  
Adapted from the ICGP recommended Consent Sheet**

## Appendix C Letter of Introduction



Address

Date

Dear \_\_\_\_\_,

I am delighted to announce \*\* & \*\*Surgery are involved in a research project being undertaken with the University of Limerick. We would like to invite you to take part in the research which aims to explore people's experiences of self compassion in those with a mental health difficulty.

Please find enclosed an information sheet, and consent form. Please take your time to read the information before making a decision about whether you would like to take part. Participation is completely voluntary and will not impact on your future medical care in any way. Your participation will be completely anonymous, and all information from the study will be kept separate from your medical file.

If you decide you would like to take part, the research would involve an interview/discussion at the surgery with Clinical Psychologist in Training, \*\*. If you would like to participate, please complete the consent form and return in the stamped, addressed envelope by \_\_\_\_\_ 2014. If you have any questions or queries whatsoever, please feel free to call either \*\* or \*\* surgeries and ask for \*\*.

On receipt of the consent form \*\* will make contact with you by telephone to arrange a time and date that suits you for the interview/discussion.

Many thanks for taking the time to read this.

With warmest regards,

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Dr \*\* M.R.C.G.P., M.I.C.G.P.

## Appendix D

### Semi-Structured Interview Protocol

Version 1. 13/5/14

#### Introduction to the interview

1. Gather demographic information including; age, marital status, children, diagnosis, length of time with diagnosis, receiving pharmacological intervention at present
2. Re-iterate the contents of the consent form and the information sheet, e.g. that participation is voluntary, and consent can be withdrawn at any stage without needing to provide a reason even after the interview has been completed
3. Remind participants about the limits of confidentiality in the event of disclosures
4. Describe to participants the difference between research and a therapy session
5. Provide participants with the option of reviewing the transcript if they wish
6. Inform participants that quotes from the research will be put forward for publication
7. Obtain verbal consent for the interview to be audio-recorded, and inform participants the audio-recording will be destroyed after being transcribed
8. Ask if the participants have any questions

#### Preliminary interview protocol

##### Perception of compassion:

1. What does the word compassion mean to you? How would you define it?
2. How would you define self compassion, in comparison to compassion for and from others? In what way is it different or the same?

##### Lived Experience of self compassion:

1. What is your experience of being self-compassionate? Do you find it easy/difficult to be self compassionate? [Take your time, tell me about your experiences, as if you were telling me a story.]
2. Thinking back, can you describe anything that you found particularly helpful/unhelpful about being self compassionate?
3. Has your ability to be self compassionate changed over time? If so, describe it to me.
4. Does your ability to be self compassionate change depending on the event/situation/topic? If so, please give me some examples?
5. Do you feel your mental health difficulties have impacted on your ability to be self compassionate? If so, tell me about it.

Challenges of being self compassionate:

6. Do you have any concerns or fears about being self compassionate? If so, tell me about the barriers you have experienced?
7. Where do you think your concern over being self compassionate came from?
8. What do you think will happen if you become more self compassionate?
9. What is your experience of how Irish society views self compassion? Do you think this is the same or different from other cultures?

General:

10. Any questions/comments/feedback? Or anything you would like to add?

**Appendix E**  
**Interview Debriefing Sheet**

**Are people afraid of being self compassionate? A qualitative  
exploration of self compassion in a primary care mental health group**



We really appreciate your time and effort in taking part in this research study. It is much appreciated, and your comments are highly valued. We hope that this has been an interesting experience for you.

If at any stage you have questions, or wish to receive a copy of the results of the study please feel free to contact \*\* on \*\* or \*\*.

**Many Thanks**

Researchers: \*\*, Clinical Psychologist in Training

Dr \*\*, GP

*This study has been approved by the CREC Ethics Committee on 9<sup>th</sup> June 2014*

## Appendix F

**Template 1**

<b>Superordinate Themes</b>	<b>Subordinate Themes Level 1</b>	<b>Subordinate Themes Level 2</b>	
<b>Barriers of being self compassion (SC)</b>	1. need for justification to self and others		
	2. negative perception of sc	2.1 sc is dangerous/threatening 2.2 sc quota/dichotomy	
	3. perception self criticism is useful		
	4. societal pressure	4.1 negative perception of sc from society	
	5. sc is difficult to practice	5.1 timing 5.2 high self criticism 5.3 lack of compassion from others 5.4 mental sc is harder than practical sc 5.5 lack of knowledge to be sc mentally 5.6 peer pressure/societal pressure 5.7 difficulty depends on topic	
		5.8 self image/identity/self belief/ self confidence	
		5.9 negative belief re sc	
	6. causes of sc being difficult	6.1 perception of family history 6.2 mental health and shame 6.3 uncertainty	
	7. guilt		
	<b>Ambiguity of perception</b>	1. negative perception of sc	1.1 sc is self-indulgent 1.2 sc is dangerous or threatening 1.3 sc is self pity 1.4 sc is selfishness/feeling sorry for the self 1.5 sc is not being firm
		2. compassion is for others	
		3. approaching sc dichotomously	
		4. sc, compassion for others, and receiving compassion are distinct but interlinked	
		5. sc is multi-faceted	5.1 sc includes practical components 5.2 sc includes mental components 5.3 sc has to be meaningful/authentic 5.4 sc is being kind to yourself 5.5 sc is appreciating the small things/being mindful 5.6 too much sc is negative 5.7 sc is limitless 5.8 sc is understanding yourself 5.9 sc is acceptance of self and difficulties 5.10 sc is minding yourself 5.11 sc is liking/loving yourself
6. sc is conditional		6.1 sc needs to be deserved/earned 6.2 disparity between logical understanding of sc and emotional acceptance of benefits	

<b>Template 1 Continued</b>		
<b>Clarity of definition of compassion</b>	1. compassion relates to loss/grief/bereavement	
	2. emotional and a practical component	
	3. compassion is for others	
<b>Mental health difficulties are linked with sc</b>	1. mental health difficulties eradicates sc	
	2. sc is an essential part of recovery	
	3. sc is an important part of maintaining wellness	
	4. past experiences of mh difficulties raised sc for others	
	5. isolation reduces sc	
<b>Lived experience of sc and society</b>	1. compassion towards others more practical in Ireland	
	2. more compassion towards others in rural communities	
	3. societal pressure to conform	
	4. self consciousness of the Irish	
	5. differences between societies	
	6. changes between generations	
	7. negative perception of sc by Irish	
	8. gender differences	
	9. Irish very self critical	
<b>Lack of awareness about sc</b>	1. lack of awareness of topic	
	2. triggers for awareness	
	3. lack of awareness about cultivating sc	
	4. term is not commonly used	

## Appendix G

### Template 2

<b>Barriers to being Self compassionate (sc)</b>	1. negative Perceptions of SC	1.1 Individually	1.1.1 SC is dangerous/threatening
			1.1.2 SC quota
		1.2 Society	
	2. perception self criticism is useful		
	3. mixture of factors	3.1 Lack of experience	
		3.2 timing	
		3.3 high self criticism	
		3.4 mental sc is more difficult than practical sc	
		3.5 difficulty depends on topic	
		3.6 self image/identity/self belief/ self confidence	
	3. causes of s-c being challenging	3.1 rship with caregiver or family history	
		3.2 uncertainty	
<b>Variation in the perception of sc</b>	1. negative perception of sc	1.1 sc is self indulgent	
		1.2 sc is feeling sorry for yourself/self pity	
		1.3 sc is being lenient with yourself	
	2. approaching sc dichotomously		
	3. sc is conditional	3.1 sc needs to be deserved/earned	
	4. sc is multi-faceted	4.1 s c includes practical components	
		4.2 sc includes mental components	
		4.3 sc has to be meaningful/authentic	
		4.4 sc alleviates distress	
		4.5 sc is not being firm	
	5. positive perception of sc	5.1 sc is being kind to yourself	
		5.2 sc is appreciating the small things/being mindful	
		5.3 too much sc is negative	
		5.4 sc is limitless	
		5.5 sc is understanding yourself	
		5.6 sc is acceptance of self and difficulties	
		5.7 sc is minding yourself	
		5.8 sc is liking/loving yourself	
		5.9 sc is believing in yourself	
		5.10 sc is empathy	
<b>Sc, compassion for + from others is inextricably linked</b>	1. perceptual dissimilarity and similarity between sc, comp for and from others		
	2. clarity of compassion for others	2.1 compassion is for others not me	

## Template 2 Continued

<b>Sc, compassion for + from others is inextricably linked</b>	2. clarity of compassion for others	2.2 compassion has multitudinous components	2.2.1 emotional + practical component 2.2.2 spiritual 2.2.3 empathy, support, care
		2.3 compassion for others is easier than sc	
<b>Sc and its role in mental health difficulties</b>	1. mental health eradicates sc		
	2. mental health decreases compassion for others		
	3. sc, recovery and maintaining wellness		
	4. external support		
<b>Sc can be cultivated</b>	1. persistence and determination		
	2. sense of belonging		
	3. thinking more systemically		
	4. developing skills		
	5. experience		
	6. time		
	7. age		
	8. maturity		
	9. objective thinking		
	10. mindfulness		
	11. interests/hobbies		
	12. confidence		
<b>Socio-cultural influences</b>	1. societal pressure	1.1 negative perception of sc by Irish people 1.2 self consciousness of the Irish 1.3 pressure to conform	
	2. 'Change is coming'	2.1 gender differences 2.2 generational changes	
	3. expression of compassion in Irish society	3.1 compassion towards others more practical 3.2 kind/compassionate society 3.3 more compassion in rural areas 3.4 Irish could be more sc	
<b>Lack of awareness about sc</b>	1. unfamiliarity with term sc		
	2. novel topic area	2.1 triggers for awareness 2.2 lack of awareness developing sc	2.1.1 peer groups 2.1.2 psycho somatic

## Appendix H

### Template 3

<b>Variation in the Perception of Sc</b>	1. Negative perception of sc	1.1 sc is self indulgent		
		1.2 sc is not being firm		
	2. Positive perception of sc	2.1. sc is multi-faceted	2.1.1 sc is acceptance of life and self	
			2.1.2 sc includes practical and mental components	
			2.1.3 sc needs to be genuine	
			2.1.4 sc is limitless	
		2.2 sc is related to well being	2.2.1 sc is being present/appreciating the small things	
			2.2.2 sc is being empathetic	
			2.2.3 sc alleviates distress	
			2.3 sc is related to self worth	2.3.1 sc is being kind to yourself
2.3.2 sc is understanding yourself				
2.3.3 sc is protecting/minding yourself				
		2.3.4 sc is loving yourself		
		2.3.5 sc is believing in yourself		
<b>Relationship between SC, compassion for + from others</b>	1. Sc, comp for and from others is inextricably linked	1.1 perceptual dissimilarity and similarity between sc, comp for and from others		
		1.2 clarity of perception of compassion for others	1.2.1 compassion has multitudinous components	
			1.2.2 compassion is for others	
			1.2.3 compassion for others is easier	
<b>Mental health and Sc</b>	1. Relationship between mental health and sc	1.1 Mental Health decreases ability to be sc and compassionate to others		
		1.2 self blame		
		1.3 guilt		
		1.4 shame		
	2. Sc is conditional	2.1 sc is undeserved		
		2.2 need for justification/rationale to self and others to be sc		
		3. Past experiences of mental health difficulties increase sc and compassion for others		
4. Sc is integral to recovery from mental health difficulties				

### Template 3 Continued

<b>Recovery and Cultivation of sc</b>	1. Persistence/ Determination	
	2. Being proactive	2.1 knowledge/information
		2.2 interests/hobbies
		2.3 mindfulness and gratefulness
		2.4 objective thinking
		2.5 prevention
		2.6 acceptance
	3. Developmental process	3.1 time
		3.2 age
		3.3 maturity
		3.4 confidence
	4. Relationship with others	4.1 more acceptance socially
		4.2 lack of compassion from others decreases
		4.3 being compassionate to others increases sc
		4.4 external support
		4.5 recognizing larger continuum/context
<b>Socio-cultural influences</b>	1. Socio-cultural pressure	1.1 negative perception of sc in Ireland
		1.2 pressure to conform
	2. Change	2.1 gender differences
		2.2 generational changes
	3. Mixed expression of compassion in Irish society	3.1 compassion towards others more practical
		3.2 kind/compassionate society
		3.3 more compassion towards others in rural community
		3.4 Irish could be more self compassionate

## Appendix I

### Template 4

<b>Relationship between S-C, Compassion for others and Compassion for others</b>	1. Differences between sc, comp for others and from others	1.1 Lack of awareness about s-c and clarity of perception of compassion for others	
		1.2 Compassion for others is easier	
	2. S-c, comp for others and from others is inextricably linked	2.1 Lack of compassion from others decreases s-c	
		2.2 Being compassionate to others increases s-c	
<b>Socio-Cultural Influences</b>	1. Mixed lived experience of compassion in Irish Society		
	2. Generational changes		
<b>Barriers to being SC</b>	1. Negative Perceptions of SC	1.1 Individually	1.1.1 SC is dangerous/threatening
			1.1.2 SC quota/dichotomously
		1.2 Societal pressure to conform	
		1.3 Self Criticism	1.3.1 Perception self criticism is useful
			1.3.2 High prevalence of self criticism
		1.4 Causes of s-c being challenging	1.4 Relationship with caregiver/family history
			3.2 Uncertainty
<b>Variations in the Perception of Self Compassion</b>	1. Self compassion is self-indulgent/self pity		
	2. Positive Perceptions of self compassion	2.1 Self compassion is multi-faceted	2.1.1. Sc includes practical and mental components
			2.1.2 Sc is being present in the now/ appreciating the small things
			2.1.3 Sc is understanding yourself

**Template 4  
Continued**

<b>Variations in the Perception of Self Compassion</b>	2. Positive Perceptions of self compassion	2.2 Sc relates to well being	2.2.1 Sc alleviates distress
			2.2.2 Sc is being kind to yourself
		2.3 Sc is related to self worth	2.3.1 Sc is loving yourself
			2.3.2 Sc is believing in yourself
<b>Mental Health and S-C</b>	1. Active mental health difficulties decrease ability to be s-c and comp to others		
	2. Self blame and guilt		
	3. Sc is undeserved		
	4. Sc need for justification/rationale to self and others to be s-c		
<b>Recovery and Cultivation of S-C</b>	1. Sc in recovery can be developed	1.1 Staying in the present and gratefulness	
		1.2 Distance from thoughts/situation	
		1.3 Acceptance of difficulties	
		1.4 Prevention/being proactive	
	2. Developmental process	2.1 Experience and Learning	
	3. Relationship with others	3.1 More acceptance of s-c socially	
		3.2 External support	
		3.3 Recognizing context/larger continuum	

## Appendix J

### Template 5

<b>Interdependency and Engenderment</b>	1. Differences between self compassion (sc), comp for others and from others	1.1 Lack of awareness about s-c and clarity of perception of compassion for others
		1.2 Compassion for others is easier
	2. Sc, comp for others and from others is inextricably linked	2.1 Lack of compassion from others decreases s-c
		2.2 Being compassionate to others increases s-c
<b>Socio-Cultural Influences</b>	1. Mixed lived experience of compassion in Irish Society	
	2. Generational changes	
<b>Fear of Self Compassion</b>	1. SC is dangerous/threatening	
	2. SC quota/dichotomously	
	3. Societal pressure to conform	
	4. Self Criticism	4.1 Perception self criticism is useful
		4.2 High prevalence of self criticism
	5. Causes of s-c being challenging	5.1 Relationship with caregiver or family history
		5.2 Uncertainty
<b>Heterogeneity of perception</b>	1. Negative perception of s-c	1.1 Self compassion is self-indulgent/self pity
	2. Positive Perceptions of self compassion are multi-faceted	2.1. Sc includes practical and mental components
		2.2 Sc is being present in the now/ appreciating the small things
		2.3 Sc is understanding yourself
		2.4 Sc alleviates distress
		2.5 Sc is being kind to yourself
		2.6 Sc is related to self worth

**Template 5  
continued**

<b>MH difficulties eradicates S-C</b>	1. Active mh difficulties decrease ability to be s-c and comp to others	
	2. Self blame and guilt	
	3. s-c is undeserved	
	4. s-c need for justification/rationale to self and others to be s-c	
<b>Recovery and Cultivation of S-C</b>	1. Persistence and Determination	1.1 staying in the present and gratefulness
		1.2 Distance from thoughts/situation
		1.3 Acceptance of difficulties
		1.4 Prevention/being proactive
	2. Developmental process	
	3. Relationship with others	

## Appendix K

<b>Final Template</b>	
<b>Diverging perceptions: 'self pity' versus 'self promotion'</b>	1. Self pity
	2. Multi-faceted Self Promotion
<b>Socio-Cultural Effects</b>	1. ' <i>Compassion is for Others</i> '
	2. Pressure to Conform
	3. Reciprocity
<b>Distrust: 'It's not allowed'</b>	1. Self Compassion is ' <i>Dangerous</i> '
	2. Self Compassion Quota
	3. Pervasive Self Criticism
<b>'Emptiness' and Mental Health difficulties</b>	1. ' <i>Disappearance</i> ' of Self Compassion
	2. Self blame and Guilt
	3. Being Undeserving
	4. Need for ' <i>Permission</i> ' and Justification
<b>'Seeing the Colours': Recovery</b>	1. Determination
	1.1 Gratefulness and The Present
	1.2 Distance from Thoughts
	1.3 Acceptance
	1.4 Prevention
	1.5 Experience and Learning
	2. External Support

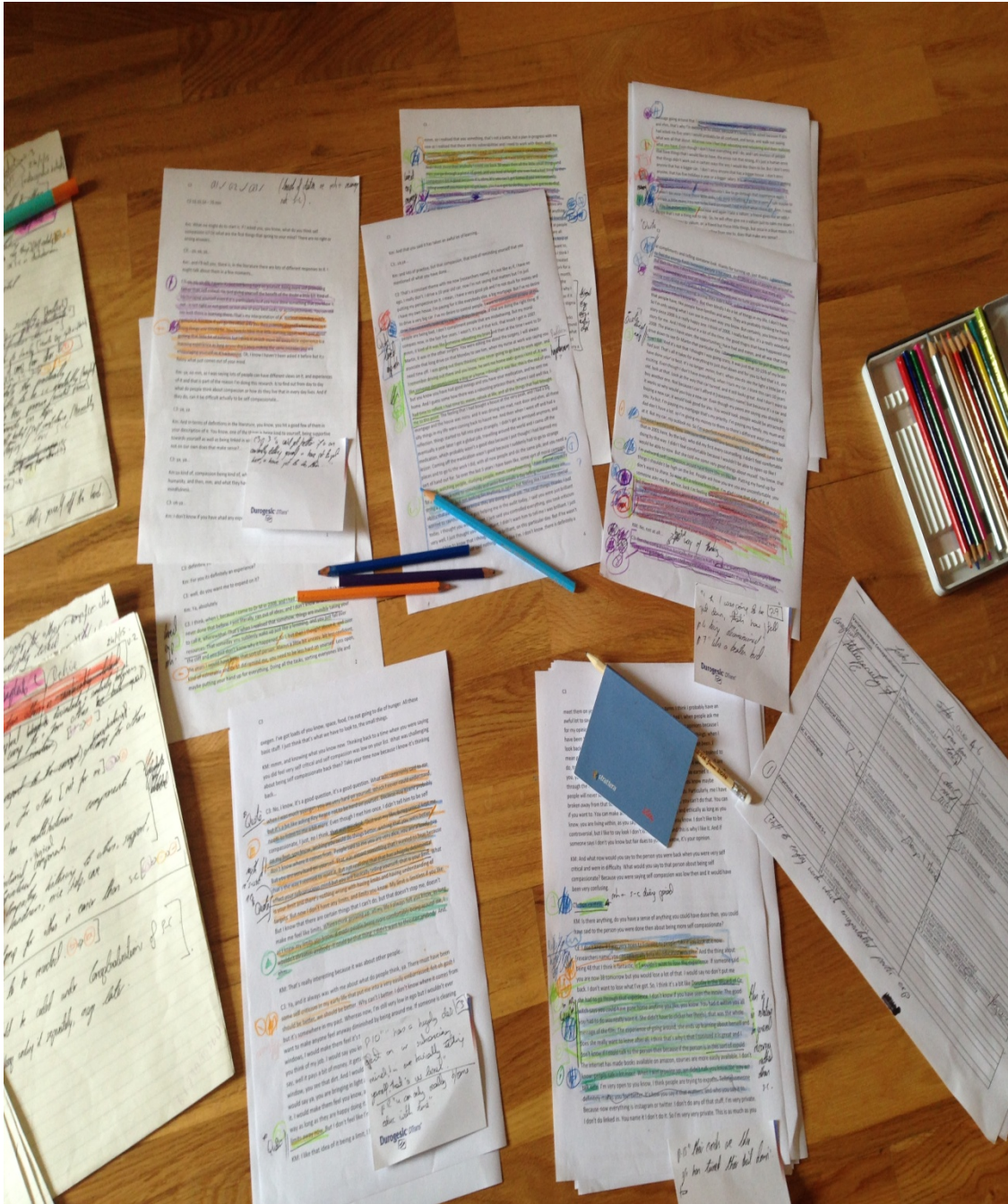
## Appendix L

### Mind Map of Themes



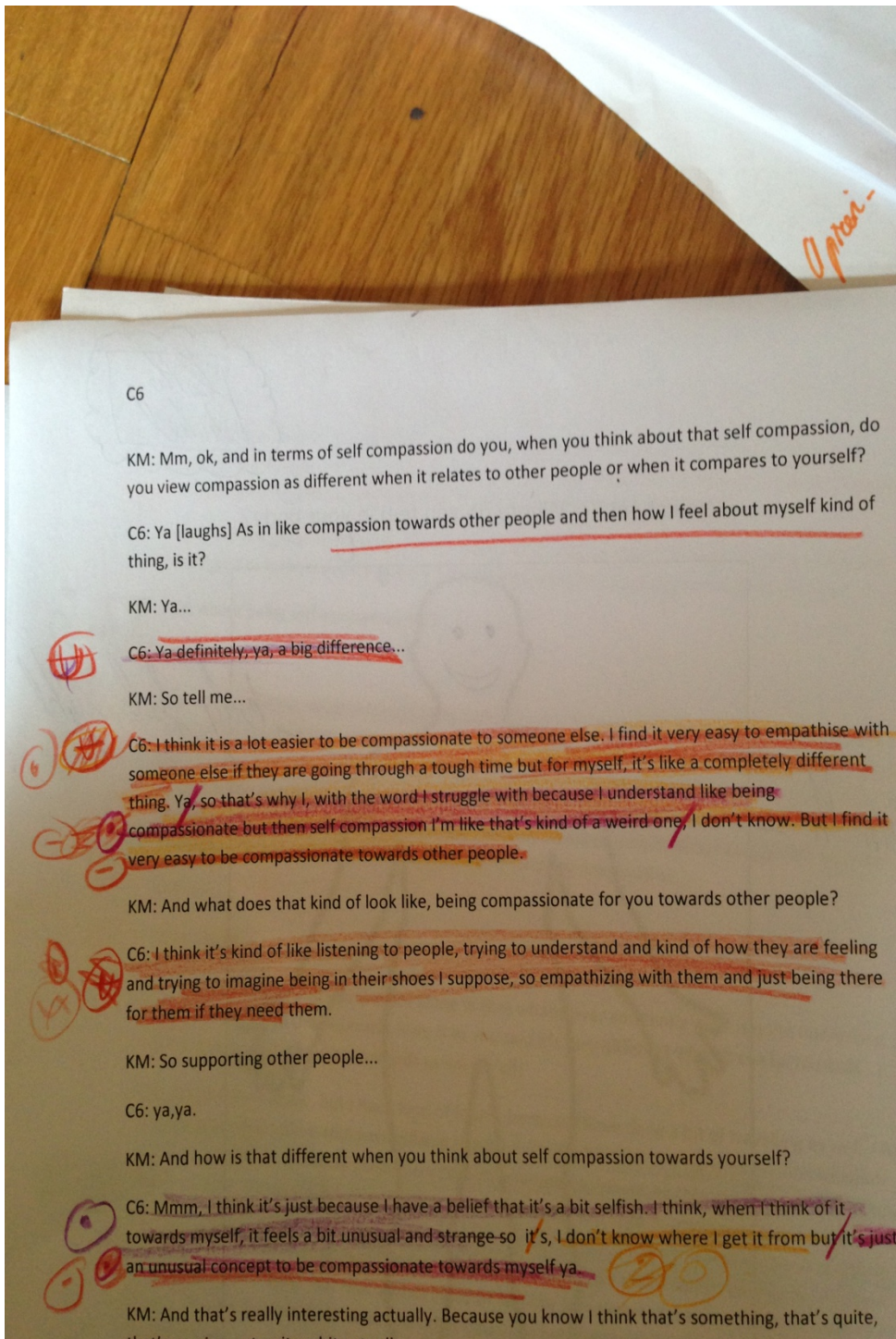
# Appendix M

## Picture of Coding Process



## Appendix N

### Sample of Coding



impossible, and then in everyday life I might sometimes do things to help myself. Like sometimes, you know, like do little things here and there and it's okay. But I think when the low mood sets in, it becomes I suppose critical side of me comes out, and I find it very very difficult, almost impossible. But ehm, ya.

KM: So it's harder when the mood is low.

C6: Oh ya, definitely.

KM: Much much harder, there is a tiny bit of space for it maybe when you're...

C6: Like if I'm doing well mentally and I'm looking after myself and everything is going well. I can, there are definitely times where I can do stuff to help myself just little things like taking some time out for myself. You know, like making sure I eat properly, going to the gym. And I'm definitely, I'm better than I used to be before. I could just neglect myself completely but I'm definitely, I think because I've kind of had Depression for so long. I've had it I'd say, well I only got diagnosed when I was 16 but I've had it since I was probably 14. So because I've had it so long I feel like I'm nearly an expert in it myself. So I know like even though it has taken so long, I kind of know how to get out of it quicker. Whereas before, I could end up like months and months in a very bad episode. But ehm, it's definitely a lot easier now but the self compassion part definitely is like, highlighted when I'm low. Definitely, ya.

reflective fog  
mental health  
+ s-c  
s-c & recovery?  
- several recovery?  
- internalised?

KM: It seems like actually self compassion is a big part of depression for you...

C6: Oh massively ya. I think it's like, I think it's like one of the main things actually ya. Ya. If I think about it, because everything goes back to that, especially when I'm low. It's like oh I will do this, 'oh no no no, that's mm', you know I feel guilty about doing something nice for myself. It actually gets sometimes, it gets quite bad, quite severe. I start thinking that I don't even deserve to eat [laughs nervously], and I would completely neglect myself and I get to the stage where I wouldn't even basic things like. Things like, needs like eating, showering and stuff like that just basic self compassion I would kind of not think that I deserve any of those, that's when it gets very bad. Mmm, so but that's when I think my mind gets completely distorted and I don't know. It's like mmm, no-one can talk to me then. I'm just in a different world then. Ya, so definitely when I get very low, it's probably the main thing that is stopping me getting out of that main mood as well. Ya.

Quote  
med  
c &  
mh-

reflective fog  
participate  
became  
emotional  
daily intention

KM: And you said it's stopping you from coming out of the fog, and not being able to see the wood from the trees?

C6: mmm

KM: do you see it also that it keeps it going? Do you view it that way as well? Is it both?

C6: ya, I think so. I think it's kind of feeding into it almost sometimes like. Like, mmm, it's like, mmm, [pause] it's like very hard to get out of because I start convincing myself oh ya, I just stay here now I don't deserve this, I don't deserve this. It feels like it's feeding into it, and it's just obviously old thought patterns from when I was younger. But they are just very, it's like I have dealt with all this stuff. But that seems to be the main thing, that I find extremely hard to, mm, to I suppose get rid of when I get very low. It's the main thing, I'm much better now. I can kind of, I don't even know how I