'It felt like I was giving a present to myself':

An Exploration of Service-users' Experience of Developing Self-Compassion

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1 Abstract

This thesis explored service-users' experience of developing self-compassion using Compassionate Mind Training (CMT). A systematic review of the existing literature on compassion and compassion-based interventions identified the primarily focused of research has been on symptom outcome measures utilizing quantitative approaches. No study that explored the experiences and processes of developing self-compassion was identified.

The aims and epistemological stance of the researcher led to a qualitative methodology being used. Once ethical approval was gained, six participants were recruited from two CMT programmes, being run by the same facilitators. All service-users who completed the programme reported a development of self-compassion. Participants were interviewed face-to-face using a semi-structured interview schedule. Interpretative Phenomenological Analysis was selected to analyse the transcribed data.

The analysis of the data identified four super-ordinate themes: essential components of self-compassion; process of self-compassion development over time; group experiences; and negotiating change. The first two themes focused on the development and experience of self-compassion. The second two themes included the experience of developing self-compassion in a group and the general change process. Each theme is discussed and presented with supporting quotes.

The study found that service-users are able to develop components of self-compassion using CMT. However, continued practice of compassionate behaviours needs to follow the end of the programme for self-compassion to become habitual. The study also identified a number of group factors and processes that prevented or promoted therapeutic change. The results are discussed with reference to the current literature on self-compassion, compassion-based interventions, group processes, mechanisms of change, and

further investigation. A model of self-compassion development is proposed. Finally, the researcher's critical reflections of the research process are presented.

2 Acknowledgements

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3 Statement of Contribution

The main author was responsible for the design of the project, applying and gaining ethical approval, interviewing, transcription, data analysis and the write up of the study. The recruitment of participants was supported by Dr Helen McLay. Research supervision was provided by Dr Thomas Schröder, who aided with the design and analysis of the study and provided feedback for the write-up of the study. Dr Helen McLay and Dr Ashleigh McLellan also assisted with the development of the research aims and design.

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4 Systematic Review

A systematic review of the effectiveness of self-compassion based interventions within adult mental health *

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4.1 Abstract

The impact of self-compassion on psychological well-being has become a widely researched area. This has led to the development of interventions that focus on fostering self-compassion. These interventions are becoming popular in clinical practice. Therefore, the aim of this study was to systematically review the evidence concerning the effectiveness of such interventions for adults with mental health disorders. Electronic databases, EMBASE, Medline, and PsychINFO, and bibliographies, were searched. The quality of each study was measured against the TREND statement. Five studies were identified that used interventions to increase self-compassion with people who met the criteria for a mental health disorder, including depression, psychosis and personality disorders. Interventions included compassionate mind training, mindfulness based stress reduction and loving kindness meditation. The studies found improvements in participant's symptoms and increased self-compassion. The quality of the studies, included in the review, was considered to be poor due to the small sample size and lack of control groups. However, the evidence for the effectiveness of interventions based on increase self-compassion is promising. The review considers the impact of the research on clinical practice and highlights future areas of research.

Keywords: self-compassion, mental health, interventions, treatment, systematic review

Key Practitioner Message:

- Interventions based on improving self-compassion are becoming popular with clinicians for the treatment of mental health disorders.
- A review of the evidence into the effectiveness of self-compassion based interventions is required in order to provide evidence-based practice.
- The low quality and limited evidence available makes it difficult to develop valid conclusions about the effectiveness of the interventions.

4.2 Introduction

Self-compassion originated from Buddhist philosophies and has become an interest in the western world. Over the past ten years there has been an explosion of research into the concept of self-compassion.

4.2.1 What is self-compassion

Self-compassion involves being sensitive and gentle towards oneself in the face of adversity or perceived inadequacy and requires the acknowledgment that suffering, failure, and inadequacies are part of the larger human experience (Neff, 2003). Neff (2003) proposes that self-compassion is composed of three components which mutually influence and motivate each other: self-kindness, common humanity and mindfulness.

Self-kindness involves offering a non-judgmental understanding in order to promote healthy behavioural changes over time. This does not mean protecting ourselves from potential harm, as this may lead us to be more fearful and cause distress, but instead recognising mistakes and pain without being critical. Common humanity is the ability to experience the pleasures and discomfort of life whilst being aware that others are having similar experiences. For example, if one fails, rather than becoming self-critical, it is recognising that failure is part of life and everyone will fail (Neff, 2003). This also prevents over-identification, in which one can become carried away by one's own emotions, which in turn become exaggerated. Finally, mindfulness is defined as a balanced state of moment to moment awareness in which emotions are accepted without the individual being carried away by them (Neff, 2003). It is suggested that this allows for thoughts and feelings to be observed as they arise, whilst still having a connection to them. Neff (2003) suggested that individuals who are self-compassionate should present with less depression and anxiety, and have greater life satisfaction.

4.2.2 Association between self-compassion and psychological well-being

To date the majority of the research on self-compassion has focused on its association with psychological well-being. Neff and her colleagues have led the way in this research. Their research has suggested that self-compassion helps protect against anxiety and depression (Neff, Kirkpatrick & Rude, 2007; Neff, Rude & Kirkpatrick, 2007). Leary, Tate, Adams, Allen, and Hancock (2007) have also found self-compassion to be associated with lowering negative emotions to real-life distressing situations, such as rejection, embarrassment and failure. Critically, these studies have been conducted on non-clinical populations, such as students, and have used artificial settings, such as distressing stories, over real life events. As a result these findings cannot be generalised across populations. This also limits the understanding of the association between self-compassion and mental health disorders, and whether improving self-compassion will have the same positive affects for people who are in real distress.

4.2.3 Development of self-compassion based interventions

There have been a number of developments in the fields of attachment, psychological and neurological development, personality and mental health (Gilbert, 2010). There has also been an increase in the number of interventions that focus on increasing individuals' self-compassion. This was evidenced in a recent examination of how these interventions are used in clinical practice (Welford, 2010; Gross & Allan, 2010; Cree, 2010; Lowens, 2010).

An important research direction is determining whether psychological interventions can influence an individual's level of self-compassion. As mindfulness is a component of self-compassion it is expected that mindfulness-based interventions will have an influence. A recent meta-analysis on Mindfulness-Based Stress Reduction (MBSR) provided evidence for this intervention being effective in enhancing self-compassion (Chiesa & Serretti,

2009). However, the samples used in the studies in the meta-analysis were classified as 'healthy participants'.

Loving-Kindness Meditation has a growing body of research showing its effectiveness at improving psychological well-being. The evidence suggests this intervention cultivates feelings of warmth and kindness towards oneself. In turn this results in increased positive emotions, and reduced pain, anger and distress (Hutcherson, Seppala & Gross, 2008; Pace, Negi, Adame, Cole, Sivilli, et al., 2009). However, the studies have not included a measure of self-compassion. Therefore, it is not possible to conduce whether these interventions actually improve self-compassion or whether self-compassion instigated the positive outcomes.

Compassion Focused Therapy (CFT) was originally developed from the Cognitive Behavioural tradition by Gilbert and his colleagues. The goal of the therapy is to help people with high levels of shame and self-criticism to develop self-compassion. It was proposed that this would help people engage in therapy (Gilbert, 2005). Based on an evolutionary-neuroscience approach, CFT suggests that there are three systems in the brain that regulate and create feelings of well-being and safeness (Gilbert, 2009): the threat system, the drive resource-seeking system and the soothing system (Gilbert, 2005). It is important that each system is equally balanced and interacting. In CFT it is proposed that past experiences (e.g. being neglected) can lead to the threat system becoming hypersensitive and the soothing system underdeveloped. This influences the way a person views themselves, others and the world. Using a range of interventions and techniques the key role of CFT is to develop balance between these three systems.

To date the evidence for self-compassion based interventions within adult mental health has not been reviewed. Due to the increased pressure to provide evidence based practice it is important to identify and review the quality of the evidence available. By identifying possible methodological strengths and

shortfalls in the existing literature it is hoped that the design of future research will be improved, and the evidence for self-compassion based interventions will continue to grow.

4.2.4 Objective

The aim of the systematic review is to determine the effectiveness of self-compassion based interventions in reducing symptoms associated with mental health problems in adults.

4.3 Methods

In order to identify studies that evaluated the effectiveness of increasing self-compassion, a systematic review was undertaken. Given the relatively recent interest in self-compassion, and what was anticipated to be a relatively small area of research, the search strategy was designed to maximise sensitivity towards relevant studies. Searches of medical and social science databases were undertaken.

4.3.1 Eligibility criteria

The titles and abstracts of all studies were read, and the following criteria were applied. If there was any degree of uncertainty the full-text article was obtained and the criteria then applied.

1.3.1.1 Inclusion criteria

The review sought to examine the evidence concerning interventions used with patients with mental health disorders that focus on improving self-compassion. Studies were considered for inclusion based on two main criteria.

1. Studies that included an intervention aimed at improving self-compassion.
2. Studies that used a sample that consisted of adults who would meet the diagnostic criteria for a mental health disorder as classified by a recognised diagnostic system such as: International Classification of

Diseases (World Health Organization, 1992) or Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000)

Controlled and uncontrolled evaluations were included as it was expected that the available literature would be relatively small. There were no specific quality criteria for the inclusion of studies.

1.3.1.2 Exclusion criteria

Articles were excluded if they had not been published in peer review journals. This also included dissertations, speculative reports and other sources of grey-literature due to resource constraints.

4.3.2 Information sources

The following databases were searched for relevant articles:

EMBASE - 1980 to 2010
Medline - 1950 to August 2010
PsychINFO - 1806 to August 2010

The decision to use three databases was based on previous research which suggests using one database is inadequate for retrieving all the relevant literature required (Hopewell, Clarke, Lusher, Lefebvre, & Westby, 2002; Stevinson & Lawlor, 2004). These databases were selected as they are the main international databases for medicine, nursing and psychology, and when compared to other databases have been found to be highly sensitive (Taylor, Wylie, Dempster & Donnelly, 2007). The databases were searched from their start date, in order to maximise the search for relevant articles. Additionally, further studies were found by hand-searching bibliographies of retrieved articles, commentaries, conference reports and relevant books. The search was restricted to papers written in English and was conducted in August 2010.

4.3.3 Search Strategy

The following terms were used for the search: compass$, compassion focused therapy, compassionate mind training, disease, disorder, intervention, intervention study, mental disease, mental disorder, mental health, psychiatric, psychiatric disorder, psychiatric problem, psychiatric treatment, psychological disorder, psychological problems, psychological well-being, psychotherapy, self-compass$, self kindness, self-warmth, self-soothing, therapy, treatment,.

All terms were mapped to subject headings and explored where possible. The search terms can be split into three main areas relating to: self-compassion, mental health disorders and treatment, as these were the areas of interest for the review. It was decided to use the terms self-soothing, self-warmth and self-kindness as these are common terms used to describe self-compassion.

4.3.4 Assessment of Methodological Quality

In order to assess the methodological quality of research rating scales have been devised. Whilst the majority have been designed for use with randomized controlled trials (RCTs; e.g. Higgins & Green, 2008), a number of rating scales do exist for different methodologies. The Transparent Reporting of Evaluations with Non-Randomized designs (TREND) statement (Des Jarlais, Lyles, Crepaz et al., 2004) is a 22-item checklist developed to guide standardised reporting of nonrandomized controlled trials. The TREND statement has previously been used in systematic reviews (Riethmuller, Jones, & Okely, 2009). It is considered to be the equivalent of the Consolidated Standards of Reporting Trials (CONSORT) statement for RCT (Schulz, Altman, Moher et al., 2010). As it was anticipated that the review would not identify RCT's the TREND statement was considered to be a more appropriate checklist. Critically, the use of rating scales to measure the quality of studies have not been empirically well supported (Juni, Witschi, Bloch, & Egger, 1999). However, they are still regularly used in systematic reviews. Therefore, the TREND statement was used as a guide only to highlight the quality of the studies.

4.3.5 Data Extraction.

The key data was abstracted from each study and entered onto separate data extraction sheets. This information was then combined onto one form. The following data was considered to be relevant: author, date of publication, objective of study, design, sample size, sample population, dropout rates, intervention, outcome measures, follow up time, and results. The quality of each study was then checked against the TREND statement.

4.4 Results

4.4.1 Study Selection

Using the search strategy 154 articles were found. The abstracts of the articles were read and those that met the inclusion criteria were included in the review (figure 1). Excluded from the analysis were: book chapters (27), commentaries (36), conference proceedings/papers (6), dissertations (8) review articles (23) and studies with non-clinical samples or when the sample was not specified (23). From the 154 articles, 31 were screened for eligibility. Twenty seven studies did not use a self-compassion based intervention, therefore were excluded from the review. Using this method four studies were considered appropriate for the review. A further study was found from hand searching which was also included.

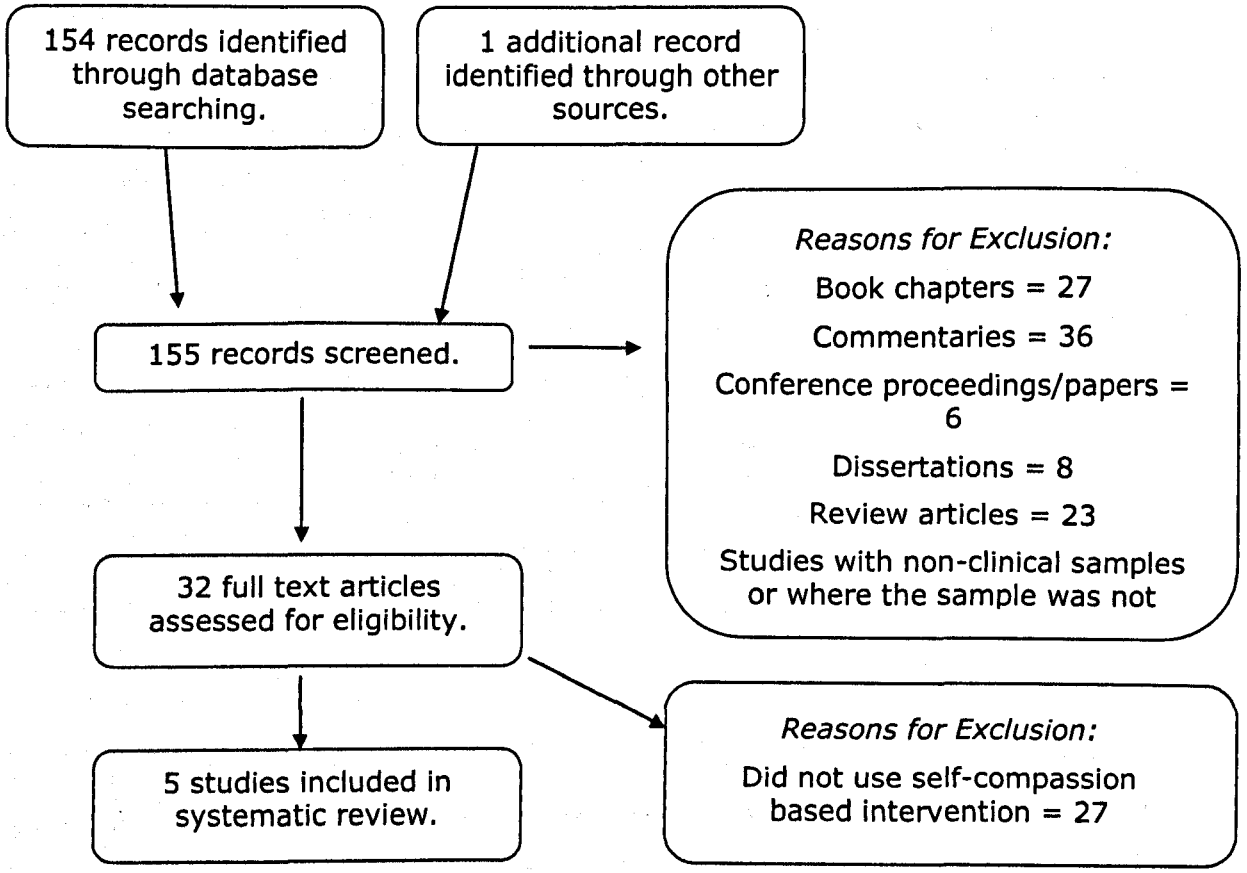

Figure 1 Flow chart of records through the phases of the review process.

4.4.2 Scope and quality of the included studies.

An outline of the included studies can be found in table 1. All the studies included in the review were conducted within the last seven years. In terms of treatment, the interventions include: compassionate mind training (CMT), mindfulness based stress reduction (MBSR), loving-kindness meditation and recovery after psychosis (RAP) program (based on CMT). All studies were comparable as they used the same outcome measure and similar interventions. Mental health disorders being treated in the studies included: bi-polar disorder, depression, personality disorder (not stated which type), psychosis and schizophrenia. Four studies delivered their interventions within a group, with one study delivering one to one therapy. The majority of the interventions were brief

(4-12 sessions), and the therapists carrying out the interventions were all clinical psychologists. The facilitators of the interventions were involved in the completion and analysis of outcome measures. This may have caused a bias in the results, therefore, reduced the reliability of the studies.

All studies included detailed descriptions of the interventions used, how they were delivered, and the duration of the interventions. A range of study designs were identified, including, pre-post test design studies without controls, randomized controlled trials (RCT) and case series design. Although pre-post test designs are useful in the development of interventions, they are difficult to interpret because of unknown confounds, such as spontaneous remission. The one randomized control trail (Lee & Bang, 2010) did not have a clear description of the randomization in order to judge the quality of this method. Four of the five studies completed a follow up, however the amount of time between ending of intervention and follow up varied. By carrying out a follow up, the studies were able to determine whether the effects of the intervention persisted.

Three of the five studies recruited participants from the community, one study (Laithwaite, O'Hanlon, Collins, Doyle, Abrahm, et al., 2009) included participants from an inpatient unit and two studies (Gilbert & Procter, 2006; Mayhew & Gilbert, 2008) used day patients. As these participants would have received previous treatments or were receiving a different therapy at the time of the study, it is possible that the intervention being studied may not have been the direct cause of the outcomes found. Only one study stated that participants were not currently receiving treatment for their disorder (Lee & Bang, 2010).

The sample size for all the studies ranged from seven to seventy-five. Due to the small sample size of the studies, it is difficult to generalise the results to the population they used in the study. Power analysis or justification for sample size was absent from all studies. Dropout rates were also high, with no study having a full data set at the end of the study. Two studies provided justifications for participants dropping-out i.e. became physically unwell, reported they were

feeling better so did not want to continue or having difficulties attending the sessions. No study reported whether incomplete data was used in the analysis.

Table 1 Characteristics and key findings of presented studies

Study no.	Authors & Date	Objectives	Participants	Design	Outcome Measures	Intervention	Drop -out rate	Length of follow up	Summary of results
1	*Gilbert & Irons (2004)*	*Explore how people experience their self-criticism and to see if compassion ate imagery could be generated. To explore whether participants thought self-compassion could help counteract self-criticism.*	*2 men 7 women from a self-help depression group. Diagnosis: depression*	*Pre-post test without control group*	*Self-attacking and self reassuring diaries, Self-report measures not reported*	*4, 1½ hours group meetings. Exploration of the nature of self-criticism, self-compassion and imagery work*	*1*	*4 weeks*	*Significant increase in the ease of generating compassionate images and soothing oneself in a self-critical situation. A small non-significant reduction in scores for self-criticism.*
2	*Gilbert & Procter (2006)*	*To explore a systematic group format of CMT.*	*4 men 5 women, From day unit Diagnosis: personality disorders and/or chronic mood*	*Pre-post test without control group*	*HADS, Weekly Diary measuring , FSCS, FSCRS Social*	*12 week group CMT programme (includes series of steps)*	*3*	*2 months*	*A significant reduction in anxiety and depression. A significant decrease in self-persecution and self-hatred but not self-correction.*

			disorders		*Rank Variables, OAS, Social Comparison Scale, Submissive Behaviour Scale*				*A significant increase in self-reassurance and self-compassion. Sufficient reliable date was not collected at follow up for analysis; however, patients reported continuing practicing their compassionate images.*
3	*Mayhew & Gilbert (2008)*	*To explore whether the explanation of CMT is helpful for people who have paranoid experiences and hear malevolent voices.*	*6 men aged 23-64. 1 women aged 25. Diagnosis: schizophrenia and experienced hostile auditory hallucinations*	*Case series*	*Beliefs about Voices Questionnaire, FSCRS – short form, FSCS – short form, SCL-90, Voice Rank Scale, SCS*	*1:1 CMT over 12 sessions*	*4*	*6 months*	*All participants showed a decrease in symptoms. Only 1 participant showed changes in self-compassion or self-criticism. Diary measures were inconsistent with self-report questionnaires, suggesting all participants felt their self-compassion and their psychological well-being had improved.*

4	*Laithwaite, O'Hanlon, Collins, Doyle, Abrahm et al (2009)*	*Evaluation of RAP Programme.*	*19 male patients at a maximum security hospital. Diagnosis: schizophrenia, paranoid schizophrenia or bi-polar affective disorder*	*Pre-post test without control group*	*Social comparison Scale, OAS, SCS, BDI, Rosenberg self-esteem measure, Self Image Profile for Adults, PANSS*	*20 session RAP Programme based on CMT*	*1*	*6 weeks*	*Significant improvements were found in depression, self-esteem, social comparison and psychotic symptoms. A small increase in self-compassion was found but this was not significant. These changes were maintained at follow up.*
5	*Lee & Bang (2010)*	*Does MBCT combined with self-compassion training have positive benefits on increasing psychological well-being and positive affect?*	*75 Korean middle aged women from the community with depressive mood*	*RCT*	*PWB, PANAS, BDI, SCL-90-R, Mindfulness scale, SCS*	*8, 2½ hour group sessions of MBCT plus 'loving kindness' meditation* *Waitlist control.*	*3 from intervention group, 12 from waitlist control*	*none*	*Significant changes were found across all measures between post-treatment and base-line scores. Mindfulness and self-compassion both increased significantly. Significant decrease in anxiety and depression symptoms compared to waitlist control.*

Key: CMT, compassionate mind training, HADS, Hospital anxiety and depression scale, FSCS, Functions of the Self-Criticizing/Attacking Scale, FSCRS, Forms of Self-Criticizing/Attacking and Self-Reassuring Scale, OAS, Others as shamers scale, SCL, Symptoms checklist, SCS, Self-compassion scale, RAO, recovery after psychosis, BDI, Beck depression scale, PANSS, Positive and negative syndrome scale, MBCT, Mindfulness based cognitive therapy, PWB, psychological well-being scale, PANAS, Positive negative affect schedule, RCT, randomized control trail

All studies used self-report methods to measure the effectiveness of the intervention. The five studies used validated instruments to measure changes pre and post interventions, for example Hospital Anxiety and Depression Scale (HADS), Beck Depression Inventory (BDI), Self-Compassion Scale (SCS) and the Symptom Checklist-90-R (SCL- 90-R). Four of the five studies reported information on how the instruments had been validated and what they were designed to measure. Two studies also used weekly diaries to measure changes in self-compassion and self-criticism. The statistical analysis varied for each study. All but the case series design study used a form of statistical test and reported significant and non-significant statistical results. It is important to note, that of the studies that reported the effect size of the changes in outcome measures, all are classed as small (under 0.3). This may be due to the fact that the studies were under powered, due to their small sample size, and therefore underestimating the effect size. This does not mean that they are unimportant results. As this is a new area of research, the studies results can be used as a starting point for future research.

The main tool used to measure self-compassion was the SCS. The SCS has six subscales, self-kindness, mindfulness, common humanity, isolation, over-identification and self-judgement, and gives an overall score of self-compassion (Neff, 2003). It is considered a valid and reliable scale and has been used in numerous studies. However, it was developed using a non-clinical sample (mainly students) and the validity and reliability of the assessment has not been tested with a clinical population. Therefore, the results of the four studies may not be valid.

Due to the variability in study design, quality, interventions and outcomes it is inappropriate to attempt a quantitative summary. Therefore a narrative summary of the evidence is provided below.

4.4.3 Results of the included studies

The results of the five studies reviewed vary. Overall they imply that interventions that have been developed to improve self-compassion in people

with mental health difficulties, do cause positive changes to a person's psychological well-being and impact on the symptoms they present. Gilbert and Irons (2004), Gilbert and Proctor (2006), and Lee and Bang (2010) explored interventions based on CFT with people with depressive symptoms. They all found reductions in psychological symptoms and distress. Using weekly diaries, Gilbert and Irons (2004) investigated what elicits self-criticism and whether compassionate imagery would reduce or change this. They found participants were surprised at the amount of self-criticising they did. Over the course of the intervention there was a small reduction in self-criticism and an increase in the ability to use compassionate images to self sooth. However, all participants had difficulties completing the diaries; therefore, a complete data set was not obtained and a reliable conclusion cannot be drawn with regard to these changes.

Gilbert and Proctor (2006) also asked participants to keep diaries and found participants reported their self-critical thoughts became less frequent, powerful or intrusive, and their self-compassionate thoughts became more accessible and powerful. They supported this report, using a range of psychometric assessment and also found statistically significant changes in depression, anxiety, self-correction, self-persecution and social comparison. It is possible that the self-compassion intervention may not have caused these changes, as research has shown that expressive writing can improve psychological well-being (Lepore & Smyth, 2002). Therefore, keeping a diary of their self-criticism may have caused the changes reported. Furthermore, Lee and Bang (2010), found using loving-kindness meditation alongside Mindfulness Based Cognitive Therapy (MBCT) to develop self-compassion was effective. Using a randomized control study, they found statistically significant differences in the level of self-compassion for the intervention group compared to the waiting list control group. This would suggest that this type of intervention is as effective as CMT at improving self-compassion levels and psychological well-being.

Interestingly, not all studies found an increase in self-compassion at the end of the intervention. In Mayhew and Gilbert's (2008) case-series study, only one participant showed an increase in the level of self-compassion. However,

all participants showed decreases in their symptoms including changes to the voices they heard. Additionally, Laithwaite, O'Hanlon, Collins, Doyle, Abrahm, et al. (2009) found a small increase in self-compassion but this was not statistically significant. They did find statistically significant decreases in psychotic symptoms as well as changes to depression symptoms, self-esteem and social comparison. Participants in both studies had a diagnosis of schizophrenia or bipolar disorder and were experiencing psychotic symptoms, such as hearing voices, at the time of the study. As both studies used CMT for a relatively short period of time (12 weeks and 20 weeks respectively), this may suggest that people with complex mental health disorders may need additional support to develop their self-compassion.

Four of the five studies delivered their intervention using a group format. Research has shown that being in a group can have psychological benefits, due to the support that is offered and the general processes of being in a group (Castelein, Bruggeman, Busschbach, Van Der Gaag, Stant, et al., 2008; Corey, Corey & Corey, 2008). It is possible the change reported in these studies may not be caused by the intervention but from being in a group of people with similar experiences. However, Mayhew and Gilbert's (2008) study, where participants received one-to-one therapy over 12 sessions proposes that CMT is effective as an intervention for reducing distressing symptoms. Critically, it is important when evaluating interventions the impact of variables that are not measured or controlled, such as therapist factors, have on outcome measures. It is possible that these nonspecific factors are accountable for the changes that occur, not the specific intervention.

4.5 Discussion

The aim of the study was to determine the effectiveness of self-compassion based interventions in reducing symptoms associated with mental health problems.

4.5.1 Summary of evidence

From the vast literature on the concept of self-compassion and its role in psychological well-being, only five studies were discovered that met the criteria for the review. Generally, the quality of the studies included in the review was poor, due to small sample sizes, the high rates of drop outs and the lack of control conditions. This reduces the possibility of drawing valid conclusions about the effectiveness of self-compassion based interventions. Due to the limited amount of research that has focused specifically on participants with mental health disorders it is not possible to generalise the results of previous studies that have used non-clinical samples. However, the research does show positive progress within this field.

The five studies included in this review all indicated that participants who would meet the criteria for a mental health disorder benefited from the interventions used to increase their self-compassion. Although, changes in self-compassion levels were small, the studies showed that the interventions used did have positive effects on participant's psychological well-being (e.g. reduction in distressing symptoms). Therefore, these studies support the previous findings of research using healthy participants (Leary, Tate, Adams, Allen, & Hancock, 2007; Neff, Kirkpartrick & Rude, 2007; Neff, Rude & Kirkpatrick 2007). It is also possible that this supports the theory Neff (2003) proposed, that individuals who have self-compassion will present with less depression and anxiety.

The studies also showed that overall participants rated themselves low in self-compassion, before they received an intervention. This may supports the theory behind compassion focused therapy is true. That the three affect regulation systems in the brain may not develop adequately or may have

become dysfunctional, which results in the person being unable to show compassion towards themselves when in distress (Gilbert, 2009). However, it is not clear whether the participants in these studies had low levels of self-compassion before they developed their mental health problems; it is possible their self-compassion levels decreased due to their distress. Therefore, it is not possible to say whether self-compassion is a precursor or maintenance factor in mental health disorders. This is a difficult question to address and one that needs further investigation. What is clear is that self-compassion has a role in a person's psychological well-being.

The Cochrane collaboration suggests that systematic reviews can be used to categorize interventions in two ways (Higgins & Green, 2008). Either to show that sufficient evidence has been collected to have implications for practice or to influence priorities for future research. This review can imply the latter and some of these priorities are considered below.

It is clear that higher quality studies, such as RCT's, into the effectiveness of self-compassion based interventions are required. Although the studies included in the review have shown positive results for depression and psychosis, they suggest that the more complex the problems, the less effective self-compassion based interventions are. It is possible that the effectiveness of these interventions may depend on the disorder they are used for. Therefore, future research should focus on using sensitive sampling methods in order to gain more homogeneous samples. Greater controls over confounding variables, such as therapeutic factors, are also needed.

The majority of the studies in this review used compassionate mind training (CMT) as their intervention. CMT was originally developed for people who showed heightened levels of self-criticism or shame. The aim of the training is to help people develop self-compassion so that they can then engage in therapy. The studies all used CMT as their only form of intervention, which may have been why the effect size was small for their outcome measures. It would be valuable to compare changes in psychological well-being for people who had received CMT prior to engaging in a different intervention with

people who had not received CMT. Furthermore, long-term follow-ups are also needed to obtain whether the effects of the interventions remain.

This review has highlighted that there is a gap between evidence and clinical practice. Although there is poor evidence to support the effectiveness of the interventions they are still being used by clinicians. As previously mentioned, there is an ever increasing push to provide evidence based practice in order to integrate current best evidence with clinical policy and practice to provide an effective and efficient service. Review bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Cochrane Collaboration have been developed to review evidence and provide guidelines for clinicians to base their practice on. These guidelines are developed using 'gold standard' scientific studies, such as RTC's. Although this form of research is useful it is not the only form of valuable research. It is suggested that evidence based practice is not only based on scientific evidence, but also on clinical expertise (Spring, 2007). Case studies and qualitative research, looking at service users' experience and satisfaction, can also provide important information on the effectiveness of interventions.

This review has not drawn a conclusion on whether self-compassion based interventions should or should not be used in clinical practice. What is apparent is that more consideration of other important factors, such as the clinicians experience and expertise, and the patient's needs and presentation is needed when deciding what intervention would be most effective for the patient. This review only included scientific studies and did not consider other evidence, such as clinical experiences and service user satisfaction, which may limit its value. This may also halt the progress in the development of evidence for these interventions. Bridging the gap between research and practice will help develop the knowledge and understanding of the area in question and make decisions about which intervention to use easier and justifiable.

4.5.2 Limitations

There are a number of limitations to this review. Firstly, the search was limited to studies published in English; this may have resulted in important

literature being missed. The search could also have been strengthened by contacting leading experts in the field to enquire about relevant grey literature. It is also possible that this would have resulted in studies which report non-significant results to be indentified, as these are less likely to be published in academic journals. Furthermore, the data extraction was only conducted by a single reviewer. This may have led to recording errors or bias to occur. Therefore, the results of the systematic review should be treated with caution.

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5 Journal Paper

'It felt like I was giving a present to myself': An Exploration of Service-users' Experience of Developing Self-Compassion[†]

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5.1 Abstract

Objectives. The concepts of compassion and compassion-based interventions have attracted significant interest over recent years. Research suggests the development of self-compassion may benefit those with mental health difficulties. Little attention has been paid to the experience and processes involved in self-compassion development. This study aimed to explore and understand how service-users made sense of the experience of developing self-compassion using Compassionate Mind Training (CMT).

Design. A qualitative method was used to explore service-users experiences of developing self-compassion. A small purposive sample was selected, and in-depth, open-ended interviews were conducted.

Methods. Six participants who completed CMT were interviewed using a semi-structured interview. The transcribed data was analysed using Interpretative Phenomenological Analysis.

Results. Four super-ordinate themes were extracted: essential components of self-compassion; process of self-compassion development over time; group experiences; and negotiating change. Participants identified four essential components of self-compassion. When applying these self-compassionate components to their lives participants felt more able to overcome their difficulties. The development of these components was seen as a continuous process, which was a difficult journey for the participants. The first two themes are explored in detail.

Conclusions. This study demonstrates that service-users are able to develop self-compassion using CMT and provides a first insight into how they make sense of their experience. The development of self-compassion is a multifaceted process. Obstacles related to self-compassion development can be overcome. However, self-compassion needs to be practised to become a habitual process. Findings are discussed in relation to existing literature on self-compassion.

5.2 Practitioner Points

1. People receiving usual treatment for mental health problems such as depression, are able to develop self-compassion through Compassionate Mind Training.
2. The development of self-compassion is a continuous process that requires practice and monitoring beyond initial learning. Clinicians using CMT should build in maintenance sessions to promote continued use of self-compassion.
3. Service-users have fears relating to self-compassion, which need to be addressed as part of their self-compassion development.

5.3 Introduction

It has been proposed self-compassion can reduce shame and self-criticism experienced by service-users, with mental health difficulties (Cox, Fleet, & Stein, 2004; Cox, MacPherson, Enns, & McWilliams, 2004; Gilbert, 2000). Research into compassion based interventions has increased. How these therapies operate in practice, and the mechanisms by which self-compassion develops remain unclear.

Compassion is a difficult concept to define, with many definitions in the literature (Baer, 2010). Neff (2003a) proposes self-compassion comprises three qualities: self-kindness, common humanity and mindfulness. It is suggested that if self-critical individuals develop these qualities they will be able to address their own experiences of failure, rejection and suffering more appropriately (Leary et al., 2007; Neff, Kirkpartrick, & Rude, 2007; Neff, Pisitsungkagarn, & Hsieh, 2008).

Based on the evolutionary model of social-mentality theory Compassion Focused Therapy (CFT) was designed to target shame and self-criticism through developing self-compassion (Gilbert, 2000). The theory proposes three emotional regulation systems evolved: The *threat system*, detects threats and produces feelings such as anxiety, anger and disgust (Nesse, 1998). These feelings produce behavioural responses such as, fight, flight and submission (Marks, 1987). The *incentive/resource system*, encourages individuals to seek resources for survival by generating feelings such as excitement (Depue & Morrone-Strupinsky, 2005). The *soothing system*, gives

a feeling of inner peacefulness, safeness and compassion, when threats are removed or resources are sought (Gilbert, 2009). Although evidence supports the development, physiological responses, and operations of the threat and incentive/resource systems, research into the soothing system is sparse (Porges, 2001).

CFT suggests humans develop social-mentalities that enable them to form relationships to meet biosocial goals (Gilbert, 2009; Liotti & Gilbert, 2011). The organization and interaction of the affect systems to produce the correct mentality, depends on the biosocial goal being pursued. If the systems do not develop or interact appropriately, an individual may struggle to achieve the appropriate social-mentalities required to meet biosocial goals.

According to CFT, problems within the systems result from emotional neglect during early development (Gilbert, 2009). This can lead to the development of threat-focused mentalities, which may produce more competitive and aggressive behaviour. These mentalities are likely to lead to isolation, rejection, and distress (Liotti & Gilbert, 2011).

CFT takes an interactional view, in that change in one mentality will influence the organisation of other mentalities (Gilbert, 2009). Developing self-compassion may affect the experience of negative emotions such as shame. CMT was developed to help individuals stimulate their underactive soothing system and desensitise the threat system; by increasing experiences of care and compassion.

CMT involves psycho-education and exercises that develop compassionate attributes and skills. CMT has been widely applied across different clinical settings, in individual and group formats (Lee, 2010). The treatment model is considered transtheoretical and not designed to be a standalone treatment (Gilbert & Procter, 2006).

Empirical evidence on the effectiveness of CMT has consisted of pilot and case studies using self-report measures, or in combination with other therapies (Gale, Gilbert, Read, & Goss, 2012; Gilbert & Irons, 2004; Gilbert & Procter, 2006; Kelly, Zuroff, & Shapira, 2009; Laithwaite et al., 2009;

Mayhew & Gilbert, 2008). Anecdotal accounts on the effectiveness of the approach have also been reported (Cree, 2010; Goss & Allan, 2010; Gumley et al., 2010: Lowens, 2010; Welford, 2010). The limited evidence identified CMT as an effective intervention for the reduction of anxiety, depression, distress, paranoia, and self-criticism. CMT has been found to increase the ability to self-soothe and focus on feelings of warmth (Gilbert & Procter, 2006). These studies have been marred by small sample sizes, high dropout rates, lack of control conditions, and limited follow-ups. Furthermore, evidence has been based on a self-report measure of compassion; the Self-Compassion Scale (SCS; Neff, 2003b). Although this scale has robust reliability, it has been suggested it may not be a valid measure for clinical populations (Gilbert, McEwan, Matos et al., 2011). Until CMT is subjected to rigorous evaluation it is not possible to verify it as an effective intervention.

A neglected area of research is service-users' experience of the development of self-compassion. The perspectives of service-users should play an important role in the evaluation of treatments (Department of Health, 2001). Service-users hold unique knowledge and can contribute to a more complete conceptual understanding of theory and practice (Newton, Larkin, Melhuish, & Wykes, 2007). Although the current literature exploring service-users' experience of treatment is not extensive, studies have elicited clinically important information regarding the experience of psychological treatments and internal processes (Hodgetts & Wright, 2007).

In summary, the research into self-compassion is limited. As the internal process of compassion itself is difficult to operationalise, measuring it quantitatively may not be effective. Further investigations using qualitative methods would provide additional insight into self-compassion and the processes this involves. This study aims to understand how service-users have subjectively experienced and made sense of the phenomenon of developing self-compassion using CMT.

5.4 Method

5.4.1 Design

For the purpose of exploring the unique experience of developing self-compassion using CMT, Interpretative Phenomenological Analysis (IPA) was used. IPA was deemed a more suitable approach than other qualitative methods due to its focus on personal meaning and sense-making of a phenomenon (Smith & Osborn, 2008), and congruency with the researcher's critical realist stance. Using this idiographic approach, detailed nuanced analysis on a phenomenological level, taking into account the hermeneutic process between the researcher and participant, could be achieved. The integrity of IPA's roots has been questioned and criticised for not meeting scientific criteria and lacking trustworthiness as an approach (Giorgi, 2011). However, Smith, Flowers and Larking (2009) argue IPA is a clear, auditable, systematic process, which enables enriched and critically integrated understanding of lived experiences.

5.4.2 Participants

A homogeneous sample of service-users who had completed a CMT programme was used. To be included, participants attended a minimum of 8 sessions and understood English without an interpreter. Participants were excluded if the interviewer (JL) deemed they were in distress prior to gaining consent. Those who met the inclusion criteria were sent information sheets and asked to contact the researchers if interested. Six participants followed this up and were recruited, no one was excluded; see table 2 for demographic information.

Table 2 Demographic Features of Participants.

Participant*	Age Range	Primary diagnosis	Duration of mental health problems	Previous treatments
Peter	21-30	OCD	10 years	CBT, Counselling (not specified)
Ruth	41-50	Bipolar Affective Disorder	20 years	CBT, Stress Management, Relaxation, Medication
Dawn	41-50	Depression	18 years	Antidepressants, Counselling (not specified), CBT
Sarah	31-40	Depression	15 years	Antidepressants CBT
Rebecca	31-40	Anxiety	10 years	Counselling (not specified)
Emily	21-30	Depression	12 years	Antidepressants Counselling (not specified)

** In the interests of confidentiality pseudonyms have been used.*

5.4.3 CMT

Service-users attended two, ten-session, CMT programmes run by a NHS Mental Health Service in 2010. Two Clinical Psychologists, who had received training on CMT, designed and facilitated the programmes based on a CMT guide (Gilbert, 2010). The focus of the program was on the development of compassionate attributes using skills training, outlined in the CFT model. Fortnightly sessions consisted of theoretical teaching and experiential skills practice; with self-therapy exercises set between sessions. This included detailed exploration of CFT model and self-criticism, mindfulness exercises, compassionate imagery, compassionate letter writing, and thought challenging (for detailed information on the content of CMT see Gilbert, 2009).

Self-report measures were used at pre, post, and follow-up points, to measure levels of compassion and diagnostic symptoms. All service-users

who completed the programme reported an increase in self-compassion. Therefore, the study only accessed the accounts of participants who experienced a development of self-compassion.

5.4.4 Procedure

Once ethical approval was gained participants were sent an information sheet and consent form. On contact with participants the interviewer, who was independent of the clinicians facilitating the programmes, explained the procedures and written consent was obtained. One-to-one, semi-structured interviews were conducted, to gain information on specific areas, whilst remaining open to participants' experience (Figure 2). The interviews were conducted eight months after the programme and lasted 30-80 minutes. They were audio-recorded and later transcribed verbatim by the interviewer.

Interview Questions

1. Tell me a little bit about yourself and why you wanted to take part in this study?
2. Tell me about your experience of Compassionate Mind Training?
3. Tell me about the change you feel you have made/went through? Prompt: How do you make sense of this change?
4. Is there anything else you would like to say about your experiences or anything that I have not asked that you would like to talk about?

Figure 2 Semi-structured interview schedule.

5.4.5 Analysis

Each transcript was analysed by the interviewer, incorporating IPA principles (Smith et al., 2009). The transcripts were read and re-read, noting summative descriptions of the narrative. The transcripts and notes were re-read and higher-level interpretations were recorded. The interpretations were clustered into related concepts, to generate themes. Themes were checked

against the data to ensure their foundations were in participants' accounts. In order to encapsulate the idiographic and shared nature of participants' experience, the initial themes were kept in mind when analysing each transcript whilst remaining sensitive to new concepts. Super-ordinate and sub-themes were developed to summarise experiences.

5.4.6 Quality Assurance Measures

The study employed a set of accepted guidelines, to ensure the credibility and quality of the research (Yardley, 2008). After the first transcript was analysed, all themes were reviewed to ensure the analysis was reasoned and embedded in the data. An audit trail was developed and a reflective diary was used to document knowledge, ideas and expectations that may have influenced the process. This was vital, as the philosophical underpinnings of IPA recognise the analytical process involves researchers making sense of others making sense of experiences, but cannot truly bracket off their own perceptions. The researcher (JL) entered the study from a critical realist perspective and as an engaged observer in CMT. The researcher's conceptions of self-compassion may have influenced the analysis process, in a different way to someone who had not engaged with the topic.

5.5 Results

Four super-ordinate themes were generated: Essential Components of Self-Compassion; Process of Self-Compassion Development over Time; Group Experiences; and Negotiating Change. Within the super-ordinate themes, a number of sub-ordinate themes were identified (Table 3). As the aim of the study was to explore the experience of developing self-compassion, the first two themes will be examined in detail with supporting extracts from participant transcripts. The third and fourth themes will be presented in future papers, as these themes outline wider change processes.

Table 3 Super-ordinate and sub-ordinate themes.

Super-ordinate themes	Sub-ordinate themes
Essential Components of Self-Compassion.	Acceptance and expression of a range of emotions. Self-acceptance. Nurturing the self. Focusing on the here and now.
Process of Self-Compassion Development Over Time.	Understanding lack of self-compassion. Acceptance of past events. Breaking the self-criticism cycle. Overcoming fear of compassion. Continual process.
Group Experiences.	Group functional factors. Internal views of the group. Commonality, identifying with others.
Negotiating Change.	Catalysts of change. Barriers to change.

5.5.1 *Essential Components of Self-Compassion*

This theme relates to participants' experience and understanding of actively being self-compassionate. Participants identified four specific components that were the essence of their self-compassion: accepting and expressing emotions; self-acceptance; nurturing the self; and focusing on the here and now. Skills learnt during CMT enabled participants to engage with these components. For some participants, these components had become a natural part of their daily functioning; others had to actively employ them when needed. All found them fundamentally important to overcome difficulties and maintain their wellbeing.

Acceptance and expression of emotions

Participants discussed past difficulties in being able to display and operationalise their emotions. Having awareness, being able to accept and experience the physical sensations of emotions, was an essential part of self-compassion for all participants. Being self-compassionate meant linking the correct emotion with a situation, and being open to a range of emotions.

> **Rebecca:** it's ok to feel down or angry when things go wrong.

> **Ruth:** To feel happiness you've got to have sad times, you've got to have the rain to get a rainbow.

As Ruth highlights, participants recognised they need a range of emotions to experience life fully. This insight enables emotions to become unstuck and not be viewed negatively. As part of being self-compassionate participants recognised the importance of understanding their feelings.

> **Sarah:** I guess recognising that it is ok to feel low or sad or upset when bad things happen, and not to feel guilty [...] I've actually got quite angry about things, which would never have happened. Anger was a bad thing in my life [...] But now it's not a bad thing.

Sarah's acceptance of her feelings removed the guilt and shame she carried with her from past experiences, of being punished for her emotions. Reconnecting and allowing her anger to flow gives her a sense of relief, enabling her to stop self-punishing and experience emotions fully.

> **Rebecca:** ... well I have a better understanding of myself now. Erm you know, why I do get upset and anxious so easily, [...] so I'm able to look at that differently and not get as upset for getting upset ...

Rebecca's acceptance of her emotions helped her to explore them in ways she previously averted. Having that understanding allows her to regulate her feelings appropriately and recognise triggers, instead of being self-critical.

There was a sense participants actively avoided others emotions in the past. For example, Dawn discussed how she would constantly try to read others in fear of being confronted by negative emotions, which may echo her own distress. CMT provided a safe environment for exposure to and exploration of emotions. Not only did this exposure enable the participants to test beliefs about expressed emotions, but it also modelled more positive and compassionate responses. This contrasted with their early experiences of not learning from their caregiver.

> **Dawn: ...**if they react a certain way I think, try and be more compassionate, I suppose, and think, you know maybe they're not angry, maybe they are frightened.

Dawn recognises different emotions may underlie those being expressed. This reflection gives an insight into Dawn's external emotional expressions not matching her internal feelings. By recognising this conflict she is able to be compassionate toward, rather than avoid, the underlying emotions.

> **Sarah:** So to see others being allowed to er cry and the therapist in the group, I suppose, showing us how to be compassionate not only to ourselves but to others was ... it was nice and strange all at the same time.

This quote draws attention to the conflict Sarah experienced between her own beliefs and the here and now. The positive sensations she is experiencing feel 'strange' compared to her usual negative feelings. The 'strange' feeling Sarah is experiencing may also be triggering feelings of warmth and love towards the facilitators, as they act like the loving parental figures she never had.

Self-acceptance

For participants being self-compassionate meant accepting who they were, recognising personal qualities and strengths, and understanding their role within the wider existence. This included admitting limitations, as shown by Peter.

> **Peter:** Me being perfect is something that I am not.

All participants described how they had 'put on a mask' to feel accepted by others and were denying who they truly were. This suggested participants felt they had to please others and live up to expectations, that they were faultless, thereby preventing rejection and shame.

> **Sarah:** And I think I've Shocked a lot of people ... I'm putting myself first for a change and telling people how crap my life has actually been. [...] I'm safe to allow others to see the more vulnerable side of me.

The emphasised term 'Shocked' suggests although Sarah attributes this to others, it was actually herself who was shocked by the sadness of her situation. Her self-compassion has given her the strength to be vulnerable in front of others.

> **Dawn:** ... I've realised that I'm quite a different person, there's this different side that I'm trying to integrate.

Dawn identified she portrayed two personas, public and personal. Being self-compassionate meant 'integrating' these to be true to herself. Participants' acceptance of themselves and recognition that they deserve to be treated the

same as others, was a huge part of being self-compassionate. Peter discussed how difficult this was.

> **Peter:** ... you know the idea that [sigh] 'I'm a person too' is actually really rather lovely.

The awareness that he never considered himself a 'person' brought a lot of sadness to this statement, emphasised by the sigh. He balances this with the compassion he is able to show himself.

Nurturing the self

The ability to show love and nurture inwards was also described as an essential component of self-compassion, to remain healthy. Showing kindness to the self internally (e.g. positive self talk) and externally (e.g. doing an activity), also helped participants to grow. Rebecca shows how she uses her self-compassion to nurture herself after a failure, and push forward.

> **Rebecca:** You could have done that better, but, maybe next time don't don't give up. Just because it didn't work first time, doesn't mean you can't do it again.

> **Emily:** ... there would have been a time where it's like 'why am I taking that couple of hours out just for me' [...] Whereas now it's like 'no I am going to go and do it because it's really good for me' ...

Emily showed how, by nurturing herself, she now experiences less guilt, which allows her to experience pleasure. This ability to self-nurture was a new concept for many participants. They recognised a need to balance the compassion they showed to others with self-compassion. Many participants struggled to achieve this balance. There was a sense, throughout their lives they had put others before themselves, neglecting their own needs. This was related to the fear of rejection and seeking comfort they were unable to give themselves.

> **Ruth:** not putting me at the bottom of the pile any more ... but it also means not putting me first all the time.

Ruth recognises nurturing herself does not mean becoming self-absorbed, but recognising when to put her needs ahead of others to look after herself.

Focusing on the here and now

Focusing on the here and now helped participants to recognise what was happening around them, rather than being distracted by past experiences. There was a sense that by being in the moment participants did not become overwhelmed, by their emotions, and felt freer.

> **Sarah:** I can now just stop and appreciate what is happening at that moment ... not beating myself. That's nice.

> **Ruth:** Let's just take now, I can't do anything about the past, the future hasn't come yet but we've got the now and let's just stop and take stock.

All participants identified this skill as being vital, especially at times they felt overwhelmed. For some participants this was hard to master as they had become so stuck. Peter talked about using this component to help him experience pleasure.

> **Peter:** I was going by a church [...] um I just smelt the grass, beautiful smell of grass [...] and the sun was blazing and it was absolutely beautiful and um that was one of the things somebody, said was you know 'well use that image that smell that thing, that's putting a good place in your head' and I think that's very very valid um [...] I found it very hard to think of things that made me happy. So it was nice to be opened up to that.

This validating experience gave Peter a sense of relief. He was able to feel pleasure, and in that moment the burden of pain he carried was removed.

5.5.2 Process of Self-Compassion Development over Time.

Participants described how the components of self-compassion developed over time through four processes: understanding lack of compassion;

acceptance of past events; breaking the self-criticism cycle; and overcoming fear of self-compassion. Although self-compassion was exercised throughout these processes they were not seen as continuous components. Participants identified self-compassion development as a continuous process, as they refined their compassionate skills over time.

Understanding lack of compassion

All participants felt it was important to understand why their self-compassion had not initially developed. Emily, Sarah, Rebecca and Ruth felt if they had not had this understanding, it would have prevented them from allowing self-compassion to develop. This may have been due to the blame they placed on themselves for not being able to regulate their emotions.

> **Rebecca:** I was never shown how to do it, so how was I to know what compassion was, or how it felt or how to show it, to others let alone myself.

As exemplified by Rebecca, there was an acceptance that she had never had the opportunity to develop the skills necessary to self-soothe. Developing this understanding may result in the removal of self-blame and guilt they held about past experiences, current distress, and perceived inability to manage emotions. Additionally, rather than seeing these experiences as shameful, participants were able to experience understanding, warmth and empathy towards them. Sarah showed how she replaced blame with self-compassion for her actions.

> **Sarah:** A big weight has been lifted, as what I've been doing makes sense to me ... I was seeking something that I couldn't do for myself and that was caring and loving me.

Acceptance of past events

In order to develop this understanding, participants had to endure the painful experience of reliving past events and tolerate the associated feelings. This enabled participants to accept these events, as part of the broader

experience of life, and move forward with their recovery. Ruth and Peter highlighted the outcome of this process:

> **Ruth:** I no longer felt that dirty shame inside.
>
> **Peter:** It was really really nice to be able to unburden myself.

This was not an easy process. For Emily, painful images were easily triggered and at points she struggled to carry on.

> **Emily:** ...it triggered an image, that triggered a feeling, that triggered another image. It's just, you know, that vicious circle, erm, and it it does sometimes and it does sometime, it did get me down sometimes.

The change in tense in the statement from 'does' to 'did', suggests Emily's pain from past events is present, which initially prevents her using self-compassion. When Emily shows acceptance and understanding towards her past experiences through self-compassion she moves forward, rather than becoming burdened by them.

Breaking the self-criticism cycle

For many participants undermining self-criticism was a way to protect themselves, and they did not see it as a negative aspect of their lives.

> **Emily:** ... thinking bad of myself [...] is something that's ingrained.

A vital process of self-compassion development was the recognition of being stuck in a vicious cycle of self-criticism. Rebecca's quote demonstrates how self-criticism facilitated her avoidance of distress. Using self-compassion she identified this was preventing her from meeting her own needs.

> **Rebecca:** I recognised, I guess, that if I was critical of myself ... constantly putting myself down and thinking I couldn't do anything, meant that ... it meant that I could never fail. But now it meant that I never did anything.

Participants continued to display ongoing struggles with self-critical behaviour. This was also evident within the interviews; for example, stating they could not express themselves clearly, they had not answered the questions, or they had nothing to offer. However, they were able to recognise this and identify their feelings of shame, blame, and guilt, and use their compassion to move forward.

> **Rebecca:** Sorry this is not what you want to hear um but I guess it might be important.

Here Rebecca becomes self-critical, recognising this she uses self-compassion by placing values on what she is saying and is able to carry on. For many, their negative self-critical cycle had been broken (i.e. undermining self) and transformed into positive self-criticism (i.e. self-improving).

> **Sarah:** I've come to see that my criticisms of myself are not all true ... But you know what some of them are true and that's that's ok ... nobody's perfect ... so if I make a mistake I say 'oh stupid me' and just move on. It helps me to clear me head a bit.

Here, Sarah shows she was able to balance her self-criticism. Positive self-criticism may be a more adaptive coping mechanism, as it allows the individual to recognise mistakes or inadequacies in a more constructive way. Participants changed from living up to their worst, to their ideal self image. This enables individuals to move forward rather than ruminate or avoid feelings, by transforming feelings of distress and isolation to empowerment and contentment, as is shown by Ruth.

> **Ruth:** Before it would have been ... well 'you deserve it, you're a crap person' but it's like 'well actually its nothing I've done to deserve it it's just happened and let's just see what we can make of it now'

Overcoming fear of self-compassion

For some participants CMT was their first encounter with self-compassion and they were fearful of it.

> **Peter**: Sadly being compassionate to one's self can also be scary

This fear related to uncertainty regarding the concept.

> **Emily:** I was worried it was going to make me soft (sigh) um like, the upbringing I had and things like that I had to be very hard and um I was worried it was going to soften me up and make me a bit of a soft touch.

Emily initially saw compassion as a threat. The 'sigh' related to the idea it would 'make me soft' shows this was an emotionally-laden moment for Emily, and is now a resolved issue. Compassion as a threat triggered participants' defensive strategies, to manage their initial discomfort and anxiety. Strategies included being critical of the approach, withdrawing from exercises, or distancing themselves from others. Ruth identified her fear had been reinforced by past experiences of self-compassion.

> **Ruth:** It was easier to [sigh] take a slice out of myself than it was to be nice to myself.

However, after overcoming this initial fear, by developing an understanding of self-compassion, participants enjoyed the feelings they experienced.

Continual process

Three participants believed their self-compassion had further developed since finishing the group. By allowing time and energy to develop self-compassion participants felt it had helped them overcome their difficulties.

> **Emily**: Over time and putting it into practice, and just being a little bit patient as well it it it works out.

The other participants felt they had not fully developed self-compassion. They recognised this was the start of their journey. The initial experience of self-compassion had been a positive encounter many wanted to continue with.

Dawn: ... it felt good, it felt like I was giving a present to myself.

Dawn stated she did not feel her self-compassion had developed further, finding it hard to practise following the training. On reflecting on her experience she referred to self-compassion as a present. Seeing it as a gift suggested Dawn felt she deserved compassion, but did not see it as an everyday or natural occurrence. Other participants accepted compassion as part of their everyday life.

Peter reported he felt he had not continued to be self-compassionate following the group. However, there was a strong sense Peter was displaying compassion to himself throughout the interview, through his behaviour and narrative. For example, he did not view himself as a failure or punish himself for not continuing with the exercises, something he stated he previously would have done.

Peter: ... I've also got to be compassionate to myself um because I am a worthwhile person. Just because I'm a human being and I really would like to, I'm not there yet, but I really would like to to think that.

In this quote, whilst talking in a warm and soothing manner about his experience, Peter displayed compassion by being non-blaming, rather than self-critical, for not being 'there yet'. He later used the term 'slip in', on a number of occasions, to describe how he felt his self-compassion developed, thus proposing self-compassion may have been passively learnt and become a habitual process without a cognitive awareness. However, without this awareness it may not be possible to recognise progress. Emily also described being 'surprised' when she is self-compassionate; suggesting self-compassion is something that has happened almost despite herself. Until Emily fully accepts her compassion, the journey will not be over.

Despite some participants struggling to continue their journey, the self-compassion they reported to have developed was reflected in the soft and warm vocal tones, language, and facial expressions used to describe their experiences. For example, 'nice', 'comforting', 'warm', 'nurturing', and

'relaxed'. Participants' self-compassion was also felt within the interactions of the interviews.

> **Interviewer:** You mentioned earlier about seeing yourself as a person.
>
> **Peter:** It even makes me smile when you say that, [...] it's very nice ... just smiling at the idea that it is like putting myself in a warm place.

> **Ruth:** I've got as much right to give myself what I need as I give to anybody else. Yeah, that's nice, that's good. [laugh]
>
> **Interviewer:** You've got a smile on your face.
>
> **Ruth:** I do, yeah.
>
> **Interviewer**: It sounds as though when you are talking about it you are being self-compassionate.
>
> **Ruth:** To me, it just feels like ... this is what life should be, now.

Ruth shows how her compassion has become a part of her way of life. However, without practising self-compassion this did not become habitual. Those that did not continue to develop self-compassion hoped that in the future it would begin to grow.

> **Dawn:** ...Yeah it's like a little seed that's turned into a little plant, but it's not a tree yet [laugh].

Dawn's roots of self-compassion had been sown. With nurture, her self-compassion may grow, to give her the warmth, strength and protection needed, to face future therapeutic processes, and continue her recovery.

5.6 Discussion

The study has provided the first insight into service-users' experience of self-compassion development using CMT. All participants felt developing self-compassion was a worthwhile experience and had impacted on their lives; adding empirical support to the assertion self-compassion can be learnt through the practise of experiential exercises, and the notion self-compassion may have an important role within recovery (Gilbert, 2009; Pauley & McPherson, 2010; Pence, 1983). This is supported by participants finding the exercises challenging at first, and describing the development of various compassionate skills, which implies they were not able to display self-compassion prior to the programme.

The application of IPA revealed four super-ordinate themes. The themes 'essential components of self-compassion' and 'process of self-compassion development over time', were explored. These themes relate to the multimodal content of CMT, with the first relating to the experiential skills element of the training and the second to the development of theoretical understanding.

The study identified self-compassion as being made of four main components: accepting and expressing a range of emotions, being able to focus on the here and now, self-acceptance, and nurturing the self. The elements described by participants do not appear to concur with Neff's (2003a) definition of self-compassion. Of the four elements, three map on to two of Neff's concepts: focusing on the here and now with mindfulness; and nurturing the self and self-acceptance with self-kindness. Participants did not appear to see common humanity as a component of self-compassion, rather as part of the overall process of change. It is proposed common humanity may need to be a pre-condition for self-compassion development, rather than an actual component of self-compassion. The acceptance and expression of a range of emotions was seen as a vital component of self-compassion, which is not accounted for in Neff's definition. As Neff's model was developed through the study of non-clinical populations, it is possible expression of emotion is a natural behaviour, not considered to be related to self-

compassion. However, it is problematic in clinical populations. As highlighted in this study, the ability to accept and express emotions may need to be explored prior to additional self-compassion components.

The components identified appear to map on to the compassionate attributes and skills outlined by Gilbert (2009). The ability to accept their own and others' emotions without the need to control or avoid them, was demonstrated by participants acceptance of themselves for who they were in a non-judgemental way. They were able to experience pleasure and nurture themselves, showing they were motivated to look after their well-being. Finally, by focusing on the here and now, participants were able to show sympathy and empathy by being open, emotionally in tune, and understanding their experiences. Critically, not all participants developed all of these attributes. There may be a number of reasons for this. Firstly, they may not all be important; secondly, there may be additional elements required for some individuals to develop self-compassion; and thirdly, some individuals may need additional support.

The second theme appears to be consistent with the basic tenets of the theory behind CMT. The notion that self-compassion development is part of a larger journey of change, and requires the development of skills and attributes, is consistent with the research on compassion and CFT as a transtheoretical approach (Gilbert, 2009). The first stage towards the development of self-compassion was the development of insight into the origins of one's difficulties, and the validation and acceptance of these experiences. Within CFT, this is termed the development of wisdom (Welford, 2010). Once wisdom was acquired participants were able to take responsibility for change, and felt ready to engage in the emotionally challenging process of accepting their past experiences and recognising their self-criticism. It is important to note, whilst this process is not specific to CMT, it does support the evidence on the importance of formulation in the process of change (Kuyken, 2006).

Participants also had to overcome their fear of compassion. Fear has been identified in the literature as one of the main barriers to self-compassion (Gilbert, McEwan, Matos & Rivis, 2011; Pauley & McPherson, 2010). Research

using non-clinical samples found fear of compassion is associated with self-criticism (Gilbert, McEwan, Gibbons et al., 2011; Rockliff et al., 2008). The present study adds clinical support to these previous findings. Participants had to break their self-critical cycle to overcome fear. Furthermore, evidence suggests self-compassion may be perceived as a threat (Gilbert, McEwan, Gibbons et al., 2011; Gilbert, McEwan, Matos, & Rivis, 2011). This was also found in participants' accounts, as they were unsure of the impact of self-compassion. This may have important clinical implications. It is suggested that for those who show strong fears towards self-compassion, it may be more beneficial to focus on modifying their self-criticism, which may result in self-compassion developing; i.e. distracting their attention away from what they perceive as a threat.

Participants viewed self-compassion development as a continual process. This suggests, as with any change process, self-compassion development takes time (Carey et al., 2007; Higginson & Mansell, 2008). The study also supports previous findings of compassion being an active process (Pauley & McPherson, 2009). It is proposed, until self-compassion becomes a habitual process, service-users may struggle to overcome their self-critical behaviour. There also appeared to be a delay between the development of self-compassion and the cognitive awareness of it. This is an interesting result, which has not been found in previous studies. It is proposed, self-compassion can develop without the individual's awareness, but it will not be fully accepted until the individual has a cognitive recognition of its role.

For three participants, self-compassion had become a part of their mentality, which helped their recovery. Despite initial self-compassion development, three participants struggled to use it away from the safe environment of the training, resulting in their distress persisting. Nevertheless, they were able to draw on what they had learnt and apply it to future therapy. This is an important finding, as CMT is not considered a standalone intervention, rather as a precursor intervention to promote engagement (Gale et al., 2012; Gilbert & Procter, 2006). Although this suggests that self-compassion needs to be over-learnt and generalised to wider settings, further research is

required to understand the differences between those who progress and those that do not.

5.6.1 Limitations

A limitation of the study is that findings are based on retrospective accounts of CMT. The components of self-compassion identified by participants may be a result of what they have been taught, as it is likely CMT would have initially structured their experiences. However, as the interviews were completed eight months after CMT, participants may have re-interpreted their experiences and developed their own understanding of self-compassion. A comparison of how participants make sense of self-compassion before and after training, would help to identify the impact the language used in CMT has on their understanding and experiences.

Furthermore, the study only included participants who had self-reported developing self-compassion. However, there was variety in the continued use of self-compassion within the sample. Including participants who did not develop self-compassion may have provided additional information.

The small sample size is consistent with the traditions of a qualitative approach, as it allowed a detailed investigation of participants' experience. Although the findings of the study cannot be generalised to the wider population, this was not consistent with the aim of this study, the critical realist stance of the researcher, or the methodology used. The analysis will inevitably reflect the interpretations of the researcher. However, by being clear of the position of the researcher, and by grounding the results in examples, the trustworthiness of the study is improved.

5.6.2 Summary and Future Research

This study has provided an insight into self-compassion development and demonstrates self-compassion can be learnt using CMT. The development of self-compassion may not be limited to CMT. As CMT is a multimodal approach, the elements and processes of self-compassion development identified may also be found in different therapeutic approaches.

Consequently, future research may benefit from comparing service-user experiences of a range of therapies, to develop a clear understanding of self-compassion development, and improve treatments.

The study also identified difficulties associated with developing self-compassion, such as fear. Understanding the factors preventing self-compassion from developing may improve compassion-based interventions.

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6 Extended Paper

6.1 Extended Introduction

The following section provides additional information on the literature on compassion and compassion-based therapies, to provide a rationale for the present study.

6.1.1 Research on Compassion

The concept of compassion was initially studied as an alternative to self-esteem. Although both correlate with psychological wellbeing, this comparison can be problematic. Compassion can be utilised when suffering occurs due to external circumstances, including personal mistakes, failures and inadequacies; and can prevent self-criticism and shame. Self-esteem is related to judging and evaluating oneself against another, which can lead to feelings of inadequacy and shame (Neff, 2011).

There are numerous definitions of compassion as it is a multifarious process (Gilbert & Tirch, 2009). McKay and Fanning (1992) saw compassion as involving understanding, acceptance, and forgiveness. Goetz, Keltner and Simon-Thomas (2010) defined compassion as a "distinct affective experience whose primary function is to facilitate cooperation and protection of the weak and those who suffer" (p.351). The majority of research on self-compassion has been based on Neff's (2003a) definition. Neff argued self-compassion incorporates three components that overlap and mutually interact; these are defined below.

Self-kindness: Refers to the ability to be kind and understanding to oneself, rather than critical or judgmental. Personal inadequacies or failures are treated in a gentle, supportive manner and the self is accepted as being imperfect. When faced with external challenges the individual is able to offer themselves soothing and comfort.

Common humanity: Involves the ability to understand one's own experience as part of a larger existence, so that one feels connected, rather than disconnected, to others when in distress. It also involves recognising

that imperfection is part of a shared human condition, so that one does not feel blame or shame.

Mindfulness: Involves being aware of the present moment experience, in a balanced manner. This includes recognising that one is suffering and being able to view one's experience from a more objective perspective. This prevents one becoming overwhelmed by emotion and fixated on negative aspects of oneself.

From this definition, the Self-Compassion Scale (SCS) was developed to measure the presence or absence of self-compassion (Neff, 2003b). It is measured through six factors: self-kindness, common humanity, mindfulness, self-judgement, isolation, and over-identification. High scores on the first three factors indicate high levels of compassion, whereas; high scores on the last three factors indicates low levels of compassion. These six factors have been shown to be highly inter-correlated, with a single higher-order factor (self-compassion) accounting for this inter-correlation. The scale has strong convergent and discriminate validity, and good test-retest reliability (Neff, Kirkpatrick & Rude, 2007).

The majority of research on self-compassion has utilised this scale, and has shown self-compassion is strongly associated with psychological health (Neff, 2011; Neff, Pisitsungkagarn & Hsieh, 2008; Shapiro, Brown & Biegel, 2007). A review of the research revealed that self-compassion has been associated with life satisfaction, emotional intelligence, social connectedness, learning goals, wisdom, curiosity, optimism, and positive affect. Furthermore, low levels of self-compassion have been associated with depression, anxiety, fear of failure, perfectionism, disordered eating behaviours, and self-criticism (Neff, 2009). Self-compassion has also been found to be associated with the appropriate use of internal and external resources to navigate situations involving threat (Masten & Wright, 2009). Additionally, neurological research suggests that expressing self-compassion internally is associated with increased happiness and optimism, through the stimulation of pathways within the left prefrontal cortex (Lutz et al., 2004).

Using experimental manipulation one study examined how students with high self-compassion coped with distressing life events (Leary et al., 2007). This study found self-compassion was associated with reduced negative emotions resulting from real-life distressing situations, such as rejection, embarrassment, and failure. Additionally, people with high self-compassion were more accepting of their own undesirable characteristics and behaviours; judged themselves less harshly; and had more self-relevant thoughts. Self-compassion, therefore, appears to have psychological benefits. However, the studies that support this have mainly been conducted with non-clinical populations, such as students. This limits the understanding of the role self-compassion has in the development and maintenance of mental health difficulties, and its potential use in treatment.

Although there have been several narrative overviews of the impact self-compassion has on mental health, there have been limited studies investigating this in clinical samples (Gilbert, 2005a; Neff, 2003a; Neff, 2011). Van Dam, Sheppard, Forysth and Earleywine (2011) used measures of mindfulness (Mindful Attention Awareness Scale: Brown & Ryan, 2003) and self-compassion (SCS) to predict symptom severity (i.e. depression, anxiety or worry), in a large sample of participants who reported moderate to severe levels of anxious and/or depressive distress. They found that the construct of self-compassion, was a more robust predictor of depressive and anxious symptomatology than the construct of mindfulness. The results of this study may actually reflect more about self-report measures used, than the constructs being studied. For example, there are multiple measures of mindfulness; using a different measure may have resulted in a different outcome.

Levels of self-compassion in a sample of people with social anxiety disorder (SAD) compared to a healthy control group (HCs) has also been investigated (Werner et al., 2011). Using the SCS, they found that individuals with SAD reported less self-compassion than HCs; however, this difference was not statistically significant. Looking at the six subscales of the SCS separately, compared with the HCs the SAD sample showed statistically significant less self-kindness; greater self-judgment; less of a connection to a common

humanity; greater isolation in their suffering; less emotional balance; and feeling more overwhelmed by negative emotions. As with the study by van Dam et al. (2011), a number of the clinical sample had received or were receiving, psychological treatment for their difficulties. This may impact the results of these studies, as these participants may have developed a heightened awareness of their lack of self-compassion through therapy, compared to those waiting for treatment. Therefore, in order to understand the association between mental health difficulties and self-compassion further, this variable needs to be controlled in future studies.

Although evidence proposes an association between self-compassion and mental health, research is yet to investigate whether low self-compassion is a causal mechanism, a maintenance factor, or a consequence of mental health difficulties. Furthermore, the role self-compassion has in different disorders may vary. As well as gaining a greater understanding of mental health disorders, research into this area may help develop and improve preventative strategies and treatments.

6.1.2 Compassion-Based Interventions

Whilst still in the early stages, and by no means conclusive, research on the construct of self-compassion suggests a positive association with psychological wellbeing and negative association with distress and suffering. Consequently, there has been an increase in the number of interventions recognising self-compassions role within reducing emotional distress. These include: Mindfulness Based Cognitive Therapy (MBCT: Kuyken et al., 2010; Lee & Bang, 2010; Rimes & Wingrove, 2010); Mindfulness-Based Stress Reduction (MBSR: Birnie et al., 2010; Chiesa & Serretti, 2009; Shapiro et al., 2007); Loving-Kindness Meditation (Fredrickson et al., 2008; Hutcherson, Seppala, & Gross, 2008); and Compassion Focused Therapy (CFT: Gilbert, 2009a; Laithwaite et al., 2009). The limited research, into the association between self-compassion and these interventions, has found a change in levels of self-compassion during treatment. However, there is a paucity of data to show whether this change in self-compassion is associated with symptomatic improvements. The significance of the study's results are

limited due to a number of critical factors, such as small and heterogeneous samples, lack of control measures, and poorly validated outcome measures. Additionally, many of these studies have included healthy-participants and have not specifically measured self-compassion; focusing instead on symptom reduction or quality of life (Rimes & Wingrove, 2010; Shapiro et al., 2007). This limits the understanding of the role self-compassion plays within these interventions, and the generalisability of the findings. Furthermore, no study has considered the long-term outcomes, or benefits of developing self-compassion.

In a study, that attempted to address some of these quality issues, Kuyken et al. (2010) used a randomised controlled design to examine the mechanisms involved in MBCT for the treatment of depression. Participants were randomly assigned to attend an 8 session MBCT course, or to continue with their medication (control group). Using the SCS to measure self-compassion, the Kentucky Inventory of Mindfulness Skills (KIMS: Baer, Smith, & Allen, 2004) to measure mindfulness, and the Hamilton Rating Scale for Depression (HRSD: Willams, 1988) to measure depressive symptoms after treatment; they found increases in self-compassion and mindfulness mediated the effect of MBCT on depressive symptoms. No change in self-compassion levels was found in the control group. Furthermore, an increase in self-compassion during treatment was associated with lower depressive symptoms at a 15-month follow-up. Unfortunately, self-compassion was not measured at follow-up. This prevents an understanding of whether self-compassion is maintained, and precludes a conclusion regarding the mechanism of change in depressive symptoms.

Of the four interventions mentioned, CFT is the only one based on a theory that specifically identifies the role of self-compassion in psychological wellbeing. This is described below.

6.1.2.1 Compassion Focused Therapy

CFT was developed from a number of observations that people with high levels of shame and self-criticism have difficulty showing themselves warmth or kindness. It is known that negative experiences during childhood, such as

abuse, neglect, or lack of affection, are likely to lead to high levels of shame and self-criticism in adulthood (Blatt & Zuroff, 1992; Gilbert et al., 2004; McCranie & Bass, 1984). Within CFT, it is proposed these early experiences prevent the development of self-compassion required to soothe oneself when faced with distress, causing emotion dysregulation (Gilbert, 2010). A recent study found that low self-compassion was statistically significantly linked to experiences of childhood maltreatment (Vettese, Dyer, Li, & Wekerle, 2011). Furthermore, the study demonstrated self-compassion levels predicted emotional dysregulation above other factors, such as childhood maltreatment, current psychological distress, and addiction severity. This suggests self-compassion may play an important role in emotion regulation. However, these findings are based on a small, homogenous sample of offenders convicted of substance abuse and mandated to treatment, therefore cannot be generalised.

CFT draws on evolutionary, developmental, social and attachment models to inform social mentality theory (Gilbert, 2000). Social-mentalities are the motives, emotional attention, reasoning and behavioural elements that enable the individual to navigate the world and achieve their biosocial goals. This theory proposes; humans have developed a set of complex rules, routines and roles (mentalities) to maximise our chance of survival (Choi-Kain & Gunderson, 2008; Fonagy, Bateman, & Bateman, 2011; Liotti & Gilbert, 2011). A person will draw upon a number of these social-mentalities depending on the challenges they face, relationships they form, and the feedback they receive (Gilbert & Procter, 2006). The mentality we use will depend on the outcome sought and past experiences (e.g. competitive, care-seeking, care-giving, and threat detection); thus it is important that they are interchangeable (Liotti & Gilbert, 2011). Mentalities develop from biological make-up, early experiences and attachments (Gilbert, 2005b; MacBeth, Schwannauer, & Gumley, 2008). Thus, a child who is abused or neglected will learn that seeking help from others is not worthwhile, or potentially threatening. Consequently, their care-seeking mentality will not be activated but their threat mentality will; making them sensitive to threats to increase their survival chances. The literature on this theory is largely theoretical and is based on neurological concepts that have yet to be evidenced. Research

has shown disruptions to the infant-care-giver attachment and ruptures to the feelings of safeness, leads to increased sensitivity to threat and poor self-soothing. It is likely that the infant will become over-reliant on threat-based strategies to regulate their feelings. This rupture in safeness may affect interpersonal functioning at a physiological, psychological, emotional and behavioural level (Gerhardt, 2004; Schore, 2005; **Error! No bookmark name given.**Vettese et al., 2011). This is believed to increase the individual's vulnerability to self-critical thoughts, anxiety, and depression.

The CFT model focuses on the interplay between threat, motivation, and soothing psychobiological systems, to understand behaviour. Research on the neuroscience of emotions has identified three affect systems. These regulate our emotions, thoughts, attention, behaviours, and underline the social-mentalities we develop (Depue & Morrone-Strupinsky, 2005; Panskepp, 1998). These systems are constantly interacting and forming patterns that result in the occurrence of various emotions and behaviours. The function of each system and its relation to CFT is explained below. Although the evidence in support of these systems is growing it is important to note that this may be a simplification of a more complex and currently unknown system. The three systems model may not be the only way in which our emotional regulation system can be understood, mapped, or conceptualized (Panskepp, 1998).

Threat System

The function of this system is to detect threats quickly to produce feelings of anxiety, anger, or disgust. These feelings alert us to take behavioural action and self-protect; for example fight flight or freeze (Gilbert, 2001; Marks, 1987). Problems in this system can occur when we become flushed with physiological responses before we are able to cognitively make sense of the threat. This can lead to false attribution of feelings. As this system is there to protect, it is easily conditioned and is vulnerable to developing problems (Gilbert, 1998). Operating within the amygdal and hypothalamic-pituitary-adrenal axis, the neuroscience of the threat system is becoming well understood (see LeDoux, 1998).

Research has shown the threat system can be activated by external world stimuli or internal process, such as self-criticism and comparison with others (Hooley et al., 2005; Longe et al., 2010). The threat system can also be activated through emotional memories, personal beliefs, rumination, and worry (Gilbert & Tirch, 2009). This can lead to a number of safety strategies developing, such as avoidance of social situations or appearing inferior to others (Thwaites & Freeston, 2005). These safety strategies can result in increased vulnerability to anxiety and depression, rumination, and stress, which may also be perceived as a threat (Gilbert, McEwan, Bellew et al., 2009). This can leave the individual in a vicious cycle where the threat system is continually alert, producing perpetual negative affect.

There is significant evidence in support of the existence, function, and physiological aspects of the threat system and its role in negative affect and behavioural consequences (Gilbert, 1993; Nesse, 1998; Rosen & Schulkin, 1998). Research and practice has tended to focus on the understanding and regulation of negative emotions, and less on positive emotions (Gilbert, McEwan, Gibbons, et al., 2011). There has been a recent shift in focus in clinical psychology (Carr, 2004), which has led to an increase in research aiming to understand the function and neurophysiologic mediators of positive emotions. Positive emotions have previously been understood to be along a single dimension. However, Depue and Morrone-Strupinsky (2005) identified two types of positive affect associated with two distinct systems. The first relates to appetitive/seeking motivation (incentive/resource seeking system) and the second to consummatory behaviour (soothing system). These are briefly described below.

Incentive/Resource Seeking System

Evolution theory states that for survival we need to be motivated to seek out basic resources, such as food, territories, and sexual opportunities (Gilbert, 2006). Therefore, this system is linked to drive, arousal, and seeking out resources. The system produces positive feelings to energise and guide us to seek rewards, resources, and achievements. Positive feelings, such as desire, excitement, elation, enthusiasm, and pleasure (Berridge, 2003), are produced through sympathetic nervous system activity (Di Chiara & North,

1992). Once sought, the system produces feelings of satisfaction. These feelings are often short lived, as we need to seek the necessary resources repeatedly for survival. In order to increase survival chances, we also need to develop attachments (Gilbert, 2006). This system is also responsible for the drive to seek these social resources, such as feelings of self-worth and validation from others (Depue & Morrone-Strupinsky, 2005). If a person fails to achieve their goal, they may become self-critical, activating the threat system and leaving them with negative emotions (Gilbert, 2010).

Soothing System

It is proposed when a resource or reward has been achieved and no threats are around, the soothing system takes over to produce feelings of contentment, gratification, and wellbeing (Gilbert, 2010). Depue and Morrone-Strupinsky (2005) suggest these feelings are produced due to the activation of the parasympathetic nervous system. The production of endorphins and oxytocin play an important role in this system (MacDonald & MacDonald, 2010; Rockliff et al., 2011, Wang, 2005). The development of this system is linked to attachment behaviours (Depue & Morrone-Strupinsky, 2005). Caring behaviour, such as grooming, stroking, and resting, stimulate the system (Polan & Hofer, 1998), which produces feelings of safeness and reduces distress (Carter, 1998). It has been suggested if an infant does not experience this caring behaviour (e.g. it is not modelled by the mother), they will not develop the capacity to self-sooth and feel safe (Gallop, 2002). It is proposed that difficulty in accessing this system may be a vulnerability factor for a range of mental health difficulties (Gilbert, 2000). However, there is limited empirical evidence to support this.

CFT does not view the problem lying within a single system, rather as an imbalance between the three systems. For example, too many threat signals will result in the over-activation of the threat system and under-development or stimulation of the soothing system. To address the imbalance, the aim of the intervention is not to target specific core beliefs, but to alter a person's whole orientation to him or herself; through focusing on the development of positive feelings, such as contentment and safeness. The aim is to change an individual's internalized dominating-attacking style to a compassionate way of

being with one's distress. This will allow the individual to focus on their underlying beliefs and causes of their distress, without becoming overwhelmed and judgemental.

Central to CFT is the intervention strategy of Compassionate Mind Training (CMT). CMT is a multimodal intervention that builds on the advances of a range of approaches: Acceptance and Commitment Therapy, Cognitive Behavioural Therapy, Dialectical Behaviour Therapy, and Behaviour Therapy (Gilbert & Procter, 2006). CMT aims to teach individuals how to self-soothe and generate feelings of warmth when they are feeling threatened, experiencing negative emotions, or being self-critical. This is done through providing training in multiple skills to develop the attributes that comprise self-compassion. These attributes include: care for well-being, sensitivity and tolerance of distress, empathy and sympathy, and being non-judgemental. Within CMT, the therapist demonstrates the skills required to develop these attributes, through the use of compassionate attention, reasoning, imagery, feelings, and sensations.

6.1.2.2 Effectiveness of CMT

The first reported investigation was a pilot study of a newly developed CMT group programme (Gilbert & Irons, 2004). Six participants attended 12 sessions, completing pre and post self-report measures to assess self-criticism, depression, anxiety, and shame. They also kept weekly diaries. The study found a reduction in anxiety, depression, self-critical thoughts, external shame, and submissive behaviour. They also found an increase in self-soothing thoughts. At the end of the programme, several participants expressed that they found the programme "a moving and 'deeply helpful' experience" (p373). Although suggesting that CMT was effective, the participants were based in a day hospital, in which they also attended groups based in CBT and had good support throughout the process. Furthermore, there was no control group in this study. Therefore, it is not possible to say that participants made improvements as a result of attending the CMT group, as it may be due to other variables.

Following on from this, Mayhew and Gilbert (2008) explored the use of CMT with people with paranoid experiences. They were particularly interested in whether participants could develop self-compassion, and if so, how this would affect their hostile voices, anxiety, depression, and self-criticism. Using a case series design, seven participants

were recruited. Only three completed the 12 one-to-one sessions. Participants were asked to complete six self-report questionnaires before, at the end, and six months after the programme. They also kept weekly diaries of voice activity, and self-critical and compassionate thoughts. The participants showed a decrease in their positive symptoms (e.g. delusions or hallucinations), obsessive compulsions, depression, anxiety, and paranoia. Their voices became less malevolent and persecuting, with two participants reporting more reassuring voices. The participants reported "CMT made a lot of 'sense' and that it was a helpful way to engage with their fears and voices" (p133). Again, it is difficult to draw firm conclusions from this study, due to the small sample size and lack of control group. There was also a sizable dropout rate, which may reflect something about the intervention, such as its inaccessibility for all.

An interesting finding from Mayhew and Gilbert's (2008) study was that all three participants rated themselves as highly compassionate, before starting the programme. However, after engaging in CMT they reported that they had not understood what the term self-compassion meant. Additionally, a study on the use of CMT groups with inpatients with a diagnosis of schizophrenia, paranoid schizophrenia, or bi-polar affective disorder, found there was a small increase in self-compassion reported by participants but this was not statistically significant (Laithwaite et al., 2009). This may suggest that using outcome measures, such as the SCS, is not an effective way of evaluating the development of self-compassion. Furthermore, the SCS measure is based on the definition of self-compassion from Neff (2003a). The concept of self-compassion that CMT is based on is different to Neff's. Therefore, the scale may not be reliably measuring the underlying processes or changes participants are making.

This posed a question: what do people with mental health difficulties understand of the term self-compassion? Furthermore, can people identify experiences of self-compassion? Using a qualitative methodology, ten service-users, receiving treatment for depression or anxiety, were interviewed to explore the meaning and experiences of self-compassion (Pauley & McPherson, 2009). The participants identified compassion as an active process with involved kindness and warmth. Participants were able to explain the concept of compassion, but struggled to understand the meaning of self-compassion or identify experiences of compassion for themselves. The researchers suggested the lack of identified experiences might show that people with depression or anxiety may never have had, or may have lost the ability to be compassionate. There seem to be little foundation for this explanatory account, and the researchers did not explore this in great detail. An alternative explanation maybe that participants were unable to access these

memories during the interviews. Critically, the researcher who interviewed the participants was also their therapist, which may have influenced the participants' response. Furthermore, as previously stated, there is no universal definition of self-compassion. It is therefore not surprising that participants struggled to explain self-compassion. Further research is required to understand how people make sense of self-compassion.

6.1.2.3 CMT Group Approach

In addition to considering the theory and application of CMT, it is important to consider the delivery of the treatment. To date, the limited research has mainly focused on a group approach. Group-based psychotherapies work differently to individual therapies. The main difference is the varied and multiple interactions and relations, which can arise and develop between participants in a group (Whitaker, 2001). This can result in the key processes required for the development of self-compassion to be more easily accessible than in individual therapy. Yalom (1985) described a number of critical therapeutic factors that influence change, the main one being a sense of cohesiveness and universality. Many people entering group therapy will have a strong sense of being alone in their emotional world, and see others as unlikely to understand them. Being in a group enables the discovery that other people suffer with similar difficulties, and they belong, are accepted, and their experiences are validated. The experiences of cohesion, belonging, normalisation, and identification, may counteract the experiences of isolation, loneliness, difference, self-criticism, and shame (Yalom & Leszcz, 2005). Furthermore, group therapy is seen as being successful in instilling hope and stimulating social and interpersonal learning (Yalom & Leszcz, 2005). These factors may help the individual engage in the therapeutic process.

Research into the change mechanisms in group psychotherapy, have found support for these factors. Qualitative studies exploring experiences of change in therapeutic groups have shown participants value the following factors: sharing experiences with others with similar experiences; receiving support from peers; and learning from others' (Bru, 2010; Mason & Hargreaves, 2001; Newton, Larkin, Melhuish, & Wykes, 2007; Wykes, Parr, & Landau, 1999). As these factors have been shown to be important across a range of

psychological interventions, it may be possible that it is these factors that enable change to happen, rather than the therapeutic model used. Group therapy may also present new challenges for individuals, or the negative aspects of the person to arise. Participants may see the group as a threatening situation, and may draw on previously learnt coping strategies, such as withdrawing from the group or becoming competitive, depending on their interpersonal style. Additionally, issues of rivalry, social comparisons, or envy may emerge. These issues may prevent individuals from engaging in the therapeutic process and developing self-compassion.

No study has focused on the change mechanisms involved in group CMT. The exploration of these factors and the experience of a CMT group programme may provide important information for developing our understanding of self-compassion, and the processes involved in its development. Furthermore, it may highlight the importance of specific and non-specific factors of CMT.

6.1.3 Current Research

The evidence base for self-compassion and compassion-based interventions is growing. Research appears to be focusing on the effectiveness of interventions rather than the understanding of self-compassion and the processes involved in its development. As CMT is focused on the development of new skills and attributes, it is important to understand how service-users may make sense of these and be able to apply them to themselves.

Without an understanding of the mechanisms and processes involved, it will be difficult to truly understand the value that self-compassion plays in the treatment of mental health difficulties. Furthermore, development of interventions also requires a clearer understanding of the processes involved. Understanding the experience of developing self-compassion may highlight barriers that clinicians need to be aware of, in order to be prepared to address these and prevent treatment dropout. As CMT is a process involving specific techniques, rather than a disorder-focused intervention, improved understanding of the processes, challenges, and barriers involved may also help clinicians identify who would benefit from this intervention. This is vital in group therapy where cohesion has a significant impact on outcome.

This study aims to explore service-users' experience of developing self-compassion through completing Compassionate Mind Training (CMT). This will include how they made sense of their compassion, the processes they went through and the experience of developing self-compassion in group therapy.

6.2 Extended Methodology

This section provides additional detail regarding the epistemological stance and rationale for the chosen methodology. There is an outline of the study procedures, including: interview schedule, sampling techniques, inclusion and exclusion criteria, and recruitment procedure. Furthermore, there is a discussion regarding quality assurance measures and ethical considerations of conducting the research.

6.2.1 Qualitative Research Rationale

There are many differences between qualitative and quantitative research; it is beyond the scope of this paper to give a full historical overview of the divergences and development of the two modes of enquiry. Consideration is given to the related differences of the philosophical underpinnings and aims of enquiry.

A significant difference between qualitative and quantitative research is ontological and epistemological positioning. At one end of the ontology spectrum lays the belief that there is an objective reality that can be sought. This naïve realist ontology traditionally informed a positivist epistemological position. The belief that knowledge is gained through the testing of hypotheses that can be observed, measured and objectively analysed, lent itself to quantitative methodologies (Guba & Lincoln, 1994). Over time, the focus of some quantitative research has shifted towards a post-positivist position, in which falsifying hypothesis became the aim of enquiry (Guba & Lincoln, 1994). Within this movement researchers started to recognise the interpretative aspect of the production of knowledge (Ryan, 2006). This shifted the position along the spectrum towards critical realism.

At the other end of the spectrum lies the belief that there are multiple realities constructed, based on historical, social, and cultural influences (Bilgrami, 2002). This relativist ontology informs a range of constructivist and interpretive epistemologies (Smith, 2003). This stance favours qualitative methodologies, which are concerned with gaining individuals interpretation of phenomenon (Ashworth, 2003). The dynamic relationship between the researcher and individual, throughout the knowledge gaining process, is also acknowledged within this stance (Schwandt, 1994).

Although, qualitative and quantitative approaches are often classed as being opposed to one another, it is important to see past this and consider how they actually complement each other. This is vital with the increasing emphasis on evidence-based practice.

The vast majority of research into psychological treatments has focused on the evaluation of outcomes. As has been shown, the research into CMT has concentrated on its effectiveness of reducing symptoms and increasing self-compassion. This has mainly consisted of the use of psychometric outcome measures, which have been tested for validity and reliability. It is this accepted ability, to measure the rigour of results, which has resulted in the greater reliance on quantitative methodology. One of the criticisms of qualitative research is that the rigour cannot be tested. However, this is an inaccurate assumption and the focus within qualitative research is on the trustworthiness of the findings. There have been many proposed methods of testing the trustworthiness of qualitative research, which will be discussed later. Therefore, qualitative research should also be considered important evidence, based on its quality.

Evidence should not only be based on the questions of 'what', 'when' and 'where', that quantitative research aims to provide, it should also be based on the 'how' and 'why', which qualitative inquiries seek (Jones, 2002). In a review of evidence-based practice, Hollway (2001) pointed out that 'evidence' needs to be based on a variety of different formats and that practitioners should not become complacent about the types of evidence they use. Qualitative research can provide a flexible approach to understanding and evaluating treatments.

The Department of Health (2001) clearly stated research on treatments and services need to be informed by service-users' perspectives. Qualitative methodologies can provide an effective means of exploring these perspectives. Furthermore, it is important to consider that service-users may evaluate the effectiveness of the treatment they have experienced in a way outcome measures may not be able to determine. Without openly asking service-users about their experiences, it may not be possible to fully understand how interventions facilitate change. Qualitative studies have started to provide insights into this therapeutic process (Hodgetts & Wright, 2007). Tapping in to service-users' unique knowledge and experiences will not only contribute to our understanding of theories and practice, but help tailor treatments to the needs of service-users (Jones, Hughes, & Ormrod, 2001).

6.2.1.1 The study of Experience

Human experience is the main epistemological basis for qualitative research. The qualitative tradition defines the notion of experience differently to the quantitative tradition. The scientific conception of experience is that it is an object that can be tested, validated and standardized. Within the qualitative tradition the object of study is that of a person's lifeworld as it is lived, made sense of, accomplished and felt. Using qualitative methods to observe and inquire about experience research can reveal, describe, recount, represent, and map a phenomenon as it was lived or undergone by a particular subject in a particular circumstance. Merleau-Ponty (1962) wrote, "The world is not what I think, but what I live through" (pp. 16-17). If one wants to study the world as lived through, one has to start with a "direct description of our experience as it is" (p. 7).

The concept of lived experiences (translated from the German Erlebnis) has been discussed in the works of Dilthey (1985) and Husserl (1970). It is the intent to explore directly the pre-reflective dimensions of experience. Dilthey described lived experience as a reflexive or self-given awareness that inheres in the temporality of consciousness of life as it is lived. Husserl (1970) stated that "all knowledge 'begins with experience' but it does not therefore 'arise' from experience" (p.109). He described a lived experience as having a

transformative effect on the person. Lived experiences can be seen as something that befalls, overwhelms, or strikes a person, and it can be understood more actively as an act of consciousness in appropriating the meaning of some aspect of the world. Thus, lived experience should form the starting point for inquiry, reflection, and interpretation.

The current study aims to understand how participants make sense of their experience of developing self-compassion through CMT. As the research aims to be exploratory and generate knowledge, informed by service-users' understanding of their experience, it is well suited to a qualitative methodology.

6.2.2 Epistemological Position

The following section considers the epistemological stance the researcher took during the course of the study. It is important to consider this as it guided the design of the research, including the selection of Interpretative Phenomenological Analysis (IPA) as the methodological approach. The researcher employed a critical realist position. To understand why this position was taken a review of different paradigms will be discussed.

The positivist paradigm follows a realist ontological view, which assumes that a reality exists. This reality can be understood by testing beliefs and when found to match reality they become truths (Niiniluoto, 1999). Additionally, the researcher and the object under investigation are seen as being independent of each other. At the other end of the spectrum, the constructivist paradigm follows a relativist ontological view. This assumes that there is no absolute truth and that multiple realities exist (Guba & Lincoln, 1994). Reality is made up of different constructs, dependent on the experiences of the individual. Thus, the knowledge gained through research will be influenced by the interaction between the researcher and the object (Willig, 2008).

Between these two extremes lies critical realism. This stance implies a reality exists, which is independent of conceptualisations (McEvoy & Richards, 2003). However, it applies a critical stance towards being able to obtain

actual truths and accepts that observations are fallible, as our conceptual frameworks, which are socially determined, shape them. Thus how individuals experience the world will differ. It is these interpretations of the world that may lead us closer to the truth. Although a form of realism, it follows the view of a constructionist approach, in that it recognises the role of subjectivity in the production of knowledge.

As the aim of the research is concerned with the participants' experiences of a reality not the reality itself, it is congruent with a critical realist stance. Within the critical realism paradigm, multiple plausible truths are acknowledged; therefore, participants' account of their experiences were accepted as their truth. Furthermore, critical realists are also concerned with obtaining knowledge about underlying causal mechanisms (McEvoy & Richards, 2003), also the aim of the study.

6.2.3 Research Methodology

Since qualitative research has been shown to be an acceptable way of developing knowledge there has been a growing body of approaches. Each of these approaches is informed by different ontological and epistemological stances (Willig, 2008). It was important to consider which of these methods would be the most appropriate for answering the aims of the research. The researcher needs to be familiar with the origins and details of different approaches in order to select the most appropriate method (Starks & Trinidad, 2007). Therefore, the methodologies considered are briefly outlined below and a rationale of why they were not selected is given.

6.2.3.1 Thematic Analysis

Thematic analysis (TA) is a widely used qualitative method, which consists of identifying and analysing patterns within a data set (Braun & Clarke, 2006). It consists of searching for themes that are important to the description of a phenomenon. Unlike other methods it is not connected to a pre-existing theoretical framework. It can be used flexibly to develop knowledge about reality, from a deductive top down or inductive bottom up approach. There are also two levels of analysis. Semantic analysis primarily focuses on

meaning of what is being said. Latent analysis focuses on ideas and assumptions, theorising what may have shaped what was being said (Braun & Clarke, 2006). It may be argued that an inductive latent TA method of analysis is similar to IPA. TA does not stem from a particular theoretical or philosophical underpinning and it is this that separates the two methods of analysis. For the purpose of this study, it was felt that the phenomenological and hermeneutic roots of IPA were important to understand lived experiences of developing self-compassion. Furthermore, within the traditional framework of TA, there is limited acknowledgement of the impact the researcher's own interpretations and experiences have on the analysis. As the researcher had prior experience of delivering CMT, this was important to acknowledge within the hermeneutic cycle. Therefore, TA did not fit with the epistemological stance and beliefs of the researcher.

6.2.3.2 Grounded Theory

Grounded theory (GT) aims to examine personal experiences in order to construct a theory (Charmaz, 2001). Within GT the aim is to initially analyse an individual case to develop interpretations, which are created into more abstract conceptual categories, to build a theoretical analysis. It is an inductive process in which the researcher can shape and alter the method throughout the study in order to pursue specific strands. Like TA the researcher is seen as independent from the data, disengaging from their own perceptions. This is helped by delaying the review literature until after the analysis. As the researcher had explored the theoretical bases of CMT prior to the study this would have affected the analysis process. Additionally, as the aim of GT was to generate a theory it was considered to be incongruent with the study's aims. The aims of the study were more exploratory as there was yet no literature on service-user experience of developing self-compassion.

6.2.3.3 Discourse Analysis

Discourse Analysis (DA) is a qualitative method that follows a social constructionist position and considers the importance of language (Potter & Wetherell, 1987). DA views language as a behaviour that is dependent on context. Thus, it is interested in how a message is conveyed in a given situation rather than the meaning of what is said. Although, it does take in to

account the researcher's position within the analysis, it was not considered appropriate for meeting the aims of the study. Nor did it correspond with the researcher's epistemological position.

6.2.3.4 Narrative Analysis

Narrative Analysis (NA) is interested in the way individuals use stories to interpret the world (Lawler, 2002). A narrative is classed as a social product that is influenced by the social, historical, and cultural context. NA is concerned with how individuals link events to make them meaningful to others (Reissman, 2005). These events need to have a beginning, middle and an end. Although a useful approach for exploring how individuals make sense of the world, it was not applied, as service-users may not identify an ending to their experience. Again this methodology is aligned to relativist ontology and thus distinct from the researcher's own ontological and epistemological view.

6.2.3.5 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) aims to offer an insight into how an individual makes sense of lived experience (Smith & Osborn, 2008). It embraces the concept of the researcher's own conceptions and interpretations being involved within the analysis process (Smith, Flowers, & Larkin, 2009). IPA adopts a flexible approach to explore in detail a phenomenon, paying particular attention to what it was like for that individual, due to its idiographic sensibility and inductive process. This enables both shared themes and individual variations to be considered. When connected to existing literature they can make significant contributions to our understandings.

With this in mind IPA was selected as the most appropriate approach for meeting the aims of the study. The philosophies behind IPA are also concurrent with a critical realism stance.

6.2.3.6 Theoretical Underpinnings of IPA

IPA has two main aims: to describe the individuals' world and develop an interpretative analysis of that world situated in the wider social, cultural, and

theoretical context (Larkin, Watts, & Clifton, 2006). It is able to do this by drawing on the philosophies of phenomenology and hermeneutics (Smith, 2004).

Phenomenology is a philosophy interested in what the experience of being human is like, and how we make sense of our life-world. The founder of this philosophy, Edmund Husserl, saw phenomenology as an in depth and rigorous approach to finding the essential qualities of an experience. He believed if this was possible, it might illuminate a given experience for others too (Smith et al., 2009). Within this, he saw what is experienced as being within the conscious of the individual and thus there is an 'intentional' relationship between the process occurring in the consciousness and the object of attention (to form the life-world). This was a move away from the positive paradigm, as the experience cannot be studied objectively. Husserl, proposed that for this to happen, instead of ignoring our own prejudgements and prior knowledge about a phenomenon, these should be recognised and set aside (bracketing) during the research process (Husserl, 1927). However, Heidegger (1927) argued that Husserl's work was too abstract and suggested that 'bracketing' was an unattainable idea.

Heidegger's work in the field of phenomenology was noted to be the beginnings of the hermeneutic emphasis in phenomenological philosophy. Hermeneutics is the theory of interpretation. Heidegger proposed phenomenology is an explicitly interpretative activity, in that the researcher 'brings their fore-conceptions (prior experiences, assumptions, and preconceptions) to the encounter, and cannot help but look at any new stimulus in the light of their own prior experiences' (Smith et al., 2009; p 25). However, he emphasised that these fore-conceptions should not be given priority over the object being studied. Furthermore, he proposed that these fore-conceptions often only become known after the encounter with new events. Thus 'bracketing' is a cyclical process that can only be partially achieved. Within IPA reflective practice is encouraged to account for this. Furthermore, it acknowledges that double hermeneutics occurs. Firstly, the researcher makes an interpretation of the participant's own interpretation of their experience. Secondly, two interpretative positions are taken:

hermeneutics of empathy, the researcher takes an 'insider's perspective' (Conrad, 1987), and hermeneutics of questioning, the researcher questions the data (Smith et al., 2009).

IPA requires the combination of phenomenology and hermeneutics, to get close to a person's experience and understand how they made sense of it.

6.2.3.7 Critique of IPA

When selecting IPA it was important to consider the criticisms of the approach. Firstly, the idiographic nature may be seen as a weakness, as it can lead to subjective, intuitive, and impressionistic accounts of the data, meaning important variables may be missed (Malim, Birch, & Wadeley, 1992). This is often the case when novice researchers make basic interpretations and social comparisons that lack the in-depth analysis required (Smith, 2004). IPA promotes the use of a small sample size. Again, this may appear to limit the quality and application of the findings. However, as the aim is to develop a deeper level understanding of how participants make sense of their experiences, it is argued that this depth can be sacrificed when larger samples are gained. This is again particularly true for novice researchers who can become overwhelmed by the amount of data they have, and only providing a descriptive account of the data (Smith, 2004). Willig (2008) also highlighted the fact IPA favours those who are able to articulate their experiences. This may result in important information being lost due to variety of experiences not being explored. Furthermore, Willig (2008) states that talking about an experience may not mean that the experience is being described, as participants are limited to the questions they are asked. IPA studies have favoured flexible approaches to interviews to allow participants to talk openly and freely about their experience in the hope to capture the important aspects and means of that experience. While IPA does not claim that the thoughts of an individual are transparent in verbal reports, analysis is undertaken within the assumption that meaningful interpretations can be made about that thinking.

A further criticism is related to the philosophical background and nature of the approach. Particularly in relation to the hermeneutic cycle that occurs, in

that the researcher interprets the participants own interpretation of their experience. The researcher will approach their interpretation from their own world view and expectations. Meaning the they will only get out what they put in. Thus will favour and reflect the researchers view point. This makes IPA inevitably subjective as no two analysts working with the same data are likely to have the same interpretations. This has raised questions of the validity and reliability of the approach (Brocki & Wearden, 2006). It is important that care is taken to minimise researcher bias in the analysis process. Smith et al. (2009) outlined a number of ways this can be done and emphasize the need for reflexivity throughout the research (see section on quality assurance measures for more information).

Smith et al. (2009) have also developed a stepped approach of IPA to improve the consistency of analysis and skills of novice researchers. However, this has resulted in the criticism that they have tried to operationalise phenomenology and have lost the essence of qualitative research, by turning it into a prescribed method. Smith et al. insist these are guidelines that are open to adaptation and aim to open qualitative research to an audience that is familiar with using a more rigid approach to research. Furthermore, they argue it is essential that the researcher understands the philosophical roots of IPA, and it is this understanding that results in greater quality research. Giorgi, (2010) has questioned the crude nature of IPAs identity with its phenomenological underpinnings and poor following of phenomenological criteria. Meaning it is not scientific. Yet Smiths' (2011) extensive and detailed review of the literature highlights the processes for ensuring high quality within IPA research.

6.2.3.8 Summary

For the purpose of the study a critical realist stance was taken. After reviewing other qualitative approaches and despite the critiques of IPA it was considered the most appropriate method for answering the research aims. The researcher felt confident that with the support of experienced researchers they would be able to engage in the in-depth interpretive analysis of the phenomenon required by this approach.

6.2.4 Method

6.2.4.1 Sampling

As the aim of IPA is to look in fine detail at the experiences, meanings and understandings of participants, a small sample is favoured. Smith and Osborn (2008) suggested a distinctive feature of IPA is "its commitment to a detailed interpretative account of the cases included, and many researchers are recognising that this can only realistically be done on a very small sample – thus in simple terms one is sacrificing breadth for depth" (p.56). It is recommended that for inexperienced researchers, four to six interviews will enable them to engage in the depth of analysis required without becoming overwhelmed by the data (Smith, 2004). Given the lengthy process of analysis and with the researcher being new to qualitative research, a sample of six participants was considered appropriate. This was also in line with other research, using IPA to study the experience of therapy and process of psychological change (Higginson & Mansell, 2008; Murphy & Lahtinen, 2011).

A purposive sampling method was used to recruit participants. Individuals who were likely to provide the greatest insight of the experience of the phenomenon being explored were selected. This method was used as it was in line with the methodology chosen. IPA focuses on exploring a specific phenomenon in detail, thus a relatively homogenous sample is advocated (Smith, 2004). This enables the researcher to identify similarities and differences across the data to inform existing theory. Rather than creating a general theory to be applied across a population.

The sample was considered homogenous, as all participants attended a CMT programme that had the same facilitators and structure. Further homogenous characteristics were not sought in order to prevent the researcher's preconceptions guiding recruitment or analysis, or constrain the findings. Having diversity, in terms of gender, age and diagnosis, enabled the exploration of convergences and divergences between participants' experiences.

6.2.4.2 Inclusion Criteria

The following two inclusion criteria were used to identify suitable participants.

1. Had completed one of two CMT programmes run by a Community Mental Health Team in North Yorkshire.

   The service providing the programme considered service-users to have completed the programme if they had attended a minimum of 8 sessions.

2. Be English speakers.

Participants were being interviewed by an English speaking researcher. Therefore, were required to speak and understand spoken English. This was determined by whether the participant could attend and understand the CMT programme, without the use of an interpreter. As IPA is a two stage interpretation process (the participant attempts to make sense of their own experiences, then the researcher tries to make sense of the participant trying to make sense of their experiences) using an interpreter would have added a third process to the interpretation. Additionally, the service-user's personal meaning could be lost.

6.2.4.3 Exclusion Criteria

One exclusion criteria was identified:

1. Be in a high state of distress.

The decision to not include service-users who were in a high state of distress was taken to prevent any further risk to the individual. Participating in an interview in which an emotional process is being discussed may have caused the participant more distress. If at the time of gaining consent the interviewer felt the participant was in a high state of distress and the interview would cause further upset the participant would have been excluded from the study. The interviewer used their clinical judgment when making this decision.

All participants were deemed able to participate in the interview.

6.2.4.4 Compassionate Mind Training Programme

Participants were recruited from two CMT programmes run by a Mental Health NHS Service in North Yorkshire. CMT is classed as usual treatment for service-users within this service. Two Clinical Psychologists facilitated the groups, which were run at the same time in 2010. Both facilitators had attended training courses on CMT and group therapy, and had previous experience of practicing CMT. The programme consisted of ten sessions, which were two and a half hours long and conducted on a fortnightly basis. Each session was divided into two parts, teaching on the theory of CMT and experiential skills practise, which were separated by a break (see Appendix A for session plan). Service-users were also set tasks to practise and develop their self-compassion between group sessions. All service-users who attended the groups were assessed prior to starting the programme. This ensured service-users' were able to complete the full programme and were suitable for the group environment. Post group assessments were conducted four to six weeks after the last session. This allowed the service-users to reflect on their experience and any changes that occurred. Pre and post psychometric assessments, administrated by the programme facilitators, were used to measure the service-users' level of self-criticism, compassion, depression and anxiety before and after the group. As the researcher was independent of the service, access to this data was not available.

6.2.4.5 Ethical Considerations

The study was reviewed and given a favourable opinion and approval from Nottingham Research Ethics Committee One and the NHS Trust's Research and Development Department (Appendix B).

The following ethical considerations were addressed prior to the research commencing.

6.2.4.6 Informed Consent

Informed consent ensures that participants are made aware of all aspects of the research prior to agreeing to participate. It is the responsibility of the researcher to inform participants of what will happen during their direct

involvement in the research and with the data afterwards. This information may affect whether the participant chooses to become involved in the research.

The informed consent was obtained from all participants after being given the opportunity to read an information sheet and discuss the study with the researcher. Participants were also given the opportunity to ask questions prior, during and after the interviews. The procedures for the interview and the requirement for these to be audio-recorded and transcribed were discussed. Participants were informed of the rationale for anonymous quotes being used in the write up of the study. They were also informed about confidentiality issues, their right to withdraw and any potential risks or benefits of taking part.

Each point on the consent form was discussed prior to the participants signing it (Appendix C). The researcher used their professional judgment to assess the participants' capacity to give informed consent, following the Mental Capacity Act (Department for Constitutional Affairs, 2007).

6.2.4.7 Confidentiality

Participants were informed that their participation in the research, and the content of their interview was confidential and would not affect the services they were receiving. They were made aware that confidentiality may have to be broken if they disclosed anything that may put themselves or others at risk. The facilitators of the group were not informed who was participating and did not read the transcripts, to prevent participants being identified. Participants were assigned a pseudonym which was used in the transcription of the interviews and for quotations in the write up of the study. Names of third parties and places were either omitted or made anonymous (for example the facilitators names).

6.2.4.8 Information Management

The data, including demographic information, interview recording and transcripts, were stored in locked filing cabinets. The recordings and transcripts were stored on an encrypted CD and all files were password

protected. All data will be securely stored for seven years at the University of Nottingham in accordance with the University's Research Code of Conduct.

6.2.4.9 Risk of Harm

When developing research the possible risk of harm needs to be considered both for the participants and the researcher. There was a possibility that the interviews would cause the participants distress. The participants were informed of the areas that would be covered in the interview so they were aware of what might cause them distress. They were also informed that they had the right to refuse to answer any question that they did not feel comfortable with or could stop the interview at any point. If a participant did become upset the researcher ensured they were happy to continue with the interview. A debrief period followed each of the interviews. The researcher had the opportunity to contact one of the facilitators of the CMT, with the participant's consent, if they felt the participant needed further support after the interview.

In order to reduce the risk to the researcher all interviews were conducted at an NHS base, where other members of staff would be on hand if necessary. The researcher was also able to access supervision after an interview, if they felt it necessary.

6.2.4.10 Data Collection

In order to capture how service-users experienced the development of self-compassion and made sense of the changes that had occurred, one-to-one interviews were conducted. A focus-group method was also considered as it can provide an opportunity for multiple voices to be heard at once, which can provide rich experiential data (Palmer, Larkin, de Visser, & Fadden, 2010). However, as the focus of the study was on how the participants have made sense of their personal experience, a group format may have prevented these stories from being heard and lead to more of an evaluation of CMT. Therefore, a focus-group method was not adopted.

The interviews were supported by a semi-structured schedule. This allowed the interviewer to remain focused on the aim of the study, whilst remaining

open to the participant's experience. Smith and Osborn (2008) supported the use of semi-structured interviews as they believed this technique helps develop rapport, flexibility and produce richer data. The schedule design included specific questions with a series of prompts to allow for flexibility within the interviews and was used as a guide only (see Appendix D). This allowed the questions to be modified and new areas to be discovered, whilst enabling the participant to be the expert on the subject. The questions were designed to guide the participants to discuss their experiences, how they felt they had changed and developed self-compassion, and how their experience and the techniques they have learnt helped them with these changes. As the interviews were semi-structured the ordering of the questions was determined by what the participant was discussing at the time. Although the researcher was interested in the participants' experience of developing compassion, the questions were designed to be open; so that participants could discuss other factors that may have impacted on their experience.

A pilot interview was conducted, using the semi-structured schedule, with one of the facilitators of the programme. This enabled the interviewer to develop their research interview skills and assess whether the questions were accessible to the participants. Questions deemed difficult to answer were given further prompts.

6.2.5 Study Procedure

A summary diagram of the full procedure of the study is shown in figure 3.

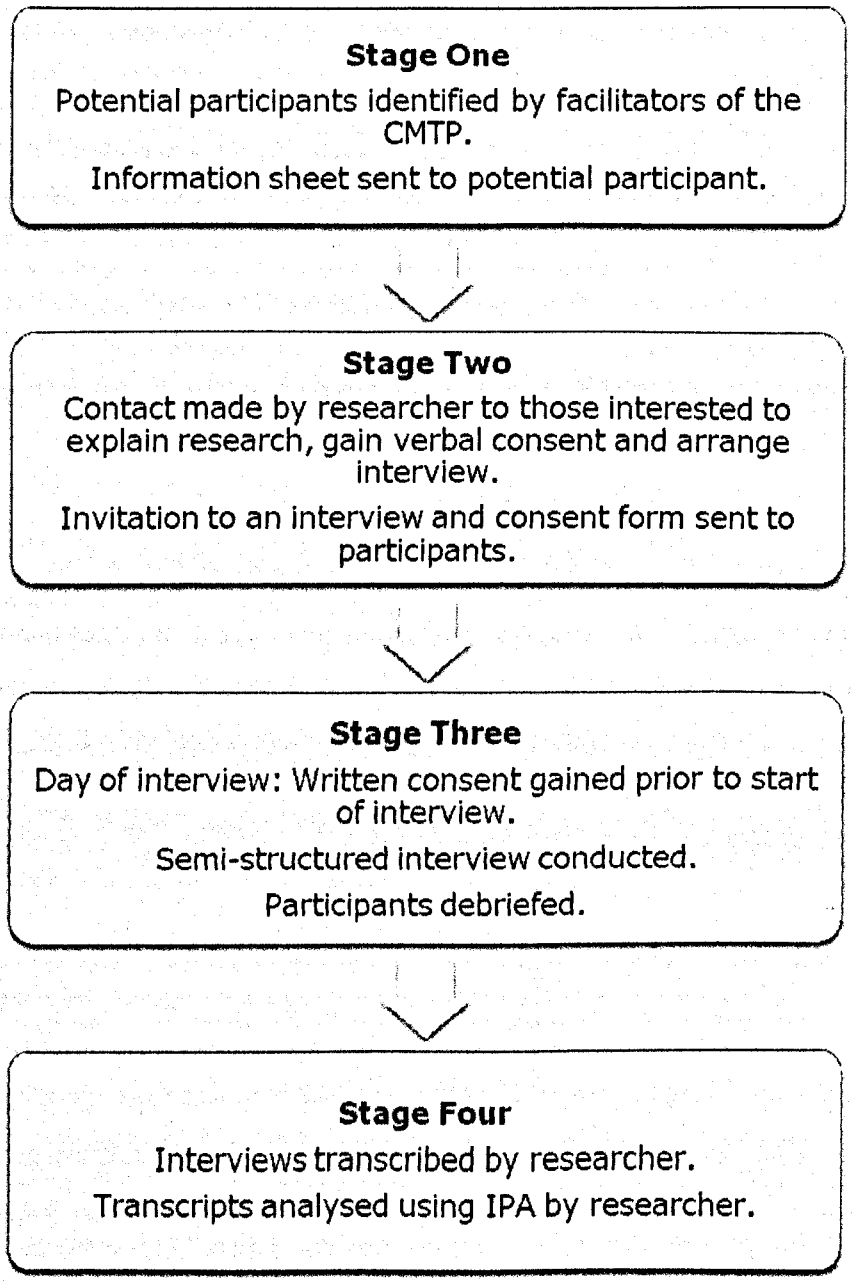

Figure 3 Flow chart of research procedure.

Stage One and Two

The facilitators of the programme identified service-users who, in their follow-up assessment, had identified that they had started to develop self-

compassion. These service-users were sent an information sheet (Appendix E) about the research, as they met the inclusion criteria. Service-users who showed an interest in participating in the research were then contacted via telephone by the researcher, to discuss the study further. During this telephone conversation the participants were informed the researcher was independent from the CMT and any services they may still have been receiving. The participants were informed their participation was entirely voluntary, and had the opportunity to ask questions regarding the research, before being asked if they still wanted to take part. The interviews were arranged, at the same location as the programme they attended, and at a convenient time for the participant. The interviews took place at least one week after contact had been made. This allowed participants time to withdraw from the study. The interview time, date and location was confirmed by letter (Appendix F), which also included a consent form. It was decided against holding the interviews at the participants' homes due to potential risk issues and the possibility of disturbances during the interview. Contact details were provided to participants in case they wished to withdraw or had any further questions.

Stage Three

On the day of the interview the researcher went through the information sheet and consent form, giving the participants chance to ask questions, before they gave written consent. Once consent had been gained participants were asked for their demographic information. Participants were informed this information would be used in the write up of the research in order to give the reader an idea of who the participants were. This information also provided insight into factors that may have impacted upon their experiences during the analysis of the interviews. The demographic information collected included their age range, gender, ethnicity, if they had a diagnosis, how long they had had this condition, and if they had received any previous treatments. After the interviews, participants were given the opportunity to discuss the interview and ask any questions they had regarding the research.

Stage Four

All digital-audio recordings were transcribed by the researcher. Identifying information was anonymised. Features such as pauses, laughter, false starts and sighs were included in the transcription (Appendix G). The transcripts were then analysed by the researcher using IPA. This process is described below.

6.2.6 Analysis

Analysis followed the five stages described by Smith et al. (2009). It is suggested a novice researcher follows these steps, whilst remaining flexible to the analysis process. Following the idiographic approach of IPA, a detailed examination of one transcript was undertaken before moving on to the next transcript (Smith, 2003). Although each transcript was viewed in its own terms, to do justice to its individuality, it is acknowledged it is difficult to 'bracket' the ideas and themes identified in earlier analysed interviews (Smith et al., 2009). The first two stages were carried out individually for each transcript. Stages three to five represent how the individual analyses were brought together.

Stage One

The first transcript was read and re-read whilst also listening to the recording in order to become submerged in the data. During this, notes were made about what was found to be interesting or significant. These notes were on three levels: descriptive, linguistic and conceptual. These notes were then examined on an interpretative level and were developed into themes that portrayed the meaning of what was being said.

Stage Two

The themes were developed into a list; this helped the researcher identify connections between the themes in order to identify clusters. The clusters were checked against the original data to make sure they were grounded within the text. At this stage some themes were disregarded as they were not related to the aims of the study. Once the themes were clustered into concepts, the concepts were then clustered together to form super-ordinate

themes. This was through a process of abstraction, in which patterns between concepts where identified. The concepts became sub-ordinate themes. A table listing all the original themes, which sub-ordinate theme they went with and which super-ordinate theme they were in, was developed. Instances of where each theme was identified within the original interview were included in the table (see Appendix H for an example). During this process themes were checked within the data and some were disregarded due to a lack of evidence.

The decision to include or disregard themes was not purely based on numeration. Factors such as; its importance within the overall account, its function within the transcript, and the researcher's internal observation of their reaction to the content of the data, were also considered.

Stage Three

Once all transcripts had been analysed, a comparison of super-ordinate and sub-ordinate themes was made between all the transcripts. A table was developed to identify similarities and differences between transcripts. Each transcript was then re-analysed to identify if it contained themes previously not identified but found in the other transcripts.

Stage Four & Five

Once all transcripts had been re-analysed a final table of super-ordinate and sub-ordinate themes was constructed (see Appendix I for summary table). This table identified which themes were represented in which transcript.

6.2.7 Quality Assurance Measures

As previously stated, qualitative research has been criticised for lacking scientific rigor, with an inability to measure the validity and reliability of its results. There has been considerable debate about whether the quality of qualitative research can be established, and what procedures should be used (Flick, 2007). Criteria for evaluating quantitative research is not applicable to

qualitative research as it is not in line with the epistemological underpinnings and fundamental aims of qualitative research (Willig, 2008).

Due to the variation in qualitative approaches, there is no single set of quality assurance measures. However, what has been established is that focus should be on the trustworthiness of the study by making the process of analysis visible and auditable. Yardley (2008) outlined a number of procedures for ensuring the credibility and trustworthiness of research. These were considered throughout the study. More recently Smith (2011) produced guidance on measuring the quality of IPA research. These were also considered and the procedures followed are described below.

6.2.7.1 Reflexivity

Engaging in reflexivity is imperative within qualitative research as it addresses the implication of the researcher and the researched (Shaw, 2010). Reflexivity has been defined in many ways, but in essence refers to the need for the researcher to recognise their role within the research process (Shaw, 2010). As IPA is an interpersonal process and involves the interpretations of the researcher, it is essential, for it to be credible and trustworthy, that this process is specifically addressed (Smith et al., 2009).

Prior to the research commencing I kept a reflexive diary of my personal assumptions, experiences, training and beliefs about CMT and of conducting research. This helped identify ways in which I may influence the study, such as my prior experience of practicing CMT. I also used it to reflect on how my role as a Trainee Clinical Psychologist might impact on the interviews, both in the way they were conducted and participants' experiences and views of psychologists. After each interview I recorded my reflections. This included the mood of the interview and my reactions to participants. The diary was also utilised throughout the analysis process, to acknowledge how my preconceptions may have influenced the developing themes. The aim of this was to increase my awareness of my assumptions rather than bracketing them off (Smith & Osborne, 2003; see Appendix J for extracts).

As part of this reflexive component of this approach it is also important to identify personal influences that may impact on the research process. Therefore, a brief reflexive account of my roles is provided so that the reader is able to judge the degree to which the results may have been influenced by my personal world-views.

I am a 28 year old white female trainee clinical psychologist, who takes an integrative approach to my clinical practice. Having worked in different fields of psychology I have drawn from a range of psychological theories such as attachment, cognitive-behavioural, psychodynamic and systemic. I was intrigued by theories surrounding compassion during my early development as a psychologist. This led me to explore compassion on both a personal and professional level. Having only used CMT on an individual basis, but having run different forms of therapeutic groups I was interested in how CMT could be adapted to a group format. I was not involved in the service or the planning, facilitating or evaluation of the CMT programme, in which participants were recruited from. Being engaged in compassionate practice does influence my personal viewpoint, yet I maintain an open critical awareness of the challenges surrounding this concept. Furthermore, prior to this research I had limited opportunity to employ qualitative methods. Therefore, this was an opportunity to broaden my research knowledge and skills.

6.2.7.2 Grounding in Examples

Transparency is vital as it highlights the analytic decision making process in order for the analysis to be assessable and auditable (Baxter & Eyles, 1997). During the analysis, an audit trail was created to show the decision making process the researcher went through. This included each stage described above. Using multiple extracts from the transcripts in the write up of the study enables the reader to see how the themes are grounded in the participants responses. This transparency allows the reader to witness the interpretations made and decide themselves whether the conclusions drawn are indeed trustworthy.

6.2.7.3 Credibility Checks

In order to minimise data misinterpretation it has been suggested that member checks or triangulation should be used (Elliott, Fischer, & Rennie, 1999). Member checking involves returning the analysis to the participants who provided the data to assess whether the researcher's interpretations maintain their original meanings. Triangulation involves cross-checking interview data (i.e. themes) with different methods of data collection or quantitative data to validate the interpretations (Olsen, 2004). It can also be used to corroborate researchers' perspectives to strengthen the understanding of the findings (Yardley, 2008). Neither of these approaches was used.

These approaches do not match the epistemological stance of the researcher or the theoretical underpinnings of IPA, as these approaches can be perceived as trying to find a 'truth' (Ponterotto, 2005). It is possible that the participants may have disagreed with the researcher's interpretation or different researchers may have interpreted the data differently. This does not mean that the researcher's interpretations are incorrect as it is in line with their critical realist approach, which accepts that multiple truths exist. Furthermore, the participants own interpretations of their experiences may have changed since the interviews and would be viewing their original meanings differently. This would also add a further level of interpretation, which is inconsistent with the double hermeneutics central to the IPA process. This does mean that IPA privileges the researcher's interpretations, which is a strength and weakness of the double hermeneutic cycle. Furthermore, although participants did complete pre and post-qualitative measures as part of the programme, this data was not available to the researcher.

6.2.8 Challenges during Research Process

The following section addresses some of the challenges faced by the researcher and the actions they took to overcome these during the recruitment and data collection process.

Challenge: Access to digital audio recorders and transcription kits was limited.

Actions: Liaised closely with other trainees and administration staff to make sure recorders were available when booking interviews. Learnt how to transcribe the interviews without the use of the transcription kit (for example using keys instead of a pedal).

Challenge: Building rapport with participants in a limited period prior to the interviews.

Actions: Telephone contact was made with all participants to enable them to become familiar with the researcher. Used clinical therapeutic skills to engage with participants and ease their anxiety.

Challenge: Participant talking generally about the CMT

Action: Prompts were used to encourage participants to talk more specifically about their experiences.

Challenge: Maintaining confidentiality, as interviews were conducted at the same location as where the programme facilitators were located.

Action: Interviews were arranged, where possible, when the facilitators would not be on site.

6.3 Extended Results

This section analyses the two remaining super-ordinate themes; Group Experience and Negotiating Change. These additional themes were not included in the journal article, as they relate to experience of developing self-compassion in a group format and general change processes. These themes have additional subthemes. An in-depth exploration of the themes will be described and supported by further illustrative quotes from participants.

6.3.1 Group Experiences

This super-ordinate theme relates to participants experience of the group process and includes three subthemes; group functional factors, internal views of the group, and commonality, identifying with others.

Group Functional Factors

When describing the experience of being in a therapeutic group, all participants talked about the following functional aspects of the group; support and encouragement, safe place, facilitator factors, learning from others, and putting theory into practice. Negative aspects of the group included; time restrictions and loss of support.

Participants identified the support and encouragement received by the facilitators and peers within the group, aided their development of self-compassion. This was important as the group focused on distressing experiences, which may have triggered their normal defence strategies, such as disengagement. Having support enabled participants to stay with their emotions, which consequently developed their compassionate skills.

> **Emily:** If someone was upset and you gave them that support and you just, you know, put your hand on their shoulder, that made them feel good and it makes you feel good as well.

Emily highlighted the emotional and physical nurture within the group. Both receiving and giving nurture enabled Emily to experience the warmth and kindness of compassion. This helped her recognise she was able to show

compassion. The encouragement within the group was also thought to assist participants in recognising the changes that they were making. Ruth, Emily and Sarah all discussed this in their interviews and highlighted how others recognised their compassion, even when they could not. This encouraged them to continue practising the techniques and make changes to their lives.

> **Ruth:** ... and people have noticed and had said 'well your just completely different'...

The majority of participants identified the group as a safe place, where they were able to share with their peers. However, Dawn had difficulty with this and it greatly affected her experience. She illustrated how the difficulty with trusting others in the group prevented her from opening up and experiencing compassion.

> **Interviewer:** What was that like, to feel compassion from others?
>
> **Dawn** ... erm it felt it felt good but again I think I had trouble trusting that even, it felt like they don't know me so is it real? Um and I think in a way I was scared of it because it would um it's really messed up, but, isn't not like they were compassionate to this vulnerable side of me.

Dawn appeared to be unable to trust the compassion from the group as being 'real', implying that she either did not deserve this or that it was false, as she was not sharing her true self. This made the group an unsafe place for Dawn as she did not see others as being honest and trustworthy. The belief that she did not deserve compassion from others prevented Dawn from fully developing her self-compassion.

All participants positively described the impact the two facilitators had on their experience. They felt that they both took time to really listen, understand, and show an interest in everyone in the group, which made the group feel safe.

> **Rebecca:** ... they didn't put pressure on you to do anything really, erm ... they were really encouraging and supportive. If you don't

get something they would try explain it in a way you could, or if you struggled with a technique then they would help you.

Rebecca describes here how the facilitators modelled compassion. By removing the pressure she would normally place on herself, Rebecca felt safe to share, learn, and try new techniques. This also allowed her to experience the nurturing she never received as a child. Peter also felt a lovely 'motherliness' from the facilitators, which was a contrast to his own critical mother experience. Having this within the group, helped him to experience what he had been longing for during his childhood.

Peter: ... I think there was a bit of motherliness from [facilitators] which was lovely [...] it was nice and gentle and I think that ... again helped.

All participants stated that they enjoyed the group discussions, as they were able to learn from each other. There was a sense that participants had difficulty accepting the theoretical information and relating it to themselves, until they were able to share their understandings with each other and actually experience compassion.

Sarah: But I couldn't really see how it really related to me. It wasn't until we had a group discussion and other members of the group were talking about their histories and their problems, that is sort of clicked and got me thinking about what I had been through.

Emily: ... when I read the books at home and go back over the information it's quite difficult to take in, I think because you have a group of people and you can talk about things amongst yourself ...

Sarah had a detached view of how the theoretical element of the programme related to her, which suggests she may have detached from her own experiences. It was not until Sarah discussed her past, she reconnected with the experiences and recognising the lack of nurture in her past. Emily also reflected how she was able to connect her experiences with the theory. All participants liked the fact that the group had two elements; the theoretical

side of compassion, and the practical techniques. Participants felt this enabled them to use what they were learning there and then. Peter, Ruth, Dawn, and Emily talked about how practising the techniques in the group helped make sense of the theoretical information.

> **Peter:** ... with this group there's things that slip in because you're talking about, your mapping your brain, you're er you're understanding its makeup and how it works and you're also er literally being compassionate to each other...

Peter uses the term 'slip in', suggesting he did not have a cognitive awareness of the skills and information he was absorbing. These were new ideas to him, which helped him make sense of his experiences and the feeling of compassion. This also suggests, Peter was developing self-compassion despite himself and he could not avoid the compassion within the group situation.

When participants struggled to master a technique it provided a good opportunity for them to practise what they had been learning. Being able to see their difficulties with a compassionate sense, prevented participants reverting to old coping strategies.

> **Sarah:** I know why I was really struggling to do the exercises [...] I remember sitting there think 'I must not let go, I must not let go' and then someone else was talking about something and I could feel a tear [sigh] running down my cheek. Now usually I would have got very angry with myself, but for some reason it felt ok and it it felt ... normal.

Within this quote, Sarah is re-experiencing the feelings she had in the group when she allowed herself to release her sadness. Previously, Sarah may have tried to avoid her emotions and misattribute her feelings of sadness, so that she did not appear weak or vulnerable. Anger was an emotion that felt more comfortable for Sarah. It was easier for her to express anger than to tolerate the distress sadness brings. However, in this instance she allowed herself to

express and accept her emotions rather than become critical of herself, instead feeling 'normal'.

Group functional factors participants found difficult to cope with were, time restrictions and the ending of CMT. All participants felt that the programme was too short and they struggled to cope when it finished, in terms of both the length and number of sessions. Ruth identified that she would have benefited from more time within the sessions to discuss the process they were going through. For Dawn, Peter, and Rebecca, there was a sense that they did not feel ready to 'go it alone' after ten weeks.

> **Rebecca:** It felt like we had gone through this journey together and it was sad that it was ending just like that, and we weren't going to see each other again. You know, it felt like I had shared a part of myself in the group and when it ended it was as if I had lost it ... lost a part of me ... lost the support and the comfort I received.

Most striking in this extract is the sense of grief. For Rebecca, the warm, comforting, safe environment was taken away from her; something she had never experienced before. She was faced with the reality of losing the external compassion in her life, before she had fully internalised it and be able to do it on her own.

Internal Views of the Group

This subtheme relates to individual views and experiences of being in a therapeutic group situation, which for four of the participants was a new experience. It includes: feelings of being outside the group, fragmentations within the group, and comparing oneself with others.

The feeling of being on the outside and looking in on the group was illustrated by Dawn and Emily. These participants were in different groups yet both felt on the outside of their group. They attributed this to the fact that they were quieter and at times felt stifled by other group members, when they wanted to join in discussions.

> **Dawn:** ... it made me um sort of withdraw into myself but wish that I could talk about things, because things were coming to my mind but um there was people in the group who were a lot more talkative and vociferous I suppose ...

Within this quote, Dawn perceives other group members as a threat. This triggered her belief about being inferior to others, vulnerable, and not deserving of attention or compassion.

> **Dawn** ... I think about half way through I started talking a bit more, but I think instead of improving it it [the fear] got worse again. Maybe I felt more self-conscious because I had started opening up in the group and feeling safe, so I frightened myself and went back in. It's not like I upset or disgusted anyone, if anything they were supportive.

For Dawn it was not just the threat of others, but it was also the threat to herself, that prevented her from being able to talk freely. Within her interview, Dawn emphasised how others in the group were strangers, she had difficulties trusting. Her fears of being judged and rejected prevented her from becoming part of the group. When Dawn tried to share, her old defences were activated, she shut down again. Dawn appeared to be unable to use the safe environment and supportive responses, to overcome this fear.

Although all participants enjoyed the group situation, not all participants felt like they were always a part of the larger group. Three participants talked about a clear splitting within their group. This influenced their ability to talk openly and freely.

> **Ruth:** ...I didn't want to upset her [group member] [...] it... it was like she wasn't part of group and by saying something it would alienate her, so we [other group members] tended to discuss it over the coffee (breath) because it was easier. It's not easy being the outsider.

Two points stand out in this quote. Firstly, concern for other people and not wanting to upset others, was a common theme within Ruth's interview. This often led to Ruth's own needs not being met and she felt afraid of sharing her own experiences. Secondly, 'it's not easy being the outsider' is an empathic statement; here, Ruth appears to be drawing on her own experiences of being on the outside and relates to the feeling of alienation. She goes on to explain how this had an impact on her experience.

> **Ruth:** ... for me it was like we we ended up almost having a separate group of three cause we just really got on so well together ... yeah the compassion between that little group was really good. But the compassion within the whole group wasn't as good.

The sub-group provided a safer environment for Ruth to express and receive compassion. However, sub-grouping meant others were prevented from sharing in this experience and could have been viewed as a threat.

The group also provided an opportunity for participants to compare their situations, experiences, and feelings with others. Although this aspect of being in a group enabled participants to gain a sense of commonality, which is later explained, it also produced negative outcomes. Peter, Dawn, Emily, and Rebecca often made comparisons of themselves with other people within the group. For Peter, Dawn, and Rebecca this was related to comparing their abilities with others. At times, this fed into their undermining self-criticism resulting in feelings of jealousy and worthlessness.

> **Peter:** ... I think I envied the er maybe the release or the er ... maybe it was the achievement actually, [...] that other people had when they cried.

Peter alludes here to feelings of failure; he sees crying as an 'achievement', not as a bodily response to emotion. This was a critical period in the interview, as Peter described still longing to experience that release of emotion. Here Peter was on the edge of his emotions, but he could not find the self-compassion to safely experience them.

> **Rebecca:** ... I was I was sad that I didn't make the improvements that others made.

Rebecca compared her journey of self-compassion development in terms of the improvements she could see others making, rather than focusing on her own development. As with Peter, there is a hint of competition within this statement, suggesting that their self-critical parts were still present. Being in a group increases the chances of comparing and competing with others, which adds an additional barrier to enabling the compassionate-self to balance the critical-self. Alternatively, these emotions presented as excellent real life challenges for the participants to test their self-compassion.

> **Emily:** ... a couple of people there, when we were sat talking and, you know [...] I didn't want to judge anybody, but it's like 'I would not want your life, I would not want to be you' and it just seemed like they were in a really really bad place really bad place erm. That's a horrible things to say but, ... it just made me really sad it made me really ... It made it made me feel that I'm not as bad as I thought I was. And that was hard to get through.

Here, Emily is judging others' lives as being worse than hers, which provides disconfirmation of her original fears. Initially, Emily had a sense of relief. However, this was coupled with feelings of shame and sadness. The shame was related to her judgement of others, but the sadness was seen to relate to a sense of loss of identity, possibly leaving her questioning who she was. Emily needed to use her compassion to recognise that these feelings were ok so she could move forward.

Commonality, Identifying with Others

This sub-ordinate theme relates to the participants feelings of commonality and ability to identify with other members of the group. This presented throughout all interviews as a vital and positive part of their overall experience of the CMT programme.

The feeling of commonality with others helped to normalise participants' past experiences, thoughts, and emotions, and the difficulties they were having with developing their self-compassion.

> **Emily:** ... the people who were there, erm very ordinary people, ... I feel like because I'm different in my head, that I'm different on the outside as well and I'm I'm not I'm just ordinary like everyone else was.

Emily demonstrates how this normalisation transformed her view of herself. Her view appeared to have moved from being different, to seeing herself like others. This was related to the fact that she could see others also had difficulties but they appeared 'ordinary' to her.

> **Rebecca:** I suppose it was the first time I ever thought that there may be other other people who also have difficulties. Oh how selfish of me to think that I'm the only one. But yeah I did I really did think like that. That no one could possibly understand what I'm going through because I'm so different, you know I'm so bad. [...] Not only had these people been through similar things to me but they also felt the same and had similar thoughts (sigh).

This emotional shift from feeling alone to belonging helped Rebecca move from being self-critical to self-compassionate. She was able to recognise the emotions connected to her self-critical beliefs of seeing herself as something special, which she was able to refocus with self-compassion, empathy, and a sense of belonging. The sigh at the end of the extract highlights how Rebecca is re-experiencing the sense of relief she had when realising she wasn't alone.

> **Emily:** ... if I did speak about something it probably wouldn't shock other people in the group, erm and you didn't really have to think too much about what you were saying, cause the chances are another person in that in that group has probably been through exactly the same.

Furthermore, Emily discussed how the worry and shame of upsetting others was removed as they shared experiences everyone could identify with.

> **Peter:** ...It was soo good to be able to share those .... [sigh] to say 'I've got a problem' and to say it to somebody else who says 'I've got a problem too' and to say and to be able to have common ground ...

Furthermore, Peter was able to gain reassurance that his problems were real and he was not alone. Additionally, Peter mentioned that they were on 'common ground'; which suggests he felt he did not need to compete with or feel inferior to others. Dawn, Peter, Ruth, and Sarah all discussed how seeing others having similar problems with using the techniques, to develop their self-compassion, prevented them from becoming self-critical.

> **Sarah:** ... I blame myself a lot for not being able to do or understand things and having others around who also didn't understand or had difficulties doing the techniques again made me feel less guilty.

> **Peter:** ... um seeing other people having those basic problems was really nice and er and really slightly reassuring and um ... helpful.

> **Rebecca:** Hearing that other people found it hard too, again, that I'm not ... not the only one. Yeah that was nice. Normally I would have just given up.

These quotes identify the shame and guilt participants felt, when unable to master a technique instantly. However, witnessing others having similar problems normalised this experience, preventing their old coping strategies from emerging and allowing them to maintain their engagement.

Although all participants had concerns about being in a group situation, the commonality they felt removed these concerns. This made the experience enjoyable, by allowing participants to open up to one another and engage with the process of developing compassion.

> **Sarah:** But they didn't feel like strangers, I felt we connected somehow, I don't know how, it yes it felt right.

Having this connection enabled participants to develop a sense they were valued and needed.

> **Peter:** ... I do remember one time [facilitator] had brought in um a little er cymbals [...] and I remember she tried to get our attention and she 'dinged' them but she was just doing that little pause and smile because it was awkward, and I thought well that's that's lovely seeing that human being thing that, you know that she's a bit awkward too.

Peter was also able to experience a shared awareness with the facilitator of the group. Witnessing another person experience the same awkwardness helped to normalise the embarrassment and shame Peter regularly encountered.

6.3.1.1 Summary of theme three

Overall participants found being in a group a challenging but valuable experience. The way the group functioned provided the opportunity for participants to be able to explore and develop their self-compassion, in a safe environment. It provided support and encouragement within the group, and the modelling from facilitators, enabled participants to directly experience compassion. Participants were able to learn from each other's experiences, preventing them feeling shame when struggling to develop self-compassion. The most valued part of their experience was recognising that they were not alone. The opportunity to share their experiences with others who could truly understand, enhanced their self-compassion. The feelings of being isolated and different were removed and replaced with feelings of being 'connected' and 'ordinary'. However, negative factors were also identified by participants. Fragmentations within the group made an intimidating and unsafe place for some participants. They were able to compare themselves with others, which may have added to their negative self-views. Although this presented as a challenge for some participants, others were able to balance their critical-self

with their newly developing self-compassion. It is important, this balance is created within the group to prevent self-criticism being reinforced.

6.3.2 Negotiating Change

In addition to the processes identified in the development of self-compassion, mechanisms relating to the overall change process were identified. This theme relates to the process participants went through to enable change to occur. These include non-specific factors relating to general change processes and specific factors related to CMT. Within this theme two interacting sub-ordinate themes were generated; Catalysts of change and Barriers to change. These themes identify the factors participants had to negotiate, in order to facilitate change and what prevented change.

Catalysts of Change

All participants identified important factors they required for change to occur. Including; recognising and understanding their problems, readiness for change, letting go of control, and the development of new skills and hope. The theme was mainly supported by extracts from Emily, Sarah, and Ruth, as they identified that they had made significant changes and continued to make progress after the programme ended.

When talking about factors that helped the participants to start to make changes, they all identified that it was vital that they first recognised the problems they had. Being able to recognise the difficulties and the areas of their lives that were affected by these problems, helped participants to identify that change was necessary. For many participants, they had avoided making changes in the past as they did not know where to start and felt overwhelmed by their emotions, when they had tried. Emily illustrated this:

> **Emily**: But then when you break it down, and you know, when you go right to the beginning [...] it's such a complex thing, it really is and I thought it worked quite well. Starting right at the beginning erm it made things make sense.

In this extract, Emily talks about breaking her problems down into more manageable pieces, rather than one over arching problem. This enabled her to see problems as less complex and identify where the process of change starts. Allowing for the process to be taken in smaller steps and developing confidence to build as these steps are achieved.

Identifying and recognising the different components within the larger structure of their problems was the initial step in the change process. For Peter and Dawn, this was as far as they were able to go.

> **Peter:** I wasn't though completely in the right place to take it all on board, because responsibility and the idea of goals and doing things is a great problem for me.

Peter proposes that his problem with taking responsibility prevented him from engaging with CMT. However, the fact that he was able to recognise this difficulty helped him understand why he was unable to make the progress he desired in previous treatments. Having this insight did not make change occur but was a big step in Peter's journey, as it broke down the larger structure into smaller components.

Developing an understanding of their problems and their vicious cycle, helped participants remove some of the blame they carried. Recognising that their past experiences shaped who they were gave them back responsibility and control. They had the power to stop this cycle and prevent further distress for themselves and others; for example, their own children.

> **Sarah:** ... it's not all my fault and that actually there is light at the end of the tunnel that there are something's that I can do which would help me overcome things. And I did not expect that to happen at all.
>
> **Interviewer:** What was that like?
>
> **Sarah:** [sigh] it was quite freeing really... you know, I've been blaming myself all these years and and not being able to see past things.

Having this understanding opened the door for Sarah to be able to see through her problems and take the first steps in her recovery. This remoralisation instilled hope that she was able to make positive changes and escape the distressed state in which she felt trapped.

> **Ruth:** I'm like I am because my parents did what they did, but they had it done to them [...] actually the way we've been brought up has influenced quite a lot of who we are now. [...] so we have a responsibility to be different in our relationships, almost back to our parents erm and stop the hurt from continuing any further.

Ruth moved from blaming herself for the way she behaved to developing an understanding, that her behaviour had been greatly affected by past experiences. The removal of blame allowed Ruth to make peace with her mother, which was a big turning point in her recovery. She went from feeling out of control to taking the responsibility for making changes, to prevent distress from going further, allowing her to identify her own strengths and abilities.

> **Ruth:** That strength was in there all along its nothing new it just needed unlocking.

Participants also identified the need to feel ready to engage with the process of change. All participants recognised that it was not an easy process. Previous experiences of treatments, which had failed, reinforced this. This readiness to change gave the participants the motivation and the confidence required to face the challenges again. Participants identified different factors, which had enabled them to develop this readiness. In addition to having a greater understanding of how their problems arose, they also reported, going through previous therapy helped them get to a stage where they felt able to make physical changes and move forward.

> **Dawn:** I needed to have gone through the previous therapy and got so much out erm and have all those thoughts and patterns behind me.

Emily: [previous therapist] got me where I needed to be.

Both Dawn and Emily felt they needed to have the opportunity to discuss their thoughts, feelings, and behaviours for a period of time, before being able to start making changes. This enabled them to work through their confused and distressed state in order to think more clearly about what they needed to do and be open to this. This also built their confidence in their own abilities, so they were able to talk about their experiences in group.

Four participants reported that removing the pressure they placed on themselves to achieve, enabled the changes to occur more naturally. This may have been attributed to previous treatment failures, whereby participants pressured themselves into making changes out of shame and guilt, before being ready or prepared. This enabled participants to end the process this time with fewer expectations. The environment they were in also facilitated this, along with the compassion they were experiencing and learning. In the following extract, Rebecca had talked about how she struggled with some of the exercises:

Interviewer: Did you get annoyed at yourself for taking a longer time than others?

Rebecca: You know what, now that I think about it I didn't. I thought I would of, because, that's what I do. But actually now that I think about it I didn't get annoyed with myself, I was actually quite patient, and allowed myself the time. Yeah.

Interviewer: Why do you think that was?

Rebecca: I think it was because there was no pressure on me, I wasn't putting the pressure on myself for a change.

Removing the pressure, Rebecca was more open to the process of change. She had already become more compassionate, allowing herself the time to make the changes rather than letting her emotions take control of her, which was a barrier in the past.

The development of new skills was also identified as part of participants' negotiation with change. These skills were necessary for helping participants overcome barriers to change and continue their journey. The emphasis here is on the development of multiple skills. Within the CMT, many different techniques are provided to encourage the development of compassion.

> **Sarah:** ... We were taught lots of different techniques [...] I didn't get on with all of them but we were told that was alright. I think there were too many to be able to use them all but I've continued on with some of the ones I liked.

As Sarah shows, not all the techniques are easy to engage with or appropriate for all. All participants reported they struggled with at least one of these techniques and were not able to use all of them after the group. However, being armed with multiple skills made them feel more prepared and allowed their self-compassion to grow.

> **Ruth:** The ones I've really got into are the ones I practised and the ones I couldn't get into I decided it wasn't worth doing. But looking back at it that's kind of being compassionate to myself, which at the time it didn't feel that way, but looking back it was.

Having a range of techniques allowed participants to experiment with what they found helpful or difficult. In the extract above, Ruth was able to test her compassionate view, by identifying what would help her the most and allowing herself to not become distressed by what she could not do. If participants were only given one or two new skills their journey may not have progressed. They may not have engaged with the techniques, viewed them as a threat, or become self-critical if they were difficult. Furthermore, they may become reliant on one of these skills, which would not suit different situations. This may have resulted in them seeing it as a failure and reverting back to their old strategies. For Sarah and Ruth, being allowed to not 'get on' with all the techniques removed the shame and feeling of failure. This in itself was a part of negotiating change as they were able to prevent their critical self returning.

Five participants reported that they had one skill which they favoured and continued to use, but were not dependent on only this skill. Recognising which skill to use at what time was extremely important in the process of change

> **Emily:** ... it's given me a tool box of things [...] in situations instead of barging in, you know, all guns blazing I just take a step back and think 'right hang on, you know, I can handle this differently' and I do.

Emily could draw on the multiple skills she developed to prevent her previous coping strategies from reappearing. However, it was important that the participants continued to practise these techniques, so that compassion became a habitual process. For Dawn, Peter, and Rebecca, this was something they did not do, which may have contributed to why they struggled to continue to make progress or maintain the changes they had implemented. Without practicing the techniques, they did not become automatic responses and so previously learnt responses took over; as illustrated by Rebecca.

> **Rebecca:** So yeah without the practising I couldn't carry it on, it hadn't become natural to me.

However, because they had not become automatic responses did not mean that the skills developed were completely neglected or seen as unhelpful. Here, Dawn shows she still believed she would benefit from using the techniques.

> **Interviewer**: ... Do you use any of the techniques currently?

> **Dawn:** ... I haven't recently no, they pass through my mind but I haven't recently um. I should do because I've been pretty stressed [...] Looking at it again today, before I came down, there's a whole lot of stuff in there that would help.

Another non-specific factor that helped Emily, Sarah, and Ruth continue to make and maintain their progress was the importance of other people

recognising the changes they had made. This validated the changes and the difficult experience they have gone through to make these changes. Additionally, participants reported having others recognise the changes reinforced why they were going through this process, at times when they were struggling. For many participants, it was not until others recognised their changes they were able to recognise their own personal growth.

> **Emily:** ... as time went on over the meetings they would both say 'we can see that it's doing something' you know, and even bring the information home, you know my partner would read through it and be like 'well that makes sense'.

For Emily, having an external other to validate the changes reinforced her motivation for change. There was an uncertainty about whether she was doing the right thing or that she could trust what she was being told. Having someone she trusted allowed her to feel safe, not being deceived or taken advantage of, and allowed her to continue to make progress.

> **Rebecca:** ... people around me noticed that they were happening... my friend said that she could see a change in the way I responded to everything and I had a calmer sense to me.

> **Rebecca:** ...when I noticed that I hadn't made any more improvements I stopped trying...

Rebecca also needed external recognition to allow her to accept the changes. This also kindled a sense of hope that the participants were able to change and that change was positive. This development of hope contradicted the participants' feelings of hopelessness prior to starting CMT. However, when this recognition stopped the hopelessness returned.

The fact that at the end of the ten weeks she did not see a significant change in her mental health left her feeling disappointed and hopeless. This prevented her from recognising the differences she was making or continuing with the process on her own.

The participants had to accept that change takes time and that they would experience setbacks, but that this was part of the process. This recognition prevented them from losing hope and seeing themselves as failing.

> **Emily:** I think it's just years and years of thinking in a bad way, erm erm, being brought up the way I was ... and its just its just going to be time that makes that better.

Reflecting on processes she had used in the past helped Emily to understand it was going to take time to unlearn the self-critical behaviours that had maintained her distress, and to allow compassionate behaviours to become innate. She could see how repeated behavioural patterns become routine and so practising the exercises would help her over learn compassionate skills, so that they become the habitual processes she relied on.

> **Sarah:** Erm, I still have bad days but they are slowly becoming less frequent. Before the group everyday was a bad day and recently I'm having about 1 or 2, yeah, bad days a week. But even that I'm looking at differently, I'm allowing myself to have those days, because everybody does ...

Here, Sarah normalised the way that she feels, accepting that it is part of the process of recovery and normal human condition. Recognising that she is having less frequent 'bad days' shows that she can clearly see the progress she has made and no longer sees these as setbacks. There was a sense of achievement and accomplishment within Emily, Ruth, and Sarah at how far they had gone in their recovery. Reflecting back on how they were in the past, enabled them to feel proud and encouraged them to continue on their journeys.

> **Emily:** ...I'm really really proud of myself.

> **Ruth:** ... it was hard but I'm glad I did it.

> **Sarah:** ... I'm getting there ... I've surprised myself at how far I have come really.

Finally, having an open mind was a specific factor identified by all participants. They were open with the fact that they were quite cynical, thinking that the concepts and skills introduced were 'strange' or 'a load of clap trap'. However, having an open mind to these processes helped them to recognise the reasons behind them and benefits of trying the exercise. Emily illustrates this:

> **Emily:** I think it can help a lot of people if they open their minds to it. I think there will be a few people who are like, this makes no sense, it's just chit chat. It's just jargon it doesn't make no sense, but if you just open your minds for a little bit it really really helps, really helps.

Barriers to Change

Participants described barriers they had to negotiate to change. It was felt that overcoming these barriers was a major mechanism in the change process. Not all participants were able to conquer these barriers. The recognition, rather than denial, of these barriers helped participants to shift their perspective, which in itself was a major transformation. The barriers discussed are mainly supported by extracts from Dawn, Peter, and Rebecca's interviews, as they had the most difficulties.

One of the main barriers, identified from all participants' interviews, was their past negative experiences of therapy. There was a sense that participants felt that they had previously failed at therapy, which had left them with a feeling of hopelessness.

> **Sarah:** I've have had lots of different types of treatments, over the years, and yeah I found some of them helpful but nothing really seemed to make that much of a difference.

Participants blamed themselves for this failure, reinforcing their hopelessness as they viewed themselves as being 'untreatable'. These experiences also left the participants with a number of defences against change and therapy as a whole.

> **Ruth:** I wasn't really sure about it and I thought yeah ok sounds a bit like CBT stuff and all this other stuff that doesn't work.

By comparing her experience of CBT with the CMT her presumptions of what was involved created a barrier towards learning different strategies. For Ruth, CBT was an intervention that caused her more distress. There was a sense that at the start of the CMT she was avoiding the prospect of making changes. However, after experiencing some of the techniques she was able to engage with the process. Peter also discussed past experiences of CBT.

> **Peter:** But CBT itself is ... its very guilt ridden its saying you know um ... or its forcing you to look at something that scary [...] there's a lot of it that's putting me off it cause it's scary and it means change.

The awareness of this suffering was actually preventing Peter from facing the prospect of change; this prevented him doing the activities away from the safe environment of the group. Without the development of self-compassion he was unable to face the fear previous experiences had instilled in him. Fear was a common barrier for participants. This included fear of change and fear of the consequences of changes.

> **Dawn:** ... I didn't reject it because I didn't want it I think I rejected it out of fear, when I did reject it, but I was curious and I wanted to be drawn in.

The use of the term 'reject' here suggests that Dawn actually prevented changes from occurring to prevent her from having to face her fear. Being curious was a safer way of testing out the ideas whilst not being fully committed.

A fear of the recognition of their problems and their true feelings came through from many of the participants. Opening up to these feelings without the reassurance that things would improve was too frightening for some to face. This was illustrated by Peter:

> **Peter:** they showed me how I could be happier, which, and so I think that ... that gives more 3D view of my my sad state.

There was also a fear of rejection both within and outside the group. This included the fear of their vulnerable self being rejected. As well as a fear of their happier new selves being rejected, both by themselves and by others. Many participants had repeatedly experienced rejection, causing them pain and suffering. Therefore, the prospect of facing rejection again was a significant obstacle.

> **Dawn:** ... fear of them rejecting that side of me ...

Dawn talked about the fear of her peers rejecting her vulnerable side, if she opened up in the group. There was a sense this extended further away from the group. It was felt that if she started opening up then those around her would see her as being weak and would reject her. For Rebecca, the fear of her 'new' self stopped her continuing progress:

> **Rebecca:** I was scared of the progress I was making, I was scared that I would frighten people away ... erm you know if I became a different person would people still want to be my friend. I suppose it's silly really but when people said they could see differences in me, I didn't know if that was a good thing and maybe they wouldn't like me. So I suppose, I knew that if I stayed the same I wouldn't upset any one. So I stopped.

The fear and uncertainty of how others would react to Rebecca made her reconsider the process of change. This tapped into her need to please others before herself, and that her compassionate mentality was not strong enough to balance emotions or provide her with comfort.

The sense of being more in control of emotions was a conflict participants had to overcome, before change could occur. There was a feeling throughout the interviews that, prior to the start of their treatment, participants felt they had to be in control of their emotions. However, by doing this, their emotions were actually controlling them. This was illustrated by Ruth:

> **Ruth:** ... On a good day you could be ... you know it was it was blanked away in a box with a lid on with lots of locks, you could hide it and try to forget about it, but on a bad day it was there [...] Erm it was just a vicious circle that you just couldn't break.

This resulted in her trying to take control in other areas of her life, which then caused more difficulties and distress. The realisation that she had been doing this allowed her to actually let go of trying to control her emotions and experience what she had been avoiding. For some participants the release of control left them with more resources to be able to tackle change.

> **Sarah:** ... you're always on edge. As if you are waiting for the next thing to happen or because of the amount of energy you have to put into to appearing to be be in control {yeah}, and I guess you don't need to be in control as much. So you start to feel comfortable, as it is, and over the time, I was able to hold onto that feeling.

For Sarah, the desire to be in control all of the time left her feeling out of control. Recognising that she did not need to, or could not, control everything left her feeling contented. This enabled her to focus on what truly mattered to her and concentrate on the changes that were happening.

Finally, participants expectations also presented as a barrier within the change process for some. Some participants had high expectations, which meant they entered the process with unrealistic ideas.

> **Rebecca:** I thought it would be the miracle cure and fix everything.

Rebecca's expectations of the group suggest that she did not want to take responsibility for making changes. Rather, she depended on an external source to make her feel better. Furthermore, the participants also had negative expectations of what the treatment and the process of change would do to them. For Dawn, she saw the process of developing self-compassion as something that would actually have a negative impact on her. Her

misconception about the concept initially caused her reluctance to follow through with the process.

> **Dawn:** So I thought it was going to be something that in a way would take energy from you rather than energised me. I was interested but also guarded, I think, yeah.
>
> **Interviewer:** you say take energy away from you, could you explain that a little bit more for me.
>
> **Dawn:** yeah I thought, it was something I thought I had to be compassionate towards other people and often at the cost of what I really thought, that I had to put them before me. Which was something I've been brought up with and which is what I've often do but to my own cost. [...] I thought so much of that was about being compassionate towards others and repressing I think repressing your own thoughts and feelings.

Dawn prevented herself from engaging with the programme by using her defence mechanisms. Although Dawn was able to develop a level of self-compassion, the process was slowed by this barrier. Many participants had built a hardened exterior to protect themselves. Therefore, the idea that compassion would make them 'soft' or vulnerable was a frightening prospect.

6.3.2.1 Summary of theme four

Participants recounted a number of catalysts and barriers they had to negotiate in order to make changes. Half of the participants were able to use the catalysts to overcome the barriers presented through their journey of developing self-compassion. However, the other half found the barriers were too difficult to overcome. The way participants viewed the process of change significantly affected the outcome of the process. Furthermore, past experiences, expectations, fear, control, and development of skills and understanding, were also reflected as mechanisms involved in the process of change. Finally, the development of hope and recognition from others were

seen as encouraging factors for the participants to continue and maintain their changes.

6.4 Extended Discussion

The following section contains additional discussion of the results, with further comparisons being made with the evidence base. A critique of the study will be explored along with clinical relevance and future research areas.

Four themes were identified: essential components of self-compassion; process of self-compassion development over time; group experiences; and negotiating change. These themes provided an insight into participants' experience of attending a CMT programme, how they made sense of the development of self-compassion, and the changes they made. The first two themes focused on the process of developing self-compassion. The second two themes identified specific and non-specific factors of developing self-compassion in a group format and the general change process. The process of being in a group appeared to impact on participants' experience and act as mechanisms in the development of self-compassion. Furthermore, the understanding of the catalysts and barriers involved in change enabled participants to engage in the process. These findings are discussed in the context of related literature. Finally, a model of how the participants developed and maintained their self-compassion is proposed.

In general, the participants reported the experience of being in a therapeutic group a positive one. In line with previous studies on group therapy, participants valued the support and encouragement gained, and the opportunity to learn from others (Griffiths, Camic, & Hutton, 2009; Mason & Hargreaves, 2001; Newton et al., 2007; Williams, McManus, Muse, & Williams, 2011). Furthermore, they appreciated the normalizing aspect of the group. This also supports CFT which emphasizes the need for individuals to accept and validate their experiences and feelings, which was achieved through having a commonality and identifying with others in the programme.

This enabled participants to recognise that they were not alone with their experiences or their emotional states. Helping them to validate their feelings and experiences and interconnect with others.

This is similar to what Neff (2003a) proposed as common humanity; a person recognising that suffering and personal inadequacy is part of the shared human experience. She proposes that this enables people to view their failing and life difficulties less personally by acknowledging them in a non-judgemental compassionate and understanding way. For Neff this is one of the three elements of self-compassion. However, the participants did not identify this process as a component of self-compassion, which they continued to use. For them this process enabled them to connect with the group positively; i.e. in a non-judgmental, non-competitive way, where they felt accepted and validated, as they were able to identify a shared common feature (e.g. self-criticism). Although participants were able to see they were not alone in their suffering this was isolated to the group. They did not generalise this to the wider shared human experience as proposed by Neff. Rather this experience was part of the general process of change. This experience allowed participants to develop their self-compassionate skills, such as self-acceptance, as they could see others had difficulties too. Thus it is proposed that common humanity maybe a prerequisite to self-compassion rather than a component.

Group cohesiveness has been proposed as a critical ingredient in group therapy (Yalom, 1995). It has recently been questioned whether this is important, as there is little empirical evidence to suggest that cohesion has an effect on outcome (Hornsey, Dwyer, Oei, & Dingle, 2009). This study found the majority of participants valued cohesiveness within their group. Two participants described feeling on the outside of the group. For one participant this affected her ability to develop self-compassion, as she was unable to share her own experiences or accept compassion from others. It is possible that this participant saw cohesion within the group as a threat, resulting in her struggle to trust the group members. However, this did not seem to affect other participant's self-compassion development. Therefore, it

is unclear whether cohesiveness is a vital commodity for the development of self-compassion within a group CMT.

The findings on the process of change support previous research on people's experience of change (Gianakis & Carey, 2011; Higgindon & Mansell, 2008). Furthermore, they are in line with the developmental approach of CFT (Gilbert, 2010). Change was seen as a process of stages, reliant on motivation and psychological competencies. These competences included the ability to recognise problems and think abstractly about these, take responsibility and control over emotions, and become more mindful. These stages are also in line with Howard, Lueger, Maling, and Martinovich's (1993) causal model, which proposes three stages to therapeutic change: a) remoralization, the enhancement of well-being; (b) remediation, the achievement of symptomatic relief; and (c) rehabilitation, the reduction of troublesome, maladaptive behaviours. It was clear that participants had to instil the sense of hope; i.e. by breaking down the big problematic structure into more manageable components. This helped them to explore and accept their emotions, thus removing the shame and guilt they held. Finally, for those who were able to achieve this, self-compassion was further developed and they recovered from their mental health difficulties. However, this is a linear model and does not account for the cyclical process participants experienced, in which they had to negotiate between progress and setbacks. These setbacks appear to be important within the change process as they offer the opportunity to be able to use developing skills. It is vital that therapists and service-users are aware of these stages and the potential for setbacks, to prevent disengagement with the process and to positively reframe them.

Part of the process of change involved grief. This included the grief of not receiving the compassion they desired in early childhood. Although there is little research on the loss, of what was wanted or needed, it appears that this plays a role in the maintenance of mental health difficulties (Gilbert & Irons, 2005). The space to grieve has been found to be an important part of the recovery process but is often neglected (Lowens, 2010). The development of an awareness of where problems stem from, and the increasing desire to feel

loved, cared for, and connected, can initially increase the distress experienced. Thus, grief is a normal, natural, and useful response (Lowens, 2010). This was evident in participants' narratives. For those that found this process too overwhelming, they disengaged; especially with the removal of the safe environment of the group. This finding supports the need to work with grief to enable service-users to remain engaged in therapy, and supports Gilbert's (2010) call for more research.

The development of skills was seen as an important part of the experience of self-compassion development. However, the number of techniques used in CMT appeared to be overwhelming for participants and they struggled to practise these away from the group. It has been proposed that the daily practise of techniques is essential for treatment gains when developing new skills (Segal, Williams, & Teasdale, 2002). However, it was clear that participants were still able to develop skills with minimal practise. It is possible this was the result of the removal of guilt and shame associated with avoidance, as there was no pressure to practise at home. Additionally, participants seemed to differ in the techniques they preferred. The techniques used within CMT have not been individually tested for their effectiveness. Therefore, it may be possible that the participants who did not develop their self-compassion further, may have selected less effective techniques. This area would benefit from further research.

The value placed on the development of new skills and techniques in therapy as a mechanism of change has been questioned. This study does not support the claim that service-users are not interested in skills training (Elliott & Williams, 2003; Mac Cormack et al., 2001). Many participants valued the development of multiple tools. This was a similar finding to that of Rayner, Thompson, and Walsh's (2010) study on experiences of change in cognitive analytic therapy. However, it is unclear whether it was these skills that actually resulted in the development of self-compassion. A study by Jannazzo (2009) found participation in process group therapy had a significant impact on participants' level of self-compassion. An optimistic account of this may be that self-compassion is an underlying mechanism within all psychological interventions. This poses the question as to the need for specific

interventions for developing self-compassion, if it can occur naturally in therapy. Further research should explore whether it is the techniques, the experience of being in a therapeutic group, or a combination of both, that increases self-compassion. This information would also help identify the benefits of group CMT over individual CMT.

The current study also found that multiple non-specific factors were required to activate change; similar to those found in the general literature on therapeutic and change processes (Elliott & James, 1989; Frank, 2006). Such factors included developing therapeutic and supporting relationships, self-expression, readiness to change, gaining insight, and the development of skills. It did appear that the added experience of compassion gave the CMT an additional helpful aspect and allowed participants to move from self-critical to self-compassionate.

Support, encouragement, learning from and helping others appeared to be important parts of the experience and benefits of the programme. These could be related to altruism, instillation of hope, imparting information, and development of socializing techniques, which have been emphasized as important aspects of group therapy (Finucane & Mercer, 2006; Fitzpatrick, Simpson, & Smith, 2010; Imel, Baldwin, Bonus, & MacCoon, 2008).

The skills of the facilitators were also highlighted as being attributed to the development of self-compassion. Within CMT, it is vital that the therapist has the skills to be able to express the attributes of compassion (Gilbert, 2009b). Moreover, outcomes of groups are greatly influenced by the facilitators' skills and ability to model behaviour (Yalom & Leszcz, 2005). The ability to express compassion is often a focus of therapist training, thus, it cannot be presumed that facilitators will have the capabilities to do this. Therefore, it may be beneficial for facilitators to monitor and develop their own levels of self-compassion.

It is also important to point out that the group also presented barriers for the development of self-compassion for some participants. Due to the limited time to devote to individuals and go deeply into problematic experiences, some participants were unable to develop the level of understanding they

needed to move forward. Furthermore, some participants felt they were unable to share experiences or feel part of the group. It has been proposed that it is essential for group members to be able to share personal information, to have a positive outcome (Yalom & Leszcz, 2005). It is important to recognise that a group intervention may not be appropriate for everyone.

A particular barrier that has been addressed in the literature on compassion is the fear and misunderstanding of the concept (Gilbert, McEwan, Matos, & Rivis, 2011; Lowens, 2010; Pauely & McPherson, 2010). As shown in this study, participants entered the CMT with a belief that compassion would make them 'soft' or have a negative effect on them. This fear may lead to service-users resisting engaging in compassionate experiences and behaviours. In a clinical sense, if service-users are unable to experience feelings of compassion and kindness, then no matter what therapeutic tools are used the outcome will be limited, as the affect system will remain unstable. Thus, it is vital that these fears and uncertainties are explored and an appreciation of the genuine nature of self-compassion is developed. If this is achieved these barriers may be extinguished.

It was significant that whilst the themes represent common experiences, there were also variations within them. Those who were more readily motivated, could open up to the group, and take responsibility for change, benefitted most from the experience. Additionally, participants' expectations and fears of change impacted on their experience and ability to engage with the change process. Expectations were influenced by past experiences of therapy and feelings of hopelessness. Those who did not have set expectations reported greater change in their condition and self-compassion, compared to those who had unrealistic expectations. This finding echoes themes identified in previous research of people's experience of psychological interventions. In a study of MBCT, participants whose expectations were open and flexible had fewer barriers than those that were highly optimistic (i.e. it would be a cure; Mason & Hargreave, 2001). This may also suggest change is more noticeable when it is not expected. A historical review of the research on service-users' expectations and therapeutic outcomes found this may be

more vital to the therapeutic process, than what is currently being acknowledged in the literature (Greenberg, Constantino, & Bruce, 2006).

Finally, I would like to propose a five stage model of self-compassion development and maintenance (figure 4). The model is based on the information already discussed and attachment, social learning, and behavioural theories (Ainsworth et al., 1978; Bandura, 1977; Baum, 2005; Bowbly, 1988)

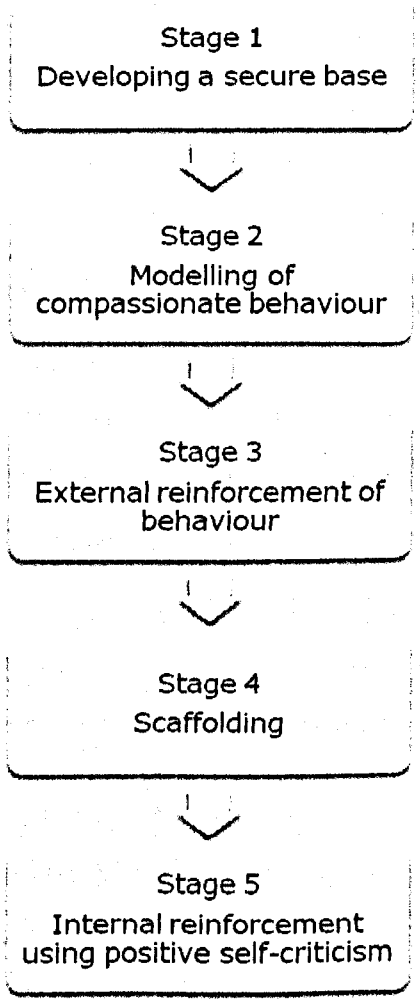

Figure 4 Proposed model of self-compassion development and maintenance.

Stage one is the development of a secure base in which participants can learn and develop self-compassionate skills, explore their experiences and regulate emotions. The group element of the CMT programme provided this base for the participants to feel supported and contained. Within this both the

facilitators and other group members may be seen as caregivers. This also allowed participants to be content, curious and engaged with the environment (e.g. the compassionate exercise) which may have been a revision of their early attachment experiences. Participants had to feel confident in facilitators (caregivers) availability and responsiveness to their needs (Waters & Cummings, 2000). The secure base allowed participants to gain an understanding of their lack of self-compassion, accept past experience, overcome fears, and address barriers of change.

The second stage involves the participants developing their self-compassionate skills through the process of modelling. Facilitators and other group members modelled specific behaviours. The facilitators modelled compassionate skills through, visual, verbal and symbolic processes. Other group members modelled how practicing compassionate skills could help address their inadequacies and failures. The participants used the four stages of modelling; attention, retention, reproduction and motivation (Bandura, 1977). For those participants who were unable to use these stages their self-compassion did not fully develop.

The third stage involved the participants receiving external reinforcement. This reinforced that new self-compassion skills were beneficial and old coping strategies have negative consequences. Initially this is within the group, but external others became stronger reinforcers. This reinforcement confirms self-compassion is worth pursuing. The conditioning of the self-compassionate behaviour involves the fourth stage. Scaffolding is used with in the group to build self-compassionate skills (e.g. the progression on to more complex exercises). This also involves the participants practising their new skills away from the group. These behaviours are then reinforced through internal processes after the programme (stage five). This includes the experience of contentment and pleasure and the shift from negative self-criticism to positive self-criticism, which enables participants to grow and develop. This internal reinforcement maintains the participant's self-compassion, resulting in it becoming a habitual response.

6.4.1 Strengths and Limitations

The methodology used, allowed for an in-depth exploration of participants' experience, an area that had not been previously researched, and a strength of the study. Each interview was individually analysed in detail, to ensure each participants' experience was captured. Furthermore, this allowed for a good level of interpretative engagement with the text, strengthening the rigour of the study.

Six participants were interviewed, which may be considered a small sample size when compared to other studies using the same methodology. However, this allowed time for the depth of analysis required for the study and guaranteed the voices of all participants were heard. This also ensured the idiographic approach of IPA was followed (Smith et al., 2009).

The small sample size prevents the ability to generalise the results of the study to the wider populations. However, as stated this was not the aim of the study or of IPA. What is hoped, is that the interpretations help understand the processes and experiences of other adults with mental health difficulties developing self-compassion.

A criticism of the study is that it used a small sampling pool. Only two CMT groups were identified for the recruitment of participants. This decision was made in order to gain a greater homogenous sample; in line with the requirements of IPA. Therefore, the experiences of the CMT may have been unique. However, the consistency between the themes in this study and across the two groups would suggest that this is unlikely. By recruiting from different programmes there would have been greater variance of experiences due to differences in the facilitation, structure, and contents of the groups. Although this would have provided the opportunity to compare and contrast participants' experience of different programmes, this was not the aim of the study.

The later interviews may have provided richer data, due to the researcher's interviewing technique improving. It is also acknowledged that the interview schedule will have affected the themes interpreted in the analysis. The

schedule showed flexibility within the interviews, so that participants could guide the interviews and unanticipated areas could be followed up. Furthermore, all the themes are entrenched in the words the participants used themselves.

The interviews took place approximately eight months after the programme. This meant that participants were able to reflect on their self-compassion development and how the experiences had impacted on their lives. However, this also meant that they may have recounted their story many times over, each time developing a different understanding, interpretation, or meaning to their experience. Conducting the interviews closer to the end of the programme may have resulted in different themes.

Although IPA was an appropriate methodology for the aims of the study, there is a limit to what information can be gained from this approach, especially when exploring the multifaceted emotion of self-compassion. Although the quotations do demonstrate the generated themes, they do not show the nuances within the participant's speech. These could have become lost in the transcription of the analysis, leading to different interpretations being formed, which other methodologies, such as conversational analysis, would have captured. This was taken into consideration during analysis; as the recordings of the interviews were repeatedly listened to, meaning the researcher was able to gain another level of interpretation.

Finally, no measure was used to identify the change in self-compassion. It is possible that service-users reported a change to please the facilitators at the time. Using a measure before and after the programme may have identified the difference in self-compassion. This information could have also been used to compare those who reported a recovery and those who did not. This may have identified factors that help people to go on to further develop their self-compassion after CMT.

6.4.2 Clinical Relevance

The results of this study are clinically relevant as they enhance the wider knowledge and understanding of self-compassion, and the processes involved

in its development. With the increasing popularity of compassion-based interventions this study is an important step into the development and improvement of services.

The study has shown service-users are able to learn how to develop self-compassion. Moving from a self-critical mentality to a compassionate mentality had significant impacts on the participants. Using self-compassion to confront painful emotions and memories enabled them to make changes within their lives and move forward in their recovery. This finding proposes that CMT groups may be an acceptable and beneficial intervention for individuals with mental health difficulties.

The study has also highlighted the benefits service-users may experience of being in a group programme. It is unclear whether this had a significant effect on the development of self-compassion. What is clear is that a group programme can provide opportunities for service-users to experience compassion in a wider context, than individual therapy can offer. Additionally, the validation that one is not alone in their experiences was a positive outcome for all participants, which may not have been possible in individual therapy. This study suggests the delivery of CMT in a group format may benefit service-users. Furthermore, it may also be a more cost effective approach than individual psychotherapy, which, in the current financial climate, is a vital concern.

Not all participants were able to utilise the skills they had developed after the programme had ended, even though they recognised it was needed. Clinicians need to be aware of these factors and identify ways in which service-users can continue the development after treatment. One possibility is that some service-users may benefit from individual therapy following the group.

Furthermore, not all participants were able to fully engage in the group. This emphasises the need for detailed assessments prior to group work, in order to identify possible barriers and expectations. This may help prepare service-users for the challenge they may face so that they do not feel like they have

failed. This will also help identify the suitability of service-users to promote cohesion within the group.

A further finding, clinicians need to consider the potential negative impact group therapeutic approaches can have on service-users. As CMT is aimed at individuals with high self-criticism and shame, it is important to consider how a group intervention may impact on these processes. Although a group can provide an excellent space for de-shaming, normalising, and identifying with others, it could also feed self-critical behaviour and be perceived as a threat as found in this study. Clinicians need to be aware of points where this may become a problem, ensuring a safe, compassionate environment in which service-users are able to readdress the balance between undermining self-criticism and self-compassion.

Finally, the study has also highlighted the wealth of information that can be obtained about service-users experiences of interventions, by using a qualitative research approach. The empirical exploration of the phenomenon of psychotherapy can provide a foundation for future research (Levitt, Butler, & Hill, 2006). By developing an understanding of processes and experiences within specific interventions, independent variables can be discovered. These can then be tested through quantitative approaches. This can strengthen the evidence base for psychological interventions and lead to the improvement of services. It is vital that clinicians do not become complacent and base their practise purely on quantitative research, based on measuring symptom outcomes. Although this is important, it is not the only way to evaluate interventions, and service-users may not consider this as the most important aspect of therapy. Clinicians need to also understand the processes and experiences service-users go through during therapy, to be able to prevent disengagement and meet the needs of the service-user. Developing these understandings may also enable clinicians to provide individualised, effective, and efficient services.

6.4.3 Future Research

The study explored a retrospective account of participants' experience. As highlighted in this report participants' understanding of compassion changed throughout the process (Mayhew & Gilbert, 2008; Laithwaite et al., 2009). Although outcome measures, such as the Self-Compassion Scale, have been used for research on the effectiveness of CMT, they have not been validated with clinical populations. The fact that participants' views and understanding of self-compassion change may mean these scales are not a true measurement of a service-user's level of self-compassion, prior to starting treatment. Using a prospective approach, in which participants' meanings and experiences of self-compassion are explored before and after the intervention, would increase our knowledge of self-compassion. This would also provide further information on the validity and reliability of outcome scales for the measurement of this complex concept.

The participants included in this study had experienced mental health difficulties for an average of 14 years and had experience of different interventions prior to entering CMT. These experiences meant that many of the participants entered CMT with preconceived expectations and a sense of hopelessness, thus making their recovery journey more difficult. It is argued that the development of self-compassion provides a good base for participants to enter therapy and have improved outcomes (Gilbert 2009b). Future research should focus on exploring the outcomes and experiences of CMT for service-users entering therapy for the first time. A comparison of the process of change and development of self-compassion would provide interesting insights. This may also provide further understanding of the development and treatment of mental health difficulties.

Only three participants' self-compassion had developed further following the end of the programme. This poses the question of how well self-compassion is retained post intervention. No previous study on the effectiveness of CMT have had significant follow-up periods to be able to state whether self-compassion is retained and what effect this has on service-users' psychological wellbeing. In order to understand the effects of self-compassion

it is important that future research in this area focuses on the long-term retention and how this may be improved.

It has been argued that in-order to understand change processes it is vital to explore when change has not occurred (Kazdin, 2007; Rayner et al., 2010). Although the study identified a number of barriers, that prevented some of the participants from continuing with the changes they had made, this would benefit from closer investigation. Exploring the experiences of service-users who do not report change or who drop out of CMT, would provide further information into the processes and barriers involved in change. This may improve interventions and help identify who would and would not benefit from such treatments. Furthermore, this study explored a group approach to CMT, which resulted in some participants not being able to fully develop their self-compassion. Therefore, it is important to explore the differences between group and individual CMT and how this may affect the development of self-compassion, for clinicians to provide the most appropriate treatment.

Using process-outcome research methods would further help explain the process involved in the development of self-compassion. This approach helps to map the relationship between process and outcome, by linking service-users behaviour outside of therapeutic session with process variables measured within sessions (Orlinsky, Grawe, & Parks, 1994). To understand this relationship four variables are studied; service-users, therapist, therapeutic intervention, and therapeutic interaction. Different methodologies have been used in process research including, correlational, descriptive, quasi-experimental, and experimental designs (Timulak, 2008). The focus on process and outcome in research has yielded interesting findings. It has helped to establish the causal role of particular therapeutic processes that help service-users bring about change (Elliott, 2010).

The development of CMT may also benefit from exploring professionals' experiences of delivering it. As was highlighted in this study the ability for therapists to model compassion is a vital role in the development of service-users' compassionate mentality. Therefore, an understanding of how this is

facilitated and the factors they feel are important, would further inform and improve the delivery of such interventions.

Finally, future research could test the model proposed in this paper to help understand the processes involved in self-compassion development. This could help improve outcomes and lead to greater understanding of therapeutic change.

6.4.4 Conclusion

The results of this study cannot make claims about long-term efficacy of CMT, nor state how it compares with individual programmes or other treatments. Neither can it state who would benefit from this treatment. However, these were not the aims of the study. The study has provided an insight into the experience of service-users' development of self-compassion, through the use of a compassionate mind training programme. The processes and stages involved in this significant change, to the participants' perceptions of themselves and reactions to their world, have been explored. The study has also developed the knowledge and understanding of self-compassion, which can be used as evidence for the use of such interventions. Additionally, it has highlighted the wealth of research that still needs to be conducted in this field. Finally, it is hoped that this study will be used in future developments of interventions, to improve the experiences of service-users.

6.5 Critical Reflection

The process of critical reflection was vital throughout all stages of the study. The following section includes some of the reflections I had during the process of conducting the research.

6.5.1 Use of a Qualitative Approach

Prior to starting training I would have said I had more of a positivist stance. In recent years, having spent time looking at the evidence for psychological approaches I have reflected on my philosophical perspective. This has left me

questioning whether there is an absolute 'truth'. This led me to consider the critical realist view and understanding of knowledge and the world as we know it. This sat better with my personal views and I believe this influenced my research. With the search not to find the truth but to understand the central meaning of the truth for that person at that time.

The next question was which qualitative approach to use. This caused many hours of debate and confusion. Identifying the differences between the approaches was at times hard to see, but after reading a paper by Carter and Little (2007) it became clear. It was essential that I kept in mind the research aims and philosophical position. The selection of IPA seemed to compliment both these points. Reflecting on the research process now, I feel this approach was appropriate. I was also aware that throughout the research process my own assumptions and experiences of the area were significant. Acknowledging my interpretative role was vital, particularly when using IPA.

6.5.2 Using IPA

As a novice qualitative researcher I endeavoured to ensure that I understood the philosophical and theoretical underpinnings of the approach selected. To do this I conducted a lot of reading and attended a workshop on IPA; as well as reviewing and reflecting on the teaching of qualitative methods received as part of my training. I also sought supervision and had many discussions and debates with my peers also utilising IPA and different qualitative approaches. However, I was also aware of not falling into the trap of seeing the approach as a set of instructions to follow, and aimed to take a flexible approach.

During the development of the research proposal and ethical application the question of numbers kept reappearing. The correct number of participants to recruit that is. I felt like I was in conflict between the recommendations of Smith et al. (2009), published work using IPA, academic requirements, and my own views on research. Within IPA it is often stated that depth is better than quality. As a newbie to this approach it frightened me a little. If I went for fewer participants would I be able to get the interpretative depth required

to justify this. At the same time if I went for larger numbers would I become overwhelmed by the data and end up with a superficial analysis. It left me the question of whether it is ethical to recruit participants if you cannot do justice to their stories. Part of this conflict was taken away due to the number of people I could sample from. Having identified two CMT groups with 10-12 people in at the start, I was confident that I would be able to recruit a sufficient number of people to get the right balance. I was satisfied with the number of participants recruited as I felt that it gave me the opportunity to focus on each individual's story. There also seemed to be a natural split in the participants, with three making progress after the group and three who did not. This made for an interesting analysis and the opportunity to compare these experiences. This information could provide valuable guidance for clinicians and researchers. However, being conscious of my studies aims I did not want to become side tracked by this.

6.5.3 Interview Process

During the first interview I was very much aware of my schedule and was almost determined to follow it. This was due to two main reasons. Firstly, the pilot interview identified the differences between a clinical interview and a research interview. I became very conscious of the fact that I was in a role that needed different skills. Secondly, I was also aware that I did not want to use leading questions or influence the participant's responses, so it almost felt safer to stick to the approved schedule. However, during this interview I found it difficult to follow as I listened to the participant's story and experiences it opened up new areas I had not considered. Reflecting on this interview I felt almost restricted by my schedule, which may have prevented the participant from talking more freely or even influenced what they had said. In the second interview I was determined not to allow this to happen, whilst still acknowledging the schedule I found this interview to be freer flowing. Over the six interviews I believe that my skills significantly developed. Although, the later interviews may have been shorter than the first, I do not see this as a negative thing as I felt I was able to elicit a great deal of information and possibly even more in depth information than in the

first. This experience may make me more inclined to carry out unstructured interviews.

6.5.4 Analysis

Being side tracked by data that did not relate to my aims was a difficulty I had to fight to overcome. This also posed the ethical dilemma; was I right to ignore or disregard parts of participant's stories? The fact that so much additional information could be obtained from the data, which could not be included in the current work left feelings of guilt, disappointment and frustrations, as the time and effort put into the analysis felt like it was wasted. However, coming to terms with this and recognising that additional publications can come out of this work helped with the dissatisfaction.

Additionally, after I started conducting the analysis I was left questioning the aims of the study. Were they too wide? Had this affected the level of interpretation? Was I trying to do too much? All these questions floated around during the analysis process and the write up. Due to the lack of research in this area it was important to have quite an open aim to allow for the exploration of participants' experiences to take place. However, this left me vulnerable to trying to convey and represent all of the experiences that took place. My original thoughts were that if I had broken the area down and looked at one aspect, I might have missed clinically relevant information, or misinterpreted the meaning of the story. However, by leaving it more general I now recognise that I was also vulnerable to the same things. This has highlighted to me the importance of research questions and the care and attention that needs to go into the development of these questions.

6.5.5 Final Thoughts

The process and experience of conducting this study, has involved a mixture of scientific, theoretical and ethical conflicts and debates, both with myself and with others. During this experience I have noticed myself becoming self-critical, turning to my self-compassion to get me through some of the more testing times. In addition, I have gained confidence in my research skills.

Finally, it has enabled me to reflect on the scientific question of what is evidence, which has such a great influence on the subject of psychology.

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7 Appendices

Appendix A: Compassionate Mind Training Programme Session Plan

Includes example of how the intervention maps on to the thematic structure of the results.

Session	Theory teaching	Experiential skills practice	Self-therapy tasks at home
1	Introductions. Contract/rules/questions. Evolution of the brain: old brain new brain. Common humanity.	Mindfulness introduction and practice. Soothing breathing rhythm. Radical acceptance.	Radical acceptance. Soothing breathing rhythm. Moment to moment awareness.
2	3 circles model. Power of the Imagination. Shame and self-criticism.	Attention. Simple body scan and relaxation. Creating a safe place.	Safe place practice.
3	What is compassion? Multi modal compassionate mind training.	Compassion colour. Compassionate self.	Compassion practice – compassion under the duvet.
4	Fear of compassion. Functions of self-criticism.	Compassion flowing out. Focusing the compassionate self on others. Compassion flowing into oneself.	Compassion practice. Reading on sadness.
5	Threat and self protection system.	Focusing the compassionate self on yourself. Creating a compassionate ideal.	Practice compassionate ideal.
6	Incentive resource seeking system.	Compassionate Behaviour. Diaries.	Practice compassionate behaviours. Complete diaries.
7	The soothing/ contentment system.	Compassionate thinking.	Thought diaries.
8	From self-criticism to self-compassion.	Compassionate letter writing.	Compassionate letters.
9	Recap sessions 1-4.	Recap exercises.	Diaries of practice.
10	Recap session 5-8. Battery of measures.	Recap of exercises. Finish with a compassion exercise.	Keep practising and revising.

Appendix B: Ethics Approval Letters

NHS
National Research Ethics Service
Nottingham Research Ethics Committee 1
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839390 (Direct Line)
Facsimile: 0115 9123300

19 January 2011

Miss Jasmine Lineker
Trainee Clinical Psychologist
IWHO, University of Nottingham
International House
Jubilee Campus
Wollaton Road
Nottingham NG8 1BB

Dear Miss Lineker

Study Title:	**Exploring Service Users' Experiences of Compassionate Mind Training (CMT)using Interpretative Phenomenological Analysis (IPA)**
REC reference number:	**10/H0403/103**
Protocol number:	**1**

Thank you for your letter of 17 January 2011, responding to the Committee's request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Response to Request for Further Information		17 January 2011
Letter of invitation to participant	Final 1.0	12 November 2010
Investigator CV	Thomas Schröder	
Investigator CV	Jasmine Lineker	
Investigator CV	Nadina Lincoln	
Protocol	Final 1	12 November 2010
Participant Information Sheet	Final 1.0	12 November 2010
Interview Schedules/Topic Guides	Final 1.0	12 November 2010
Evidence of insurance or indemnity		22 July 2010
REC application	50939/166635/1/474	17 November 2010
Participant Consent Form	Final 1.0	12 November 2010
Letter from Sponsor		17 November 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0403/103	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

P. Wheal

fp **Mr Robert Johnson**
Chair

Email: trish.wheal@nottspct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mr Paul Cartledge – University of Nottingham

R&D office for NHS care organisation at lead site – t

Professor Nadina Lincoln – Chief Investigator

Professor Thomas Schroder – Academic Supervisor

[redacted] NHS
NHS Foundation Trust

R&D Unit reference: . . . . -P01824

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5th May 2011

Dear Miss Lineker

NHS Permission to undertake a research study

Trust: NHS[1]
Study Title: Exploring Service Users' Experiences of Compassionate Mind Training (CMT) using Interpretative Phenomenological Analysis (IPA)
Ethics Committee Favourable Opinion dated: 19th January 2011

Thank you for submitting details of this study for NHS Permission from the above-named Trust, which is a member of the R&D Alliance.

I confirm that the study has NHS Permission and can now begin in the Trust.

Please note that the study must be conducted in accordance with the approved protocol, the Department of Health *Research Governance Framework for Health and Social Care* and any applicable legislation.

Please check that you are aware of the sponsor's Standard Operating Procedures that are applicable to this study. If your study is sponsored by the Trust, please refer to the Standard Operating Procedures published on the Unit's website www. nhs.uk. These should also be used as a default for externally sponsored studies where the sponsor does not have its own procedure or where there are gaps in the sponsor's procedure due to local circumstances.

Please note that this NHS Permission applies only to those documents granted a favourable ethical opinion on the above date. Please ensure that you notify the R&D Unit if there are any amendments to the study or when the study has ended and send me details of any publications that result from it.

May I wish you every success with the study.

Yours sincerely

pp

Caroline Mozley
On behalf of NHS

Cc: Professor Nadina Lincoln; *Liz Cook*

Appendix C: Consent Form

Title of Study: Exploring service-users' experiences of Compassionate Mind Training (CMT)

REC ref: 10/H0403/103

Name of Researcher:
Name of Participant:

Please initial each box

1. I confirm that I have read and understand the information sheet version number 1 dated 12/11/10 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes.

Appendix D: Semi-Structured Interview Schedule

Tell me a little bit about yourself and why you wanted to take part in this study?

Tell me about your experience of compassionate mind training?

Tell me about the change you feel you have made/went through?

How do you make sense of this change?

Is there anything else you would like to say about your experiences or anything that I have not asked that you would like to talk about?

Prompts

Can you tell me more about that?

What sense did you make of that?

What was that like?

What did/ does that mean for you?

What meaning did that have for you?

How did you experience that?

How did you feel about that?

Demographic information
(if not obtained during the interview the participants will be asked at the end):
Participant identification number:
Gender:
Age:
Ethnicity:
Occupation:
How long have you had mental health difficulties?
What other treatments have you received before compassionate mind training?

Appendix E: Participant Information Sheet

Title of Project: Exploring service-users' experiences of Compassionate Mind Training (CMT)

Researcher: Jasmine Lineker

Institute: University of Nottingham

I would like to invite you to take part in a research study on your experience of the Compassionate Mind Training programme you have recently completed. Before you decide if you would like to take part in the study you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. If at the end there is something not clear, you would like more information or have any questions you will be able to contact the researcher. We would like you to take your time to decide whether or not you wish to take part. You can talk to others about the study if you wish.

What is the purpose of the study?
Compassionate Mind Training (CMT) is a relatively new treatment. Research into this treatment has shown that it is effective in helping service-users stop being self-critical and change the way they feel about themselves, as well as improving their quality of life. However, no research has been carried out to gain service-users views on their experience of CMT or how and why they have made these changes. Therefore the purpose of this research is to give service-users an opportunity to tell their stories about this experience. It is important that service-users have this opportunity in order to understand what is important to them and what factors contribute to change. This may lead to improvements in services and better understanding of what causes mental health problems, how they can be treated and who benefits the most from this type of treatment.

Why have I been invited?
The facilitators of the CMT programme have identified that you have recently completed the programme. If you feel that you have become less self-critical and you have developed skills that helped you to becoming self-compassionate I would like to invite you to an interview where you will be able to tell your story.

Do I have to take part?
Your participation in this research is entirely voluntary. It is your choice whether to take part or not. If you decided that you would like to be involved you will be asked to sign a consent form to show that you have agreed to take part. Your decision will not affect the services you usually receive.
What will happen to me if I take part?
After reading this information sheet carefully and if you decide to take part in the research you can contact the facilitator of your programme or the researcher who will send you a consent form and an invitation to attend an

interview. Before the interview you will have the opportunity to discuss the research and ask any questions and if you are still happy to take part you will be asked to sign the consent form. The interview is expected to last approximately 1 hour and will be tape-recorded. During the interview you will be asked questions about your experiences of compassionate mind training. You will be asked to talk freely about this experience, however, the researcher may also prompt you to give more detail if they feel it is important for understanding your experience. After the interview you will be given extra time with the researcher to discuss the interview, which will not be recorded. The researcher will then transcribe (type out) the interview where you will be assigned a pseudonym (a different name) and any information which would identify you or anyone else will be removed. You will not be contacted again after the interview unless you request details of the results of the study.

Will I be paid?
You will not be offered any payment for taking part in the research.
You will be reimbursed for any travel expense you incur due to taking part in the research, up to a maximum of £5.

What are the possible disadvantages and risks of taking part?
As you will be asked to talk about your own personal experience some of the questions may cause you to become upset. You have the right to refuse to answer any questions which you believe will cause you upset and you are free to stop the interview, either to take a break or to withdraw from the study.

At the end of the interview you will be given the opportunity to talk about the interview with the research and will be given information on who to contact if you need future support.

What are the possible benefits of taking part?
There are no known direct benefits to you for taking part in the study. However the results of the study may help to improve the service offered to people like you in the future and gain a greater understanding of people's experience.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions, contact details are at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do through the NHS Complaints Procedure or PALS. Details can be obtained from your hospital.

What will happen if I don't want to carry on with the study?
You do not have to take part in this research if you do not wish to do so. If you have agreed to take part you may withdraw from the research at any point, however information already collected may still be used. This will have no affect on the services you receive. During the interview you can refuse to answer any questions that you do not feel comfortable with.

Will my taking part in this study be kept confidential?
The information collected about you during the course of the research will be kept confidential. Only the researcher will know that you are taking part in the study unless you decide to inform others. You will be assigned a pseudonym (a different name) and any identifiable information (of yourself or others) will be removed from the interview when they are transcribed. The recordings and personal information will be stored in a locked cabinet at the University of Nottingham and your contact details will be destroyed at the end of the research.

Quotes from your interview may be used in the write up of the research however they will be under a pseudonym and will not disclose your identity.

However, if during the interview you talk about anything which the researcher feels puts yourself or anyone else at danger they may have to break the confidentially. The researcher will discuss this with you.

What will happen to the results of the research study?
The results of the study will be published in a relevant scientific journal. You will not be identified in the publication. They will also be used by the researcher as part of their qualification as a Clinical Psychologist.
If you are interested in the results of the study you will be given the opportunity to receive a summary of the results or the journal paper.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed by Nottingham Research Ethics Committee and given favourable opinion.

Further information and contact details
If you have any questions about participating in the research you can ask (name of facilitator of CMT programme) or contact the researcher directly by telephone or email (contact details below).

How do I take part?
If you have read the above information and would like to take part in the research you can either:

1. give your contact details to (name of facilitator of CMT programme) who will ask the researcher to contact you directly

or

2. You can contact the researcher directly by using the details below.

Name: [removed]

Address: [removed]

Telephone: [removed]

Appendix F: Invite to Interview Letter

Address: [removed]
Phone: [removed]
E-mail: [removed]

Date:

Address

Dear [name],

Re: Research: Exploring service-users experiences of Compassionate Mind Training (CMT)

Thank you for agreeing to take part in the above research project. I would like to remind you that your participation in the research is voluntary. As you are aware it will involve an interview on your experiences of completing a compassionate mind training programme. As agreed during our telephone conversation I would like to invite you to the interview at:

(venue)
on
(Date and Time)

If this time is no longer convenient for you or you have decided you do not want to take part in the research please contact the researcher on the above number.

Please also find attached an additional copy of the information sheet and consent form. On the day of the interview you will be given an opportunity to go through the purpose of the research and ask any questions before you are asked to sign the consent form. If in the mean time you have any questions please feel free to contact the research team on the number above.

Yours sincerely,

Jasmine Lineker
Principal Researcher

Appendix G: Example from Transcript

Emergent Themes		Exploratory comments
	I: What techniques do you use now, you said you used some of the techniques what sticks out in your mind?	
Focusing on the now Being in control Gaining comfort from imagery Having a safe place that can't become unsafe Feeling relaxed	R: the very favourite one is the first one we ever did and its being in the now, and I love that, erm, I actually used it this morning [laugh] and after I used it I thought oh that's quite strange with today. Erm and its just focusing on the now bring everything back to the here and now. I just I like to focus on something erm even just the pen and looking at it, its shape and just focusing on it erm and then thinking what it does and taking my thoughts from the pen and going out and it's just stopping and erm stopping and smelling the roses kind of thing, let's just take now, I can't do anything about the past, the future hasn't come yet but we've got the now and let's just stop and take stock and yeah I like that one. My second one is, which I really struggled with is having my compassionate other erm and for me with my faith that's actually God and I don't know if you have seen the film Bruce All Mighty where there's the black guy who plays god, he's in a few of them, well erm he's kind of almost like my compassionate other, cause I can't think of face or person and my compassionate place is on a bench under a big Oak tree erm Oak trees in the Bible stand for righteousness and it's like a good thing and my bench is at a pool steam of water it's so beautiful. When I was doing the compassionate mind training I could never find a place because all my places that id ever had as safe places all	Love being in the now Being more focused – feeling of being in control Blocking things out – change in way of coping from self-harming Appreciating what is going on around – here and now Recognising what got and what needs to be done Difficulty with developing image What is god? What do you think he looks like? Not putting a face to the image – faceless – cant hurt me if don't know who you are – no identity Safe place What does Oak tree represent? – protection? Righteousness? Water – calming peaceful

Emergent Themes		Exploratory comments
Feeling relaxed	ended up as places I'd hurt myself, so this was a totally new place for me and I really enjoyed going to that place and just relaxing there that was a skill that although hard to get has become quite important to me for my place just to go and relax and be there with my compassionate other, whose God in my life.	Safe places becoming unsafe – place to hurt self – never feeling safe no one to look after her – has this happened in the past? Feeling protected and warmth Hard to develop Can relax
	I: you said it was hard to begin with why was that?	
Safe place to unsafe	R: I could actually find a place erm I liked I used to have the beach but them the beach is a place where I started going driving to and you know and walk into the sea and go so that was no longer a safe place. Erm the forests, well I'd drive up to the middle of nowhere and you know, it was cold , well I actually walked to a wood nearby and it was cold and I'd drank so much alcohol that I tried to kill myself, it was February, icy and I just thought well ill freeze there. So forests were out and the moors were out because of same sort of things and different places I couldn't find a place where I hadn't been to try and end life erm and I can't even remember who suggested a tree or a stream or how it came about but it's just this nice park bench with this great big Oak tree erm and by a stream and if it exists I'd love to go there but it exists in my mind at the moment and then this being, which didn't have a face at first and its only just gradually got this old man erm from a book that I read called 'The shake' there's an old man, it's supposed to be God, Holy Spirit and Jesus in it, and he was an old man in this book that I was sort of reading so got the face from there.	Focusing on real places – places that are supposed to be nice becoming nasty – trusting self trusting others
Support from group- Responsibility for change		Someone else developed the idea – I couldn't do it on own needed external force to help – like everything
Developing protective other		Exists in mind – important it's not real - can't be spoilt
		Old man protector – never had father figure to protect her

Emergent Themes		Exploratory comments
	I: So it all kind of pieced together	
	R: It all kind of pieced together yeah in the end, yeah and it was nice.	
	I: and when you go to that place what does it make you feel inside?	
Developing own safe place that have control over	R: Erm [pause] just really relaxed its my place, erm, nobody else can go into unless I invite them, which I'm not because it's my place, erm, it's almost like my zoned out place and I go there and close my eyes in that place and that's my time, my timeout, I'm just relaxed and I just talk to my compassionate other and [pause] and tell them everything, I suppose it's just like praying as a Christian but I just sort of everything that's on, my mind I just speak out and it just goes rather than it being bottled up inside and keeping and festering and getting bigger and being blown up out of all proportions, yeah, [laugh] it's easier to let it go these days.	Pause – reliving the feelings My place – something of my own I control it
Acceptance of emotions to be released in safe place		Allowing self to have own time – own thoughts and feelings to come out – release Talking to someone who is not real – this is ok – not strange like talking to god – justifying it. Comparison to praying
Fear of the unknown	I: When these techniques were first suggested what were you initial thoughts about practising them or doing them?	
Hopelessness	R: What a load of clap trap [both laugh] sorry, very cynical things don't work it's all just mind games, yeah, erm. I wasn't really sure about it and I thought yeah ok sounds a bit like CBT stuff and all this other stuff that doesn't work, but I'll give it a go otherwise I'll be sat here for 5 minutes just doing nothing whilst everyone else is giving it a go. So	Very cynical about things – what are these people trying to do to me – nothing works – hopelessness Comparing to past experiences of things not working – why should they work now Putting the effort in will change experience External shame – doing it for other people Self-critical Needing to practise to overcome pain / difficulty
Self-control		

Appendix H: Transcript One Audit of Themes

Theme	Line number
Acceptance of emotions/ allowing emotions to flow	344, 501, 530, 537, 572,762
Avoidance of emotions	130, 374, 450
Balance putting self first - putting own needs first	217, 247,248, 605
Barriers to engagement	123
Becoming dependent/reliant on group	478
Increased confident	229
Belonging	58, 61, 65, 486, 692,793
Blame – release	169, 180, 280, 283
Change in identity	149, 188, 253, 290, 782
Change in thinking	203
Commonality	54, 83 ,362 , 672
Compassion to others v compassion to self	143, 238
Continuous recovery	831
Developing new skills	81,213,821
Developing protective other	330
Developing self-compassion	358, 492, 500, 516, 863
Difference in expertises	809
Removing unhelpful relationships	194, 580
Experiencing range of emotions	316
Facilitator factors	444, 620, 669
False compassion	543
Fear of judgement from others	41
Feeling neglected	138
Focusing on here and now	296, 299
Gaining comfort from imagery - compassion	305
Greif	531
Group factors	73
Group factors - fragmentation/ Ruptures within group	75, 94, 406, 637
Group factors - Relaxed environment	746
Group factors - Testing the boundaries of the facilitators/group	369, 649
Group factors - time to share and process,	614
Group factors -Non judgmental	744
Helpful relationships	644,659
Hold on to security/support	471
Hopelessness to hopefulness	112, 164, 140, 270, 293, 315
Improved understanding	399, 413
Inflicting self pain – emotional v physical	116
Isolating others	102
Learning through others	724, 753, 755 802

Loss	467, 632
Meeting own needs	553, 560, 588
Need to nurture others	5,6,59,826
Opened up new opportunities	859
Power struggles	7,8
Practise	368, 390
Pressure on self	67
Preventing self-expression	97, 100
Recognising self-compassion	519, 380
Recognition by others	
Recovery journey	684
Requiring the support to continue	484, 612, 685
Responsibility for change	439, 565
Retraining brain	453
Reviewing past experiences	4,19
Safe place	44, 52,310, 340, 711
Self-acceptance	243, 275, 279, 287, 376
Self-critical	119, 266
Shame	141, 172, 258, 377, 385, 721
Support from others - group support	131, 329, 362, 663, 711
Take control	32, 194, 262, 431
Time	52
Trust	642
Uncertainty	23,25,28,109,120
Vicious cycle of hurt/self-criticism	509,715

Appendix I: Summary Table of Themes

Super-ordinate theme 1	**Sub-ordinate themes**	**Original themes**	**Transcript**					
			1	2	3	4	5	6
Compassion elements			y	y	y	y	y	y
	Acceptance and expression of a range of emotions.	Accepting feelings/emotions	y		y	y	y	
		Experiencing range of emotions self and others	y	y	y	y	y	y
		Releasing emotions				y		
		Experiencing compassion from others		y	y	y	y	y
	Self-acceptance.	Denial of self/emotions		y			y	
		Accepting who they are	y	y				
		Showing others who they are						y
	Nurturing the self.	Balancing -self before others/ Compassion for others v self	y	y	y	y	y	
		Need to nurture self/ recognising own needs	y		y	y	y	y
		Nurturing others to nurturing self	y	y	y	y	y	y
	Focusing on the here and now.	Focusing on here and now	y		y	y	y	y
		taking pleasure from the moment	y	y		y		

Super-ordinate theme 2	Sub-ordinate themes	Original themes	Transcript					
			1	2	3	4	5	6
Journey of Compassion Development.			y	y	y	y	y	y
	Developed understanding of lack of compassion.	Lack of compassion experiences preventing past development	y	y	y		y	
		neglect	y	y	y	y	y	y
	Breaking the cycle of self-criticism.	Recognising self-criticism					y	y
		negative self-criticism to positive self-criticism	y	y		y		
		Positive self-criticism			y	y		y
	Acceptance of past events.	Reliving past experiences	y		y			y
		coming to terms with past			y		y	
	Continual process.	Modelling of compassion					y	
		Natural development self- compassion		y	y	y	y	y
		Need to practice	y				y	
		Recognising compassion	y	y	y	y	y	
		Time to develop compassion	y					y
	Overcoming fear.	Threat to self identity				y		y
		Greater understanding	y	y	y	y	y	y
		Uncertainty of concept	y		y		y	

Super-ordinate theme 3	Sub-ordinate themes	Original themes	Transcript					
			1	2	3	4	5	6
Group Experiences	*Group functional factors*		y	y	y	y	y	y
		Facilitator factors - modelling, experts, support, no expectations	y	y	y	y	y	y
		Group support/encouragement	y	y	y	y	y	
		Helpful relationships	y	y		y		
		Learning through others	y	y	y	y	y	y
		Time within group	y		y			y
		Nurturing others	y	y	y		y	y
		Practising self-compassion	y				y	y
		Recognition from others	y				y	y
		Safe place		y	y	y	y	y
		Theory into practise			y	y		y
		Using techniques					y	
	Internal views of group		y	y	y	y	y	y
		Belonging	y	y	y	y	y	y
		Fragmentation in group	y		y			
		Isolating self - experiencing from the outside			y			
		Normalising				y	y	y
		Trust	y		y			
			1	2	3	4	5	6
	Commonality/ Indentifying with others	Belonging	y	y	y	y	y	y
		Commonality - not the only one	y	y	y	y	y	y
		Comparing self with others			y		y	
		Identifying with others			y		y	y
		Learning form others	y	y			y	
		Sharing experiences			y			

Super-ordinate theme 4	Sub-ordinate themes	Original themes	Transcript					
			1	2	3	4	5	6
Understanding of the Change Process	*Catalyst*		y	y	y	y	y	y
		Accepting feelings	y		y	y	y	
		Breaking the vicious cycle	y		y	y		y
		Change in perspective	y			y		
		Continuing to develop skills/ recovery	y	y	y	y		y
		Developing confidence	y			y		
		Distinguishing unhelpful relationships	y			y		
		Helpful relationships	y			y		
		Hope	y			y		
		Improved understanding	y	y	y	y	y	y
		Letting go of control				y		
		Motivation				y		
		Readiness to change	y		y		y	y
		practice	y				y	y
		Recognising personal growth				y		y
		Recognition from others	y				y	
		Recognition of problems	y	y	y	y		
	Barriers		y	y	y	y	y	y
		Difficulty continuing progress without support	y				y	
		Envy of others change		y				
		Fear	y	y	y			y
		Grief	y	y	y	y	y	y
		Highlights new difficulties	y		y			
		Hopelessness	y			y	y	
		Past experiences		y				
		Not fully engaging	y	y				y
		Reliant on others	y			y		y
		Uncertainty/expectations	y	y	y	y	y	y
		Vulnerability	y		y	y		y
		Blame/shame	y	y	y		y	
		Pleasing others not self			y		y	

Appendix J: Extract from Reflective Diary

Interview one

Just done my first interview!

Interesting that I was so nervous at the start, was it because I was concerned with getting as much information. Maybe it was because I was concerned with falling in to the therapeutic interview trap I had in my practice interview. Or was it because I was trying so desperately not to let my own assumptions of what they might say come out.

I was very aware of what was going on in that room. I wonder if you can pick up on it on the tape.

Anyway after [name] had started talking I realised that there was so much information coming out. Part of me wanted to share my interpretation there and then but knew that that would affect what they were say. I suppose looking back at it now I did a little bit with the questions that I asked, which is why I probably hung on to my pre-set questions. I think that this may have affected the flow though, so will try not to do that in the next interview.

I also noticed that Peter as very anxious too. Did he pick up on my nerves or did I pick up on theirs? Anyway they thought very carefully about everything they said, but yet still became easily muddled and confused. It felt like this represented his life, lost in a field of thoughts and emotions. There was a lot of pain and loneliness there that Peter was trying to hind from me. Was he trying to please me by showing that he had improved? Was he just kidding himself? It was clear that compassion was there and if he focused it it could come out but it certainly wasn't natural. Now without the group what does he have in his life that will allow it to develop?

He spoke very warmly about the group but at the same time there was a lot of regrets, loss and sadness, again a lot of mixed up feelings. As if his regulations systems were having a fight over who could control him better. I bet when I listen back to it I will here that going on, the ups and downs in his voice representing the rollercoaster of emotions her went through in that one hour.