What does self-compassion mean for individuals who have experienced a compassion focused intervention for chronic pain?

Mark Limbert

1829758

A thesis submitted to the School of Psychology in partial
fulfilment of the requirements for the degree of
Professional Doctorate in Counselling Psychology

University of East London

May 2022

Abstract

This research explores what self-compassion means for individuals who have taken part in a compassion focused intervention for chronic pain. The background highlights the prevalence of chronic pain and how it can be difficult to treat effectively given its complex and unique nature. The relevance self-compassion may hold for chronic pain is considered from an embodied perspective, based on existing research that emphasises the interconnected nature of the body and the mind. A review of the literature identifies a significant lack of research that explores the experience of self-compassion for individuals who live with chronic pain and particularly for those who have experienced a compassion focused intervention. This is despite an established body of quantitative literature that has tested the construct of self-compassion and its relationship to pain.

Semi-structured interviews were conducted with three female contributors who had all completed a compassion focused intervention. Interpretative Phenomenological Analysis was used to conduct an in depth exploration of the data. Three superordinate themes were constructed to reflect the experience of the contributors: living with chronic pain before self compassion; self-compassion as a journey; and the practice and benefits of being self-compassionate.

The research found that the group intervention was particularly helpful to the contributors given the close connections they formed. Self-compassion emerged as transformative. It enabled the contributors to respond to their pain in meaningful ways although it was difficult to develop and required support from others. The research seems relevant to psychotherapeutic practitioners and Counselling

Psychologists who value what in-depth accounts of lived experience can tell us. The findings seem to have significance for professional practice, development and training. There are implications for further research given the potential benefits of self-compassion and the perceived need to offer psychological support to individuals living with chronic pain who may feel marginalised.

Declaration

I confirm that the work is my own and that all appropriate safeguards have been taken to ensure that plagiarism has not occurred. Sources are cited for all quoted material, summarised or paraphrased.

Name: Mark Limbert

Signature:

Student number:

Date: 03.05.2022

Abbreviations

ACT: Acceptance and Commitment Therapy

CBT: Cognitive Behavioural Therapy

CFT: Compassion Focused Therapy

CoP: Counselling Psychology

CP: chronic pain

GT: Grounded Theory

IPA: Interpretative Phenomenological Analysis

RCT: randomized control trial

SC: self-compassion

TA: Thematic Analysis

Acknowledgements

I would like to thank the contributors who took part in this research for their generosity and their openness. It has been a pleasure and a privilege to attempt to present an in-depth exploration of their experience and what self compassion means for them. I have learned a great deal about many things, thank you.

I would very much like to thank my supervisor Professor Rachel Tribe for her tireless support and helpful comments. It is greatly appreciated and will be warmly remembered. I would also like to thank Professor Cynthia Fu for getting me started and taking such an interest in my project.

I would like to thank my friend Anna for introducing me to self-compassion. I hope I am the better and the wiser for it. I would like to thank my parents and share this with them in memoriam. I would also like to thank my family and especially my partner whose unfaltering support and encouragement makes so many things possible.
Thank you.

Table of Contents

Chapter 1: Introduction

1.1 Chapter Overview

This chapter foregrounds the aim of the research and presents the background to the topic. A rationale for the research is provided with a more detailed focus on the aims of the study and why it matters. The relevance of the research to Counselling Psychology is considered. The epistemological position of the research is introduced and the importance of critical reflexivity to the study is established. The chapter closes with a brief focus on personal reflexivity and my motivation to conduct the research.

1.2 The aim of the research

The primary aim of this research is to explore the experience of self-compassion and what it means for individuals who live with chronic pain (CP).

1.3 The background

Self-compassion and compassion are closely related. Gilbert (2010, p.3) describes compassion as “a sensitivity to the suffering of self and others with a deep commitment to try to relieve it.” Self-compassion can be described as kindness to the self (Neff, 2003) based on understanding and positive self-regard. Fostering self-compassion, or the compassionate self, is the principal aim of Compassion Focused Therapy (CFT) founded in the UK by Professor Paul Gilbert (2009b). CFT is now used in the NHS and has become an established therapeutic intervention for a range of diagnostic conditions. An established evidence base suggests self-compassion can enhance our relationship with ourselves and help us to regulate difficult emotions that affect our wellbeing (Beaumont & Hollins Martin, 2015; Kirby, 2017; Cuppage et al., 2018).

Chronic pain can be defined as persistent pain that lasts more than 12 weeks (Parry & Malpus, 2017). It can develop for a range of reasons and may result from viral infections, injury or invasive surgery. It is surprisingly widespread, 1.5 billion people worldwide are thought to live in chronic pain (Carolfi and Nickasch, 2021). Between one third and one half of the population in the UK experience chronic pain, approximately 28 million adults (Fayaz et al., 2016). The impact of chronic pain can be severe physiologically, socially and psychologically and may be helpfully conceptualised from the perspective of a biopsychosocial model (Wallace et al., 2021). It can be lifechanging and often imposes significant restrictions on what individuals are able to do which can affect their daily functioning and ability to work.

From a neurobiological perspective, the mind and the body are interconnected, emotions exacerbate pain, and pain activates distressing emotional responses (Lumley et al., 2011; Hughes et al., 2021; Lutz et al., 2020). Pain can be conceptualised as multi-dimensional affecting the whole person and their lived experience (Lerma et al., 2010). Higher incidences of depression are seen in people who experience chronic pain compared to the general population and difficulties regulating emotion are known to intensify depression and pain (Linton & Bergbom, 2011; Jury, 2021). Chronic pain is often associated with adverse life experiences and is linked to post traumatic stress disorder (Brennstuhl, et al., 2015). Those who live with chronic pain face social stigma, may not be seen as a priority from a medical perspective, and often belong to marginalised groups in society (Wallace et al., 2021).

1.4 Rationale, research aims, and why the research matters

For the reasons discussed it seems important to take an interest in chronic pain and consider how psychological interventions might be able to help the people it affects. Moreover, in the last few years, the relevance of self-compassion to chronic pain has been investigated. A developing evidence base of empirical studies indicate that self-compassion is relevant to chronic pain and can help individuals respond to their pain and manage negative emotional affect (Edwards et al., 2019; Austin et al., 2021). However, very little is known about how individuals experience self-compassion. This represents a limit to our knowledge and understanding of subjective experience and the process of facilitating self-compassion effectively and meaningfully for others in therapeutic practice (Hickey at al., 2017). For this reason, the proposed research aims to explore the experience of self-compassion and what it means for individuals who live with chronic pain. The research question asks:

What does self-compassion mean for individuals who have experienced a compassion focused intervention for chronic pain?

The main objective is to explore the experience of self-compassion. The intervention provides a context and a means of ensuring the contributors all have direct experience of self-compassion. This is particularly important as some qualitative self-compassion studies have attempted to explore self-compassion without ensuring the contributors have demonstrable knowledge or experience of the topic itself (Pauley & McPherson, 2010; Waite et al., 2015). In addition, self-compassion is not necessarily a construct people are familiar with beyond a common-sense definition. It requires explanation, and the means to develop it require guidance and support, particularly as those often most in need of self-compassion find it most difficult to cultivate (Gilbert & Procter, 2006; Gilbert, 2011). This is borne out by compassionate interventions and CFT which places significant emphasis on psycho-education (Gilbert, 2014). With these considerations in mind, the research question and the design of the study were conceived from a pragmatic perspective to ensure the contributors had significant experience of the phenomena under investigation. The experience of a compassionate intervention was conceptualised as a strong indicator of demonstrable experience.

In summary, the research is thought to matter because many individuals experience chronic pain and emotional distress and may benefit from being supported to develop self-compassion through a psychotherapeutic intervention. However, very little research exists that provides insight into the experience of self-compassion. This is relevant to psychotherapeutic practitioners including Counselling Psychologists because self-compassion may be a meaningful therapeutic focus to incorporate into clinical practice. The research also seems to matter because it is likely that practitioners will work with individuals who live with chronic pain even if their pain is not the main reason for engaging in therapy.

1.5 Relevance to Counselling Psychology

The research topic seems particularly relevant to Counselling Psychology because of its humanistic value base and its interest in subjective experience. Counselling Psychology seems well placed to respond to the difficulties of this group because of its core principles which include a commitment to empathic engagement with a congruent and non-judgemental attitude. Moreover, Counselling Psychologists are encouraged to be scientist practitioners (Kasket, 2012) and to adopt a pluralistic approach (Cooper, 2019) to theory and therapeutic intervention. This means working in different ways with diverse individuals while drawing on a variety of psychological modalities which might include CFT. From a professional development perspective, Counselling Psychologists are also encouraged to extend their training and incorporate new methods into their therapeutic practice so becoming more familiar with self-compassion may be helpful. This research may be relevant then to Counselling Psychologists, the helping professions, and to individuals living with chronic pain who may want to consider self-compassion as a means of helping them respond to their difficulties.

1.6 Epistemological position and reflexivity

The perspective of the study is determined by an interpretative phenomenological epistemology and uses Interpretative Phenomenological Analysis (IPA) as a method of exploration. Epistemological reflexivity is considered to be of central importance to the research because IPA seeks to construct knowledge about the experience of others through subjective interpretation (Willig, 2013). Reflexivity will be considered in detail in both the methodology and discussion chapters.

1.7 Personal reflexivity

Personal reflexivity is also considered to be important to IPA research because of the central position of the researcher and the values, beliefs and pre-conceptions they bring with them (Willig, 2013). Personal reflexivity will be discussed further in the methodology and discussion chapters and was considered throughout the analysis as I became more aware of my pre-conceptions.

1.7.1 Motivation to conduct the research

I would like to close the introduction by providing a reflexive insight into my motivation to conduct the research. Firstly, the therapeutic construct of self-compassion was first introduced to me by a friend. We often seem to be introduced to things worthy of consideration by others and for this reason I was motivated to research the topic and introduce it to others who may not know much about chronic pain or the possible applications of self-compassion.

The clients I have worked with during my doctoral training have inspired this research. This is particularly the case with two clients who lived with chronic pain. More recently, the clients I worked with using CFT inspired the research encouraging me to explore self-compassion further. My motivation to write up the research was fuelled by my regard for the contributors and my aim to present the meaning of their experience comprehensively. Ultimately, I feel motivated to share with others what I have learned with them.

Chapter 2: Literature Review

2.1 Introduction

This chapter first presents a context for the research by introducing self-compassion (SC) and Compassion Focused Therapy (CFT). CFT is the principal compassion focused approach used in the UK which provides a model for a range of compassionate interventions including the one the contributors in the proposed study participated in. The relevance of SC and CFT to Counselling Psychology (CoP) will be considered throughout. A consideration of the theoretical and evidence bases for both SC and CFT will follow. Next, an introduction to CP will be provided followed by a consideration of the relevance of self compassion to chronic pain. A review of the existing literature offers a critical perspective from an interpretative phenomenological epistemological perspective. The final section focuses on the proposed research, introduces the research question, and provides a rationale for why the research matters. The review concludes with a brief summary of the chapter.

2.2 An introduction to self-compassion and its relevance to Counselling Psychology

From within the USA, Kristin Neff has been instrumental in helping to define and establish the therapeutic relevance of SC. Neff (2003) suggests SC has three main principles: kindness to the self; common humanity; and mindful awareness. Kindness to the self is the epitome of SC and is a compassionate alternative to self-criticism. Common humanity (meaning connection to others) emphasises the relational nature of human experience and the bidirectional connection between self and others. Mindful awareness relates to the importance of being aware of one's difficulties so that action can be taken to enhance wellbeing. The principle of common humanity and its focus on the self in relation to others seems relevant to the phenomenological approach associated with CoP (Murphy, 2017).

Based in the UK, Paul Gilbert has been central to the compassion movement. He founded the Compassionate Mind Foundation in 2005 and developed Compassionate Mind Training (CMT) and Compassion Focused Therapy (CFT). CFT is a third wave psychotherapeutic therapy with many applications. It was originally developed as a transdiagnostic therapy for clinical populations (Gilbert, 2014).

CFT has a science base which will be considered shortly but compassion theory also draws on ancient Buddhist ideas about the value of compassion (Shonin et al., 2014). Gilbert (2010, p.3) offers a Buddhist definition which describes compassion as: “a sensitivity to the suffering of self and others with a deep commitment to try to relieve it.” This seems relevant to the ethos of CoP and its aim to respond empathically and purposefully to others’ distress. There is a sense of social justice here relevant to CoP (Tribe and Bell, 2018) given the emphasis on “commitment” and the significance CFT places on how social context influences opportunity and development (Gilbert, 2009a).

2.3 The theoretical base for self-compassion & CFT

Self-compassion is conceptualised as a means of self-to-self relating that can help the individual to manage difficult emotions and realise their potential (Gilbert, 2010). Emphasis is placed on the “tricky brain” (Gilbert, 2009a) which experiences distress in response to threat. The tricky brain is used to describe the hybrid nature of the brain and how highly evolved thought processes can trigger much older threat responses that arouse distress (Gilbert, 2014). In CFT therapy individuals are encouraged to “de-shame” by recognising that their difficulties are “not their fault” but belong to a much wider evolutionary and social context (Gilbert, 2014). This seems relevant to CoP which looks at the individual in context as opposed to a medical perspective that pathologizes the individual (Murphy, 2017). Gilbert (2009a) suggests CFT reflects the core Rogerian principles of empathy, congruence and a non-judgemental attitude which are central to the humanistic values of CoP (Cooper, 2009). These principles are key to the way CFT aims to model compassion so the therapist is experienced as compassionate and interventions are compassion focused (2009a).

2.4 The scientific evidence base for CFT

Gilbert (2009a) states the evidence base of CFT is rooted in the science of the mind and it draws on the range of psychological sciences including developmental psychology, social psychology, evolutionary psychology and neuroscience. The main science underpinning CFT relates to the evolution of the principal human emotion regulation systems and the evolution of caring behaviour. The three systems model of emotional regulation underpins CFT (Gilbert, 2014) which emphasises the need for balance to maintain wellbeing. The three systems relate to: threat and protection; drive and reward; and comfort and affiliation (Gilbert, 2014).

The comfort system is conceptualised as having the ability to regulate heightened emotion associated with threat. The interplay between the systems is linked to the whole being and the way the parasympathetic nervous system (associated with comfort and affiliation) regulates the sympathetic nervous system (associated with threat and drive). Compassion for self and others is seen as integral to the comfort and affiliation system and self-compassion is seen as a way to engage this to regulate negative affect (Gilbert, 2014). Consequently, compassion focused interventions aim to cultivate SC in individuals to enable them to manage their emotions rather than be governed by them. McManus et al. (2018) highlight the effectiveness of CFT interventions across therapeutic practice.

2.5 Evidence for self-compassion

Narrative reviews and systematic analyses provide an emerging evidence base for the role of SC and the effectiveness of compassion focused interventions (Beaumont & Hollins Martin, 2015; Kirby et al., 2017; Cuppage et al., 2018). Beaumont and Hollins Martin (2015) conducted a narrative review of compassion focused interventions which concluded that individuals with different psychological difficulties could benefit from developing self-compassion.

Kirby et al. (2017) conducted a meta-analysis of 21 randomized control trials (RCTs) which evaluated the effectiveness of compassion focused interventions in the last 12 years. Moderate effects were identified for reducing depression, anxiety and psychological distress and for increasing wellbeing. Other research has focused on SC for specific clinical conditions such as: depression (Krieger et al, 2016); psychosis (Braehler et al., 2013; Waite et al., 2015); personality disorders (Schanche et al., 2011; Lucre & Corten, 2013; Feliu-Soler et al., 2017); sexual abuse (McLean et al., 2018); trauma (Lee, 2009; Lawrence & Lee, 2013); and substance use (Chen, 2019).

Although an evidence base exists, most studies have their limitations. For example, the Beaumont and Hollins Martin (2015) narrative review was based on 12 studies as 873 were rejected because they did not focus on clinical populations. This reduces the extent to which the findings can be generalised. The authors emphasised the essential need for further quantitative and qualitative research to investigate how self-compassion works and how it is experienced.

In summary, SC is believed to have the potential to regulate emotional distress and mitigate shame and self-criticism which are thought to underly and maintain a range of psychological difficulties (Cuppage et al., 2017; D'Raven & Pasha Zaidi, 2014). Self-compassion is part of an objective to empower individuals and enable them to reach their potential rather than be limited by the restrictions that may be imposed by psychological distress. This seems relevant to CoP practice and its focus on wellness and what is meaningful for the individual (Murphy, 2017). The evidence base that underpins the construct of compassion and its commitment to relieving distress in the self and others seems relevant to CoP and Shullman's (2017) scientist-practitioner, advocate-leader model.

2.6 An overview of chronic pain

Chronic pain can be conceptualised as multidimensional with emotional and cognitive elements in addition to the physical aspect (Costa & Pinto-Gouveia, 2013). Barnes et al. (2021) stress how individuals with chronic pain may often experience physical limitations, concentration difficulties, anxiety, stress and depression and that their needs are often unmet. Hession (2010) suggests that historically pain was viewed as a problem within the individual and was not responded to compassionately by dominant psychological models. Individuals who experience chronic pain often report feeling judged and stigmatised (Wallace et al., 2021). Consequently, individuals may feel rejected and become isolated which can intensify their pain and emotional distress as both are connected by the same physiological system (MacDonald and Leary, 2005). Chronic pain can be difficult to treat given its unique nature and the way it often evades diagnosis (Penlington, 2019). Typically, the primary intervention involves prescribing analgesics and long term use may carry side effects. Opioid painkillers, often associated with stigma, are frequently prescribed which can lead to dependency, misuse and overdose (Atkinson et al., 2021). Furthermore, documented inequities in healthcare are believed to impact on the experience of those living with chronic pain (Wallace et al., 2021).

Relevant to Counselling Psychology, its humanistic values (Cooper, 2009) and social justice perspective (Tribe & Bell, 2018), is the way chronic pain is often associated with poverty, social disadvantage and stigma (Carr, 2016; Wallace et al., 2021). Consequently, the chronic pain community can often be side-lined and underrepresented. Moreover, treatment in speciality pain clinics is not always easy to access (Beehler et al., 2021). Wallace et al. (2021) suggest chronic pain is more than a health issue and should be regarded as a social justice concern seen in the social context of discrimination. Wallace et al. (2021) contend that the stigma and discrimination associated with chronic pain connects to other stigmas including but not limited to race, ethnicity, class, sexual orientation, substance use and mental health.

In summary, chronic pain is not simply a physical problem but a holistic issue. It is often associated with psychological, social and economic factors and disproportionately effects those living in poverty. Chronic pain is complex, can be difficult to understand, and is often unresponsive to treatment. Moreover, prescription painkillers, and especially opioid analgesics, may do more harm than good (Atkinson et al., 2021).

2.7 Chronic pain and its association with shame and guilt

Serbic et al., (2022) foreground the connection between chronic pain, shame and guilt. They suggest the scientific literature often uses the terms shame and guilt interchangeably but posit that they are distinct concepts. Tangney et al., (2007) distinguish between the two by contending that shame relates to a negative evaluation of the self and guilt relates to a negative evaluation of one's behaviour. Guilt has affective and cognitive aspects and distressing emotions may relate to an individual's belief that they have behaved wrongly or hurt somebody (Kubany and Watson, 2003). Serbic et al. (2022) suggest health related guilt is an important psychological factor associated with pain and functional impairment. Moreover, guilt may link to self-blame and relate to the diagnostic uncertainty often associated with chronic pain. Guilt can lead to reduced pain acceptance and can increase anxiety and depression.

Smith and Osborn (2007) highlight the connection between shame, chronic pain and the limitations it can impose. They suggest shame relates to a diminished sense of self in a social context based on how individuals in chronic pain may think and feel about themselves in relation to others. Gilbert (2000) suggests shame is related to distress and social anxiety. It originates from the fear of negative evaluation from others and negative self-evaluation based on comparisons with others. Paulson et al. (2002) suggest that an improved ability to manage pain is directly related to a positive sense of self, moving from shame to self-respect.

2.8 The relevance of self-compassion to chronic pain

Purdie and Morley (2016) conducted a topical review of compassion and chronic pain research not long after compassionate interventions began in the UK. Their position was that compassionate interventions could help foster SC which has a particular relevance to chronic pain. They highlight social context and link the physical restrictions imposed by pain to potential changes in social role performance. Consequently, the limitations imposed by pain can lead to experiences of feeling discredited or devalued by others. In turn this may lead to negative self reappraisal which may elicit shame and self-criticism. Due to the established psychological, social and neurobiological connections there is a bi-directional relationship between pain and emotion. Pain can trigger difficult emotions which can intensify pain and make it harder to manage.

Purdie and Morley (2016) contend that the affiliative aspect of compassion that connects us to others is beneficial in itself. However, the affiliative aspect also helps to create an affiliative or caring connection with the self. They suggest SC transcends a “performance based evaluation of the self” (p.3) which is rooted in a social context and relates to what one is able to achieve in terms of social expectation. Self-compassion enables the individual to replicate internally an affiliative relationship and regulate negative affect by self-soothing. The authors postulate that SC can help individuals to manage difficult emotions and develop adaptive coping strategies to face some of the difficulties associated with pain.

2.9 The historical and contemporary context of psychological therapy for clients living with chronic pain.

Despite the potential SC may hold compassion focused interventions for chronic pain are a recent development and do not represent a typical treatment offer. This contrasts with the way CFT has become a more established psychological intervention for a range of other presentations as previously explored. However, research has begun to recognise the effectiveness of compassion focused interventions in NHS pain clinics (Parry & Malpus, 2017; Edwards et al., 2019; Gooding et al., 2020).

Historically, treatment for chronic pain has had a medical bias with a physiological and pharmacological approach which involved prescribing analgesics alongside surgery, injections, physiotherapy and the use of spinal cord stimulators and other forms of neuromodulation (Darnall 2019). With the establishment of the biopsychosocial model as the primary means of conceptualising chronic pain psychological interventions have become a key part of pain treatment in recent years (Driscoll et al., 2021). Four broad categories of intervention have been identified including behavioural and cognitive behavioural therapies, mindfulness based interventions, and third wave therapies (Sturgeon, 2014; Lazaridou et al., 2020). Although CFT is a third wave therapy, Lazaridou et al. (2020) suggest Acceptance and Commitment Therapy (ACT) is the most broadly established third wave therapy used for treating CP. However, Cognitive Behavioural Therapy (CBT) continues to be the treatment recommended by the National Institute for Health & Care Excellence (NICE) (Kilic et al., 2021) and is widely recognised as being the predominant evidence based intervention for chronic pain (Sturgeon, 2014; Lazaridou et al., 2020; Driscoll et al., 2021).

Psychological interventions are now a well-established part of an interdisciplinary approach to CP (Lazaridou et al., 2020). Nonetheless, Darnall (2021) suggests they are often delivered after physiological and pharmacological interventions have been unsuccessful leading the author to suggest that psychological interventions should be offered from the outset of care. Lumley and Schubiner (2019) recommend an integrated approach to psychological treatment and McCracken (2020) advocates approaches which draw on different therapies and utilise evidence based change processes tailored to individual needs. One such process might involve developing a compassionate self to help manage the impact of pain and this was the central aim of the compassion focused intervention the contributors in this doctoral research took part in. Their particular intervention was designed to respond to their striving tendencies and it dispensed with a fear avoidance approach to CP often associated with CBT. This was based on the premise that individuals with psychologically motivated striving tendencies need to be kind to themselves which includes rest and recuperation rather than taking on more activity which can lead to burn out, increased pain and greater psychological distress (Parry and Malpus, 2017).

2.10 Critical review of the existing literature

The extant literature on self-compassion and chronic pain is mainly conducted from an empirical position and there are very few qualitative studies. A wider body of literature exists in the broader category of self-compassion and health. A systematic review of the effectiveness of self-compassion for individuals with chronic physical health conditions (Kilic et al., 2021) concluded that self-compassion interventions increase levels of self-compassion. The authors suggested that by increasing self-compassion the interventions facilitated enhanced psychological and physiological outcomes but it is unclear from their review how self-compassion brings about change. This may be due to the way included studies relied on the Neff (2003) self-report standardised compassion scale to measure self-compassion levels rather than explore the experience of self-compassion and what it enabled individuals to do differently with greater efficacy.

Nonetheless, a strength of the Kilic et al. (2021) systematic review was that it focused exclusively on randomized control trials which all included control groups as a central feature of their research design. The results showed enhanced psychological outcomes were associated with the compassion focused interventions compared to other types of intervention for chronic physical health conditions. However, eleven different types of compassion focused interventions were represented in the review and different interventions acted as a significant variable affecting the conclusions that could be drawn about the efficacy of self-compassion for individuals with chronic pain health conditions. The inclusion criteria required selected studies to have only a minimum of one focused self-compassion session and the interventions varied from single sessions to typical eight week treatments. There was a considerable difference in the effect sizes of the different interventions perhaps due to the variance in the length and nature of treatment with interventions such as compassion based cognitive therapy having a far more concentrated focus on developing self-compassion than more broadly focused mindfulness interventions. Surprisingly, the range of interventions reviewed did not include either compassion focused therapy or compassionate mind training interventions which maintain a sustained focus on developing self-compassion. If the review had included dedicated compassion focused interventions the results may have been more conclusive and may have told us more about the potential of self-compassion. This seems particularly the case given the way the different interventions reviewed had a range of clinical priorities and did not focus exclusively on developing self-compassion in the way CFT does.

Lanzaro et al. (2021) carried out a systematic review which assessed the effectiveness of compassion based interventions for CP across seven studies involving 253 participants. They then tested the relationship between self-compassion and eight pain related outcomes looking at nine studies and a total of 1,430 participants. Outcomes included the way self-compassion can mediate distress, anxiety and pain related coping. As with Kilic et al. (2021), the conclusions that could be drawn about the efficacy of self-compassion interventions and the relationship between self-compassion and chronic pain in this review were limited due to the dissimilar nature of the studies.

If the Lanzaro et al. (2021) review had sharpened its focus on a specific intervention with a clear theoretical base and defined clinical aims it may have provided more definitive conclusions. Although the study showed positive indications that self-compassion was correlated with enhanced pain outcomes both physiologically and psychologically the conclusions were tentative as the different studies selected for review varied in the way they assessed the quality of the interventions. The Kilic et al. (2021) and Lanzaro et al. (2021) studies seem to indicate the limited value of systematic reviews in the field of self-compassion for chronic health conditions and chronic pain given the relatively small body of extant literature which seems to be characterised by a focus on a range of interventions with different quality assessment methods.

Whereas the systematic reviews focused on studies that explored self compassion among clinical populations a qualitative narrative study by Barnes et al. (2021) focused on seven female student contributors in Canada who reported experiencing chronic pain. The aim of the study was to explore the role of SC in managing the affective-emotional experiences of CP. The analysis set out to interpret the participants’ stories and the findings emphasised commonality. The study suggested that self-compassion helped to mitigate isolation and the way the participants’ experiences of pain could lead to disconnection from others. In keeping with compassion theory, a sense of common humanity emerged from the analysis as self-compassion was linked to feeling connected to others.

The study employed three main methods of investigation. These included: focus groups talking about the experience of pain; participants taking photographs for one week to capture their affective-emotional experience of pain; and one-to-one interviews which discussed the meanings the photographs represented. However, from an interpretative phenomenological epistemological perspective homogeneity was an issue as the participants did not have prior experience of the phenomena of self-compassion although they reported experience of chronic pain. To compensate for this the researchers introduced a definition of SC to the participants and explained the concept to them. This was followed by an information video and a SC reference sheet was provided for participants to refer to during the interviews. This method seems to have primed the contributors with an imposed understanding of SC at odds with the research aim to explore self-compassion through narrative enquiry.

The study's account of how the narratives were put together and what they represent seems unclear. The authors explain that individual transcripts were made but the narratives seem to have been written up as a composite of collective experience rather than a reflection of individual experience. There seems to be some confusion about what the data represents and whose voices are represented which limits our understanding of contributors' experiences of CP.

A significant limitation of the study seems to be the way participants were invited to discuss the potential role SC might hold for them in the future. Discussions seemed hypothetical rather than experiential and focused on how participants might use SC to help them manage their affective-emotional experience of CP. Selected quotations in the study seem to represent speculative accounts of what the experience of SC might be like. This seems to limit what the study can tell us about self-compassion for chronic pain. Follow up interviews might have invited the participants to reflect on their experience of CP after they had been introduced to SC.

Randomized control trials (RCT) have tested the efficacy of psychotherapeutic interventions with clinical populations with the aim of telling us more about self-compassion for pain. Torrijos-Zarcero et al. (2021) compared the effects of a mindful self-compassion intervention for individuals with CP (62 participants) with the effects of a CBT programme (61 participants). The study concluded that the self-compassion intervention promoted self-care and was more effective than CBT (the gold standard treatment for CP) in mediating pain anxiety and interference and helping to foster pain acceptance. The authors suggest that self-compassion interventions for CP have a psychotherapeutic value for people with CP and should be promoted over other treatments. However, the impact of this study maybe limited by not having a no treatment/waiting list control group. Purdie & Morley (2016, p.6) highlight how this can detract from research findings as it can become impossible to "distinguish the benefits of a SC intervention from other variables such as social support or normalization within a group setting which may also have predicted positive change."

Further to this, Mistretta & Davis (2021) caution on the conclusions that can be drawn from looking across RCTs due to small effect sizes. They conducted a meta-analysis of RCTs that evaluated self-compassion interventions with individuals with chronic illness. The study reported that self-compassion interventions for chronic illness showed small improvements in depression, anxiety, pain and quality of life but studies did explore the lasting benefits of self-compassion. The authors suggested future RCT research should include follow up assessments to determine whether over time self-compassion interventions were an effective treatment for the co-morbid mental and physical health challenges faced by individuals with chronic illness.

Empirical research in the field seems to be at a relatively early stage and this was seen with RCTs which have tested the effectiveness of SC interventions for chronic pain. There seems to be the need for further empirical research but also for alternative epistemological approaches which present more nuanced insights into lived experience which can contribute to our knowledge and understanding. Gooding et al. (2020) conducted an IPA study triangulated with facilitator reflections and questionnaire data which asked four participants about mood, pain awareness, pain disability, and self-reassurance versus self-criticism. The purpose of the research was to explore the effectiveness of a 12 week CFT intervention in a pain clinic setting. It appears to be the first IPA study to focus specifically on a CFT intervention for chronic pain. The study identified five superordinate themes and emphasised the importance of the affiliative experience of the group connection which enabled participants to process negative emotions related to their pain. It emerged from the analysis that SC helped the participants to self-soothe and the authors concluded that the intervention enhanced individual wellbeing.

However, the aim to evaluate the effectiveness of the intervention seemed to heavily influence the interview schedule perhaps at the expense of enabling exploration of issues more relevant to the participants. Questions foregrounded specific elements of participant experience around the categories of group connection, quality of life, and the participants’ ability to apply taught skills on a daily basis. These categories seemed to echo the focus of questionnaires that were also used to gather data and reflect the study's commitment to triangulation. These methods may have more to do with the researcher's concern for validity and testing convergence from different sources of information as opposed to eliciting a depth of understanding by having a more open and less prescriptive interview schedule. From a phenomenological epistemological perspective, the study may not have maximised all its opportunities to provide a detailed exploration of unique experience.

Although IPA was central to the investigation of the effectiveness of a particular intervention the conclusion seemed to move beyond the idiographic experience of the participants involved. It implied a representative value by suggesting that CFT may offer a helpful therapeutic approach to individuals who experience high levels of shame and self-criticism. Although reflexive methods were adopted to consider how the data were interpreted the conclusion seemed to generalise and make a claim more associated with nomothetic research.

Empirical approaches that explore the relationship between CP and SC seem to offer more confident results about the value of SC than was seen in the RCTs. Wren et al. (2012) examined the relationship between SC and psychological functioning, pain coping and disability in 88 obese participants who experienced chronic musculoskeletal pain. The results indicated SC was a significant predictor in each domain and the authors concluded SC seemed to be an important factor in understanding variability in this group. However, regression analysis was based on a self-report measure participants were asked to complete either before or after they saw their anaesthesiologist regarding their medication. The timing may have significantly affected the way participants responded depending on their relationship with and attitude to pain medication and how straightforward or distressing it was for them to meet their anaesthesiologist. Moreover, it is not clear how the temporal variable of “before or after” was controlled for or how it might have influenced data collection and the subsequent results.

Edwards et al. (2019) investigated the relationship between self-compassion and measures of functioning in 343 adults with chronic pain who completed a battery of standardised measures prior to their first assessment in a United Kingdom community based pain clinic. Regression analyses indicated that SC was related to lower pain related fear, depression and disability. SC was also correlated with higher pain acceptance and improvements in valued activity and pain coping strategies. The most significant correlations related to psychological functioning and valued living. The study concluded that SC is a relevant adaptive process for those who experience chronic pain and that SC interventions help individuals to cope with the impact of CP.

Despite the rigour of the study the impact of the Edwards et al. (2019) study maybe limited. Although regression analyses indicated a relationship between self-compassion and enhanced coping strategies the methodology was unable to provide evidence of causation between SC scores and functioning measures. Moreover, the study was based on predominantly white European women who were treatment seeking and mostly cohabiting. For these reasons the results cannot be generalised to other ethnicities, genders or non-treatment seeking individuals who may not be living with a partner.

Carvalho et al. (2020) conducted the first longitudinal study testing the relationship between self-compassion and chronic pain over 12 months. A sample of 86 female participants completed questionnaires at three time points that assessed pain intensity, functional impairment, depressive symptoms, mindfulness, and self-compassion. The study reported that self-compassion helped to reduce depressive symptoms at both 6 and 12 month points after their interventions. The authors concluded that self-compassion had the ability to reduce the way functional limitations associated with chronic pain made depression worse.

The correlational studies reviewed here aimed to provide nomothetic insight based on the representativeness of significant sample sizes. The statistical methods may be seen to be impartial and provide scientific rigour. A sense of objectivity may also be reflected in the way the participants completed their questionnaires independently without interacting with the researchers. However, whereas this might be a strength from a positivist position it can be seen as a limitation from a phenomenological perspective because the participants did not have the opportunity to make sense of their experience in relation to a researcher through an interactive process. Moreover, there are issues with using standardised measures to test for associations between SC and aspects of CP. Questionnaires may impose categories of meaning on participants which determine the sort of response they provide. Questions were closed rather than open which enabled quantification rather than qualification. This restricted opportunities for meaning making that might be explored by a phenomenological method aimed at uncovering detailed accounts of how self compassion was experienced.

Parry & Malpus (2017) used IPA in their published pilot study to explore how six participants developed self-compassion for chronic pain based on an eight week group intervention run by the authors in an NHS pain clinic. As with the Gooding et al. (2020) IPA study, there was also the objective to evaluate the effectiveness of the intervention. The Parry & Malpus (2017) study is particularly relevant because the contributors in this proposed doctoral research took part in a pain clinic group intervention based on the same model described in the Parry & Malpus (2017) study.

The study provides numerous insights into the benefits of self-compassion for chronic pain in the context of a group intervention. Firstly, descriptive statistics based on eight participants’ responses to six pre and post group measures were presented. IPA findings were then based on group discussions with six participants. The descriptive statistics suggest a reduction in pain related anxiety and depression and an increase in self-compassion, pain acceptance and activity engagement. IPA findings suggest the intervention helped the clients to become more self-compassionate which helped them to find new ways of perceiving and managing their pain which was beneficial to their emotional wellbeing. A strong sense of the participants’ process of rediscovery and reconnection emerged from the analysis.

However, the authors acknowledged a potential bias in that the service providers also conducted the research, ran the discussion group which provided the data, and then carried out the analysis themselves. They attempted to address this through a reflexive process, meeting to discuss and compare their own independent analyses and identification of themes. However, both authors remained insiders connected to the research by their dual role as service providers. Moreover, the focus of the research seemed to emerge from a specific context which aimed to evaluate the efficacy of the intervention. The authors (p.146) suggested that a compassionate intervention might be more appropriate than an established CBT approach based on a “fear avoidance approach to pain.” The CBT approach was perceived as unhelpful to participants who demonstrated striving tendencies as their attempts to cope with pain by doing more activity were counterproductive both physically and psychologically.

A key strength of the study was its commitment to providing a platform for the voices of the service users. The IPA rationale for the study was to encourage participants to reflect on their thoughts and emotions in relation to their experience of pain. However, the experience uncovered may have been restricted by the context of the study and its dual objectives to assess the effectiveness of an intervention and to simultaneously respond to a gap in the literature by investigating “the therapeutic utility”(p.146) of compassion.

As IPA research, a further limitation might be the way in which idiographic accounts of experience were collected in a group setting. The study foregrounds the importance of the group connection amongst the participants but does not seem to acknowledge how a group discussion setting might have influenced individual sense making and the process of data collection. It may be the case that the data provided might have been influenced by the presence of other group members and a sense of group identity. There is a possible tension between the use of an idiographic IPA method and the research design itself as the participants made sense of their experience in the presence of other insiders. A more neutral setting might have been more appropriate for exploring the depth of unique experience.

2.11 The proposed research

The proposed doctoral research aims to provide an opportunity for its contributors to reflect and make sense of their experience of self-compassion with a researcher positioned as an outsider. This seems important in response to the critique of the Parry & Malpus (2017) study. The research question seeks to explore what SC means for individuals and has a more singular aim than the previous IPA studies as it does not aim to evaluate the intervention itself. Mindful of the suggested limitations of the Barnes et al. (2021) narrative study, a compassion focused intervention provides a context for this research. It ensures homogeneity with the contributors all having had personal lived experience of the phenomena of self-compassion which is being explored. Unlike the two aforementioned IPA studies, the intervention itself is not intended to be the primary focus, nor is there an attempt to evaluate its effectiveness, or its value as an alternative approach to CBT for individuals with striving tendencies.

The proposed research attempts to respond to a gap in the literature and the need for explorations of lived experience to complement insights from empirical studies. Moreover, there is a significant lack of qualitative research that tells us what it means for individuals to experience self-compassion in the context of chronic pain. It seems important to contribute to the field because collections of phenomenological studies can add to our knowledge (Smith et al., 2009). The proposed research may be able to tell us more about how self-compassion is experienced by different individuals with potential implications for ways of thinking and approaching clinical practice. By learning about others, therapists may be better able to respond to and support the individuals they work with in therapeutic settings and other areas of engagement. With these considerations in mind the research question asks:

What does self-compassion mean for individuals who have experienced a compassion focused intervention for chronic pain?

The research seems to matter on two key levels. Firstly, because self-compassion for CP is under researched and yet existing research highlights its potential to enhance the quality of life for those living with CP. This seems to warrant further exploration to advance knowledge and understanding of what might be helpful for people living with pain and emotional distress. Secondly, studies with a phenomenological commitment to exploring lived experience seem important as individuals living with pain may experience medically undiagnosed symptoms and may be misunderstood, stigmatised, and isolated (Carr, 2016; Wallace et al., 2021). It seems important from a social justice and advocacy perspective (Shullman, 2017) to take an interest in bringing the stories of individuals to light so more is known and can be done to support them.

2.12 Summary

This chapter introduced SC and CFT with a consideration of their relevance to CoP values and practice. The theoretical and evidence bases for SC and CFT were considered highlighting the multi modal approach of CFT which aims to foster self-compassion to help manage distressing emotions and enhance relationships with the self and others. An introduction to CP was presented which established how it affects the whole being as both physiological and psychological elements are interrelated. The relevance of SC to CP was explored drawing on the Purdie & Morley (2016) topical review which suggested SC helps to foster an affiliative relationship with the self. This can help to manage negative self-appraisals that represent threat and may lead to psychological distress. The literature review described some of the key research on both SC and CFT to establish a context for the proposed research before offering a critical review of the extant literature from an interpretative phenomenological epistemological perspective. The review then presented the research question and argued that the research mattered because it may contribute to understanding more about how individuals with CP experience SC so more might be done to help and support them both therapeutically and in other contexts.

Chapter 3: Methodology

3.1 Introduction

In this chapter I will identify my research paradigm and present a consideration of my epistemological and methodological position. A rationale for my use of Interpretative Phenomenological Analysis (IPA) will be provided with a brief consideration of alternative methodological approaches. This will be followed by an overview of the aims and central ideas of IPA and how I consider them to be relevant to my research. An outline will be provided of the research design, the data collection process and the IPA analytic procedure. Subsequent sections will focus on the research contributors, recruitment, validity, ethics, and reflexivity in qualitative research.

3.2 The research paradigm: Ontology and epistemology

It seems important to identify my research paradigm and present my ontological and epistemological position to help the reader understand how the research has been conceived, what it sets out to do, and how it may be assessed. My IPA research is based on a constructivist paradigm with a relativist ontology (Ponterotto, 2005) and an interpretative phenomenological epistemology (Larkin and Thompson, 2012).

Guba and Lincoln (1994) describe a paradigm as a “worldview” based on ontological, epistemological and methodological assumptions. Willig (2013) suggests ontology is concerned with what is there to know and epistemology focuses on how we can know it. To take this further, Ponterotto (2005) describes ontology as “the nature of reality and being” and epistemology focuses on how we acquire knowledge of “reality and being”. Consequently, my research paradigm is based on what I believe there is to know, how it can be known, and the means of investigation. This in turn is influenced by axiology, the values the researcher brings to the research (Ponterotto, 2005).

For Ponterotto (2005), a paradigm sets the context for research, it provides a philosophical foundation and guides the researcher through the project. Madill et al. (2000) suggest a paradigm provides research with a “logic of justification” and determines the standards by which it can be evaluated. Morrow (2005) echoes this indicating a paradigm guides the reader by providing a basis for assessing the value of research. In this sense, presenting a clear research paradigm seems essential as it provides a means of evaluating the research based on what it is, what is sets out to know, and the methods it adopts to do this.

The constructivist position seems particularly suited to the qualitative study of human experience and consciousness with its emphasis on meaning making and interpretation. I subscribe to Ponterotto’s (2005) contention that constructivism has a relativist ontology which posits that there are multiple realities which are constructed in the mind of the individual in a specific context. The relativist ontological position suggests there are multiple realities we can seek to know which all hold the same value rather than just multiple interpretations of a single reality (Schwandt, 1994; Ponterotto, 2005).

Ponterotto (2005) suggests our realities are hidden but become knowable through an epistemological approach based on a hermeneutic process of reflection and interpretation. This epistemology is linked to IPA. Central to constructivism is the belief that the interaction between researcher and participant facilitates reflection and meaning making (Ponterotto, 2005). My constructivist paradigm provides me with a foundation for my research and an interpretive phenomenological epistemology underpins my research aim to explore what self compassion means for individuals who have experienced a compassion focused intervention for chronic pain.

3.3 Rationale for using IPA

As a methodology, IPA is devoted to the study of lived experience (Smith et al., 2009) which seems well suited to my idiographic research aims. IPA also appears relevant to my position as a trainee Counselling Psychologist as therapeutic practice focuses on meaning making through a process of interaction and reflection with others. IPA’s focus on subjective experience seems highly compatible with CoP and its humanistic values of empathy, congruence, and a non-judgemental attitude endorsed by Cooper (2009). Cooper (2009) emphasises the importance of applying these humanistic values to both professional practice and research and they help to shape my axiology and guide this study.

The philosophical underpinnings of IPA have been influenced by Husserl’s contention that human experience is rooted in consciousness and that making sense of experience involves a process of bringing to light what maybe hidden from view (Smith et al., 2009). The IPA process of bringing phenomena to light requires critical reflexivity (Willig, 2013). This corresponds with the values of CoP which advocate a critical stance regarding the process of meaning making which is complex and characterised by contradictions and uncertainty (Kasket, 2012). To help respond constructively to the uncertainty Kasket (2012) recommends psychologists develop a “negative capability.” Cox and Theilgaard (1987, p.63) suggest this means sitting with “uncertainties, mysteries and doubts” and making sense of them as Heidegger might through a phenomenological approach.

Before settling on IPA other research methods were considered. I thought about grounded theory (GT) (Glaser, 1992; Charmaz, 1996) because it is inductive and seeks to extrapolate meaning from the data. However, I decided it was not appropriate because it seeks to integrate meaning into a theory that might explain a social process (Willig, 2013) which was not my intention. I wanted to explore experience in depth and consider what self-compassion means for individuals who had experienced a compassionate intervention for chronic pain.

I considered thematic analysis (TA) (Braun and Clarke, 2006) but discounted it because of its emphasis on identifying convergent themes and what is shared by individuals. I wanted to pursue a more idiographic approach and IPA seemed more accommodating of convergent and divergent themes (Smith et al., 2009). Willig (2013) suggests IPA's interpretive phenomenological epistemology accepts different voices will emerge even though they may be incompatible at times. This supports my research aim to explore how individuals experience self-compassion and is more in line with my ontological position regarding multiple and equally valid realities.

I also considered narrative analysis and discourse analysis approaches but I decided they were not appropriate for my research because of their social constructionist focus on the constitutive role of language and how it shapes rather than expresses experience (Willig, 2013). Narrative analysis seemed more interested in how contributors organise their narratives and why certain stories are told in a specific way (Willig, 2013). My chief interest was to explore experience and the way language conveyed meaning in context (Langdridge, 2007).

I decided that an IPA interpretative analytical approach was more suited to my research aim to explore in depth how individuals make sense of self-compassion and what it means for them in relation to chronic pain. Also the central role of interpretation in the pursuit of knowledge meant IPA provided a good fit with my epistemological position. IPA acknowledges and accommodates the intersubjective process of interpretation by grounding it in the data through a stepped analytical process (Smith et al., 2009). IPA also accommodates what the researcher brings to the research from a quality standards perspective by emphasising a reflexive approach (Willig, 2013).

3.4 IPA

IPA is a qualitative research methodology that seeks to explore how people make sense of lived experience in relation to context (Smith at al., 2009). Experience is considered to be highly significant as it can teach us about human involvement with the world (Larkin and Thompson, 2012). However, its focus is on the individual and IPA does not seek to make general claims. There are three key aspects to IPA which include: phenomenology; hermeneutics; and idiography. It seems important to give a brief description of these aspects to give a clearer sense of the methodological approach adopted in this research and what the research aims to do.

3.4.1 Phenomenology

Phenomenology itself is a “philosophical approach to the study of experience” (Smith et al., 2009 p.11). Husserl pioneered the approach and advocated experience should be explored based on “the way it occurs, and in its own terms” (Smith et al., 2009, p.12). Phenomenology explores what is “experienced in the consciousness of the individual” (Smith et al., 2009, p.12) and is largely concerned with perception and what experience means for the individual. Husserl suggested that we need to put aside our preconceptions of experience as we try to focus on the “the things themselves” (Smith et al., 2009, p.12). He advocated a process of “bracketing” prior knowledge in order to get to the essence of conscious experience as it appears “in its own terms” (Smith et al., 2009, p.13).

In contrast, Heidegger contended it is not possible to put aside what we know and get directly to the thing itself. Instead, the way we experience objects in the world cannot be separated from our position in it. Heidegger (1962/1927) used the term “Dasein” (being there) to convey our position in relation to other objects. The term intersubjectivity can help illuminate how our attempts to make sense of the world are always in relation to others and to our position in the world (Smith et al., 2009). Heidegger (1962/1927) emphasised how a process of interpretation which considered the influence of our pre-conceptions might enable us to get close to the meaning of experience.

Merleau-Ponty (1962/1945) emphasised the embodied nature of our situated position in the world and how it determines our perception. He referred to people as body subjects and emphasised how our experience is determined by being a body in the world (Merleau-Ponty, 1962/1945). This gives an idea of the self as distinct from other body subjects and indicates perception and experience are integral to the physical body we inhabit. These considerations seem relevant to the experience of the contributors in this study who live with chronic pain which can be understood to impact them both physically and psychologically based on the premise that the mind and body are interconnected (Mehta, 2011; Penlington, 2019).

Sartre’s contribution to phenomenology seems related to its existential element (Smith et al., 2009). This seems important to IPA given its interest in what phenomena mean for individuals. Smith et al. (2009, p.19) highlight the importance of Sartre's notion that "existence comes before essence" and how this points to a developing self that is always in a state of "becoming". These ideas seem particularly relevant to my research and my interest to explore what self-compassion means for the contributors and how it might have affected their way of being and potential development.

3.4.2 Hermeneutics

Hermeneutics relates to the theory of interpretation and the purposes and methods of interpretation (Smith et al., 2009). Hermeneutics was originally associated with the interpretation of religious texts and became more widely associated with the study of historical and literary texts. It has a direct relevance to IPA and the process of interpretating data in the way we might aim to interpret a text.

Smith et al. (2009) describe Heidegger's emphasis on the hermeneutic process as central to the development of IPA and the way we make sense of phenomena based on our "fore-conception", our preconceptions connected to our position in the world. Smith et al. (2009) explain how texts, or data, influence our thinking and our thinking influences our interpretation. This can be seen as a cyclical process which recognises how our preconceptions might not become known to us until we consciously reflect on the process of interpretation (Smith et al. 2009). This seems directly relevant to the need for personal reflexivity in IPA to consider how the researcher influences the research (Langdridge, 2007).

Hermeneutics emerges as central to IPA and the role of the hermeneutic circle and the idea of the double hermeneutic are relevant to my research process. The hermeneutic circle refers to the relationship between the parts and the whole and the way we need to consider both in relation to the other in order to develop a detailed understanding of phenomena (Smith et al., 2009). This is reflected in the way IPA organises data into themes which facilitates a detailed understanding of the parts and a clearer sense of the whole. The process of phenomenological interpretation requires a detailed exploration of language reflected by Heidegger's (1927) claim that language is "the house of being" from which meaning about the nature of experience can be interpreted.

The double hermeneutic is also integral to the process of IPA interpretation. IPA regards the individual as a "sense making creature" and considers the meanings a person constructs can tell us about the experience itself (Smith et al., 2009, p.33). The double hermeneutic relates to the way the IPA researcher attempts to make sense of the participant's sense making process. Consequently, my IPA approach is an attempt to get as close as possible to the experience of the contributors assisted by empathy but limited by my distinct position in the world. My research does not claim to represent experience exactly as it is but as I understand it based on the double hermeneutic and my subjective interpretative process.

3.4.3 Idiography

Idiography relates to the "particular" and the individual as opposed to nomothetic research which looks at groups and what might be representative for a population (Smith at al., 2009). Idiography is central to IPA research and its interest to explore the experience of a small number of contributors or even a "single case" (Smith at al., 2009). This translates into a more detailed level of analysis of individual experience than might be expected from other qualitative approaches that are more focused on commonalties. Smith et al. (2009, p.29) emphasise how idiography has contributed to IPA's interest to explore how "particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context." This is directly relevant to my research interest to understand how the experience of self-compassion ("a process/relationship") for a small number of contributors who live with chronic pain ("particular people") can be understood against the background of a group intervention for pain ("a particular context").

3.5 Validity in Qualitative research

In order for research to make a meaningful contribution to knowledge and understanding there needs to be a means of assessing its validity (Morrow & Smith 2000). This is particularly the case with qualitative research and IPA which explores subjective experience based on the researcher's interpretative process which is influenced by their values and beliefs. Questions regarding my own research have been influenced by Yardley's (2000) four criteria for evaluating the validity of qualitative research.

Yardley's (2000) four criteria are: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Yardley (2000) suggests a qualitative study can show sensitivity to context through an awareness of the contributors' perspectives, their setting, and the social-cultural context of the research and how they influence the data and its interpretation. For Yardley, commitment and rigour refer to the researcher's engagement in the study, including data collection, skilful use of methods and detailed analysis. Yardley suggests the research should be transparent and clear so others can see how interpretations were grounded in the data. The principles of impact and importance relate to the need for qualitative research to produce useful knowledge that may have a practical impact or influence how people think. I will consider these issues further in the discussion chapter.

3.6 Ethical Considerations

The ethical considerations for this research were guided by the University of East London's Code of Good Practice in Research Guide (2014), the British Psychological Society's Code of Ethics and Conduct (2018) and the Code of Human Research Ethics (2021).

Ethical approval to conduct this study was provided by the University of East London School of Psychology Ethics Research Committee (Appendix A1 & A2). Due to the Covid pandemic situation in 2020 a stipulation was made that data collection should take place online to avoid face-to-face contact.

Contributors were first sent an Information Poster (Appendix B). After they expressed an interest to take part in the research they were provided with more information in the form of a participant information letter (Appendix C). Once contributors had confirmed their interest they were sent a consent form (Appendix D) and a separate data form (Appendix E). Contributors were informed about arrangements for securely storing their data and how their anonymity would be protected. Documents were stored electronically on a password protected laptop which was kept in a locked cabinet.

The interviews were recorded on Microsoft Teams and on a second voice recorder as back up. The recordings were then transferred and kept securely on the password protected laptop which was kept in a locked cabinet. Only the researcher had access to the recordings. Transcripts of the interviews were immediately anonymised and potential identifying features such as the names of other people or places were omitted. The transcripts were stored electronically on the password protected laptop which was kept in a locked cabinet.

Given the personal nature of the interviews the contributors were informed that they could choose not to answer particular questions and they could end the interview at any time without consequence or the need to provide a reason. Directly after the interview took place the contributors were sent a debrief letter (Appendix F). This explained that they had up to 21 days to withdraw their data from the study if they chose to but after that it would not be possible to withdraw as the analysis would have begun. At the end of the interviews contributors were debriefed and it was suggested that they might like to seek support if they felt adversely affected in anyway after taking part. It was explained that a debrief letter would be emailed shortly after the interview providing sources of support. The contributors were provided with contact details and were invited to email the researcher, the research supervisor, or the Director of the Psychology Research Ethics Committee if they had any questions or concerns.

3.6.1 Ethical approach

My ethical approach was guided by the values of Counselling Psychology. Cooper (2009, p.120) describes CoP as “ethics in action” based on its humanistic values that should be applied to all areas of professional engagement including research. I regarded the contributors as experts and wanted to put them at their ease by trying to create a non-hierarchical relationship as best I could. I aimed to show contributors a compassionate regard throughout the interview process in keeping with the principles of Compassion Focused Therapy. This seemed particularly important given the sensitive nature of the topic and the physical pain and emotional distress associated with chronic pain.

I tried to create a non-hierarchical relationship and a relaxed environment for the interviews through the recruitment information and in the way I managed the process. I emphasised meeting together would be like an “informal conversation” to avoid connotations of an assessment often associated with the term “interview.” I wanted to stand back from a hierarchical relationship which placed me in a position of authority or judgement. I tried to establish an immediate rapport by valuing the contributors’ involvement and showing a congruent interest in their experience and wellbeing.

3.7 Conducting the study

3.7.1 Sampling

In an IPA study sampling is purposive and seeks to recruit a small homogenous sample (Smith et al. 2009). Homogeneity is important to ensure contributors all have experience of the phenomena under investigation. A small sample is sufficient given IPA’s idiographic focus and its aim to present a detailed analysis of lived experience. With refence to student work Smith et al. (2009, p.106) say “we would often advocate three as an optimum number.” They suggest this allows for a nuanced analysis and also provides the opportunity for differences to emerge.

3.7.1.1 Inclusion and Exclusion Criteria. Contributors were recruited on the basis that they had experienced a compassion focused intervention. The research was focused on the adult experience of self-compassion so people under the age of 18 were excluded.

3.7.1.2 Contributors. The contributors who took part in the research and the Clinical Psychologist who ran the group intervention will be referred to using pseudonyms to protect their anonymity.

Three adult female contributors agreed to take part who will be referred to as Tina, Hannah and Magda. Tina is in her forties and is a single mother with two children. She is British and lives with her children in the UK. Hannah is in her fifties and is a mother with two grown up children who now live independently. She is British and lives in the UK. Magda is in her forties and is a mother with three children. She lives in the UK with her husband and children. Magda is originally from Southeast Europe.

The contributors had all taken part in the same eight week compassion for pain group intervention in an NHS pain clinic but at different times. The contributors had been living with chronic pain for a number of years approximated as follows: Tina (3 years); Hannah (11 years); Magda (18 years). The contributors did not discuss current employment and it seemed to be the case that chronic pain meant they were not able to work at the time the research took place.

3.7.2 Data collection

3.7.2.1 The process. The contributors in this study were recruited after I contacted the Clinical Psychologist (Joanne) who had run the compassion for pain group intervention the contributors took part in. The contact developed in response to advertising my research on the Compassionate Mind Foundation forum. The Foundation was established in 2006 as the home of Compassion Focused Therapy (CFT) and Compassionate Mind Training (CMT).

Joanne agreed to help with my recruitment by contacting members of past groups and sending them my recruitment poster (Appendix B). Potential contributors were asked to contact me by email if they would like to take part in an independent research project. In response to emails from potential contributors I provided more information in the form of a participant information letter (Appendix C), a participant consent form (Appendix D), and a participant data form (Appendix E). I also offered to meet on Microsoft Teams to answer any queries if necessary.

This process led to six female contributors expressing an interest to take part. However, three did not proceed to the interview stage although two contributors had returned their consent forms, one of whom withdrew on the day of the interview. Although three individuals withdrew, the data provided by the three contributors who took part seemed suitably rich to provide the basis for a nuanced idiographic analysis in keeping with the aims of IPA. I was encouraged by Wendy Wood at the University of Deby who indicated three contributors would have been ideal for her PhD research which focused on self-compassion among clinical practitioners.

3.7.2.2 The interviews. The research question asks: What does self-compassion mean for individuals who have experienced a compassion focused intervention for chronic pain? In order to explore this, semi-structured interviews were conducted with the contributors as recommended by Smith at al. (2009). The Interview Schedule (Appendix G) consisted of questions belonging to three categories, “your experience of self-compassion”, “what self-compassion means to you”, and “anything else you might like to say about self-compassion.” Prompts were used to seek clarification or encourage contributors to elaborate on their responses.

Three contributors were interviewed separately on Microsoft Teams for up to 40 minutes. The length of the interviews was based on helpful advice gratefully received from Professor Paul Gilbert in the context of conducting IPA doctoral research. Contributors were made aware that they did not have to answer a specific question and that they could end the conversation at any point without consequence. They were given the opportunity to ask me questions both at the start and at the end of the process.

At the end of the interview contributors were debriefed verbally and were informed that they would be emailed a debrief letter (Appendix F) the same day which would offer sources of support in case they felt adversely affected by the process. The recordings were then transcribed verbatim based on repeated listening to ensure the greatest accuracy possible.

3.7.3 Analytic process

The analytic process I followed was based on the six stage IPA approach recommended by Smith et al. (2009). This was adopted due to its clarity, perceived effectiveness, and flexibility.

3.7.3.1 Stage 1: Reading & rereading. The first stage required a reading and re-reading approach to become familiar with the data. I listened to the recording while reading the transcript for the first time and re-read the transcript several times to get closer to the data. I made some initial notes about how I felt during this process and what I perceived to be significant to the contributors.

3.7.3.2 Stage 2: Initial noting. The second step I followed was an initial noting process. I organised my approach based on guidance from Smith at al. (2009) which meant producing a three column table (Appendix H). I pasted the transcript into the central column and began to highlight features. I then made exploratory comments in the right-hand margin. The left hand column was reserved for noting emergent themes in the next stage of analysis.

My exploratory comments were organised into three categories: descriptive comments (using normal typeface); linguistic comments (italicised); and conceptual comments (underlined). The descriptive comments related to what seemed to matter to the contributors. I highlighted key words and phrases grounding the comments in the data. Highlighted sections were later used as supporting quotation. The linguistic comments focused on the way the contributors used language to convey meaning. My exploratory comments were interpretative and were often phrased as questions pointing to possible meanings for further consideration.

3.7.3.1 Stage 3: Identifying emergent themes. The third step involved identifying emergent themes which meant breaking up the narratives, moving away from the whole, and looking more closely at significant parts. My aim was to capture key aspects that were developed or repeated in the narratives. I recorded my themes in phrase form, often incorporating key words used by the contributors such as “daily battle”, “self-realisation”, or “acceptance.” The idea was to produce a long list that could be considered further (Appendix I) .

3.7.3.4 Stage 4: Looking for connections across themes. This step required looking for connections across emergent themes one case at a time. To do this I listed the themes in each case in the chronological order I identified them. I then printed the list, separated the themes with scissors, and began to move them into provisional clusters, grouping and re-grouping as I observed similarities and differences (Appendix J). I then followed a process of “abstraction” (Smith et al., 2009, p.96), grouping related themes under the heading of a “superordinate theme.” The outcome was a table of provisional superordinate themes and their related themes which resembled a family tree laid out on a large table.

3.7.3.5 Stage 5: Moving to the next case. Stage five involved moving to the next case (Appendix K) and repeating the process followed in stage four. Smith et al. (2009) emphasise how the IPA researcher analysing more than one case will inevitably be influenced by the previous case. For this reason it was important for me to honour the idiographic nature of IPA by attempting to bracket what had emerged from the previous case using my journal. To do this I tried to rigorously follow the steps in stage four to allow the idiographic nature of the second case to emerge and I reflected on interpretations I brought from the previous case. I then repeated the process with case three trying out new clusters to reflect the individuality of the contributor.

3.7.3.6 Stage 6: Looking for patterns across cases. The final stage required looking for patterns across cases (Appendix L). I did this by placing the three tables/tree diagrams together to see if I could combine them into one definitive table of themes for the group. My aim was to accommodate the similarities and differences preserving the individual nature of each case. I shuffled and re-shuffled themes, combined some overlapping ones, regrouped them and renamed some so they were more comprehensive or coherent. I took some photographs of the process and constructed a final table of superordinate themes with their related themes and sub-themes (Figure 1 & Appendix M).

3.7.4 Reflexivity

Langdridge (2007) describes reflexivity as a critical position the researcher adopts to assess how their pre-conceptions, beliefs, values and methods have shaped the research. Reflexivity requires the researcher to consider how they have influenced all aspects of the research including the research question, data collection and data analysis. Willig (2013, p.25) emphasises the importance of reflexivity in qualitative research because it encourages us to “foreground and reflect upon the ways in which the person of the researcher is implicated in the research and its findings.” For these reasons it was essential for me to consider reflexivity throughout my research in relation to its validity and how it may be received. I used a reflexive journal to support this process (Appendix N).

Willig (2013) identifies two types of reflexivity which require careful consideration, personal reflexivity and epistemological reflexivity. Many aspects of the researcher influence the research including their interests, experiences, and social identity which all relate to personal reflexivity. A second element to personal reflexivity relates to how the research has impacted on the researcher.

Willig (2013) also emphasises the importance of epistemological reflexivity which considers how the research question has determined what can and cannot be discovered, and how the design of the study and the analytical method have influenced the data and the findings. Willig suggests IPA itself emphasises critical reflexivity and invites researchers to consider how their beliefs and assumptions affect the way they interpret others' experience based on their position in the world (Willig, 2013).

Reflexivity will be explored further in the discussion chapter of this study in which I will reflect on how I may have influenced the research. However, in keeping with a suggestion from Willig (2013), I would like to close the methodology section with a few details about myself, my gender, my experience of the subject under investigation, and foreground how these factors might affect data collection and the research as a whole.

I think it is important to acknowledge that I am a male researcher exploring the lived experience of three female contributors who had all taken part in a compassion for pain group intervention for women. My gender may have positioned me as an outsider, possibly giving me the vantage point of a curious and empathic onlooker. Conversely, it may have limited my insight and understanding. The same considerations apply to my position as an individual who has not experienced chronic pain. Both factors are likely to have influenced how I interacted with the contributors and interpreted the data.

With regard to the topic of self-compassion, I think it is important to disclose my interest in the topic and my experience as a trainee Counselling Psychologist. In my final year some of the clients I worked with therapeutically followed a compassionate focused intervention designed to facilitate self-compassion. My interest in self-compassion and my experience will have had an influence on the questions asked and the way I made sense of the data and presented the findings. Similarly, my interest and sensitivity to the experience of others living in chronic pain may have also influenced the research. This interest developed in response to working earlier in my training with two particular clients who lived with chronic pain.

I think it is also important to foreground my sense of a developing identity as a Counselling Psychologist. I think my critical stance regarding a medical model of psychological distress, my interest in embodied experience, social justice, and humanistic values will also have had a bearing on the research. For me, humanistic values and social justice include compassion for others and this motivates my interest in encouraging self-compassion. Connected to this is my hope that self-compassion may carry benefits and may have the potential to enhance wellbeing. My belief that the experience of self-compassion is likely to be different for individuals influences my epistemology and my choice of IPA based on its idiographic focus.

3.8 Summary of chapter

This chapter presented my constructivist research paradigm and interpretative phenomenological epistemology linked to my IPA methodology and my values as a researcher. A rationale for my use of IPA was provided in relation to my research aims. A brief consideration of alternative methodological approaches was offered. This was followed by a description of the aims and central ideas of IPA and their relevance to my research. This led to a focus on validity (Yardley, 2000) and ethical considerations with reference to my ethical approach (Cooper, 2009). A description of the analytical procedure was presented based on a six stage IPA approach (Smith et al., 2009). The final section focused on reflexivity (Willig, 2013). Issues regarding validity and reflexivity will be considered further in the discussion chapter.

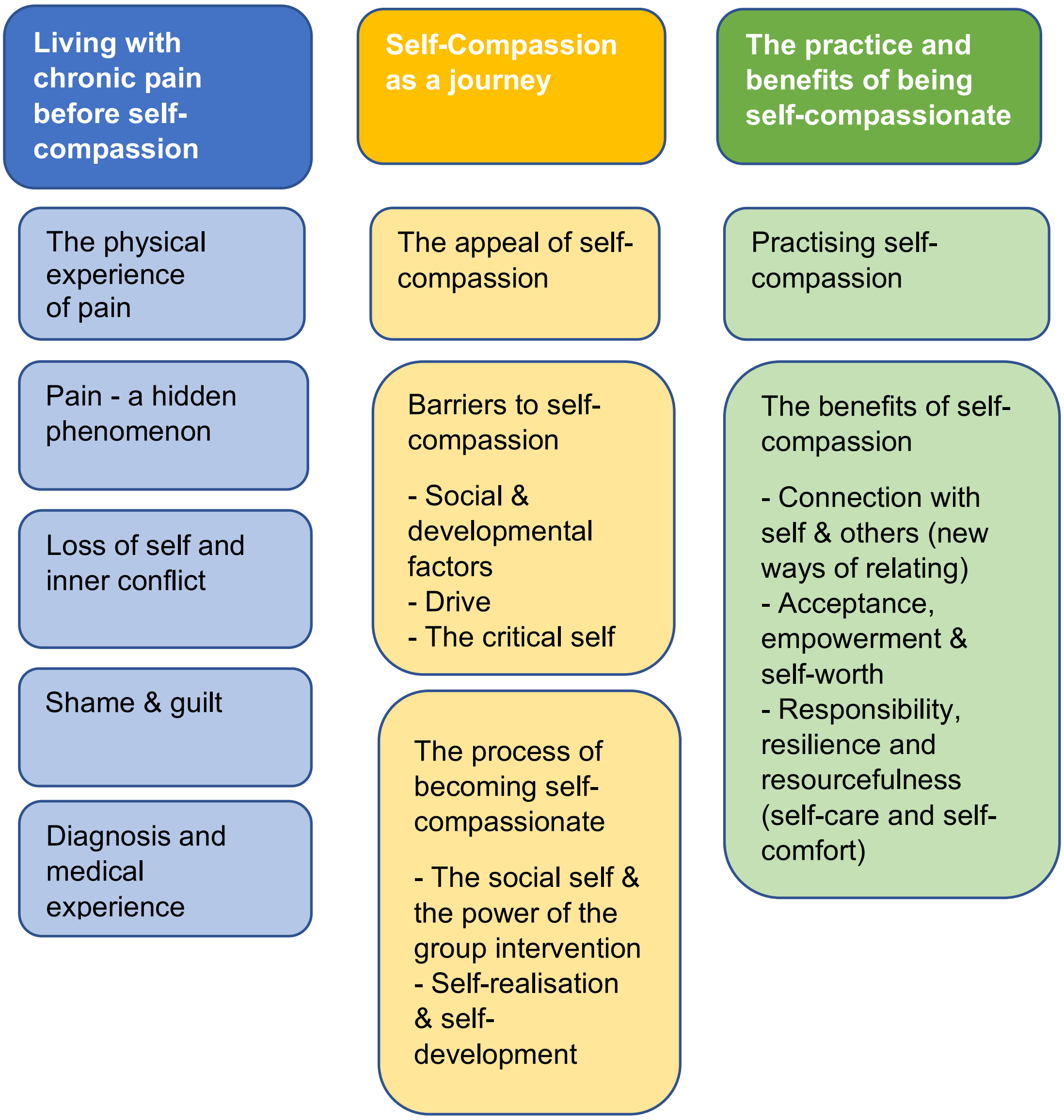
Chapter 4: Analysis

4.1 Introduction

The main findings of the study are presented in this chapter. The analysis is based on an IPA approach and follows the guidelines presented by Smith et al. (2009) as discussed in the methodology chapter. It attempts to offer an idiographic and interpretative account of lived experience. The aim is to present a nuanced interpretation based on the experiences of the three female contributors who had taken part in a compassion for pain group intervention. This approach is opposed to a more descriptive or thematic overview of the experiences of a larger number of contributors.

The analysis contains three superordinate themes as follows: living with chronic pain before self-compassion; self-compassion as a journey; and the practice and benefits of being self-compassionate. The three superordinate themes are shown in the figure below with their related themes and sub-themes.

Figure 1: Superordinate themes with related themes and sub-themes



The first superordinate theme (living with chronic pain before self-compassion) explores the contributors' accounts of what it meant for them to live in chronic pain before they developed self-compassion. Both the physical and the emotional aspects of their experiences are explored with an interpretation of how living in pain affected each contributor's sense of self.

The second superordinate theme (self-compassion as a journey) explores the process of becoming self-compassionate. The analysis explores the appeal of self-compassion, barriers to self-compassion in a social and developmental context, and the transformative nature of the group intervention.

The third superordinate theme (the practice and benefits of being self-compassionate) explores how the contributors practice self-compassion. It provides an interpretation of how they make sense of the benefits they describe in terms of connections with self and others and their enhanced ability to live with chronic pain.

4.2 Superordinate theme 1: Living with chronic pain before self-compassion

This superordinate theme focuses on the contributors' experience of living with chronic pain before they began to develop self-compassion in response to their group intervention. It represents their lives before self-compassion and seems central to the way each contributor made sense of self-compassion and what it meant for them. There are five themes which focus on the physical experience of chronic pain, the limitations it imposed, the psychological effects it seemed to have, and how it influenced the self. Superordinate themes two and three will focus on how self-compassion helped the contributors respond to chronic pain during and after their group intervention.

4.2.1 Theme 1: The physical experience of pain

This theme seems to set a context for the research topic. It explores the contributors' experience of chronic pain before self-compassion. Tina described how:

> *It's been very difficult to describe nerve pain because it moves all the time… it's a constant change of burning, pins and needles, and numbness in places.*

Her pain appeared dynamic, unpredictable and relentless. Tina described it as a "nightmare" she could not "run away from" and had to "sit with." The word "nightmare" conveyed the horror of her pain and her inability to "run away" connoted a feeling of entrapment. Self-compassion appeared later as a way of helping Tina to "sit with" her pain and develop the capacity to live with it in more manageable ways.

Tina talked about life before chronic pain and the limitations her pain imposed on her:

I was fit and very healthy… so to go from that to struggling to drive a car is massive for me… I can't drive any distances, obviously because it's sitting, and standing is an issue.

There is a sense of loss connected to the memory of being "fit and healthy" before the limitations of chronic pain. Tina presented life before self-compassion as a "struggle" which carried "massive" implications in practical terms but also in terms of her identity and the shift she experienced from feeling capable to feeling significantly restricted. Later themes will explore how self-compassion helped Tina respond to changed circumstances and a new sense of self.

Magda's fears and her distress provided a context and a background to her interest in self-compassion which came to represent hope and a new approach to living with persistent pain. One of the chief ways of doing this was by learning how to value herself and recognise her own needs without feeling she was neglecting her duty to others. Before she discovered self-compassion Magda talked about her experience of pain and how it had impacted on her ability to look after her three children including her disabled son:

> *I can barely support my son, I have to hold on to him when we are out to physically restrain him, but my biggest worry, I am no longer, my body is just giving in. My feet are so poorly and my arms are aching, I can't hold on to him properly… My situation deteriorated so much I could barely walk. I was using my son's crutch and he was using the other.*

Magda's description of her body "just giving in" conveyed a sense of the destructive nature of her pain and the disability it imposed. Her language suggested she was almost defeated by her pain and there was a sense of hopelessness before she discovered self-compassion. As a mother she seemed highly distressed by the limitations she faced and how they might impact on her child's wellbeing. Self-compassion later enabled Magda to share her responsibilities and accept help from others based on self-acceptance and being kind to herself.

Hannah spoke in a very matter of fact way about her pain and she explained:

> *I live with chronic pain. I had surgery 11 years ago… and it has left me with chronic pain and I have also got fibromyalgia as well now. And my bowel does not function properly either.*

It became clear for Hannah and the other contributors that their psychological intervention for chronic pain did not make their pain go away. Their pain continued to be present in their lives but self-compassion helped them to respond to it in helpful ways. On the day I met Hannah she said she was "having a bad pain day" and had decided to stay in bed for our video meeting. I felt a strong sense of empathy and recognised how her pain could be a controlling, unpredictable force in her life. Hannah explained that self-compassion enabled her to prioritise her own needs and helped her to rest and recuperate. The analysis will pick up later on how Hannah uses self-compassion regularly as an alternative response to her pain whereas before self-compassion Hannah would fight her pain which caused more debilitating pain flare ups and became an unsustainable response.

4.2.2 Theme 2: Pain – a hidden phenomenon

Two of the contributors talked about pain as a hidden phenomenon before self-compassion. It was interpreted as being like an invisible disability (Tina), something to hide from (Magda), or hide from others (Tina/Magda).

Magda said, “for many years I didn’t want to tell anyone.”

> *I had to do lots of, well, pretending in front of the children because my boys and my daughter… were very close to me and they catch on to my emotions and I had to do consciously lots of pretending that I wasn’t in pain.*

Magda’s pretence seemed connected to her sense of herself as a mother, her devotion to her children, and her concern for how they might be affected by her pain. As Magda talked about her experience of pain before self-compassion I interpreted a sense of invisible suffering and a history of putting others first that eclipsed her needs.

Magda conveyed a strong sense that hiding her pain meant hiding her emotions from others and also hiding from them herself:

> *For a long time, even throughout all of my mother’s life, and she was close to me… I never told her that now my pains were even more… I had to keep that to myself because it was such a big burden I didn’t want it to be the truth. I was hoping I had imagined it.*

Magda’s description of her pain as a “burden” seems to hold a double meaning for her. Magda seemed to consider her pain as a “burden” to others, something she needed to “hide” based on a deeply held sense of duty. But her pain also seemed too much of a “burden” to acknowledge and carry psychologically as it seemed to threaten her sense of self. Magda’s disclosure that she hoped she had “imagined it” suggests her experience was too much to bear, she had tried to block it out and she said candidly:

> *I was no longer willing to er, acknowledge the pain within me, even me accepting it or telling others what I'm experiencing.*

There is a sense that before self-compassion Magda had not been able to accept her pain which seemed unacceptable to her sense of self, her values, and her social role as a mother.

Before she experienced the compassion focused intervention Magda seemed reluctant to share her fears or seek professional support. Perhaps the thought of disclosure induced distress associated with the conflict between the limitations of chronic pain and her deeply held beliefs about how she should behave. It seems it was preferable for Magda to believe her pain was something she had "imagined" rather than something real which was unacceptable and seemed impossible to adapt to.

The experience of hiding her pain meant that for a long time Magda disengaged from specialist services and continued to take increasingly ineffective pain medication until her GP persuaded her to revisit her pain clinic:

> *Pain relief helped me to a point but then I just got used to it and it wouldn't help me anymore, and some days were just so bad, I felt so much pain it didn't matter which medication I had taken, it's almost like it made no difference… I'd been to my doctor… and she said you've got to go back, they have to look at your medication, you've got pain in your feet… you can't use your arms.*

A cruel irony emerges from the theme of pain as a hidden phenomenon. While pain remains ever present, the ways in which it is hidden from self and others seem to exacerbate the interrelated experience of pain and psychological distress which led to a critical point in Magda's life. It seems Magda's struggle to accept the reality of her pain was connected to her sense of self and how her nurturing role as a mother and comforter of others was threatened by the limitations of chronic pain. The analysis will explore later how Magda's compassionate intervention helped her to realise the nature of her avoidance and helped her to foster a mindful awareness and self-regard that enabled her to accept her pain and encouraged her to make changes in her life.

Tina spoke candidly about how she felt isolated and disconnected from others by her experience of chronic pain. Before she took part in the compassion for pain group intervention she described how "chronic pain was invisibly suffering alone." In this way her pain was hidden from others without validation. Tina elaborated by describing how this felt for her:

> *Most people see me when I have got a brave face on, they don't ever see me when I am absolutely at my wit's end crying, can't get out of bed, can't move, can't get dressed… because of pain really, nobody sees that side.*

The "brave face" Tina described, like Magda, seemed connected to her sense of herself as a woman and a mother. Tina seemed to find it difficult to allow her suffering to be seen by others, perhaps because of the effect others bearing witness to her pain might have on her own self-concept and sense of self-worth. By putting on a "brave face" Tina was not only hiding her experience of pain from others but also hiding from it herself.

There seemed to be a tension between hiding the "nightmare" of pain from others and the self and a need for validation and professional support that would later enable Tina to enhance her self-care based on self-compassion. Tina described how compassion from others made a real difference to her experience:

> *When somebody says to you, "I'm sorry you are going through that, it must be terrible." It does make you feel that somebody actually cares, and it makes you feel a little bit like yeah I can go on actually, yeah.*

As Tina began to develop her story I sensed that sharing with others through the group intervention enabled her to gain validation and support but it also enabled her to develop self-compassion. This seemed to mean no longer hiding from her pain and the limitations she associated with it but instead giving herself understanding and comfort in the way others had:

> *You get your compassionate self to, you know, give compassion to… all the different selves you become when you are in so much chronic pain.*

4.2.3 Theme 3: Loss of self and inner conflict

This theme emerged from the analysis of all the contributors and relates to the ways in which living with chronic pain engendered a loss of self and inner conflict regarding their relationships with themselves before self-compassion.

Before self-compassion helped Hannah to recognise and respond to the limitations imposed by chronic pain she described attempting to carry on regardless. She described how she felt "cross" with herself for not being able to do the things she wanted to when she was in pain:

> *When I had a bit of a down day, a bad pain day… I would be cross with myself because I didn't feel well enough to do this, that, or the other I had planned.*

Hannah's relationship with herself seemed to suffer and she alluded to frustration with herself and a tendency towards negative self-appraisal. This seemed very significant for Hannah as it fed her self-acknowledged “critical self” and seems to have caused psychological distress in the form of self-blame:

> *In the past I would always have thought of things being my fault. If something went wrong I would blame myself.*

Hannah’s experience of pain before self-compassion seems to have been more difficult because she conceptualised the limitations imposed by chronic pain as her own deficiencies. The difficult emotions triggered by these thoughts are likely to have intensified her pain compounding her own sense of inadequacy and culpability.

Hannah’s pain seemed to place limitations on what she was able to do and there seemed to be a loss of physical vitality which existed before and continued after her compassionate intervention. However, before self-compassion Hannah seemed to be self-critical and found it difficult to respond compassionately to her pain and she continued to push herself. The analysis will explore in more detail later how self-compassion helped Hannah recognise and respond helpfully to her striving tendencies. Before self-compassion Hannah’s pain seemed to be compounded by her psychological motivation to seek approval. This seemed linked to the developmental history Hannah later described and her heightened sense of drive seemed connected to her need to feel valued and loved which represented an insecurity she described in childhood.

Magda’s difficulty accepting her pain and her tendency to hide from it was considered earlier and seems connected to a sense of loss and inner conflict. Talking about her pain Magda said:

> *I think I had major mental difficulties in comprehending it, accepting it… I couldn’t speak or acknowledge other than in tears, you know, the tears I could not stop.*

Magda’s pain is both complex and chronic and after living in pain for a considerable time she was diagnosed with fibromyalgia. However, her experience of pain began with a physical injury she expected to recover from. Magda’s sense of distress seemed connected to a heavy weight of expectation that she laboured under:

> *There’s always been a lot expected of me and I think I just learned that since I was young. I come from a society where I think they just expect a lot really… others depend on me, the house will depend on me, my children having healthy meals will depend on me, so much depends on me, my friend’s shopping being done, driving her to the Doctors… somehow I could never get rid of that feeling that somebody needs me.*

Magda conveyed a strong sense of expectations, both the expectations of others and her own expectations of herself. Connected to this I interpreted a fear of letting others down. For Magda, accepting her pain seemed to mean disregarding her expectations and this appeared to be deeply troubling to her sense of self. There seemed to be a profound and ongoing challenge making sense of life with pain before she joined the compassion for pain intervention. This challenge seemed to engender a sense of loss and an inner conflict between her deeply held values and the need to make fundamental changes in response to the limitations imposed by chronic pain which self-compassion enabled her to navigate.

Tina spoke about how pain affected her and contributed to a sense of loss:

> *It’s affected me in more ways than just that I’m stuck with pain. I’ve had to lose a lot of my life, and a lot of my identity has gone with that… You grieve for the loss of your former self almost because that person is gone, and then you know you’ve got this person.*

Tina conveyed a palpable sense of loss talking about what she was no longer able to do and the phrase, *“*and then you know you’ve got this person*”,* suggests a sense of dissatisfaction and disappointment with the self. Tina's sense of identity seemed embedded in the way she used to conceptualise herself as "fit and healthy" and she seemed to "grieve" for the active lifestyle she had lost.

When Tina referred to her loss of "identity" she reflected on how pain had affected her sense of humour and fun loving personality:

> *But I was the humour, the life and soul of the party, so to go from that person to this, and I'm sort of trying to get back to that and yeah, I'm getting there.*

I was struck by a powerful sense that Tina wanted to recover parts of her "lost" self that had been surrendered against her will. I interpreted a tension between her determination to hold on to fundamental aspects of her identity and the life changing nature of living with chronic pain. However, self-compassion seemed to help Tina foster a positive sense of self-regard and a motivation to be the version of herself she wanted to be with acceptance and kindness rather than self-blame and dissatisfaction with herself.

4.2.4 Theme 4: Shame and guilt

This theme emerged from the data specifically in relation to Tina and her experience of living with pain and the limitations it imposed before self-compassion. Shame and guilt also emerged more generally from the analysis in connection with the difficulty all the contributors experienced attempting to make time for themselves before they developed a more compassionate self. This will be considered in the second superordinate theme, and specifically in the sub-theme "barriers to self-compassion".

The previous theme explored Tina's loss of self and her inner conflict accepting "this (new) person." She talked about how she felt before self-compassion:

> *I was really quite depressed, because you do blame yourself for a lot of things and there's other elements like the shame which is a massive thing.*

Tina's low mood and shame seemed connected to the person she felt she had lost and what she was no longer able to do. She described how upsetting it was for her not to be able to pursue her main active hobby (withheld to maintain anonymity). I interpreted that her shame was connected to losing her vitality and physical strength, to no longer feeling she was the person she used to value.

Tina named guilt as another emotion she experienced:

> *Guilt, that's a huge thing for me, I feel guilty as sin, not because any of this is my fault, I know it's not, it's just that I can't do for the family what I used to do and I feel guilty for that.*

It emerged from the analysis that Tina, like the other contributors, identified strongly with her role as a mother. Pain seemed to impact on this core aspect of herself in ways that led to shame and guilt. Guilt emerged as an emotion Tina still experienced particularly in relation to how pain affected the way she behaved and could be "grumpy" and "snappy" with her family. Whereas Tina's guilt was unchecked before she developed a compassionate relationship with herself she now seemed able to draw on self-compassion and regulate her emotions recognising that the difficulties she faced were not her fault.

Tina spoke candidly with a mindful awareness associated with compassion teaching when she said:

> *I'm not going to lie to you, I do have days when I am terribly grumpy, I can be quite snappy with the, it's not pleasant for them so again massive guilt. And what I have learned from compassion is that it's not my fault and I can give myself a little bit of love and carry on in a more pleasant mood instead of lashing out and being bad tempered about it.*

Tina’s openness suggests a vicious cycle between the way she perceives her pain affects others and her subsequent guilt and shame which seem to add to her distress. The knowledge and understanding Tina attributes to compassion based on the premise “it’s not my fault” seems to enable her to “carry on” but also to be more accepting of the way chronic pain affects how she may relate to others. Self-compassion seems to help Tina mediate shame and guilt which prefigures some of the benefits of self-compassion which emerge later in the analysis in the third superordinate theme, the practice and benefits of self-compassion.

4.2.5 Theme 5: Diagnosis and medical experience

It emerged from the analysis that part of what it meant to be living with pain before self-compassion was connected to medical experience and diagnosis. This was particularly the case with Magda and Tina. However, Tina continued to be affected by what she seemed to regard as an unhelpful diagnosis after her compassionate intervention took place.

Magda described her experience of undiagnosed pain:

> *They would Xray my feet, which would hurt so badly, and, and my hands and my shoulders, there was no suggestions where was the pain coming from, so for a very long time I thought have I imagined my own pains? Could someone imagine this level of pain?*

The questions Magda asks herself convey how she began to wonder if her pain was even real when experts could not recognise it. It seemed frightening for her to consider that she might not be able to make sense of her own embodied experience, that her sense of reality was not corroborated by others. As Magda wondered if she may have imagined her pain she seems to have become burdened by self-doubt and disconnected from her own experience. Without a diagnosis Magda’s experience of living in pain seems to have been invalidated. She revealed how this made her question herself further in an attempt to make sense of her situation:

> *I even started putting it down to my, I am diagnosed with post traumatic distress disorder because of… war and some experiences I had, I even for a long time thought well perhaps it, it became modelled in my, you know, in my, my over-burdened psyche and because my brain can't process what I saw, and, and admit to, perhaps things got to that.*

Magda seems to have considered she may have been the cause of her own pain and there is a sense that she blamed herself before self-compassion enabled her to accept her difficulties and respond kindly to them. Her thoughts seem to reflect the impact of living with medically undiagnosed symptoms in a medical culture which prioritises diagnosis as the foundation for understanding and treatment. I sensed how unsettling it was for Magda to consider how her past might be contributing to her pain.

Before self-compassion Magda conveyed a sense of how difficult it was for her to prioritise her own needs and reengage with a specialist service until her GP encouraged her to. She said:

> *When I went back I found a new Doctor … we just had a terrible misunderstanding … I came to say I have so much more pains (*speaking rapidly now*) virtually spread everywhere, something I was so afraid of anyway. He wasn't, uh, he wasn't familiar with me, so I was taking the time to sort of tell him and that was hard for me, it was hard to come out with this… before I had chance to, almost tell him… he quickly went through this scan, it was on my spine, he told me where the problems were and said it was a good time to discharge me. And as I realised that our rapport wasn't there, and I got upset, and then I just left, so I had no consultation with that Doctor.*

There is sense of rejection and deep hurt here. Magda seems to have felt invalidated by the experience which became so distressing she had to leave before self-compassion helped her to value herself and seek the help she needed.

Magda seemed to need a diagnosis to make sense of her pain before she was able to find a meaningful way of responding to it through self-compassion. She described how an eventual diagnosis of fibromyalgia was particularly meaningful for her:

> *(Now) I do have a diagnosis. I have got a condition called fibromyalgia. That helped so much. I have got a name for it. I can't tell you how many times I looked into that letter and I read that word, it has a name, my condition has a name. That's, that's helped me so much.*

Magda's repetition of "it has a name; my condition has a name*"* seems joyous and validating to know that her pain was not just imagined. Magda described this as a seminal moment and her compassion for pain intervention as transformative which enabled her to develop ways of living with fibromyalgia and her debilitating pain.

Earlier in this analysis the challenges Tina faced living with a dynamic form of nerve pain were explored. Although Tina had been given a diagnosis she described how it had been unhelpful:

> *On the medical side they've given me a diagnosis, but they've misdiagnosed it, they've mistreated it, it's got worse, and worse and worse.*

The use of the pronoun "they" conveys a sense of the distance Tina feels between herself and the health professionals who do not seem to understand her pain or care for her wellbeing. The repetition of "worse, and worse and worse" reinforces her frustration and sense of desperation.

Tina described the experience of waiting for further diagnosis that might lead to a more effective treatment:

> *I've been suffering it yeah, there's further pain yet to be diagnosed, um, I'm waiting, it's just waiting and waiting, obviously with Coronavirus and everything. Um, they just kind of leave you on painkillers and say there is nothing else we can do for you, you're just going to have to cope on that.*

There is a sense that Tina felt rejected by the medical establishment and abandoned by others who “just kind of leave you on painkillers.” Tina’s description of her medical experience contrasts significantly with the way she talked about her compassion intervention. That experience helped to break down barriers and cement connections with others which enabled her to comfort and care for herself by drawing on self-compassion which will be developed later in the analysis.

4.3 Superordinate theme 2: Self-compassion as a journey

This superordinate theme has three main themes. Themes two and three both have sub-themes. The analysis interprets the appeal self-compassion first had for the contributors and then explores barriers to self-compassion and the process of becoming self-compassionate.

4.3.1 Theme 1: The appeal of self-compassion

Hannah explained that she had been involved in pain management interventions but she had not heard of compassion for pain until it was introduced to her.

> *Compassion in pain was something that I hadn’t heard of and when I went along to the introduction day I thought it sounded really interesting and I felt like I… ticked a lot of the boxes for being a striver and erm beating myself up for, for not getting things done, or not being good enough, letting people down, that sort of thing, you know, very self-critical.*

Hannah seemed to soon recognise that her heightened drive and self-critical nature made it difficult for her to live with chronic pain. Her disclosure that it “sounded really interesting” and she “ticked a lot of the boxes” suggests she felt a sense of connection with self-compassion and it held an attraction for her as a construct she could relate to and benefit from.

Magda talked about self-compassion as something new:

> *The self-compassion term was so novel, so new to me… I didn't really know what it meant exactly. How are you meant to be self-compassionate? I was always compassionate to everyone else… compassion was part of my life always. Since I was a little girl I was always compassionate.*

Magda seems to regard herself as a compassionate person and she values compassion as a way of relating to others although self-compassion appears unfamiliar. Magda's connection to compassion seemed to spark her interest in self-compassion and how it might benefit her:

> *I was so interested in that term… And we had been living in pain for a long time, and, and, just coping with my pain as best as I could and looking after my family. I think I was the person who asked about this most in the group until it became apparent… other people… were already doing (things) to help themselves. But in my case it's fair to say I started very late with self-compassion.*

Magda conveys a sense of curious enthusiasm to learn about self-compassion seen in how quick she was to ask questions. The change in pronoun use from "I" to "we" and back again to "I" may prefigure her connection to the group explored later. There is a sense of Magda embarking on a journey of discovery. Her reference to "just coping with my pain as best I could" may help to make sense of how Magda seemed drawn to self-compassion and the potential it held for her.

Tina described the attraction self-compassion represented for her:

> *I have done as much as I can to benefit myself and to sort of self-sooth if you like, so that's why I was interested to do the pain group… to see if I could learn anything.*

There is a sense here that Tina really wants to explore a new way of helping herself, and like Magda there seems to be a curiosity to learn. Tina acknowledged that until the group intervention began:

> *I never took on board the concept of what actually being kind to yourself was.*

Self-compassion seemed to attract Tina but like Magda she was uncertain what it might mean. She revealed that she and her peers in the group intervention:

> *… were all good at giving compassion out… (but) we are the last person that we think of.*

There is a sense that Tina was attracted by the potential benefits of self-compassion before she was familiar with it based on her affinity with compassion, her own sense of need, and her determination to take responsibility for her situation and not to become reliant on pain medication:

> *I don't want to be relying on sleeping medication… and I don't want to be in that place where I'm… addicted.*

All the contributors indicated a sense of loss and how pain had closed doors in their lives. However, they communicated a sense that self-compassion might hold new opportunities which represented hope and a journey of discovery.

4.3.2 Theme 2: Barriers to self-compassion

The contributors described barriers to self-compassion that they all faced. These will be dealt with in three sub-themes which focus on: social and developmental factors; drive; and the critical self.

4.3.2.1 Sub-theme 1: Social and developmental factors. When I asked Hannah if she had experienced any barriers to self-compassion she began to talk about herself as a "striver" and related this to her experience growing up.

> *I really was a striver, um, and we talked in sessions, and a lot of us related to this, that we had very erm strict parents and weren't shown a lot of love or erm, just told to work hard, you know you were praised if you worked harder and that, so you tried to work harder and harder because that is the only way you got praise.*

It is noticeable that Hannah's sense making process seemed to develop in relation to others in the group which will be explored further in the next theme, the power of the group intervention. Hannah refers to herself as a "striver" who worked hard seeking "praise" and "love" from "strict parents" who seemed to show her limited affection. Striving tendencies were explored within the group which encouraged Hannah and her peers to recognise their pain, reassess their priorities, and be kind to themselves.

When asked about barriers to self-compassion Magda explained:

> *It… was difficult having the self-compassion… (it) did not come easy to me. It almost felt like wasting time. Like, why am I not helping someone? You know, there is so much that needs doing, it was hard.*

Magda talked about how her "brain has been programmed to help others." She suggested this was a barrier to self-compassion:

> *So my brain was programmed in a certain way and um, I found it hard to switch off from that mode and get into a slightly different one.*

The term "programmed" Magda uses suggests her tendency to help others and not herself was deeply ingrained and limited her agency. She talked about family and society:

> *I think a lot of my behaviour was learned from my parents… you always need to be doing, you always need to be producing, you always need to be the best, you always need to be aiming, you always need to be reaching goals… I think the society was like that, it wasn't, maybe, just specific to my family but society was like that.*

The listing in Magda's use of language represents a series of commands from others which seem to represent the pressure of expectation she experienced. The repetition of "always" conveys the extent of the familial and societal pressure she grew up with.

This seems to represent the "programming" Magda referred to earlier which made it difficult for her to recognise her own needs and make time for herself in relation to her chronic pain.

Magda revealed how her experience of growing up against the background of war in her home country accounted for her desire to help others which seemed to overshadow the self:

> *I was forever under some kind of pressure, mostly coming from me, er, I always needed to do more work, I always needed to spend more time caring for someone, finding somebody who needed my help, in the community, in the family, friends. It was almost like some need inside me… It might have been my coping mechanism with my thoughts and my distress over the past and losing so many people, so many friends and family.*

Magda's description reflects the acute pressure that developed within herself which seems to be a response to social factors and traumatic experience. Her motivation to help others seems to represent a "need" inside her and was perhaps a "coping mechanism." There is a sense that the "pressure" Magda describes might be connected to her position as a survivor. Her "need" to help others may reflect her attempts to make sense of the meaning of her life in the context of conflict and loss.

4.3.2.2 Sub-theme 2: Drive. Being driven, or striving, seemed closely related to social and developmental factors for Hannah and Magda. Tina mentioned losing a parent at an early age and she described competing adult priorities. This had meant caring for her own family while studying and working hard with different jobs and little time for herself.

Hannah's sense of herself as a "striver" seemed connected to her family experience: She returned to the theme again in our conversation by saying:

> *A lot of us tended to be the striving self, you were always trying to achieve and always trying to get that approval but you never seemed to get it.*

There is a sense that Hannah's motivation to secure her parent's "approval" drove her to "work harder and harder" without reward but this approach does not seem compatible with the restrictions imposed by chronic pain. It emerged from Tina's account of her experience that she was prone to a "burst and bust cycle" propelled by a heightened sense of drive and the guilt she mentioned earlier about not being able to do things for the family.

> *You have a burst of energy and then you bust after it because you burn yourself out really quickly… we have all got jobs to do… we sort of attack that and try and get it done as if we were before pain. In our minds we can do because we have done it before but our bodies don't let us do that… every time we bust we are in bed for 24, 48 hours.*

There is a strong sense of awareness here about the cost of being tricked by the mind into attempting more than the body can do "as if we were before pain." The word "attack" reflects the force of Tina's unchecked striving tendencies and she highlights the danger this represents when she says, "when we bust we are in bed for 24, 48 hours." Tina's comments give a sense of the adaptation living with chronic pain requires and the need to harmonise thinking and action, body and mind.

Magda's "need" to help others was explored in the previous sub-theme. Magda returned to this topic saying:

> *You needed to be, you know, so driven and, and so much was expected and so much was asked, and so big disappointments when one wasn't as good as those others and, and (*sighs heavily*) I think that didn't help me really in the long run… I think mentally and physically it had a big impact on my body.*

It appears that Magda's heightened sense of drive may be attributable to high expectations and a fear of disappointing others. I interpreted from the timing of

Magda’s pronounced sigh how powerful it was for her to reflect on the long term consequences of not feeling “as good as those others.” It seems that Magda experienced considerable pressure and that negative comparisons with others aroused distress which impacted on her embodied sense of wellbeing affecting her both psychologically and physically.

4.3.2.3 Sub-theme 3: The critical self. The contributors were not asked directly if they felt self-critical but it emerged from the analysis as both a barrier to self-compassion and as a feature of their experience of living with pain. Hannah explained:

> *I would be cross with myself because I didn’t feel well enough to do this, that or the other I had planned… beating myself up for, for not getting things done, or not being good enough, letting people down, that sort of thing, you know, very self-critical.*

The phrase “beating myself up” conveys a sense of Hannah’s acute frustration with herself. There is a sense of Hannah punishing herself for not being “good enough.” She recalls her past distress associated with not “getting things done” and there is a sense that despite the limitations imposed by chronic pain Hannah felt she was not achieving in the way she should. Like Magda, it emerges that her distress was made more acute by the thought of letting others down. This seems to have been significant for Hannah as she described herself earlier as a “striver” who drove herself to succeed in pursuit of love and recognition.

Hannah continued later saying:

> *I knew I lacked confidence and, um, I’ve had various things happen in my life such as bullying, you know, work-place bullying etcetera. I had been told that I wasn’t… performing, and very, um, derogatory terms. And I think, um, perhaps I didn’t feel good enough.*

There is a sense that not feeling “good enough” affected Hannah’s sense of self-worth compounding her tendency to feel even more self-critical when her pain imposed restrictions on her. It emerged that Hannah needed the help and support of others to reassess her own value and recover her sense of self-worth.

> *Joanne (*the psychologist who led the group intervention*) would say, you know, “it’s good enough”, you know, “you are good enough.” And that sort of resonated...*

I interpreted how compassion from Joanne enabled Hannah to be more compassionate towards herself.

Tina gave an implicit sense of her critical self when she talked about “feeling as guilty as sin” which was explored earlier in the first superordinate theme.

> *I can’t do for the family what I used to do and I feel guilty for that.*

It seemed that Tina’s self-criticism was connected to her pain and things she could not do for her family. Tina also appeared critical of the person she felt she had become:

> *There’s grieving, you grieve for the loss of your former self almost because that person is gone, and then you know, you’ve got this person.*

During our conversation Tina gave a sense that the way she related to herself before the group intervention made it difficult for her to make time for herself and to be self-compassionate:

> *I’m the last person to look after me… I’m really good at being compassionate to everybody else but I’ve never, never stopped and paid any attention to myself… I never took on board the concept of what actually being kind to yourself was.*

Earlier in the analysis it emerged that Magda had a heightened sense of drive which seemed to compound her difficulties and make her pain worse. Like Tina, Magda disclosed that:

> *Compassion is second nature to me but it was, is, was not easy to apply it to myself.*

In the quotation that follows Magda switches tense moving between past and present, “was, is, was.” There is a noticeable temporal element to her difficulty being self-compassionate which suggests an ongoing struggle which is not just a feature of past experience. She reflected on how she felt when she first tried to make time for herself:

> *It felt really strange cos I was like, what am I doing? I’m supposed to be going, going, you know, to (*speaking very quickly*) see a disabled friend, I’m supposed to be going and helping her. What am I doing just wasting time here for (*short laugh*)… it was difficult… self-compassion… did not come easy to me… I fight my urges to be doing something else.*

Magda’s fast paced delivery, her hesitation, repetition and laughter, all seem to convey the distress she recalls when she first attempted to make time for herself. She seems to conceptualise this as putting herself before others. A sense emerges of how self-critical she could be as her priority was always to help others. Making time for herself was thought of as “wasting time” and her self-criticism seemed to be a barrier to self-compassion.

4.3.3 Theme 3: The process of becoming self-compassionate

From the analysis a theme emerged regarding the process of becoming self-compassionate. For the three contributors this process was directly related to the power of the group intervention and involved a secondary process of self-realisation leading to self-development.

4.3.3.1 Sub-theme 1: The social self & the power of the group intervention. I asked Magda about her experience of the group intervention.

> *So when finally I sat down in this group, for me, the realisation of what was happening to me, accepting it finally, oh my goodness… it was like a major event in my life, in my mental state and in my head, I finally sat there just listening and, and, and absorbing and finally being able to accept that this pain is real.*

The emphasis on “finally” repeated four times in this section of Magda’s narrative suggests both the value of what she learned from the group and the length of time she waited for such a transformative experience. There is a sense of epiphany, of realisation and acceptance that enabled Magda to respond to her pain. The repetition of “and, and, and” represents her excitement to tell me more about the value of her experience. Magda continued by talking about her strong connection to the group.

> *It taught me so much, and being amongst the people who were just like me, I can’t tell you what that felt like. For the first time in my life I didn’t need to pretend. I didn’t need to be the bravest. I didn’t need to be the one who can just do everything, I was just amongst the people who were my people, I truly called that group of people my people who I felt so comfortable and so connected with.*

Emerging from the analysis is a sense of the social self connected to others that Magda was able to identify with. When Magda says, “I can’t tell you what it felt like” there is a sense of a weight being lifted, of freedom from the need to “pretend” and an opportunity to be “comfortable” in herself.

Magda reflected further that:

> *Honestly, without Joanne… running the group, without me joining the group… my pattern of behaviour, and my mental state, which was set for so long, would never have changed. I would never have learned anything about myself. I would never have allowed myself to stop and think what is happening to me. What do I need? How, how can I help myself? Why am I not*

> *willing to do anything to help myself?… I honestly credit it for changing my life, my process of thoughts regarding myself… and it has been the best medicine.*

Themes of gratitude and self-discovery run through Magda's speech. The group was clearly a powerful experience that enabled Magda to learn about herself, and specifically about how she thought she might begin to "help" herself and consider the psychological obstacles in her way.

Like Magda, Hannah spoke about the connection with others in the group.

> *The face-to-face really worked for me, especially when we got the... chance to speak to the other girls who were living with very similar conditions and what they were doing to cope and manage etcetera, and I did find that really useful.*

Hannah's connection and close bond with the group is intimated by the phrase "the other girls". There is a sense of learning in relation to others that helped Hannah consider other ways to "cope and manage." The group seems to have been a powerful resource for Hannah as it enabled her to identify with similar others. Hannah elaborated on this by saying:

> *It was interesting that quite a few of the girls had had similar experiences you know, like they had never been told by their parents that they were loved like me.*

There is a sense of validation when Hannah discovered that others in the group did not feel loved by their parents. It seems this encounter with others enabled her to make sense of her experience. It seems the group connection helped Hannah to consider that feeling unloved was not her fault which provided an opportunity to reassess her sense of self-worth and consider the nature of her critical self.

Tina referred to the value of the group.

> *It's just good to have a group of people who identify with your pain because people don't… see a visual injury… they think there is nothing wrong with*

> *you… there's ignorance or you know, there's a lot of issues, whereas within the group, because everybody understood, there was no judgements.*

For Tina a sense of the social self also emerged as she reflected on the importance of connecting with others who understood what it meant to be living in pain. The group appeared to be supportive and non-judgemental which contrasts with "ignorance" outside the group. A sense of stigma emerges from the analysis and how Tina felt the hostility and prejudice of others who can't see a "visual injury" and "think there is nothing wrong with you." Associations with invisibility appeared significant to Tina's experience. There were the prejudices of others connected to an invisible source of pain but also how Tina experienced pain in isolation without the understanding and recognition of others which seemed to have been invalidating. Tina added:

> *It was a good group and we were all very compassionate to each other. And there was a lot of love within the group for each other. I would really promote it, yeah (*laughs*), I can't speak highly enough about it to be honest.*

Tina laughs, perhaps conscious of promoting the group with such enthusiasm. However, a sense of compassion and love emerges which seems to have provided a valuable foundation for Tina's wellbeing. There is a sense that experiencing compassion to and from others may have encouraged Tina to be more self-compassionate.

4.3.3.2 Sub-theme 2: Self-realisation and self-development. The process of becoming self-compassionate seemed to involve self-realisation and self-development, learning about the self and about living self-compassionately with chronic pain. Magda described how the process began for her.

> *It changed only very slowly, I first made mental notes of what I was hearing but what, what does it mean in practice to, to be helping yourself, to have self compassion? So I started off by being less demanding on myself.*

Magda painted a vivid picture of the slow process of becoming self-compassionate which began by being “less demanding on myself” which seemed like a response to her high self-expectations and driven self explored earlier. The phrase “I first made mental notes” conveys a thoughtful and reflexive approach to what self-compassion meant for her. There seemed to be a separation that needed to be bridged between comprehending the meaning of self-compassion and understanding how to practice it reflected in the question Magda asks herself.

Magda referred back to her sense of having been “programmed” by experience to help others (but not herself) which seemed relevant to her uncertainty about how to be self-compassionate at the beginning of her journey.

> *Like I said, it’s like some kind of mode that I was switched on to and I carried on… switching into a different one has been hard but the process is there. I began that process.*

Magda’s narrative gives a sense of her difficulty practising self-compassion but she states the “process is there.” The positive phrase “I began that process” seems to resonate with self-affirmation. It conveys a sense of Magda’s determination but also how difficult the process has been. Magda seems to demonstrate a real pride in her own achievements perhaps as she acknowledges herself positively rather than dismissing herself critically. In doing so she seems to demonstrate a self-compassionate attitude to herself.

Magda described the process of becoming in more detail.

> *I consciously started thinking of what do I need, what do I need on any given day? It started off with very small, er, in, in my case I was advised to start off with something very, very small, kind of like ten minutes of the day, um, to do, to do something that I really liked. So it started off with me spending those ten*

> *minutes in a park… (*sighs heavily*) without a child, I was always in the park with my children, looking after them…*

The use of the word “consciously” suggests an emerging self-awareness, of Magda coming into consciousness and prioritising her own needs. The importance of the park resonated deeply with Magda and she talked about her love of nature and how she grew up in the countryside in her home country. As she spoke she sighed heavily communicating a strong sense of how difficult it was for her to begin this process and separate herself from her children for a short time. It emerges that the Psychologist leading her compassion group intervention “advised” her about what might work for her. She described how “in my case I was advised to start off with something very, very small.” There is a sense of consultation and of working things out together, of the intervention addressing the needs of the group but also responding to the individual.

Magda continued to describe how the process of becoming self-compassionate developed for her.

> *It doesn’t require me giving as much time to myself, it requires me becoming conscious of myself and my critical thoughts and trying to combat them and re-direct them into more compassionate thoughts.*

It emerges that for Magda becoming self-compassionate involved self-awareness and considerable reflection. A sense of epiphany seems to emerge from the analysis as Magda described how she came to realise:

> *... how much I needed that help, to help myself to cope better, to be more compassionate in, in my head to myself…. I call it a self-realisation course that I took. It taught me something invaluable, something that I could not pay enough for, something that I could not learn myself. It taught me so much.*

Magda's description of her experience of "self-realisation" of "learning" and having been "taught" by others seems very powerful and points to her process of self-development happening in close relation to others.

Hannah explained how she was introduced to self-compassion for the first time when she joined the compassion for pain group intervention. She talked enthusiastically about the content she covered over eight weeks:

> *We looked at erm, the evolution of our tricky brains, why we need self-compassion, the soothing rhythm breathing to calm our stress response. We did mindfulness practice, erm, compassionate imagery exercises, erm focusing on compassion on our inner critic. I found that one really interesting as well, er the multiple selves.*

Hannah explained how the process of becoming self-compassionate was facilitated by members of the group sharing recordings of mindfulness practice exercises from the group on social media so they could practice at home.

> *… the practices we did… one of the girls in the group would record it on her phone and then she would share it with the rest of us … and then we could listen to the practices when we were at home… And I do still listen to them… sometimes twice a day, especially if I'm having a bad pain day.*

There is a sense of connection with others again which runs through the analysis. For Hannah, being part of a supportive group helped her self-development as she began to practice self-compassion independently to help manage her pain. There is a sense of the learning process empowering Hannah to support herself in new ways which will be developed in the final superordinate theme.

Whereas Magda described the process of becoming self-compassionate as "self-realisation", Hannah described her experience as a "shift in mindset."

> *I think I have had a shift in my mindset since doing the course. And like I say, perhaps not beating myself up so much if I can't do certain things, or, you*

> *know, if I'm not feeling well, not pushing myself to make myself do it, just giving myself the time, and sort of repeating in my head what (*Joanne*) would have said, like, you know, "you're, you're doing okay, you know, just rest up today… it's time you need to heal yourself."*

What seems to have changed for Hannah here is her attitude and her relationship with herself. She described "not beating myself up so much" which evoked a sense of self-compassion and a change from the critical self that chastised the vulnerable self for not getting things done despite her pain. Joanne emerges as a mentor and a model for self-compassion who helped Hannah to begin a compassionate relationship with herself. Hannah's experience of becoming self-compassionate seemed to respond to her need for love and the recognition she described striving for throughout her life.

Talking about the process of becoming self-compassionate, Tina disclosed:

> *If I had read this in a book, um, I would have digested the concepts of it, but to actually do it was difficult, very hard to do… I can relate to a lot of this but I couldn't grasp it until um Joanne literally held my hand and walked me through it.*

Tina's disclosure suggests the idea of self-compassion is simple and easy to grasp but practising it is a challenge. Like Hannah, the Psychologist leading the group emerges as a key figure, a mentor and a guide who "literally held my hand." In the following quotation there is a strong sense of Tina's achievement and her emphatic repetition of "never, never" emphasises the strength of a connection that helped Tina develop the self-compassion which had been unfamiliar to her:

> *I'm really good at being compassionate to everybody else but I've never, never stopped and paid any attention to myself.*

Tina indicated her connection to the group was central to her experience of becoming self-compassionate:

> *I still needed that group to sort of glue it all together. And then now I can see, now I can see how that is and it does work, it does…*

Tina's description communicated further an image of ideas about self-compassion sticking like "glue" and forming into something meaningful and transformative. A collaborative sense making process within the group emerges from the data which helped the contributors learn more about themselves and develop their ability to be self-compassionate.

Like Hannah and Magda, Tina described how the process began with daily practice:

> *I do it every day simply because it works. It's as good as taking pain killers. And the breathing, just to, you know, just to relax and just to give myself some self-love.*

There is a sense of resourcefulness and taking responsibility for the self that will be developed later. The phrase "as good as painkillers" suggests a process that helps to relieve the intensity of Tina's pain. However, this appears to be a process she is in control of which may help her avoid over-relying on medication which she described earlier as important for her. The ability to "relax" that Tina attributes to being self-compassionate seems particularly important given her sense of drive and guilt explored earlier. Tina seemed to convey the essence of what becoming self-compassionate meant for her when she said:

> *I'm the last person to look after me, I'm the one who runs around and looks after everybody else… there is kind of nobody who could look after me so in that sense putting aside sort of 20 minutes in a day… does amazingly take the edge off the pain.*

4.4 Superordinate theme 3: The practice and benefits of being self-compassionate

This final superordinate theme has two main themes. The first explores the contributors’ experience of practising self-compassion at the time the interviews took place as opposed to their more reflective descriptions of their process of becoming self-compassionate explored previously. The second theme explores the benefits of self-compassion in contrast to the barriers explored in the previous superordinate theme. This second theme has three sub-themes which explore in turn: connections and new ways of relating to self and others; acceptance, empowerment and self-worth; responsibility, resilience and resourcefulness, and what this meant for the contributors in terms of self-care and self-comfort.

4.4.1 Theme 1: Practising self-compassion

It emerged earlier how Magda began her journey towards becoming self-compassionate by spending ten minutes of the day in a park on her own. She talked again about the significance of maintaining this and the importance of combining mindfulness with nature:

> *When I make it to the park I try so hard to make it just about that, just the park, and the trees and how beautiful they are, and I make sure I can hear the birds singing, and block other stuff out, and just be there in that nature, in that moment, trying to block out so many of my own thoughts and worries. So… that again I learned from there, and I daily, I survive by it.*

The emphasis created by the repetition of “just”, “just about that, just the park… and just be there in nature” gives a strong sense of what it means for Magda to be mindful of “trees”, “birds” and “nature” around her and not to over-identify with her “worries.” I inferred from the data that enjoying the delights of sensory experience in this way might be so important for Magda as her senses seem to register pain and psychological distress so much of the time at the expense of other more life-enhancing stimuli.

Magda also talked about the significance of imagery exercises in her practice. She described how at first she used to listen to recordings of Joanne leading the exercises but now she has memorised them.

> *So I remember her voice, it then becomes a voice in my head, um: "You need to hug that little girl, she's upset, she doesn't need any criticism, she's criticised herself enough. You need to tell her she's okay, she will be okay, she's doing a lot, she needs to do things for herself." So, that is the first and the foremost place that I go to because I need that the most.*

Magda communicates a sense of being able to recognise her own vulnerability and to comfort herself which will be explored further later. She seems to have developed a compassionate self that can respond to the legacy of historical criticism and she can be kind to herself.

It transpired that for Magda living with pain represented a "daily battle".

> *It's a daily battle I have to say, a daily battle. I know now what my pain is. I know what it is called but my brain struggles to adjust and to do less.*

Her description of her "struggle to adjust and to do less" emphasises the significance practising self-compassion seems to hold for Magda in helping to navigate her "struggle." There is a sense that self-compassion requires dedicated ongoing practice and is more a way of being than a solution focused approach to pain and distress.

Like Magda and Tina, Hannah described practising self-compassion daily, "sometimes twice a day, especially if I'm having a bad pain day*."* She seemed to have her preferred way of doing this and she explained:

> *I usually start off with that, with the diaphragm breathing, and then do a bit of a body scan, and then I will go into the walk in the woods.*

Hannah described the “walk in the woods” practice:

> *When we were with Joanne we would go for a walk in the woods and you use all your senses, so you would have the smells and the sounds and the textures, you know of the bark on the trees and the soft mosses and then going to the puddles and splashing in them… I would then think about the multiple self, and myself in pain, and what would the compassionate me say. She would say, “just take it easy today, rest up, you are doing the best you can”, and give myself a hug…*

The concept of the “multiple self” appears significant for Hannah. It seems to help her engage with her compassionate self which enables her to respond to her pain in different ways. The compassionate self seems to be able to advise, reassure and offer comfort to the self in pain and distress. Hannah describes the woods as a magical place. There is a sense of childlike wonder and delight in the detail of “going to the puddles and splashing in them” which reflects the joy Hannah associates with practising self-compassion.

One year on from the group intervention Hannah explained that:

> *I don’t always listen to Joanne but it’s almost like I can retell it myself now in my head if you know what I mean, or something similar.*

It seems Hannah has learned how to lead her own meditative mindfulness practice and can adapt it as she chooses. There is a sense of empowerment and resourcefulness here as Hannah has forged a new way of self-relating and comforting herself which will be developed later.

4.4.2 Theme 2: The benefits of self-compassion

Benefits emerged from the analysis and three sub-themes were constructed during the analysis.

4.4.2.1 Sub-theme 1: Connection with self and others (new ways of relating). The previous sub-theme explored the practice of being self-compassionate and connections with the self emerged from this. Hannah described how she made sense of the multiple self she connected with:

> *And the er, multiple selves obviously change depending on how I'm feeling, whether I'm in pain, or anxious or whatever, and I feel that gives me tips almost on how to cope.*

I attempted to make sense of this with Hannah during our conversation and I responded by saying:

> *And that sounds as if it might be like… having a conversation with yourself.*

Hannah replied by saying:

> *Yeah, it is yeah, it's like that's me but that's also me, and the wise compassionate self is talking to the troubled one, whatever the trouble may be, giving it advice.*

Hannah helped me to get closer to her experience and sense making process and I appreciated that for her there seemed to be multiple selves that exist alongside each other. It appears for Hannah that the notion of the compassionate self represented a key benefit and enabled her to form connections with herself that could provide comfort and guidance "whatever the trouble".

The value of making connections with others emerged in a previous theme which explored the power of the group intervention. Hannah provided a sense that connecting with others helped her form a compassionate connection with herself.

> *You think you are the only one who is like that but when you listen to others, others have had a very similar experience… It was almost like, if another person was talking, it was about me.*

Magda talked about connecting and identifying with others in the group.

> *It was thanks to that group and Joanne, and other people who were there, who were telling me their stories… finally the realisation of what has happened to me, what is going on, what will carry on going on… it made some sense, for me that was the biggest help I could receive.*

There is a strong sense of Magda's gratitude towards others and sharing "stories" emerged as a powerful means of making "sense" of the self in relation to others. Magda's disclosure, "finally the realisation of what has happened to me," links to the "self-realisation" she foregrounded earlier in our conversation. It seemed like a moment of epiphany when Magda realised how her history made it difficult for her to help herself and would continue to do so unless she tried a new self-compassionate approach based on understanding.

The theme of connections with others facilitating connections with the self recurred throughout Magda's conversation and took on a mystical quality.

> *What I hear from other people, how they were, some of them were a little bit more advanced than me in their self-compassion and they were doing some things, and for me to hear that this is the way, they were all showing me the way, paving the way. It's, it's the best gift really, it's helped me so, so much.*

Magda's description suggests how learning from others was transformative and she makes sense of the process using evocative metaphorical language. The description of "being shown the way" and having a "gift" bestowed upon her seems like a spiritual experience. The reference to self-compassion as "the way" was interpreted as being like a conversion to a new faith amongst the elders who guided her. This seemed to be how Magda made sense of the meaning self-compassion held for her.

When exploring the power of the group theme earlier in the analysis Tina described how she "identified" with the group. She was quoted as saying:

> *It was a good group and we were all very compassionate to each other… there was a lot of love within the group.*

This compassion and love between the members of the group for each other seemed to create the foundation for learning and self-discovery. Tina connected compassion for others with compassion for the self:

> *If you spend a little bit of time being mindful, and being compassionate towards other people that gives you a warm sense of, you know, you give them some love so why can't you do that to yourself.*

There is a sense of the flow of compassion from self to others, others to self, and self to self. It seems that for Tina the connection with others including Joanne, who "literally held my hand and walked me through it", was essential to learning together in ways that enabled Tina to adopt a self-compassionate approach to her pain. With much laughter, Tina recounted how the group enjoyed learning together about the opposite nature of self-criticism and self-compassion when Joanne referenced the film *Matilda:*

> *We sort of learned to treat ourselves as if it was Miss Honey attending to us rather than Trunchbull because we all identified with that and we do, do it. And who would you rather have attending to you? Of course you'd want Miss Honey.*

The use of a popular film as an analogy seemed to help Tina and others recognise the value of a compassionate connection with themselves as they identified with the kindness of the fictional Miss Honey as opposed to the critical unkindness of Miss Trunchbull.

Like Hannah and Magda, Tina seemed to forge a strong connection with others and a new way of relating to herself based on self-compassion. She made sense of this connection with herself with refence to trauma therapy:

> *It's kind of like trauma therapy where in that case you would get the older self to look after and raise the traumatised younger self, to love and protect and give compassion where nobody else does in order to overcome that trauma. And this is kind of, kind of the same way you'd get your compassionate self to, you know, give compassion to your angry self or… all the different selves you become when you are in so much chronic pain.*

A semantic field related to nurture emerged from the analysis seen in the phrases: "look after; raise; love; protect; compassion." The words seem to represent the care a parent might provide to a child. Tina gives a sense of being able to use self-compassion to comfort herself, to be her own parent in a metaphorical sense.

4.4.2.2 Sub-theme 2: Acceptance, empowerment and self-worth. In the previous theme, becoming self-compassionate, Magda was quoted as "finally being able to accept that this pain is real." Magda elaborated on this by saying:

> *I have had it for so long, it's going to be there, it's no one's fault, there is no one to blame, it's not going to get miraculously better as I thought it would for years, and years, and years. It (*sighs*), it, it was a major discovery and major acceptance on my part.*

Magda gives a sense that coming to terms with her pain has been a "major" breakthrough for her. There is a notable temporal element to her narrative as she references the presence of her pain in the past and the future. She indicates an acceptance that her pain will not get "miraculously better" as she hoped "for years". The references to time and the suggestion of pain carrying on indefinitely into the future give a sense of why it might have been so difficult for Magda to accept chronic pain which threatened her wellbeing and sense of self as a mother and friend to others.

Magda also seems to have given up on the idea of "miracles" which I interpreted to mean a cure for her pain. I considered this might link to her new sense of faith in self-compassion explored in the previous sub-theme. After a long period of pretending to herself and others that her pain was somehow not "real" her acceptance seems to be a form of self-compassion, a kindness to herself. This seems to have empowered Magda and enabled her to explore ways of living with pain that seem more helpful to her. Magda conveyed her acceptance further when she said:

> *I think I have let go some of my own anxieties, and, and, and what limits are placed on me by trying to look as though I wasn't in any pain. So that has been another change. I now, it's very clear that you know, that my back, my feet, my arms are hurting. I'm not as eager now to conceal it all because I was for a very, very long time.*

Magda suggests she has "let go" of some of her "anxieties", perhaps the threat pain represented to her sense of self and what she conceptualised as her primary role as a caregiver to both family and friends in her community. With this, there seems to be a further letting go of what she describes as the "limits placed on me by trying to look as though I wasn't in any pain." These limits appear self-imposed and seem to relate to the barriers to self-compassion that emerged earlier in the analysis. Before self-compassion, Magda seemed to be reluctant to accept her pain, to seek help from others, or to help herself.

For Magda acceptance seemed empowering and also connected to her sense of self-worth. Before she became familiar with self-compassion through the group intervention Magda talked about not considering herself "deserving of any help." This seemed to have changed as she began to adopt a compassionate regard for herself. She described this as "helping herself" but also as "spreading the load:"

> *And I have started (*sighs*) consciously knowing that, um, things are difficult for me, and they are becoming more and more difficult, and as eager as I am to do everything myself I knew, it became apparent to me, I was struggling more and more with the jobs that were waiting for me and I needed to bring them in.*

Magda's sense of acceptance emerges strongly here with the emphasis she places on "consciously knowing." She seems empowered to face how "difficult" her situation is, to look after herself, and actively seek help from the family, "to bring them in", because she recognises her own value and her need for support.

I interpreted that Magda's sense of herself as a mother and tireless comforter of others might originate from culturally determined gender roles. Nonetheless, Magda described the support she now welcomed in her home.

> *But my husband has been very good… he never waits for me to actually mention something that hasn't been done, like a pile of dishes, a pile of ironing, you know, there seems to be lots of dust because I can't hoover as much as I did and I need more time to do those chores… it's clear my body is not capable anymore, you know, keeping up with everything, so he'll just step in and I'm always pleasantly surprised… it's the nicest thing anyone can do for me, unburden me from my workload which I always put on myself.*

It seems that a self-compassionate attitude provided Magda with a sense of self-worth and changed the way she related to herself and to others, and perhaps the way others related to her. It emerged from Magda's story how highly valued she is and by valuing herself she helped others show their love and compassion for her.

Magda described how she had also begun to encourage her children to help her at home.

> (*I'm*) *including them a little bit, and, and letting them take a little bit of the burden off my, you know, off my daily tasks. So that is a process itself because for a long time I did everything myself… like I say, find yourself a time when you can do a chore… I'm only giving them a chore of their own choice but I think it is a good start.*

Magda talks about "including them" and "letting them take a little bit of the burden off." She conveys a new way of relating to others and connecting with her family that seems helpful to her from a practical perspective but also from an emotional one. She seems more able to share her pain and appears less isolated than she was before when she felt the need to hide it. There is a sense that she has become more accepting of herself by allowing others into her experience. This seemed to begin with the group intervention and I experienced it during our conversation together through her willingness to share her experience so generously.

Like Magda, Hannah conveyed a sense of self-compassion having facilitated self-acceptance and the limitations imposed by her pain.

> *I think in the past I would always have thought of things being my fault. If something went wrong I would blame myself whereas now I sort of think, you know, I was doing the best I could.*

Hannah's dialogue conveys a strong temporal aspect and a gulf between past and present. Hannah describes how she used to "always" blame herself "if something went wrong." Now there seems to be a sense of compassionate acceptance which represents a change in her. Hannah emphasised this when she repeated the phrase "shift in mindset" which she had used before in our conversation:

> *It definitely gave me a shift in mindset, you know, of not always being perfect.*

The recurring phrase about her change in "mindset" seems to convey Hannah's compassionate development and the way she has begun to let go of her need to be "perfect." Hannah seems empowered to let go of some of her past beliefs and conveys a sense of having addressed her critical self with a more compassionate and empathic self.

Hannah attributed her self-acceptance to what she had learned from the group intervention. She described using mantras which seemed to encourage an accepting attitude:

> *It's not your fault that you are ill. We have got tricky minds and tricky bodies and we are all living with this and trying to deal with it in our own way." And they are the sort of mantras I listen to, you know, when I am having a bit of a down day. A bad pain day. "It's fine, just have a chill day, look after yourself", whereas previously I would be cross with myself because I didn't feel well enough to do this.*

There is a sense of Hannah being liberated by mantras which free her from self-recrimination. The emphasis on "tricky minds and tricky bodies" connotes acceptance based on the understanding that living with pain is complicated and challenging. The emphasis on “we are all living with this and trying to deal with it in our own way” seems helpful for Hannah as it acknowledges her efforts to live with pain in her own unique way. The emphasis on “we” gives a sense that Hannah is not alone in her pain and that she is connected to others. For Hannah, acceptance appears to be integral to self-compassion and a compassionate relationship with herself seems empowering:

> *I can do what I want when I want to do it… I’m not trying to fit in as many things as possible and please everyone else. I’m able to do things for myself and things that matter.*

The repeated use of the first person “I” and the active voice indicates a strong sense of self-affirmation. Hannah appears empowered to “do things” for herself and she seems proud that she is “able” to do so. There is perhaps an existential element to Hannah’s disclosure when she emphasises doing “things that matter.” There is a sense that by devoting time to herself and her own needs Hannah has discovered what is meaningful for her. Hannah’s sense of empowerment seems to have given her an enhanced sense of self-worth:

> *I think I value my own opinion more whereas in the past, because I lacked so much confidence and I’d been pushed down so much, I sort of always thought people were better than me, or they were right and I was wrong. Whereas now I’ve got a bit more confidence I suppose in my opinions and what is right and what is wrong***.**

Hannah communicates how she values her own “opinion” and she seems to trust in herself. This signals a transition from past to present as she appears to have grown in “confidence” as opposed to being “pushed down so much.” She seems to have developed a greater sense of agency. There also seems to be a transition in the way Hannah has begun to speak during our conversation. The way she makes sense of herself now, compared to the way she used to think of herself, is expressed in a flowing and less hesitant stye of speech with a self-assured tone. She now appears more self-assured and less likely to be self-critical or to make negative comparisons with others. She indicates a new “confidence” in her sense of “right and wrong” and an inner strength despite the restrictions imposed by her pain.

4.4.2.3 Sub-theme 3: Responsibility, resilience and resourcefulness (self-care and self-comfort). This final sub-theme emerged at several points during the analysis. The three research contributors demonstrated responsibility, resilience and resourcefulness before and during their compassion for pain group intervention. However, this sub-theme focuses specifically on how they demonstrated these attributes by practising self-compassion after they had completed their intervention. Self-compassion may be seen to have enhanced these attributes in ways the contributors suggested were helpful to them.

When Hannah and Magda referred to their pain they used the phrases “it’s no one’s fault” and “there is no one to blame” which Joanne introduced them to during their group intervention. Tina described this by saying:

> *Like Joanne kept saying, it’s just our tricky body and our tricky minds, it’s not necessarily us, it’s just the hand we have been dealt really, and it’s not our fault, it’s just our response, our natural response to pain.*

This understanding seemed to help Tina, Magda and Hannah face their inner critics, address their sense of shame and guilt, and to take greater responsibility for their pain. They seemed motivated to do so for many reasons including the limited benefits their medication seemed to have. Tina highlighted this by saying:

> *Literally they take about 40% of the pain away. They just take the sting out of it.*

Tina gave an indication of her resolve to do as much as she could in response to her pain:

> *It's determination really because it's frustrating being in this situation, you want to get up and do stuff and when you are the only person that, that you know, can do that or has to do that, then it is really falling on your shoulders to do that and you have to find a way to do it you know.*

Tina conveys her sense of responsibility to others and also her determination to take responsibility for her own situation, "to find a way" to moderate her "frustration" regarding her pain which restricts the things she "has to do." Tina seemed to make sense of what self-compassion meant for her by describing it in terms of "love" and "warmth" for the self:

> *It's actually just giving yourself some love… just being warm to yourself… I can cope with the pain better. I'm not as moody which has affected my relationship with others.*

Tina's dialogue suggests self-compassion is connected to how she takes responsibility for the way she responds to her pain and the way it can affect her relationships with others.

I got a sense of Tina's resilience and resourcefulness from the way she described accommodating diaphragmatic breathing into her self-compassion routine.

> *So by breathing and getting air to the bottom of your lungs instead of just the top that instantly gives me the calm feeling, the relaxed feeling. I try to do a little bit more so it's deeper and slower and that really works for sleep. Now I use that for panic through my life, I do suffer from anxiety, so I've used that again, I recognise when I'm anxious, I recognise when I've started to breathe from here, and not from here.*

Tina appeared resourceful in her use of breathing as a strategy to help her sleep. She explained "I don't want to be relying on sleeping medication." It also seems to help Tina manage panic and anxiety and she seems resilient in response to recurring distress. In a similar way Tina appeared resourceful in her ability to use other strategies connected to self-compassion practice to help her side-step the “burst/bust cycle” explored earlier in this chapter. This was a significant issue for Tina and she was quoted before describing how a “burst” of energy could lead to a ”bust” which might mean she was in bed for the next 48 hours. Tina described how:

> *If we can take some time to meditate it gives us more energy to do a little bit more instead of busting completely… I’ve not actually spent a day in bed since the group ended.*

Self-compassion seems to enable Tina to take greater responsibility and to enhance her self-care. Compassionate practices, which Tina referred to as “useful tools to have in your bag”, seemed to help her to be resourceful and resilient in response to chronic pain.

Like Tina in this respect, a self-compassionate attitude seemed to help Magda “look after” herself more. Magda reflected:

> *I never had any destructive behaviours, you know, I always thought I was looking after myself, but I never consciously thought that I needed to do anything extra to help myself.*

In terms of self-care, Magda communicates a sense of herself as a responsible person without “any destructive behaviours” before she was introduced to self-compassion. However, her comment “I always thought I was looking after myself” seems to suggest that now she realises there was more she could do. The emphasis on “I never consciously thought” conveys a sense of Magda not thinking about herself much or recognising her own needs. Since she began to practice self-compassion a sense of her resilience and resourcefulness emerged from the analysis. Magda seemed resilient in response to her pain but also to the challenges of becoming self-compassionate and the initial difficulties she faced as previously explored. She referred to her struggle to “do less” and make time for herself as a “daily battle.” It seems that self-compassion brought Magda into a closer relationship with herself and inspired her to “consciously” take greater responsibility for her wellbeing understanding the nature of her difficulties. She described the process of being self-compassionate as a “daily practice” and suggested that “I survive by it.” Quotations presented earlier in the analysis give a sense of Magda’s joy and pride in her achievements which suggest she benefited from taking a greater responsibility for herself that was not possible before self-compassion.

Hannah conveyed the benefit of taking enhanced responsibility for herself and what this meant for her in practice.

> *I think probably the main thing was pacing, pacing activities and not expecting too much of myself, and it didn’t matter if I, didn’t matter if I didn’t do something that day, it could be done another time. I suppose just being kind to myself, rather than like I say, this self-critical person.*

It seems that being “kind” to herself rather than ”self-critical” helped Hannah change the way she approached her daily activities which seemed to benefit her wellbeing. Hannah continued to talk about what self-compassion meant for her.

> *Not being kind to yourself isn’t helping you and it isn’t helping your pain. So you know, by continuing to strive you are making your pain worse, you’re having more flare ups, better to just stop and rest and let things settle and when you feel well enough then you can do some more. It’ll all be there another day, but um, just don’t beat yourself up about it.*

There is a sense here that by being self-compassionate, “kind to yourself”, Hannah has taken responsibility for her self-care. She seems to have recognised that the initial barriers to self-compassion such as heightened drive and self-criticism were also barriers to her wellbeing. The compassionate approach Hannah describes had been a challenging adaptation for her to make to her daily life but it seems to help her manage her pain and reduce pain “flare ups”.

It emerged from the analysis that resourcefulness and resilience were connected to responsibility. Hannah was quoted previously describing how she might be compassionate to herself when she was experiencing a pain flare up:

> *Say I’m having a really painful time, that would be me in pain, I would then think about the multiple self, and myself in pain and what would the compassionate me say. She would say, “just take it easy today, rest up, you are doing the best you can.*

Hannah’s description of her compassionate response to “having a really painful time” conveys a sense of her resilience. Like Tina, she seems to have “tools in her bag” and she demonstrates resourcefulness and responsibility by making use of the multiple self to comfort and care for herself.

4.5 Summary of chapter

The analysis identified and explored three emerging superordinate themes: living with chronic pain before self-compassion; self-compassion as a journey; and the practice and benefits of being self-compassionate. The diagram on the first page of the analysis presented an overview of the related themes and sub-themes.

It emerged from an interpretive phenomenological analysis that the research contributors experience of self-compassion represented a journey of self-discovery. They seemed to learn a great deal about themselves in relation to others who were part of their group intervention. It emerged that the role of the Clinical Psychologist who ran the group was central to the journey experienced by the contributors and this cannot be stressed enough.

The analysis first explored what it meant for each contributor to live with chronic pain, both physically and in terms of their emotional wellbeing before self-compassion. The second superordinate theme explored the nature of the journey each individual took from an idiographic perspective. The journey incorporated the barriers to self-compassion and the process of becoming self-compassionate. The third and final superordinate theme explored how the contributors practiced self-compassion, what it meant for them, and the benefits they experienced.

It emerged that each contributor had their own unique story to tell but there was much common ground. The analysis conveyed how the contributors had all benefited from self-compassion and how valuable the group intervention had been. It emerged throughout the analysis how self-compassion seemed to help the contributors live with their pain and the psychological distress associated with it. Above all, it emerged how resilient and resourceful the contributors were and how self-compassion seemed to have empowered them to find new ways of adapting to their pain based on understanding and self-regard.

Chapter 5: Discussion

5.1 Introduction

The discussion summarises the findings that emerged from the analysis by looking back at the three superordinate themes. The findings will be considered from an interpretative phenomenological perspective and in relation to the existing literature. A perspective on what the research means as a whole will then be offered. An evaluation of the research begins with a consideration of quality based on Yardley's (2000) criteria. This will be followed by an evaluation of the IPA methodology. A section on reflexivity includes an epistemological and personal reflexive focus. A reflection on the strengths and limitations of the research will then be offered. To close, the implications of the research will be considered in relation to CoP practice, training, and further research before a final conclusion is presented.

5.2 Summary of the research

5.2.1 Superordinate theme 1: Living with chronic pain before self-compassion

This superordinate theme represented the interconnected physical and emotional experiences of living with CP before self-compassion and how I interpreted the meanings it held for the contributors. The structure of the superordinate theme consisted of five themes which considered the experience of chronic pain from an embodied perspective, the limitations it imposed, its psychological effects, how it influenced the self, and how the contributors experienced diagnosis and the medical world.

CP was described as a "nightmare", something "you can't run away from" and "have to sit with" (Tina). CP seemed frightening, relentless, and represented entrapment.

Its debilitating effects were conveyed with a sense of the “body just giving in” (Magda). However, Hannah came across quite differently. She talked about the background to her pain but very little about the pain itself. Nonetheless, I realised this did not mean her pain was any less significant for her. On the day we met online she was having a “bad pain day” and was sitting in bed with a heat pack. Paradoxically, this appeared to have brought me close to her pain although I remained separated from it. This paradox continued throughout the research and seemed to reflect the way IPA can get close to the nature of experience from an empathic position but remains separated from it. This seems linked to the double hermeneutic and the way uncovering the nature of experience depends upon the researcher’s attempt to make sense of the contributor’s sense making process (Smith et al., 2009).

The debilitating pain Magda and Tina experienced seemed to impose restrictions on their lives they seemed unable to accept before self-compassion. All three contributors had children but whereas Hannah’s children were fully independent, Magda and Tina were more closely involved with children at different life stages. Purdie & Morley (2016) discuss how social roles and performance based evaluation can lead to negative self-appraisal. This seemed to be reflected in Tina’s and Magda’s experience before self-compassion. Their pain seemed to have caused them significant emotional distress and inner conflict as they found it difficult to do the things that mattered to them in line with their sense of themselves as mothers. For Tina, this meant guilt and shame which exacerbated her pain before she explored self-compassion.

Before self-compassion Magda described pretending to others and to herself that she was not in pain which suggested a disconnection from the self. It seemed that her life had felt limited by CP which was unacceptable to her sense of identity as a mother and a support to others. Magda’s description conveyed a sense of CP as an invisible experience and a hidden phenomenon which was developed as a theme. Tina alluded to this when she talked about putting on a “brave face” and how others never saw her when “she was at her wits end unable to get dressed.” The theme of invisibility links to the literature which highlights the way CP can lead to social rejection (MacDonald & Leary, 2005) isolation and suffering alone (Austin et al., 2020).

In their IPA study on back pain Osborn and Smith (2006, p.216) describe the “self in pain” and “living with a body separate to the self.” This seems reflected in Tina’s account of loss in this research. She suggested “you grieve for the loss of your former self… and then you know, you’ve got this person.” Tina’s determination to reclaim aspects of her old self seems to echo findings in the Osborn & Smith (2006, p.216) study which described the embodied experience of CP as “an assault upon and a defence of a preferred or desirable self.”

The way the contributors talked about their experience of the medical world and the impact of diagnosis varied quite considerably. Hannah talked more about previous pain management interventions and the unique nature of the compassionate intervention. In contrast, Tina spoke about ineffective pain medication, misdiagnosis, and the frustration of waiting for a more helpful diagnosis that might lead to effective treatment. There was a sense of invalidation and distress at being left to cope on her own before self-compassion. Magda described feeling upset during the consultation process and not being helped to talk about her difficulties. Although she experienced a long wait for a fibromyalgia diagnosis it was meaningful for her and seemed both validating and transformative.

It emerged from this superordinate theme that all the contributors valued their compassionate intervention. It seemed to help them adapt and live with chronic pain more effectively than the medical interventions they had received.

5.2.2 Superordinate theme 2: Self compassion as a journey

The second superordinate theme explored the process of becoming self-compassionate and the barriers the contributors faced. The contributors conveyed a sense of a journey to become self-compassionate. They described a process of “self-realisation” and how they continued to learn and develop their skills which brought about change. This seems to relate to Sartre’s idea of becoming and the developmental nature of being which influences the philosophy underpinning IPA (Smith at al., 2009).

There was a sense of the contributors journeying as individuals while travelling together. This emerged in the way the contributors embarked on a personal journey to develop a compassionate relationship with themselves but how their experience involved a close connection to others in the group they travelled with. From a phenomenological perspective, the analysis showed how the contributors made sense of themselves in relation to each other throughout their intervention. This seems to correspond with Heidegger’s (1962) concept of Dasein and being in the world. The close bond that developed between the members of the group seemed to facilitate personal growth reflected by Parry & Malpus (2017).

The literature shows how developing self-compassion is linked to a connection with others and a sense of common humanity (Neff, 2004). This seems particularly important for individuals who experience CP because they are often thought to be isolated by social stigma (Wallace et al., 2021).

In this research connecting with others in the group enabled the contributors to identify with others. The intervention helped to validate their experience of CP and seemed to encourage self-acceptance. This appeared to provide the foundation for self-compassionate practice and encouraged adaptive coping strategies which the contributors suggested helped to reduce distress and the intensity of their pain in keeping with the literature (Penlington, 2019).

The contributors indicated they were ready to try a new initiative after exploring other means of pain management with varying degrees of success. It emerged from the analysis that self-compassion held an appeal for the contributors before they fully understood what it meant to be self-compassionate. However, their narratives indicate the central importance of learning about SC and being helped to develop it. These factors are reflected in the literature which emphasise the importance of psychoeducation, mentoring, and compassionate support from others (Gilbert, 2009).

The importance of the group intervention and the pivotal role of the Psychologist leading the group emerged as essential aspects of the contributors' journey. Gilbert (2010) explains how the compassionate therapist helps the client to develop a compassionate internal relationship with themselves rather than a critical shaming one. This was apparent in the research reflected in the way the contributors talked about forming more compassionate relationships with themselves and how this helped them to manage their pain and distress.

In keeping with the literature (Gilbert, 2013), different barriers to self-compassion emerged such as self-criticism and shame. In this research barriers were also connected to the interrelated nature of self-expectations and the expectations of others. The contributors recognised themselves as “strivers” who might feel undeserving which has been linked to difficulties individuals face recognising their own needs (Purdie & Morley, 2016). Historical factors and attachment styles emerged from the analysis as barriers to SC in keeping with the literature (Gilbert , 2009b). Magda spoke about “her brain being programmed to help others” and how familial and social factors affected her sense of drive. This seemed compounded by the way she thought she may have responded to collective trauma in her community which made it difficult for Magda to prioritise herself at the perceived expense of others.

Hannah spoke about feeling unloved by her parents which seemed to heighten her drive in search of recognition. Individuals with CP are thought to be twice as likely to have an insecure attachment style compared to the general population (Davies et al., 2009). The literature recognises how insecure attachment styles can make it more difficult for individuals to develop SC. It suggests heightened drive leads to an imbalance between the emotional regulation systems restricting one’s ability to self-soothe and regulate negative affect (Gilbert, 2010). In keeping with the current literature (Parry & Malpus, 2017, p.146) the research showed how striving tendencies can be particularly pernicious for individuals living with CP leading to a “boom and bust pattern” as heightened activity may lead to pain flare ups and emotional distress.

It emerged from within this superordinate theme that the process of becoming self-compassionate took time and depended upon a connection with others and a growing connection with the self. It involved getting to know oneself better and negotiating psychological barriers. The research showed how SC was connected to developing an enhanced relationship with the self which transcended what Purdie &

Morley (2016, p.8) describe as “value based attributions of worth”, or assessing oneself based on value driven achievements.

5.2.3 Superordinate theme 3: The Practice and benefits of being self-compassionate

The final superordinate theme explored how the contributors practised SC. It then interpreted the benefits described by the contributors which included: enhanced connections with self and others; acceptance, empowerment and self-worth; and responsibility, resilience and resourcefulness.

It emerged how the contributors all practiced SC exercises at least once a day or more, depending on the nature of their pain. In keeping with the current literature (Gilbert, 2010; 2013), SC practice involved relaxation techniques including rhythm breathing to engage the comfort and affiliation emotional system. Other techniques included imagery and mindfulness practice and making use of the multiple self by drawing on the compassionate side of oneself to provide comfort and understanding in response to pain and distress. The practice also involved making time for the self, for both rest and meaningful activity. The contributors conveyed a sense of joy and satisfaction connected to practising SC. However, the practice was underlined by a sense of need and Magda described her “daily battle” to “adjust and do less” given her striving tendencies.

The benefits seemed numerous and the contributors described their experience of self compassion with gratitude and excitement. The connection with others and the compassionate self that emerged during the process of becoming self-compassionate seemed to sustain the contributors in their daily practice. The contributors all appeared to have formed more compassionate and understanding relationships with themselves based on a compassion for each other. The analysis showed how connections with others led to self-realisation which prefigured self-development and change (Penlington, 2019). Magda talked about learning from others and learning about herself which helped her appreciate why she found it difficult to care for herself. This seemed to represent a turning point in the way she began to think and behave. Hannah and Tina described how they summoned their compassionate selves to help comfort the self in pain.

SC seemed to have facilitated acceptance and a change in mindset. This seemed to mean that the contributors were less inclined to deny their pain and more willing to respond compassionately by adapting to the limitations it imposed on their quality of life. Acceptance was interpreted as empowering because it encouraged a new compassionate approach that seemed to be working for the contributors. Magda described it as “lifesaving” and it changed the way she related to herself and to others. She was developing her ability to seek and accept support from others and she treasured this. This seemed indicative of the flow of compassion described in the literature (Gilbert, 2010) which moves from self-to-self, from self to others, and from others to self. In the lives of the contributors it seemed to make a real difference to the quality of their lives.

For Hannah and Tina there was an appreciation that pain and distress were “not their fault” and that both were connected to our “tricky brains” (Gilbert 2014) which seemed to help de-shame and encourage acceptance. SC empowered the contributors to experiment with a new way of being and it seemed to increase their sense of self-worth. Hannah described growing in confidence, valuing her own opinion more, and even feeling more secure in her sense of right and wrong. This was in contrast to having been “pushed down so much” in the past when she tended to make negative comparisons with others which seemed to lower her self-esteem.

Responsibility, resilience and resourcefulness were interpreted as benefits that SC seemed to help the contributors develop. Tina described how her experience of being self-compassionate encouraged her to do as much as she could in response to her pain and this was reflected in the attitudes of the other contributors. This links to the literature and Gilbert's (2010, p.3) use of a definition of compassion offered by the Dalai Lama as: "a sensitivity to the suffering of self and others, with a deep commitment to try and relieve it." The contributors seemed motivated by SC to care for themselves in the knowledge that their pain was enduring and that pain killers had limited effects and might be problematic (Carr, 2016).

The contributors demonstrated resilience and resourcefulness in response to CP by their willingness to try adaptive coping strategies linked to self-compassionate practice. SC seemed to help them respond to their embodied experience of pain by pacing themselves and reassessing what they might be able to do on a daily basis. The contributors seemed to convey a sense of psychological flexibility (Davey et al., 2020) that helped them manage potential distress associated with the restrictions imposed by CP. Mindfulness, diaphragmatic breathing, and self-guided imagery exercise were employed resourcefully to aid relaxation, manage pain, assist activity and facilitate rest and sleep.

5.3 Overview of the research summary: Linking the parts to the whole

The IPA analytical process involves the hermeneutic circle (Smith et al., 2009) which encourages the researcher to break down the data into parts which are represented as themes. This enables detail to emerge in pursuit of rich interpretations of lived experience. To complete the circle, the researcher is then required to reassemble the parts and make new sense of the whole. Many meanings emerge about what SC represents for the contributors both individually and collectively. Taken as a whole, self-compassion seems grounded in the data as a transformative and life-enhancing phenomena for the contributors in this research. Connections with others lasted beyond the intervention itself and seemed to enhance self-to-self relating in ways that empowered the contributors to act on their own behalf. Tina suggested SC techniques were “useful tools” that helped her “find a way” to moderate her pain. Magda referred to SC as a “gift” and having been “shown the way” by others. Hannah appeared more confident and less self-critical. SC emerged as a way of relating to oneself that encouraged a meaningful approach to living on one’s own terms.

I would like to reflect at this point on how the contributors made a strong and lasting impression on me. During the interview process I developed a considerable positive regard for Tina, Hannah and Magda. I was moved by their stories and struck by how brave and determined they were to practice self-compassion as a meaningful way of living with their pain and enhancing their wellbeing. I felt an immediate connection with the contributors and began to cherish them as I immersed myself in the data we constructed together. The contributors’ openness and generosity helped me to make sense of their experience and what self-compassion seemed to mean for them. I am indebted to them and I hope I have been able to provide a platform for their voices. I will remember them as inspirational individuals who embodied a depth of compassion for themselves and for others which seemed to make a real difference to the way they lived with chronic pain.

5.4 Evaluation of the Research

5.4.1 Evaluation of Quality

Yardley's (2000) four criteria for assessing the quality of qualitative research were considered throughout the research and reflections are offered here. I will consider the first three criteria here and refer to "impact and importance" when I reflect later on the significance of the research.

5.4.2 Sensitivity to context

Yardley (2000) suggested this can be demonstrated in various ways which include locating the research in the context of theory and existing research. I attempted to do this through a structured literature review of relevant research which defined CP and SC. The review provided an overview of the theory and evidence base for SC before establishing its relevance to CP. The strengths and limitations of the current research were considered and a rationale was offered for the proposed research.

With data collection, I attempted to maintain sensitivity to context in my attitude to the contributors and to the methods of data collection which both have an ethical significance. I was aware of potential power issues and how my position as a researcher might reflect a hierarchical relationship. I tried to redress this by addressing the contributors as the experts. I positioned myself as a researcher eager to learn about their experience and provide a platform for their voices.

I was mindful of the sensitive nature of the topic and I anticipated that the contributors were likely to be experiencing pain when we met. I was keen to accommodate the contributors as best I could during online interviews so that they did not experience additional distress. I reassured them they did not have to answer particular questions and they could stop the interview at any time. Interviews stuck to time, were purposeful, and sensitive to the wellbeing of the contributors. The interview schedule was used flexibly and the contributors were encouraged to talk about what was meaningful to them. Prompts were used when necessary as an enabling device to facilitate individual narratives.

Yardley (2000) highlights the importance of sensitivity to the data and the language used by the contributors to communicate their perspectives. Throughout the analysis I endeavoured to pay particular attention to how language conveyed meaning. Imagery and metaphor were recognised as highly significant as through these devices we attempt to describe what our experience is like and how it appears to us. My key IPA aim was to ground my interpretations in the data and I adopted a reflexive approach to monitor this throughout the research.

5.4.3 Commitment and Rigour

Yardley (2000, p.221) describes commitment as “prolonged engagement with the topic” and “the skilful use of methods”. I attempted to demonstrate this by following the Smith et al. (2009) six stage analytical process detailed in the methodology section. Yardley (2000, p.221) conceptualises rigour as “comprehensive” analysis but explains this is not related to sample size as IPA may focus on a single case. Rigour is more about the “adequacy of the sample” and the way it supplies the information needed for a comprehensive analysis (Yardley, 2000, p.221). The sample will be discussed in more detail later but I think the contributors’ accounts provided me with rich data that enabled me to answer the research question comprehensively.

Rigour is also thought of as demonstrating “completeness”, which “addresses all the complexity and variation observed” (Yardley, 2000, p.221). Although the criteria were not devised specifically for IPA, Yardley (2000, p.222) suggests that in IPA terms commitment and rigour may be assessed by the “effective use of prolonged contemplative and empathic exploration of the topic together with sophisticated theorising” which reflects the “imagination and intuition of the analyst.” As a novice IPA researcher I held these objectives in mind as helpful criteria for others and myself to assess the quality of the research.

5.4.4 Transparency and Coherence

Yardley (2000, p.222) described these criteria as “clarity and cogency”, the extent to which the descriptions, arguments, or interpretations appear clear and convincing. I attempted to do this by constructing a narrative that tells the contributors’ stories convincingly and openly with detailed references to the data. I incorporated many examples of the contributor’s own words through the liberal use of quotation as a basis for interpretation.

5.5 Evaluation of the methodology

From a methodological perspective, the research may be limited by an IPA approach. Tuffour (2017) acknowledges that IPA provides a flexible approach to studying lived experience but identifies four limitations. These include its view of the role of language, the ability of IPA to accurately capture experience, the way it falls short of explaining experience, and the role of cognition which may be incompatible with phenomenology.

With regard to language, Willig (2013) highlights how IPA does not explore the constructive role of language which can be thought of as shaping rather than reflecting experience. Discourse analysis approaches allow for an exploration of how language, thought and experience are determined by social factors. Instead, IPA’s hermeneutic epistemology focuses on the role of interpreting meanings communicated through language. With this in mind my analysis paid close attention to language and metaphor to interpret meaning beyond description as recommended by Smith et al. (2009).

Tuffour (2017) highlights how the interpretative approach of IPA may not accurately capture the nature of experience but provides opinions about that experience. However, Smith et al. (2009) refer to Heidegger and suggest that the hermeneutic approach that underpins IPA is central to the way we acquire knowledge from an epistemological perspective. This is due to our “relatedness to the world”, to our “situated position” within it, and the way we make sense of ourselves with and in relation to others (Smith et al., 2009, p.17).

The IPA method admittedly does not explain why individuals have the experiences they do which may be seen as a limitation (Tuffour, 2017). However, this is another area of scholarship outside IPA’s aim to bring the meaning of experience to light through interpretation. Moreover, other methods such as grounded theory, narrative analysis, discourse analysis and critical theory seem better placed to generate theory or explain how experience is constructed based on their epistemological positions and analytical methods.

Tuffour’s point about the role of cognition involved in interpretation was also raised by Willig (2013) who suggested it was incompatible with phenomenology. However, Smith et al. (2009) suggest IPA is “necessarily interpretative.” Interpretation would seem to require a cognitive role connected to its reflexive sense making process. Smith et al. (2009) seem to suggest this position is influenced by Heidegger whose philosophy of experience was predicated on our position as objects situated in relation to each other. This in contrast to Husserl whose philosophy looked inwards towards perception and the nature of consciousness itself (Smith et al., 2009).

On balance, I think IPA has been an appropriate method enabling me to explore my research aim by interacting with the contributors and the data to bring experience to light. Moreover, IPA's epistemology is founded on interpretation. My aim was not to explore the constructive role of language or explain why the contributors experience SC and CP in the ways they do.

5.6 Epistemological Reflexivity

Willig (2013) highlights the need for critical reflexivity in IPA and this is due to its interpretative method and the active role of the researcher in making sense of the lived experience of others. My research question itself determined what could be known. Parameters were set by its emphasis on SC and what it means for individuals who have experienced an intervention for chronic pain. A specific focus was established by who could take part.

It seems important to reflect on how my recruitment process affected who volunteered to take part. Recruitment relied on potential contributors contacting me in response to my recruitment poster (Appendix B). This process meant it was more likely that individuals with a positive experience of self compassion would want to take part because they had something meaningful to share which seems to have been the case. In contrast, individuals with negative experiences of self-compassion who may not have benefitted from their compassion focused intervention were less likely to volunteer as to do so may have been distressing. The recruitment process did not control for this and consequently there is a positive bias in the sample. This should be considered when evaluating the research and conclusions about the potential of self-compassion should only be made in relation to the contributors who took part. For this reason care should be taken not to generalise based on the findings in this study which is also common to IPA research in general (Smith et al., 2009).

The research design determined the type of data and how it would be collected. I used semi structured interviews and while they aimed to enable contributors to talk about what was meaningful to them the questions may have imposed categories of meaning that channelled the contributors' responses. To combat this I attempted to use minimal questions and I encouraged contributors to talk about what was relevant to their experience. However, the questions did not encourage the contributors to move outside the context of self-compassion or consider other ways they might have managed their pain and emotional distress. I did consider using an unstructured interview schedule with only one opening question but I thought that my novice position made this unwise and would not help me to elicit detailed accounts of experience.

Together my choice of IPA and the research design determined what could be known. My study focused on the lived experience of the contributors and did not seek to triangulate this with contributions from family, friends, or health care professionals as other approaches might. Similarly, I relied solely on the data generated from interviews whereas IPA studies do allow for other data collection methods such as diary entries. My position as a trainee CoP influenced my choice of the interview technique as a preferred means of eliciting rich accounts of experience. This is because I am used to interacting directly with clients, listening carefully to their accounts, and interpretating their meaning intersubjectively.

My interpretative phenomenological epistemology and the IPA analytical method influenced the findings by their emphasis on constructing knowledge through interpretation. IPA is founded on the interpretative role of the researcher and the double hermeneutic (Smith et al., 2009). My approach was influenced more by Heidegger than Husserl. I did not think it was possible to bracket my preconceptions completely so that they were no longer an influence. Rather, I subscribed more to Heidegger's (1962/1927) position that we become more aware of our "fore-conceptions" or "fore-structures" in relation to the object of study. Smith et al. (2009) suggest as researchers our priority should always be the object of research but we become more familiar with our preconceptions through the work itself. In the personal reflexivity section that follows I will discuss some of my preconceptions and reflect on how my beliefs, values and interests emerged in relation to the work.

In order to maintain my focus on the data I adopted a reflexive approach. I used my journal to note issues I became aware of and considered how they might have influenced my analysis. During the analysis I asked myself a series of reflexive questions to monitor my interpretations. I would ask myself: What am I saying? Where is the textual evidence for what I am saying? How am I saying it? Could it be said differently? How might the meaning or the effect change if I said it differently?

5.7 Personal reflexivity

Willig (2013) suggests the researcher's interests, experiences, and social identity all influence the research and this begins with the choice of topic. I think it is important to reflect that my interest in the potential benefits of SC shaped the research. My position as a trainee CoP contributed to my interest in the lived experience of others which influenced the research question and my choice of IPA methodology. SC seeks to de-shame and replace self-criticism with self-regard to help reduce psychological distress. These aims fit with my values and sense of identity as a CoP who wants to help others enhance their emotional wellbeing and quality of life.

When I first conceived the project I think I had a degree of idealism about the potential of SC but I think this was tempered by my experience working with CFT in my final year of training. Nonetheless, it was essential that I used reflexive journaling to consider how I interacted with contributors during the interviews, how the interview experience affected me, and how my interests and beliefs may have influenced my interpretations during the analysis. For example, I am aware that my analysis enthusiastically presents the benefits of SC. Although I think this reflects the enthusiasm of the contributors it may also reflect my enthusiasm for their stories which affirmed my hopes for the transformative potential of SC.

Similarly, my interest and sensitivity to the experience of others living in chronic pain will have influenced the research. There is a sense that this brought me into a close relationship with the data and empathising with others pain had an emotional impact on me. I reflected on how I felt moved by the data and how it might be affecting my interpretation and eagerness to tell the stories of those that often seem unheard. I reflected on how my identity as a Counselling Psychologist influenced my interpretation of the contributors’ experience of the medical world. It seemed important to reflect that my interpretation of their experience was influenced by my own critical view of the medical model. Diagnosis contributed to the lived experience of the contributors in different ways. I felt frustrated by the way their treatment and quality of life seemed to depend on how their symptoms conformed to established diagnoses. I aimed to ensure that my interpretation of their experiences was grounded in the data while acknowledging my own thoughts and feelings were connected to the research.

5.8 Strengths and limitations of the research.

A key strength of the research seems to be its homogeneity which is essential to IPA (Smith et al., 2009). This can be seen by the recruitment of female contributors who all had demonstrable experience of the phenomena of SC gained by taking part in the same compassion intervention for chronic pain. A further strength may be that although the intervention provided a context the research was not restricted to an exploration of the experience of an intervention and its efficacy. An additional strength seems to be the adoption of IPA which enabled me to approach the data interpretatively and present detailed accounts of lived experience which are lacking in the current self-compassion and chronic pain literature.

The limitations of IPA have already been considered but a perceived methodological limitation of this study might be its sample size. As might be expected, there was a level of attrition in the research. Three contributors took part whereas six were recruited initially who had all taken part in the same compassion for CP intervention. It may have been the case that a greater number of contributors, and possibly contributors from more than one intervention, may have provided more divergent themes adding to the unique nature of experience IPA seeks to present.

However, my IPA aim was to present the depth of lived experience and this can be done with a single case as IPA does not seek to generalise (Smith et al., 2009). Hefferon & Rodriguez (2011, p.756) suggest “less is more” in IPA research where the focus should be on the depth of analysis. I think it is a strength of the research that I was able to collect rich data from three participants which Smith et al. (2009, p.106) refer to as an “optimum number.” This meant I was able to do justice to the data by drawing on it comprehensively (Yardley, 2000). More participants might have generated more breadth but at the expense of depth, and possibly homogeneity if I had recruited from more than one intervention.

Three rich accounts meant I did not have to be ruthlessly selective and discard aspects of experience that a larger sample might have necessitated given the parameters of doctoral research. From an ethical perspective, I think a particular strength of the project is the way I was able to honour my IPA commitment to tell the contributors’ stories in depth.

5.9 The significance of the research

Yardley (2000, p.223) suggests the significance of research can be considered by its “impact and importance” which can be judged in different ways but always in relation to the objectives of its analysis, the application for which it was intended, and the community it is relevant to. My objectives were to bring to light what self compassion means for the contributors in this study who live with chronic pain. Beyond its given purpose to fulfil the requirements of doctoral study it intends to tell readers something about the experience of self compassion and its relevance to chronic pain. The study may be of value to others who experience chronic pain, health care professionals, those who deliver psychotherapeutic interventions, and Counselling Psychologists who may take a pluralistic approach to therapeutic practice (Cooper, 2019).

The study seems significant because there is limited qualitative research and previous accounts do not seem to explore what it means to live with chronic pain in such detail. The current literature does not seem to capture the meaning of self-compassion for chronic pain from an embodied perspective that connects the physiological and psychological aspects of experience. I think the research has been able to frame the embodied aspect of the contributors' experience and bring detailed accounts to light.

I think the research may contribute to an understanding of the acute distress individuals with chronic pain might experience. This may also be the case with the way individuals might feel isolated and let down by a medical system that prioritises diagnosis but seems to struggle to diagnose and treat chronic pain effectively because of its complexity and unique nature (Penlington, 2019). I hope the perspectives that emerge from the experience of the contributors in this study may challenge our understanding, generate empathy and awareness, and encourage action on behalf of a marginalised group. I think the research may also be significant in helping to conceptualise self-compassion, what it is, and its potential benefits, both generally and specifically for those in chronic pain.

5.10 Implications for practice, training and further research

Yardley (2000) suggests research set in a context can have a close connection to practice. I think one implication for practitioners and Counselling Psychologists is how they might want to learn more about self-compassion and consider incorporating it into their practice. This has an implication for ongoing professional development and training.

Training institutions may want to foreground interventions such as CFT alongside other compatible third wave models such as Acceptance and Commitment Therapy. They may also like to consider devoting time to considering the range of self-compassion applications, the transdiagnostic quality of self-compassion, and its underpinning theory which has a transferrable relevance to a range of modalities and forms of psychological distress. This seems particularly the case given its central focus on shame and self-criticism which are thought to underly a broad range of acute and difficult to treat clinical conditions (Gilbert, 2014).

Similarly, practitioners and training institutions may want to consider chronic pain in more detail given its prevalence but often hidden nature. There seems to be a social justice issue to consider as those in chronic pain often seem to be underrepresented and there are close links between chronic pain, poverty, discrimination and social marginalisation (Wallace et al., 2021). Practitioners may want to consider the value of an embodied approach to emotional wellbeing and ask questions about the nature of pain considering how the body and mind interconnect and influence each other as opposed to a more western attitude of Cartesian dualism which separates the two (Mehta, 2011).

There are implications for further research and a range of qualitative studies seem necessary to help build a knowledge base about self compassion and chronic pain. There is a need for further explorations of lived experience and for studies that focus on diverse ethnicities, other genders, and people of different ages who may experience pain differently. There is also a need for studies from a social constructionist perspective that explore how discourse regarding compassion, self-compassion, and pain shape experience. Grounded theory and critical approaches may be able to investigate the reasons why we experience self-compassion and pain in the ways we do. At the same time, there is scope for action research which might involve contributors more centrally and operate with an active agenda to initiate a change in attitudes and practice toward those living with chronic pain.

5.11 Conclusion

This IPA study contributes to the current literature by helping to redress the significant lack of qualitative research which explores the lived experience of self-compassion. It appears to be one of very few studies which have explored the experience of self compassion for individuals who have taken part in a compassionate intervention for chronic pain. Accounts of lived experience can complement quantitative research and add to our knowledge base by providing insights into what self-compassion means for individuals who live with chronic pain. The study emphasises the connected nature of the mind and body challenging notions of mind-body dualism. This seems particularly relevant to Counselling Psychology and its embodied phenomenological perspective. The research is thought to be relevant to people who live with chronic pain, to health professionals, psychotherapists, and Clinical and Counselling Psychologists who might want to extend their professional development by incorporating a compassionate focus in their therapeutic work.

The female contributors in this study all lived with chronic pain and experienced self-compassion in a way that seemed powerful and transformative. Self-compassion emerged for them as a helpful way to respond to chronic pain and emotional distress. Taking part in a compassionate intervention seemed instrumental in helping the contributors to develop a compassionate self. However, the process of becoming self-compassionate was not straightforward. It represented a journey of self-discovery made possible by the close connections formed within the group and the pivotal role of the Clinical Psychologist leading it. Specific barriers emerged for the contributors who all identified as “strivers.” Their heightened sense of drive and their self-expectations seemed to act as a barrier to self-compassion and also made it difficult for them to adapt to their pain. The contributors provided a sense of having developed a more compassionate, understanding relationship with themselves that helped them to feel less shame and to be less self-critical. Enhanced ways of self-to-self relating involved acceptance and kindness to the self. Self-compassion appeared to be empowering leading to an enhanced sense of self-worth. Self-compassion emerged as a way of being and as a resource for daily living which enabled the contributors to enhance their quality of life. Having a greater sense of agency, and being able to do something to help manage their own pain, was interpreted as empowering and transformative for the contributors in response to feeling powerless in the face of chronic pain.

References

Atkinson, T. J., PharmD, BCPS, CPE, Scruggs, J. H., RN, MSN, ANP-BC, Perkins, T. L., RN, MSN, & FNP-C. (n.d.). *Where Did the War on Pain Go Wrong?* Practical Pain Management. Retrieved 10 December 2021, from https://www.practicalpainmanagement.com/resource-centers/opioid-prescribing-monitoring/where-did-war-pain-go-wrong

Austin, J., Drossaert, C. H. C., Schroevers, M. J., Sanderman, R., Kirby, J. N., & Bohlmeijer, E. T. (2021). Compassion-based interventions for people with long-term physical conditions: A mixed methods systematic review. *Psychology & Health*, *36*(1), 16–42. https://doi.org/10.1080/08870446.2019.1699090edwards

Barnes, A., Adam, M. E. K., Eke, A. O., & Ferguson, L. J. (2021). Exploring the emotional experiences of young women with chronic pain: The potential role of self-compassion. *Journal of Health Psychology*, *26*(3), 367–377. https://doi.org/10.1177/1359105318816509

Beaumont, E., & Hollins-Martin, C. J. (2015). A narrative review exploring the effectiveness of Compassion-Focused Therapy. *Counselling Psychology Review*, *30*(1), 21–32. (2015-20488-003).

Beehler, G. P., Loughran, T. A., King, P. R., Dollar, K. M., Murphy, J. L., Kearney, L. K., & Goldstein, W. R. (2021). Patients' perspectives of brief cognitive behavioral therapy for chronic pain: Treatment satisfaction, perceived utility, and global assessment of change. *Families, Systems, & Health*, *39*(2), 351–357. https://doi.org/10.1037/fsh0000606

Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., & Gilbert, P. (2013). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. *British Journal of Clinical Psychology*, *52*(2), 199–214. https://doi.org/10.1111/bjc.12009

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Brennstuhl, M.-J., Tarquinio, C., & Montel, S. (2015). Chronic Pain and PTSD: Evolving Views on Their Comorbidity. *Perspectives in Psychiatric Care*, *51*(4), 295–304. https://doi.org/10.1111/ppc.12093

British Psychological Society (2018). *Code of Ethics and Conduct*. https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct

British Psychological Society (2021). Code of Human Research Ethics. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Carolfi, K., & Nickasch, B. (2021). What Do Primary Care Providers and Nurses Need to Know About Managing Chronic Pain? *Pain Management Nursing*, *22*(4), 455–458. https://doi.org/10.1016/j.pmn.2020.12.014

Carr, D. B. (2016). President’s message. Patients with Pain Need Less Stigma, Not More. *Pain Medicine*, *17*(8), 1391–1393. https://doi.org/10.1093/pm/pnw158

Carvalho, S. A., Trindade, I. A., Gillanders, D., Pinto-Gouveia, J., & Castilho, P. (2020). Self-compassion and depressive symptoms in chronic pain (CP): A 1-year longitudinal study. *Mindfulness*, *11*(3), 709–719. https://doi.org/10.1007/s12671-019-01292-7

Charmaz, K. (1996). The search for meanings: Grounded Theory. In J.A. Smith & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27-49). Sage.

Chen, G. (2019). The Role of Self-Compassion in Recovery from Substance Use Disorders. *OBM Integrative and Complementary Medicine*, *4*. https://doi.org/10.21926/obm.icm.1902026

Cooper, M. (2009). Welcoming the Other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, *24*(3–4), 119–129.

Cooper, M. (2019). *What is the pluralistic approach and how is it different from eclectic practices*? https://www.icpn.co.uk/post/what-is-the-pluralistic-approach-how-is-it-different-from-integrative-eclectic-practices

Costa, J., & Pinto-Gouveia, J. (2013). Experiential avoidance and self-compassion in chronic pain. *Journal of Applied Social Psychology*, *43*(8), 1578–1591. https://doi.org/10.1111/jasp.12107

Cox, M., & Theilgaard, A. (1987). *Mutative metaphors in psychotherapy: The aeolian mode*. Routledge.

Cuppage, J., Baird, K., Gibson, J., Booth, R., & Hevey, D. (2018). Compassion focused therapy: Exploring the effectiveness with a transdiagnostic group and potential processes of change. *British Journal of Clinical Psychology*, *57*(2), 240–254.

Darnall, B. D. (2019). *Psychological treatment for patients with chronic pain* (2018-36943-000). American Psychological Association. https://doi.org/10.1037/0000104-000

Darnall, B. D. (2021). Psychological Treatment for Chronic Pain: Improving Access and Integration. *Psychological Science in the Public Interest*, *22*(2), 45–51. https://doi.org/10.1177/15291006211033612

Davey, A., Chilcot, J., Driscoll, E., & McCracken, L. M. (2020). Psychological flexibility, self-compassion and daily functioning in chronic pain. *Journal of Contextual Behavioral Science*, *17*, 79–85. https://doi.org/10.1016/j.jcbs.2020.06.005

Davies, K. A., Macfarlane, G. J., McBeth, J., Morriss, R., & Dickens, C. (2009). Insecure attachment style is associated with chronic widespread pain. *Pain*, *143*(3–24), 200–205. https://doi.org/10.1016/j.pain.2009.02.013

D’raven, L. L., & Pasha-Zaidi, N. (2014). Positive psychology interventions: A review for counselling practitioners. *Canadian Journal of Counselling and Psychotherapy*, *48*(4), 383–408.

Driscoll, M. A., Edwards, R. R., Becker, W. C., Kaptchuk, T. J., & Kerns, R. D. (2021). Psychological interventions for the treatment of chronic pain in adults. *Psychological Science in the Public Interest*, *22*(2), 52–95. https://doi.org/10.1177/15291006211008157

Edwards, K. A., Pielech, M., Hickman, J., Ashworth, J., Sowden, G., & Vowles, K. E. (2019). The relation of self-compassion to functioning among adults with chronic pain. *European Journal of Pain*, *23*(8), 1538–1547. https://doi.org/10.1002/ejp.1429

Fayaz, A., Croft, P., Langford, R. M., Donaldson, L. J., & Jones, G. T. (2016). Prevalence of chronic pain in the UK: A systematic review and meta-analysis of population studies. *BMJ Open*, *6*(6), e010364. https://doi.org/10.1136/bmjopen-2015-010364

Feliu-Soler, A., Pascual, J. C., Elices, M., Martín-Blanco, A., Carmona, C., Cebolla, A., Simón, V., & Soler, J. (2017). Fostering self-compassion and loving-kindness in patients with borderline personality disorder: A randomized pilot study. *Clinical Psychology & Psychotherapy*, *24*(1), 278–286. https://doi.org/10.1002/cpp.2000

Gilbert, P. (2000). The relationship of shame, social anxiety and depression: The role of the evaluation of social rank. *Clinical Psychology & Psychotherapy*, *7*(3), 174–189. https://doi.org/10.1002/1099-0879(200007)7:3<174::AID-CPP236>3.0.CO;2-U

Gilbert, P. (2009a). Compassionate mind training. *Healthcare Counselling & Psychotherapy Journal*, *9*(4), 11–15.

Gilbert, P. (2009b). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199–208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Routledge.

Gilbert, P. (2011). Shame in psychotherapy and the role of compassion focused therapy. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour.* (pp. 325–354). American Psychological Association.

Gilbert, P. (2013). *The compassionate mind: a new approach to the challenges of life*. Robinson.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6–41. https://doi.org/10.1111/bjc.12043

Gilbert, P., & Procter, S. (2006). Compassionate Mind Training for People with High Shame and Self-Criticism: Overview and Pilot Study of a Group Therapy Approach. *Clinical Psychology & Psychotherapy*, *13*(6), 353–379.

Glaser, B. G. (1992). Emergence vs forcing: Basics of grounded theory analysis. The Sociology Press.

Gooding, H., Stedmon, J., & Crix, D. (2020). ‘All these things don’t take the pain away but they do help you to accept it’: Making the case for compassion-focused therapy in the management of persistent pain. *British Journal of Pain*, *14*(1), 31–41. https://doi.org/10.1177/2049463719857099

Guba, E.G., & Lincoln, Y.S. (1994). Competing Paradigms in Qualitative Research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp.105-117). Sage.

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *The Psychologist*, *24*(10), 756–759.

Heidegger, M. (1962) *Being and time* (J. Macquarrie and E. Robinson, Trans.). Harper and Row. (1927).

Hession, N. (2010). The Counselling Psychologist working in a pain context. In Milton, M. (Ed.), *Therapy and Beyond Counselling Psychology Contributions to Therapeutic and Social Issues.* John Wiley & Sons, Ltd.

Hickey, T., Nelson, B., & Meadows, G. (2017). Application of a mindfulness and compassion-based approach to the at-risk mental state. *Clinical Psychologist*, *21*(2), 104–115. https://doi.org/10.1111/cp.12132

Hughes Maria, Brown Stephen L, Campbell Sophie, Dandy Shannon, & Cherry Mary G. (2021). Self-Compassion and Anxiety and Depression in Chronic Physical Illness Populations: A Systematic Review. *Mindfulness*, *12*(7), 1597–1610. https://doi.org/10.1007/s12671-021-01602-y

Jury, J. (2021). *Psychological variables involved in chronic pain outcomes: The role of pain catastrophizing and self-compassion* (2021-27916-094; Issues 8-B) [ProQuest Information & Learning]. https://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2021-27916-094&site=ehost-live

Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, *27*(2), 64–73.

Kılıç, A., Hudson, J., McCracken, L. M., Ruparelia, R., Fawson, S., & Hughes, L. D. (2021). A Systematic Review of the Effectiveness of Self-Compassion-Related Interventions for Individuals with Chronic Physical Health Conditions. *Behavior Therapy*, *52*(3), 607–625. https://doi.org/10.1016/j.beth.2020.08.001

Kirby, J. N. (2017). Compassion interventions: The programmes, the evidence, and implications for research and practice. *Psychology and Psychotherapy: Theory, Research and Practice*, *90*(3), 432–455.

Kirby, J. N., Tellegen, C. L., & Steindl, S. R. (2017). A meta-analysis of compassion-based interventions: Current state of knowledge and future directions. *Behavior Therapy*, *48*(6), 778–792. https://doi.org/10.1016/j.beth.2017.06.003

Krieger, T., Berger, T., & Holtforth, M. Grosse. (2016). The relationship of self-compassion and depression: Cross-lagged panel analyses in depressed patients after outpatient therapy. *Journal of Affective Disorders*, *202*, 39–45. https://doi.org/10.1016/j.jad.2016.05.032

Kubany, E. S., & Watson, S. B. (2003). Guilt: Elaboration of a multidimensional model. *The Psychological Record*, *53*(1), 51–90.

Langdridge, D. (2007). *Phenomenological Psychology Theory, Research and Method*. Pearson Prentice Hall.

Lanzaro, C., Carvalho, S. A., Lapa, T. A., Valentim, A., & Gago, B. (2021). A systematic review of self-compassion in chronic pain: From correlation to efficacy. *The Spanish Journal of Psychology*, *24*. https://doi.org/10.1017/SJP.2021.22

Larkin, M., & Thompson, A.R. (2012). Interpretative phenomenological analysis in mental health and psychology research. In D. Harper & A.R. Thompson (Eds.), *Qualitative* *research methods in mental health and psychotherapy*: *A guide for students and practitioners* (pp. 101-116). John Wiley & Sons.

Lawrence, V. A., & Lee, D. (2013). An Exploration of People's Experiences of Compassion-focused Therapy for Trauma, Using Interpretative Phenomenological Analysis: The Experience of Developing Self Compassion for those with PTSD. *Clinical Psychology & Psychotherapy*, n/a-n/a. https://doi.org/10.1002/cpp.1854

Lazaridou, A., Paschali, M., & Edwards, R. R. (2020). Future Directions in Psychological Therapies for Pain Management. *Pain Medicine*, *21*(11), 2624–2626. https://doi.org/10.1093/pm/pnaa335

Lee, D. A. (2009). Compassion-focused cognitive therapy for shame-based trauma memories and flashbacks in post-traumatic stress disorder. In N. Grey (Ed.), *A casebook of cognitive therapy for traumatic stress reactions.* (2009-13265-015; pp. 230–246). Routledge/Taylor & Francis Group.

Lerma. n, S., Rudich, Z., and Shahar, G. (2010). Distinguishing affective and somatic dimensions of pain and depression: A confirmatory factor analytic study. *Journal of Clinical Psychology* 66(4): 456–465.

Linton, S. J., & Bergbom, S. (2011). Understanding the link between depression and pain. *Scandinavian Journal of Pain*, *2*(2), 47–54. https://doi.org/10.1016/j.sjpain.2011.01.005

Lucre, K. M., & Corten, N. (2013). An exploration of group compassion-focused therapy for personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, *86*(4), 387–400. https://doi.org/10.1111/j.2044-8341.2012.02068.x

Lumley, M. A., Cohen, J. L., Borszcz, G. S., Cano, A., Radcliffe, A. M., Porter, L. S., Schubiner, H., & Keefe, F. J. (2011). Pain and emotion: A biopsychosocial review of recent research. *Journal of Clinical Psychology*, *4, 67*(4, 9), 942–968. https://doi.org/10.1002/jclp.20816

Lumley, M. A., & Schubiner, H. (2019). Psychological therapy for centralized pain: An integrative assessment and treatment model. *Psychosomatic Medicine*, *81*(2), 114–124. https://doi.org/10.1097/PSY.0000000000000654

Lutz, J., Berry, M. P., Napadow, V., Germer, C., Pollak, S., Gardiner, P., Edwards, R. R., Desbordes, G., & Schuman-Olivier, Z. (2020). Neural activations during self-related processing in patients with chronic pain and effects of a brief self-compassion training – A pilot study. *Psychiatry Research: Neuroimaging*, *304*. https://doi.org/10.1016/j.pscychresns.2020.111155

MacDonald, G., & Leary, M. R. (2005). Why Does Social Exclusion Hurt? The Relationship Between Social and Physical Pain. *Psychological Bulletin*, *131*(2), 202–223. https://doi.org/10.1037/0033-2909.131.2.202

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*(1), 1–20.

McCracken, L. M. (2020). Necessary components of psychological treatment for chronic pain: More packages for groups or process-based therapy for individuals? *European Journal of Pain*, *24*(6), 1001–1002. https://doi.org/10.1002/ejp.1568

McLean, L., Steindl, S. R., & Bambling, M. (2018). Compassion-Focused Therapy as an Intervention for Adult Survivors of Sexual Abuse. *Journal of Child Sexual Abuse*, *27*(2), 161–175. https://doi.org/10.1080/10538712.2017.1390718

McManus, J., Tsivos, Z., Woodward, S., Fraser, J., & Hartwell, R. (2018). Compassion focused therapy groups: Evidence from routine clinical practice. *Behaviour Change*, *35*(3), 167–173. https://doi.org/10.1017/bec.2018.16

Mehta, N. (2011). Mind-body Dualism: A critique from a Health Perspective. *Mens Sana Monographs*, *9*(1), 202–209. https://doi.org/10.4103/0973-1229.77436

Merleau-Ponty, M. (1962). *Phenomenology of perception* (C. Smith, Trans.). Routledge and Kegan Paul. (1945).

Mistretta, E. G., & Davis, M. C. (2021). Meta-analysis of self-compassion interventions for pain and psychological symptoms among adults with chronic illness. *Mindfulness*. https://doi.org/10.1007/s12671-021-01766-7

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 250–260. APA PsycArticles. https://doi.org/10.1037/0022-0167.52.2.250

Morrow, S. L., & Smith, M. L. (2000). Qualitative research for counseling psychology. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology., 3rd ed.* (2001-01878-007; pp. 199–230). John Wiley & Sons Inc; APA PsycInfo. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2001-01878-007&site=ehost-live

Murphy, D. (2017). *Counselling psychology: A textbook for study and practice*. Wiley & Sons Ltd.

Neff, K. D. (2004). Self-Compassion and Psychological Well-Being. *Constructivism in the Human Sciences*, *9*(2), 27–37.

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*(3), 223–250. https://doi.org/10.1080/15298860309027

Osborn, M., & Smith, J. A. (2006). Living with a body separate from the self. The experience of the body in chronic benign low back pain: An interpretative phenomenological analysis. *Scandinavian Journal of Caring Sciences*, *20*(2), 216–222. https://doi.org/10.1111/j.1471-6712.2006.00399.x

Parry, S., & Malpus, Z. (2017). Reconnecting the mind and body: A pilot study of developing compassion for persistent pain. *Patient Experience Journal*, *4*(1), 145–153. https://doi.org/10.35680/2372-0247.1175

Pauley, G., & McPherson, S. (2010). The experience and meaning of compassion and self-compassion for individuals with depression or anxiety. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(2), 129–143.

Paulson, M., Danielson, E., & Söderberg, S. (2002). Struggling for a Tolerable Existence: The Meaning of Men's Lived Experiences of Living with Pain of Fibromyalgia Type. *Qualitative Health Research*, *12*(2), 238–249. https://doi.org/10.1177/104973202129119865

Penlington, C. (2019). Exploring a compassion-focused intervention for persistent pain in a group setting. *British Journal of Pain*, *13*(1), 59–66. https://doi.org/10.1177/2049463718772148

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Purdie, F., & Morley, S. (2016). Compassion and chronic pain. *Pain*, *157*(12), 2625–2627. https://doi.org/10.1097/j.pain.0000000000000638

Schanche, E., Stiles, T. C., McCullough, L., Svartberg, M., & Nielsen, G. H. (2011). The relationship between activating affects, inhibitory affects, and self-compassion in patients with Cluster C personality disorders. *Psychotherapy*, *48*(3), 293–303. https://doi.org/10.1037/a0022012

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research.* (1994-98625-006; pp. 118–137). Sage Publications, Inc.

Serbic, D., Evangeli, M., Probyn, K., & Pincus, T. (2022). Health-related guilt in chronic primary pain: A systematic review of evidence. *British Journal of Health Psychology*, *27*(1), 67–95. https://doi.org/10.1111/bjhp.12529

Shonin, E., Van Gordon, W., & Griffiths, M. D. (2014). The emerging role of Buddhism in clinical psychology: Toward effective integration. *Psychology of Religion and Spirituality*, *6*(2), 123–137.

Shullman, S. L. (2017). Leadership and Counseling Psychology: Dilemmas, Ambiguities, and Possibilities. *The Counseling Psychologist*, *45*(7), 910–926. https://doi.org/10.1177/0011000017744644

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.

Smith, J. A., & Osborn, M. (2007). Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic benign low back pain. *Psychology & Health*, *22*(5), 517–534. https://doi.org/10.1080/14768320600941756

Sturgeon, J. A. (2014). Psychological therapies for the management of chronic pain. *Psychology Research and Behavior Management*, *7*.

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral Emotions and Moral Behavior. *Annual Review of Psychology*, *58*, 345–372. https://doi.org/10.1146/annurev.psych.56.091103.070145

Torrijos-Zarcero, M., Mediavilla, R., Rodríguez-Vega, B., Del Río-Diéguez, M., López-Álvarez, I., Rocamora-González, C., & Palao-Tarrero, Á. (2021). Mindful Self-Compassion program for chronic pain patients: A randomized controlled trial. *European Journal of Pain*, *25*(4), 930–944. https://doi.org/10.1002/ejp.1734

Tribe, R., & Bell, D. (2018). Social Justice, Diversity and Leadership. *The European Journal of Counselling Psychology*, *7*(1), 111–125. https://doi.org/10.5964/ejcop.v7i1.145

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *Journal of Healthcare Communications*, *2*(4), 52.

University of East London (2015*). Code of Practice for Research Ethics*. UEL.

Waite, F., Knight, M. T. D., & Lee, D. (2015). Self-compassion and self-criticism in recovery in psychosis: An interpretative phenomenological analysis study. *Journal of Clinical Psychology*, *71*(12), 1201–1217. https://doi.org/10.1002/jclp.22211

Wallace, B., Varcoe, C., Holmes, C., Moosa-Mitha, M., Moor, G., Hudspith, M., & Craig, K. D. (2021). Towards health equity for people experiencing chronic pain and social marginalization. *International Journal for Equity in Health*, *20*(1), 53. https://doi.org/10.1186/s12939-021-01394-6

Willig, C. (2013) *Introducing qualitative research in psychology* (3rd ed.). Open University Press.

Wren AA, Somers TJ, Wright MA, Goetz MC, Leary MR, Fras AM, Huh BK, Rogers LL, & Keefe FJ. (2012). Self-compassion in patients with persistent musculoskeletal pain: Relationship of self-compassion to adjustment to persistent pain. *Journal of Pain & Symptom Management*, *43*(4), 759–770.

Yardley, L. (2000). Dilemmas in Qualitative Health Research. *Psychology & Health*, *15*(2), 215. https://doi.org/10.1080/08870440008400302

Appendices

Appendix A1: Ethical Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Matteo Martini

SUPERVISOR: **Cynthia Fu**

STUDENT: Mark Limbert

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: How do individuals who have been through a compassion focused intervention experience self-compassion: An Interpretative Phenomenological Analysis?

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

1

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☒ MEDIUM (Please approve but with appropriate recommendations)

☐ LOW

Reviewer comments in relation to researcher risk (if any).

Given the current situation and since the data collection does not depend on lab-based work, this project should be run online, avoiding face to face interaction. This prevention measure could be discarded as soon as the national health crisis eases and governmental policies allow close interactions.

Reviewer *(Typed name to act as signature)*: Matteo Martini

Date: *22/05/2020*

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix A2: Ethical Approval

University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.

2. Type your name in the 'student's signature' section (page 2).

3. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk

4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

1. A copy of the approval of your initial ethics application.

Name of applicant: David Mark Limbert

Programme of study: Prof Doc in Counselling Psychology

Name of supervisor: Professor Rachel Tribe

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: How do individuals who have been through a compassion focused intervention experience self-compassion: an interpretive phenomenological analysis?	I think it is necessary to change my title and to add the words "chronic pain" because the participants who volunteered to take part in my IPA research live with chronic pain and had taken part in a compassion for pain group intervention. My research focus remains the same, namely an exploration of what self-compassion means for individuals who have taken part in a compassion focused intervention. Nonetheless, I think it is important that the title reflects the context of chronic pain. The change of title did not impact the process of how I collected my data or conducted my research.
New Title: What does self-compassion mean for individuals who have experienced a compassion focused intervention for chronic pain?	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	Yes	
Does your change of title impact the process of how you collected your data/conducted your research?		No

Student's signature (please type your name): David Mark Limbert

Date: 24/11/2021

TO BE COMPLETED BY REVIEWER		
Title changes approved	YES	

Reviewer: Glen Rooney
Date: 17/12/2021

Appendix B: Recruitment Poster

University of East London

Participant Advertisement

RESEARCH PROJECT

INVITATION TO PARTICIPANTS

Would you like to participate in a postgraduate research project on self-compassion?

As part of my doctoral study in psychology at the University of East London (UEL), I am conducting research to gain an understanding of how individuals experience self-compassion and what self-compassion means to them.

Participation is entirely voluntary. If you decide to participate it will involve taking part in a research interview which will be like an informal conversation. It is anticipated the process will last about 60 minutes and will take place on Microsoft Teams so no travel will be necessary. Your privacy will be maintained throughout the research process and interview data will be fully anonymised and securely stored in line with the UEL *Research Data Management Policy*.

I am interested in hearing from people who have experience of self-compassion. In order to take part you will need to have had a compassion focused therapeutic intervention such as Compassion Focused Therapy (CFT). Your involvement with a compassion focused intervention is likely to have been motivated partly by your experience of emotional distress. This may relate to a mental health diagnosis and/or a physical health issue.

The research project will follow the British Psychological Society's *Code of Ethics and Conduct* (2018) and the UEL *Code of Practice for Research Ethics* (2015-2016).

If you think you might like to take part in this voluntary, unpaid research, please contact Mark Limbert at the University of East London. I will be pleased to answer any questions you may have. Please email:

Thank you.

Appendix C: Participant Invitation Letter

SELF-COMPASSION RESEARCH PROJECT

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you consider what your participation would involve. Please take time to read the following information carefully, thank you.

Who am I?

My name is Mark Limbert and I am a Postgraduate student in the School of Psychology at the University of East London. I am studying for a Professional Doctorate in Counselling Psychology (PsychD). As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research which asks how people experience self-compassion and what it means for them. The title of my research is:
How do individuals experience self-compassion and what does it mean for them: An Interpretative Phenomenological Analysis?

The purpose of my research is to seek an understanding of what self-compassion means for participants and to give voice to individual experience. The research will be based on informal interviews with individuals who have experience of self-compassion. A short number of questions will be asked giving participants the opportunity to talk about their personal experience of self-compassion.

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of my ethics application has been guided by the standards of research ethics set by the British Psychological Society.

The research is entirely voluntary. Participation is unpaid as the research is non-funded and is part of my postgraduate study.

Why have you been asked to participate?

You have been invited to participate in my research as someone who may meet the description of who I am looking for to help me explore my research topic. I am looking to involve individuals who have experience of self-compassion which is likely to have been gained from either: talking therapy; therapeutic practice; life-coaching/personal development; professional training; and/or self-study and personal engagement. You may have taken part in Compassion Focused Therapy (CFT) or a similar intervention, either as an individual or as part of a group.

I am not looking for 'experts' on the topic but for individuals who would like the opportunity to talk about their experience of self-compassion in a confidential setting. You will not be judged or analysed in any way and you will be treated with respect and compassion.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be invited to have an informal conversation with me about your experience of self-compassion. Our conversation will take the form of an unstructured interview which will take place remotely using Microsoft Teams. This means we will be able to hear and see each other during our conversation although we will not be face-to-face in a physical setting. The interview will last approximately 30 minutes. Interviews will be recorded so I can look back on our conversation later as I do my research. During the interview I will ask you a few open questions. For example, I will begin by asking you to tell me about your experience of self-compassion.

I will not be able to reimburse you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. You will not be identified in the data collected, in any written material resulting from the data collected, or in any write-up of the research. During our conversation you do not have to answer all the questions and you can stop the interview at any time. We will discuss who you might contact after the interview if you want to talk to someone about how you feel after talking about your experience of self-compassion.

Are there any risks or advantages to taking part?

It is not anticipated that you will be adversely affected by taking part in the research, and all reasonable steps will be taken to minimise risks. Nevertheless, it is still possible that your participation, or its after-effects, may be challenging, distressing or uncomfortable in some way. After you have participated a *Participant Debrief Letter* will be provided. It will contain details of resources/services you may find helpful in relation to obtaining information and support if you have been affected in any of the ways mentioned.

As mentioned, participation is unpaid but there could be advantages in being able to talk about your experience in a confidential research interview. Your participation may also help others to understand how you experience self-compassion and what it means for you. This may help others consider the relevance of self-compassion to themselves and to people they know or might work with.

What will happen to the information that you provide?

What I do with the material you provide will depend on your consent. If you choose to participate you will be provided with a Consent Form before taking part.

- Personal information will be securely stored in a password protected file on my personal laptop and backed-up in University of East London secure storage. I will be the only person who has access to it. The audio recording of our interview and written data transcribed from the interview will also be securely stored in password protected files on my personal laptop and backed-up in University of East London secure storage. I will be the only person who has access to these secure files.

- All data from our conversation will be anonymised. I will use a made-up first-name rather than your real name when I refer to data in my research. I will not refer to any people or places that you might mention. Any identifying information will be removed from all data and will not appear in any written research.

- Anonymised data will be seen by my research supervisor/s and by examiners who review my research. Portions of the research study might be published in journals but the data are anonymised and it would not be possible to identify any individuals who have taken part in the project. If you consent, anonymised data may also be shared with other academics to assist their research.

- After my study has been completed contact details of all participants will be deleted from my personal secure records and from University of East London secure storage. The audio recordings themselves will also be deleted. If you consent, anonymised digital transcripts of the interviews will be deposited and archived long-term in a secure data repository at the University of East London.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have provided it. However, this request should be made within 3 weeks (21 days) of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Mark Limbert. School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email:

If you have any questions or concerns about how the research has been conducted please contact the research supervisor: Professor Cynthia FU. School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: c.fu@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.lomas@uel.ac.uk

Appendix D: Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

How do individuals experience self-compassion and what does it mean for them: An Interpretative Phenomenological Analysis?

I have the read the invitation letter relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. However, I understand that if I provide optional consent anonymised data from my interview will be deposited, archived and shared using the University of East London secure digital data repository. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw; the researcher reserves the right to use my anonymous data after analysis of the data has begun which will be three weeks (21 days) after the interview took place.

- Optional consent given for anonymised data to be deposited, archived and shared using the University of East London secure data repository.
  Please indicate yes or no: ……….

- Optional consent given for anonymised data to be disseminated for teaching or training purposes.
  Please indicate yes or no: ……….

Participant’s Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant’s Signature

………………………………………………………………………………………..

Researcher’s Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher’s Signature

…………………………………………………………………………………………

Date: ……………………..…….

Appendix E: Data Form

University of
East London

Participant Data Form

Research Title: How do individuals experience self-compassion and what does it mean for them: An Interpretative Phenomenological Analysis?

Participant's Name (BLOCK CAPITALS)

…………………………………………………………………………………….

Participant's email address: ………………………………………………………

Please give brief details regarding your self-compassion experience (e.g. talking therapy, self-study etc.)

……………………………………………………………………………………..

If a talking therapy, was it an individual or a group intervention?

……………………………………………………………………………………..

If a talking therapy, approximately how many sessions did you attend?

……………………………………………………………………………………..

Please provide brief details of what self-compassion means to you.

……………………………………………………………………………………..

……………………………………………………………………………………..

Please provide brief details of any wellbeing issues connected to your experience of self-compassion.

……………………………………………………………………………………..

……………………………………………………………………………………..

Participant's Signature

…………………………………………………… Date: ……………………………

Appendix F: Participant Debrief Letter

University of East London

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study and sharing your experience of self-compassion. This letter offers information that may be relevant now you have taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

- During the research project, personal information contained on the Participant Data Form and Consent Form will be securely stored in a password protected file on my personal laptop and in University of East London secure storage. I will be the only person to have access to it. The audio recording of our interview and written data from the interview will also be securely stored in password protected files on my personal laptop and in University of East London secure storage. Audio recordings from the interview will be deleted from the audio recorder as soon as they have been transferred as above. I will be the only person who has access to the secure files.

- All data from our conversation will be anonymised. I will use a made-up first-name rather than your real name when I refer to data in my research. I will not refer to any people or places that you might mention. Any identifying information will be removed from all data and will not appear in any written research.

- Anonymised data will be seen by my research supervisor/s and by examiners who look at my research. If you consented, it may also be seen by others for teaching and training purposes. Similarly, if you consented, anonymised data may also be shared with others through the University of East London secure repository.

- After my study has been completed, contact details/personal information of all participants and the interview recordings themselves will be deleted from my personal secure records and from University of East London secure storage. If you consented, anonymised digital transcripts of the interviews will be kept in a secure data repository at the University of East London.

- You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have provided it. However, this request should be made within 3 weeks (21 days) of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may want to contact your GP. You may also find the following resources/services helpful in relation to obtaining information and support:

Mind: www.mind.org.uk Emotional support, information and guidance for people affected by psychological distress and/or mental health issues. Tel: 0300 123 3393.

Samaritans: www.samaritans.org 24-hour confidential support for individuals experiencing distress or despair. Tel: 116 123.

CALM: www.thecalmzone.net Emotional support, information and guidance for all individuals (particularly men) who are affected by distress or despair. Tel: 0800 58 58 58.

Sane: www.sane.org.uk Emotional support, information and guidance for people (and their families and carers) affected by psychological distress and/or mental health issues. Tel: 07984 967 708.

The Compassionate Mind Foundation: www.compassionatemind.co.uk Information regarding compassion and compassion focused interventions. Tel: 01332 742722

You are welcome to contact me or my supervisor if you have specific questions or concerns. If you are interested in the research and wish to read the final report, please feel free to email me or my supervisor.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Mr. Mark Limbert. School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email:

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor Cynthia Fu. School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: c.fu@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.lomas@uel.ac.uk

Appendix G: Interview Schedule

Interview Questions
Self-compassion Study

1. Please tell me about your experience of self-compassion.

Potential Prompts

How would you describe self-compassion?

Is the way you describe it how it feels for you?

Can you describe what it was like being involved in a compassion focused intervention?

What has your experience of self-compassion been like?

In what ways has your experience of self-compassion been either positive or negative?

Has your experience of self-compassion changed over time?

2. Please tell me about what self-compassion means to you.

Potential Prompts

How would you describe to someone else your thoughts and feelings about self-compassion?

In what ways might self-compassion have been helpful or unhelpful to you?

In what ways might self-compassion have influenced the way you think and feel about yourself?

In what ways might self-compassion have influenced the way you behave?

Has self-compassion influenced the way you think and behave towards others?

3. Is there anything else you might like to say about self-compassion?

Appendix H: Extract from a three column table

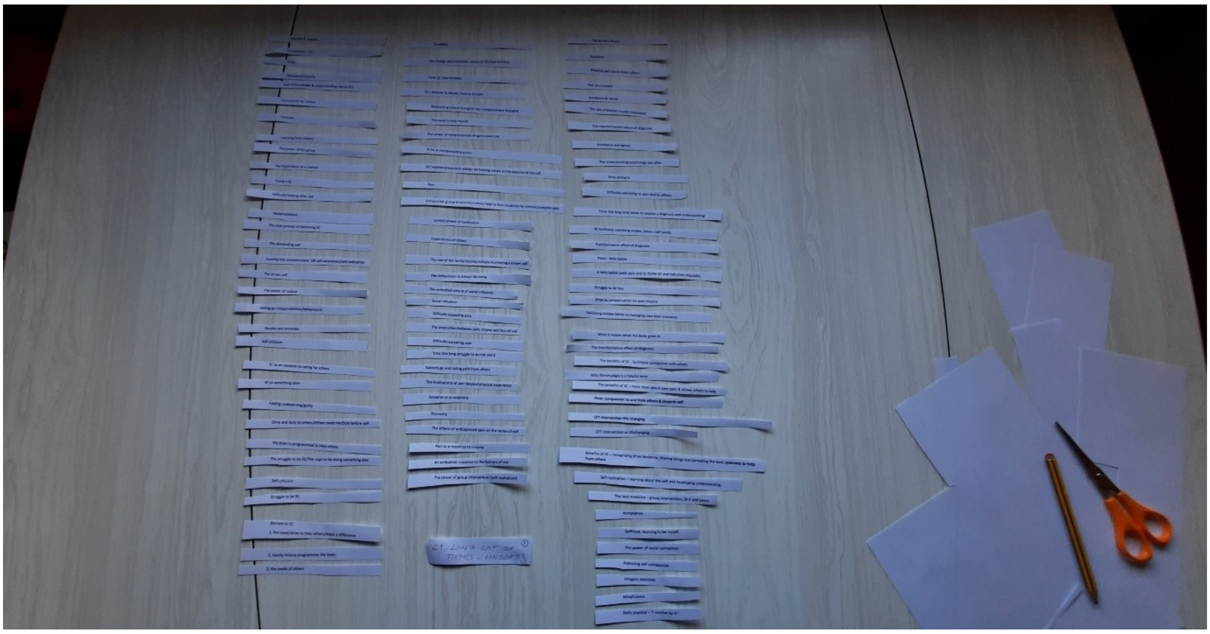
This is the first page from Case 3 (Tina) used in the first three stages of analysis (Smith et al., 2009).

Emergent themes	Transcript: Interview with T	Exploratory Comments
Self compassion as nurturing/parental SC compensates for what nobody else can do (the care others cannot provide) Anger Multiple selves SC & comforting the Mindfulness CS as something alien isolation	To begin, I'd just like to ask you how you might define self-compassion in your own words? It's kind of like trauma therapy where in that case you would get the older self to look after and raise the traumatised younger self, to love and protect and give compassion where nobody else does in order to overcome that trauma. And this is kind of, kind of the same way you'd get your compassionate self to, you know, give compassion to your angry self or your, you know, all the different selves you become when you are in so much chronic pain and how that does help in the maddest of ways, cos you just wouldn't think it if somebody said that to you you'd just toss that aside and think what, what twaddle but actually it does work. And if you spend a little bit of time being mindful, and being compassionate towards other people that gives you a warm sense of, you know, you give them some love so why can't you do that to yourself when generally what you find is I'm the last person to look after me, I'm the one who runs around and looks after everybody else and there is kind of nobody who could look after me so in that sense putting aside sort of 20	Likens compassion to trauma therapy (hard to define it/make sense of it in its own terms). Introduces idea of multiple selves, older self/younger traumatised self. Use of "older self" suggests compassion associated with experience/wisdom? *Semantic field re nurture associated with SC: "look after, raise, love, protect, give compassion."* This is parent like, perhaps what an ideal parent would do? What "nobody else does", suggests something very necessary, SC a resource that compensates for an absence of care, compassion in own lived world? Compassion to other gives you a warm sense. SC is extending this to yourself. SC connected to managing the distress of traumatic experience? Multiple selves, pain > to a fractured self, brings out different selves inc. the angry self. *"Amazingly" & the "maddest of ways", the compassionate process defies sense/rationale logic/magical/ something unexpected.* *Repetition of nobody. "Nobody who could look after me".*

regular practice of SC SC helps to manage pain "It takes the edge off the pain/It takes the sting out of it"	minutes in a day, whether it's five minutes throughout the day or if it's a block at the end of the day where I'm just you know, in a nice quiet place, relaxing environment, where I can lie down and I can give myself a little bit of love, and it does amazingly take the edge off the pain (laughs). It does work, and I studied psychology.	Sense of isolation, missing care from others. SC = loving self. 20 minutes a day, suggests SC has become embedded in daily life, requires regular practice. <u>SC a way of being?</u> SC as an antidote for physical pain. Significance of Psychology to T SC?

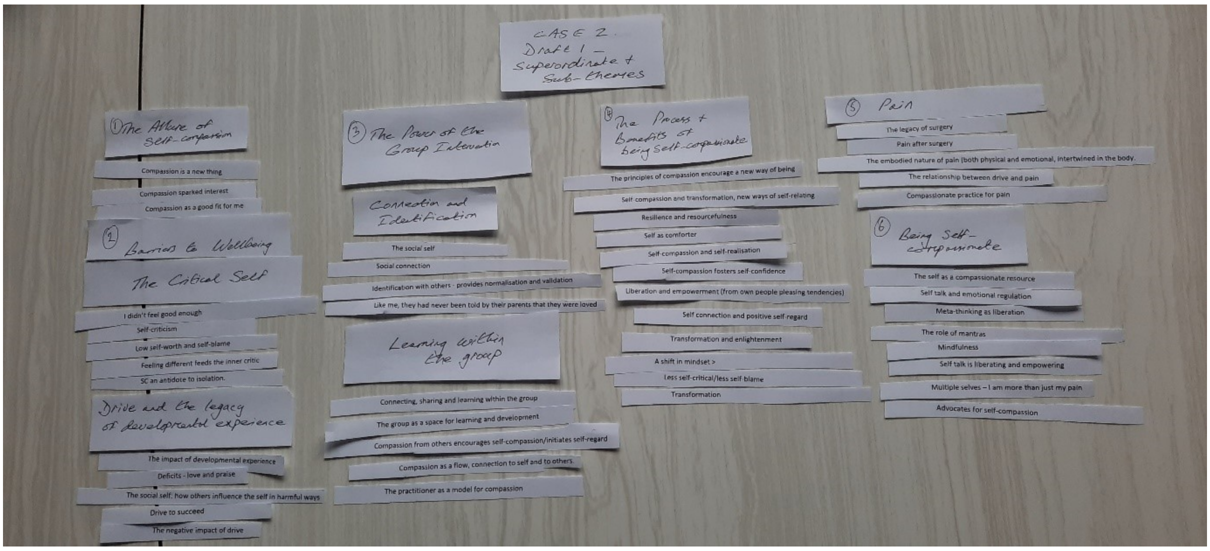
Appendix I: Example of a long list of provisional themes

Stage 3 of the analysis, identifying emergent themes (Smith et al., 2009). The long list of themes shown here for Case 1 was printed from my three column table in order to look for connections across themes in the next stage of analysis (Smith et al., 2009).



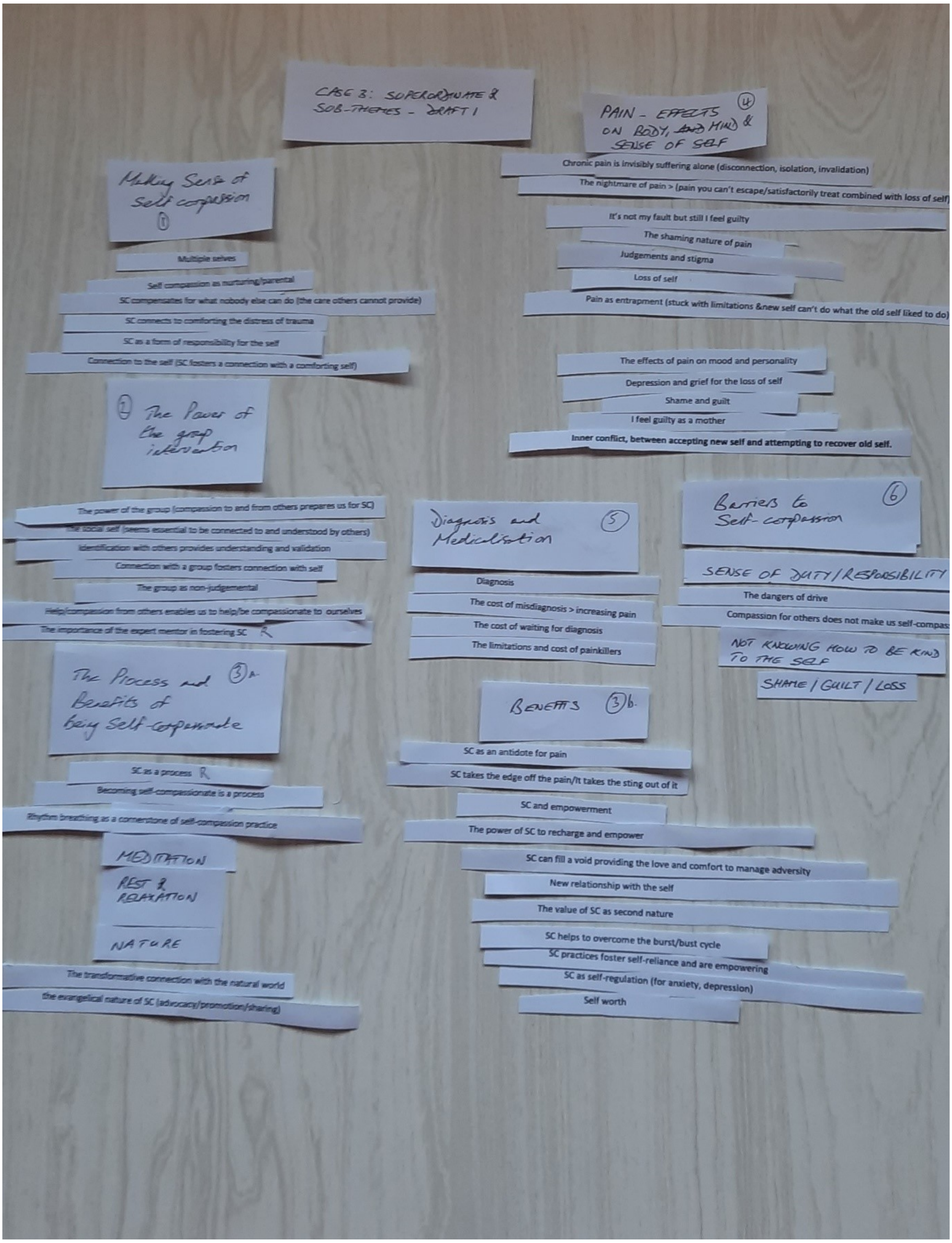
Appendix J: Stage 4 of the analysis

Looking for connections across themes (Smith et al., 2009). The preliminary draft of superordinate themes for Case 2.



Appendix K: Stage 5 of the analysis

The preliminary draft of superordinate themes for Case 3 that emerged from looking for connections across themes in subsequent cases (Smith et al., 2009).



CASE 3: SUPERORDINATE & SUB-THEMES - DRAFT 1

Making Sense of Self compassion ①

Multiple selves
Self compassion as nurturing/parental
SC compensates for what nobody else can do (the care others cannot provide)
SC connects to comforting the distress of trauma
SC as a form of responsibility for the self
Connection to the self (SC fosters a connection with a comforting self)

② The Power of the group intervention

The power of the group (compassion to and from others prepares us for SC)
The social self (seems essential to be connected to and understood by others)
Identification with others provides understanding and validation
Connection with a group fosters connection with self
The group as non-judgemental
Help/compassion from others enables us to help/be compassionate to ourselves
The importance of the expert mentor in fostering SC R

The Process and Benefits of being Self-compassionate ③a.

SC as a process R
Becoming self-compassionate is a process
Rhythm breathing as a cornerstone of self-compassion practice
MEDITATION
REST & RELAXATION
NATURE
The transformative connection with the natural world
the evangelical nature of SC (advocacy/promotion/sharing)

PAIN - EFFECTS ON BODY, ~~AND~~ MIND & SENSE OF SELF ④

Chronic pain is invisibly suffering alone (disconnection, isolation, invalidation)
The nightmare of pain > (pain you can't escape/satisfactorily treat combined with loss of self)
It's not my fault but still I feel guilty
The shaming nature of pain
Judgements and stigma
Loss of self
Pain as entrapment (stuck with limitations &new self can't do what the old self liked to do)
The effects of pain on mood and personality
Depression and grief for the loss of self
Shame and guilt
I feel guilty as a mother
Inner conflict, between accepting new self and attempting to recover old self.

Diagnosis and Medicalisation ⑤

Diagnosis
The cost of misdiagnosis > increasing pain
The cost of waiting for diagnosis
The limitations and cost of painkillers

BENEFITS ③b.

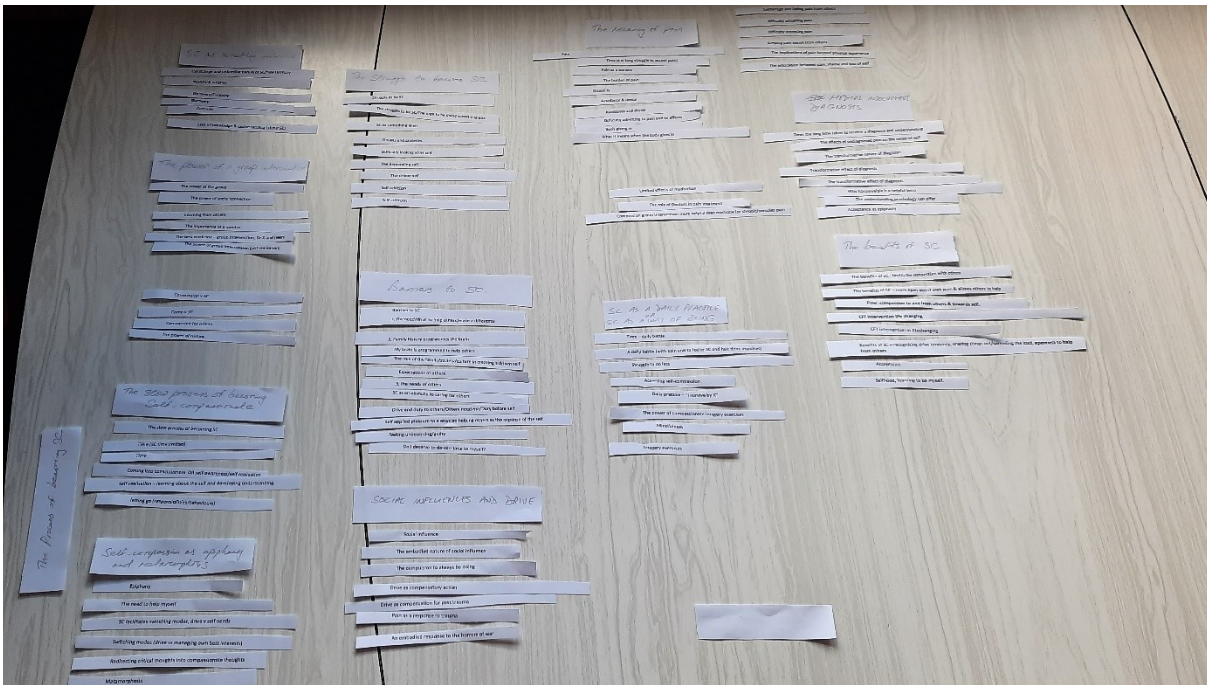
SC as an antidote for pain
SC takes the edge off the pain/It takes the sting out of it
SC and empowerment
The power of SC to recharge and empower
SC can fill a void providing the love and comfort to manage adversity
New relationship with the self
The value of SC as second nature
SC helps to overcome the burst/bust cycle
SC practices foster self-reliance and are empowering
SC as self-regulation (for anxiety, depression)
Self worth

Barriers to Self-compassion ⑥

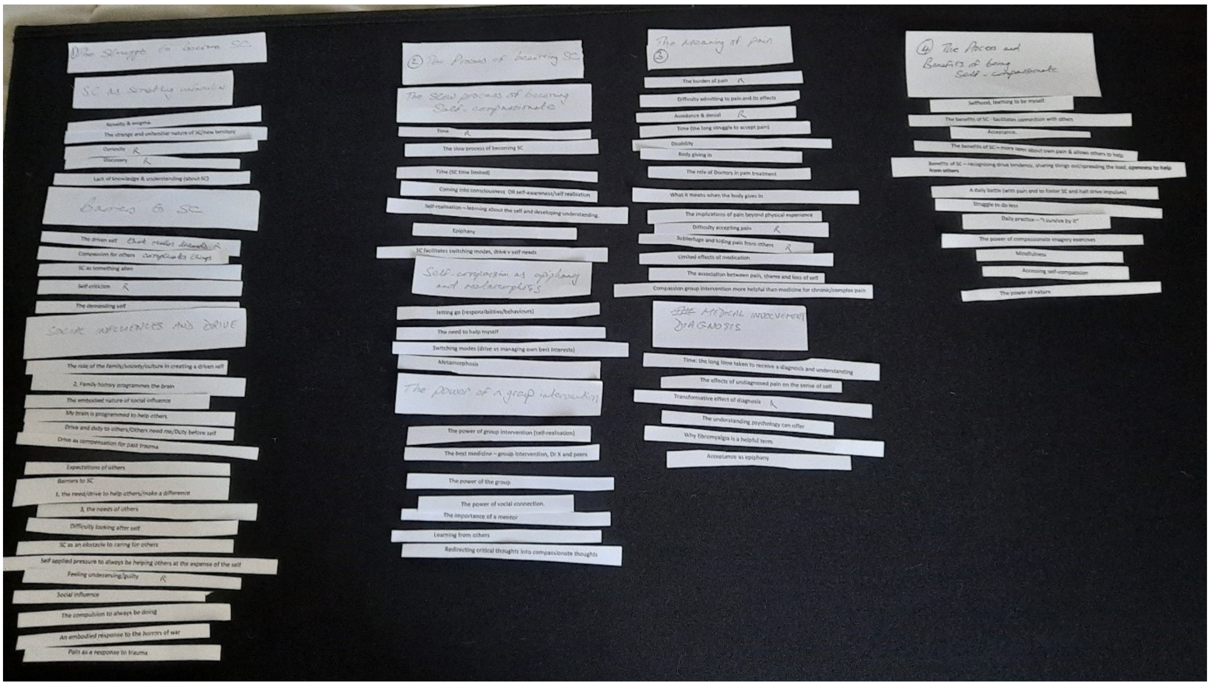
SENSE OF DUTY/RESPONSIBILITY
The dangers of drive
Compassion for others does not make us self-compas
NOT KNOWING HOW TO BE KIND TO THE SELF
SHAME / GUILT / LOSS

Appendix L1: Stage six of the analysis process

Looking for patterns across cases (Smith et al., 2009). The first draft of provisional superordinate themes across all cases.



Appendix L2: Stage six of the analysis process
The second draft of provisional superordinate themes across all cases. (The third and final draft appears as Figure 1, p.44 & as Appendix M).



① The Struggle to become SC

SC as something unfamiliar

Novelty & enigma
The strange and unfamiliar nature of SC/new territory
Curiosity R
Discovery R
Lack of knowledge & understanding (about SC)

Barriers to SC

The driven self [illegible] R
Compassion for others [illegible]
SC as something alien
Self-criticism R
The demanding self

SOCIAL INFLUENCES AND DRIVE

The role of the family/society/culture in creating a driven self
2. Family history programmes the brain
The embodied nature of social influence
My brain is programmed to help others
Drive and duty to others/Others need me/Duty before self
Drive as compensation for past trauma
Expectations of others
Barriers to SC
1. the need/drive to help others/make a difference
3. the needs of others
Difficulty looking after self
SC as an obstacle to caring for others
Self applied pressure to always be helping others at the expense of the self
Feeling undeserving/guilty R
Social influence
The compulsion to always be doing
An embodied response to the horrors of war
Pain as a response to trauma

② The Process of becoming SC

The slow process of becoming Self-compassionate

Time R
The slow process of becoming SC
Time (SC time limited)
Coming into consciousness OR self-awareness/self realisation
Self-realisation – learning about the self and developing understanding.
Epiphany
SC facilitates switching modes, drive v self needs

Self-compassion as epiphany and metamorphosis

letting go (responsibilities/behaviours)
The need to help myself
Switching modes (drive vs managing own best interests)
Metamorphosis

The power of a group intervention

The power of group intervention (self-realisation)
The best medicine – group intervention, Dr X and peers
The power of the group
The power of social connection.
The importance of a mentor
Learning from others
Redirecting critical thoughts into compassionate thoughts

The meaning of pain ③

The burden of pain R
Difficulty admitting to pain and its effects
Avoidance & denial R
Time (the long struggle to accept pain)
Disability
Body giving in
The role of Doctors in pain treatment
What it means when the body gives in
The implications of pain beyond physical experience
Difficulty accepting pain R
Subterfuge and hiding pain from others R
Limited effects of medication
The association between pain, shame and loss of self
Compassion group intervention more helpful than medicine for chronic/complex pain

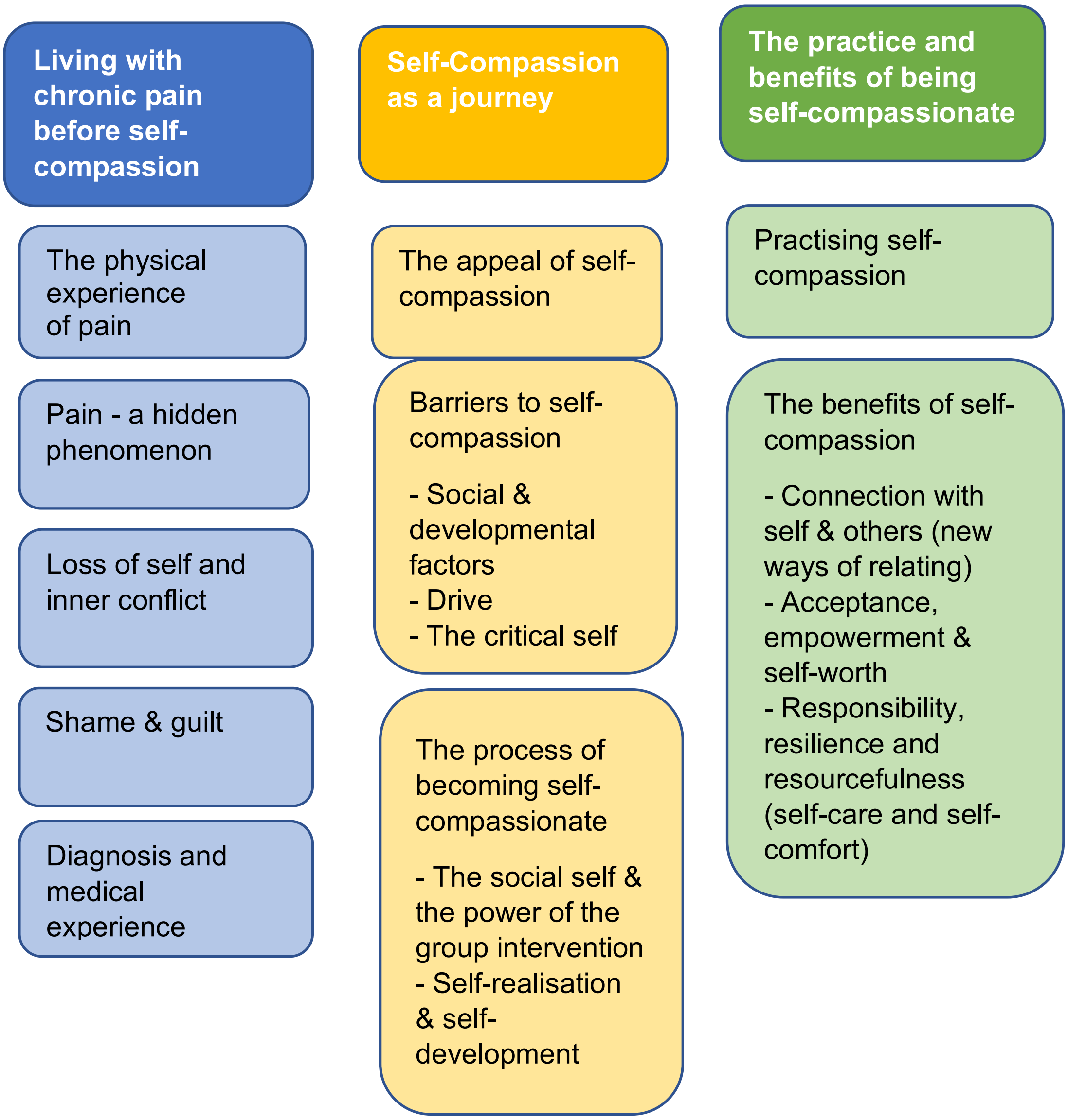
~~THE~~ MEDICAL INVOLVEMENT
DIAGNOSIS

Time: the long time taken to receive a diagnosis and understanding
The effects of undiagnosed pain on the sense of self
Transformative effect of diagnosis R
The understanding psychology can offer
Why fibromyalgia is a helpful term
Acceptance as epiphany

④ The Process and Benefits of being Self-compassionate

Selfhood, learning to be myself.
The benefits of SC - facilitates connection with others
Acceptance.
The benefits of SC – more open about own pain & allows others to help
Benefits of SC – recognising drive tendency, sharing things out/spreading the load, openness to help from others
A daily battle (with pain and to foster SC and halt drive impulses)
Struggle to do less
Daily practice – "I survive by it"
The power of compassionate imagery exercises
Mindfulness
Accessing self-compassion
The power of nature

Appendix M: Superordinate themes with related themes and sub-themes



Living with chronic pain before self-compassion

- The physical experience of pain
- Pain - a hidden phenomenon
- Loss of self and inner conflict
- Shame & guilt
- Diagnosis and medical experience

Self-Compassion as a journey

- The appeal of self-compassion
- Barriers to self-compassion
  - Social & developmental factors
  - Drive
  - The critical self
- The process of becoming self-compassionate
  - The social self & the power of the group intervention
  - Self-realisation & self-development

The practice and benefits of being self-compassionate

- Practising self-compassion
- The benefits of self-compassion
  - Connection with self & others (new ways of relating)
  - Acceptance, empowerment & self-worth
  - Responsibility, resilience and resourcefulness (self-care and self-comfort)

Appendix N: Two entries from my reflexive journal

Example 1

Level of interpretation. Looking back I think some of my analysis is too descriptive and not interpretative enough. For example, case 3. I think I have been too descriptive regarding the importance of the group. There is more meaning to interpret about identification with similar others and a theme of invisibility to explore, of not being seen by others outside the group which may be invalidating and a source of distress in itself. Does this invisibility link to shame? Shamed by others, ashamed of the self? What does it mean for T? For the others perhaps?

Example 2

Does the analysis over emphasise the benefits of SC? How are my beliefs and values influencing the interpretation and the way I’m presenting the benefits? Check back to make sure all benefits are grounded in the data and how I maybe imposing ideas from outside the data.

I’m conscious of my enthusiasm for the benefits I have interpreted from the data and how this appears in my writing. Does my enthusiasm reflect the contributors’ enthusiasm? How have I been influenced by the contributors? (Significantly, given their engaging stories that have moved me.)

What about my own preconceptions, beliefs about the potential of SC, and hopes for these contributors? I can attempt to bracket/recognise these influences but inevitably they are part of me and what I bring to the process.

These issues need acknowledging in the write up. Foreground my position and interests, acknowledge how they are connected to my choice of topic and influence my interpretation. Consider how my enthusiasm for what SC means to the contributors may well reflect the contributors’ enthusiasm but also reflects my own.