

**'A way of being in the world': an exploration of the
experience of developing self-compassion through online
training**

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D. Clin. Psy. Thesis (Volume 1)

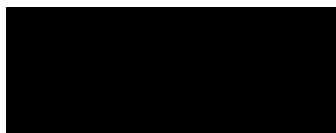
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University College London

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature



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Overview

Compassion-focused Therapy (CFT; Gilbert, 2005) has been shown to be effective at supporting people with a wide range of difficulties, but there is currently relatively little qualitative research on CFT and there has been no such research published on participants' experiences of engaging in a CFT-based approach offered in an online self-help format. This thesis sought to review qualitative CFT research and explore participants' experiences of engaging with online self-compassion training developed by Dr Chris Irons.

The empirical project was a joint project with Dr Clare Northover. Clare and I both planned the project, set up the online training on Qualtrics (using materials developed by Chris) and recruited participants online via social media posts. We had different emphases for our data collection and analyses: Clare's focus was on quantitative measures and mine was on participants' subjective experiences of engaging with the training. Therefore, I separately conducted interviews with participants who had completed the training and completed a reflexive thematic analysis (Braun & Clarke, 2006) of the interview data.

Part 1 comprises a systematic review of adults' subjective experiences of engaging with CFT-based approaches. Fifteen qualitative studies were retrieved and synthesised using thematic synthesis (Thomas & Harden, 2008). The themes generated by the synthesis highlighted various benefits and barriers often experienced by participants, potential mechanisms of change, and some core aspects of compassion described across studies.

Part 2 comprises an empirical study of participants' subjective experiences of engaging with newly developed online self-compassion training. An inductive qualitative approach was used, involving semi-structured interviews and reflexive thematic analysis (Braun & Clarke, 2006). The findings showed that trying to develop self-compassion was often incredibly challenging, but the training had a

positive overall impact on many participants' ways of relating to themselves and others. The themes point to various possible facilitators and barriers to change, including factors related to the training format and people's relational and social contexts.

Part 3 comprises a critical appraisal in which I reflect on managing the research process, methodological challenges with the literature review, reflexivity, and implications for my own clinical practice.

Impact statement

Compassion-focused Therapy (CFT; Gilbert, 2005) is now a well-established approach with a considerable body of research indicating its effectiveness for a wide range of difficulties, but there is relatively little emphasis given to people's subjective experiences of engaging with it. Exploring people's subjective experiences of approaches is invaluable for gaining insights into various factors, including mechanisms of change, barriers to engagement, different ways in which an approach can be experienced, and potential further developments. This thesis sheds light on these factors through two papers: a literature review of the existing qualitative research into CFT and a qualitative study of people's experiences of engaging with online self-compassion training (drawn from Compassionate Mind Training (CMT), based on the CFT model).

The literature review consolidates and augments the existing CFT literature. There were recurring themes focused on the positive changes to people's ways of relating to themselves and others, as well as the blocks they encountered when trying to achieve these changes. These changes and barriers are crucial for healthcare providers to consider when they are designing CFT-based approaches and thinking about how well this approach can meet individual needs. The findings could also be used to further develop conceptualisations of CFT's potential mechanisms of change. For example, there is currently greater support for group CFT compared to individual and self-help formats, and the studies reviewed indicate some ways in which participants might experience aspects of this format to be especially helpful (e.g. the presence of others helping people to feel less alone in their suffering). Participants' perspectives on the experience of engaging with CFT could be helpfully integrated into CFT training and professional development.

The empirical paper is the first study to explore people's subjective experiences of engaging in self-compassion training drawn from CMT and offered

via an online self-help format. This paper supported the literature review's findings by showing that participants described experiencing similar benefits and barriers to those described by participants in other qualitative CFT studies. The findings offer encouragement to healthcare providers that online formats could be used to increase the accessibility and scalability of CFT, and participants' descriptions provide helpful insights into some facilitators and barriers to change that should be considered. The absence of personalised or guided support was commented on by numerous participants, and they also highlighted aspects of training's delivery and their wider social contexts which influenced the degree to which they experienced the training as accessible and helpful. These findings could be used to help services design online approaches and to take a contextualised approach to offering support. Given the frequency with which barriers are experienced by people when trying to develop self-compassion, it is essential that careful thought is given to how people can be supported to overcome these without guided support or how the approach could be tailored in response to individual differences (e.g. in relation to prior understanding, levels of distress and the types of barriers encountered).

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Abbreviations

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Part 1: Literature review

**A thematic synthesis of qualitative research on the
experience of engaging with Compassion-focused Therapy**

1. ABSTRACT

Introduction: *Compassion-focused Therapy (CFT; Gilbert, 2005) has emerged as an approach that is helpful for a broad range of difficulties. However, there is a relative lack of research into people's subjective experience of engaging in CFT-based approaches. This study will aim to shed some light on this, including possible mechanisms of change and barriers to engagement.* **Methods:** *This literature review sought to explore and synthesise the findings of studies looking at people's subjective experience of engaging in CFT-based approaches. A systematic search process retrieved 15 relevant qualitative studies. Thematic synthesis (Thomas & Harden, 2008) was used to synthesise the findings.* **Results:** *Fourteen themes (five main themes and nine sub-themes) were generated. The main themes were 'New ways of relating to self', 'Flows of compassion', 'Importance of therapeutic relationships', 'Ongoing process' and 'Blocks'.* **Discussion:** *The findings consolidated and augmented the current research literature on CFT. In particular, the review identified some possible key mechanisms of change and barriers people can face when engaging with CFT-based approaches.*

2. INTRODUCTION

Shame, self-criticism and self-hatred are often experienced by people suffering from mental health difficulties (Gilbert, 2010). Indeed, self-criticism is considered by many to be one of the most central psychological processes influencing vulnerability to mental health difficulties mood and anxiety disorders, eating disorders and substance abuse (e.g. Hewitt & Flett, 2002; Whelton & Greenberg, 2005). Research has also indicated that it has a crucial role in the maintenance of posttraumatic stress disorder (PTSD; Harman & Lee, 2009). Self-criticism seems to be associated with the threat-based affective system and the aversive emotional states related to this (Gilbert, 2005; 2010).

Self-compassion (i.e. compassion towards oneself) is conversely linked with affiliative systems and has emerged as a focal point of numerous therapeutic approaches. The Dalai Lama (1995, p. 2) has defined compassion as “openness to the suffering of others with a commitment to relieve it” and Paul Gilbert’s definition of self-compassion bears similarity to this: “sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it” (Gilbert et al., 2017, p. 1). Gilbert (2018) stresses that compassion goes beyond a sentiment of kindness and includes the courage to alleviate suffering; “the preparedness to turn towards difficulty and the commitment to try to work it out by taking action” (Gilbert, 2018, p. 37).

Kristin Neff has been similarly influential in the compassion field, and she led the way in operationalising ways in which self-compassion is defined and measured (Neff, 2003a; Neff, 2003b). While Gilbert puts a greater emphasis on evolutionary psychology and attachment (see later paragraph), both of their self-compassion definitions have been highly influenced by Buddhist teachers and comprise a state of mind/mentality. Neff (2003b) contends that self-compassion includes three mutually-interacting elements: kindness, common humanity and mindfulness. Self-kindness means being understanding and supportive towards ourselves, rather than self-critical and harsh; common humanity refers to having a sense that everyone has imperfections and difficulties, rather than feeling that we are alone in this; and mindfulness refers to an awareness of the present moment (including our thoughts and feelings) without avoidance, repression or judgment.

Compassion can be experienced in multiple directions (i.e. towards oneself, towards others and from others), but research suggests that self-compassion can be especially beneficial in improving well-being and reducing psychological distress (Gilbert, 2007; Neff, Kirkpatrick & Rude, 2007). For example, studies have found negative associations between self-compassion and anxiety (MacBeth & Gumley,

2012), and positive associations between self-compassion and well-being (Zessin, Dichauser & Garbade, 2015).

Compassion-focused Therapy (CFT; Gilbert, 2005) is one of the most prominent approaches explicitly aimed at reducing people's self-criticism and strengthening their self-compassion. CFT has roots in evolutionary perspectives on the development of the human mind, and the role that affiliation has in regulating threat-processing and cultivating people's capacities for caring, sharing, helping and feeling valued (Gilbert, 2014). CFT also acknowledges how people reporting pronounced self-criticism and shame have often experienced cold, harsh and/or abusive histories (Schoore, 1998), and how frustrated attachment needs can lead to intra- and interpersonal threats, as well as associated protective strategies, that make it difficult to experience this care and compassion (Gilbert, 2014).

CFT is an integrative approach geared towards strengthening the brain systems and competencies that are important for wellbeing, prosocial behaviour and threat regulation (e.g. there has been neuroscientific research showing affiliative motives to have a significant impact on affect and self-regulation; Depue & Morrone-Strupinsky, 2005). CFT-based approaches typically employ a variety of techniques, such as mindfulness, chair work, compassionate imagery, cognitive strategies (e.g. compassionate reappraisal) and behavioural strategies (e.g. memory re-scripting and exposure) (Gilbert, 2010). As well as directly reducing negative, threat-based systems, CFT strives to give equal emphasis to the cultivation of the capacity to experience and tolerate affiliative emotions and motives. The hope is to build a compassionate self-identity, with new ways of relating to oneself and others (Gilbert, 2014).

In terms of effectiveness, CFT has been shown to be effective in various formats (Ferrari et al., 2019) for a broad range of difficulties, including reducing anxiety and depression in adolescents (Ferrari et al., 2019), psychosis (Braehler et

al., 2011), eating disorders (Kelly & Carter, 2015) and traumatic brain injury (Ashworth, Gracey & Gilbert, 2011). Leaviss and Uttley's (2015) systematic review of CFT found that the approach seems to be particularly helpful for highly self-critical clients. CFT has emerged, then, as an approach with great promise and flexibility. However, while there is increasing reason to believe that CFT has a positive effect on a variety of quantitatively-measured outcomes (including neurophysiological change; Weng, Lapate, Stodola, Rogers & Davidson, 2018), there is a relative lack of research exploring participants' subjective experiences of engaging in CFT-based approaches. Greater emphasis on qualitative and/or mixed-methods research into CFT-based approaches could help to shed light on what it is like to engage with this kind of approach, potential mechanisms of change, and barriers that people can encounter. Such insights would be invaluable in helping to inform further developments.

This literature review is aimed at synthesising the current published research on people's subjective experiences of engaging with CFT-based approaches, with the aim of providing insights into factors including mechanisms of change, barriers to engagement, and ways in which CFT-based approaches could be further developed.

3. METHODS

3.1. Search strategy

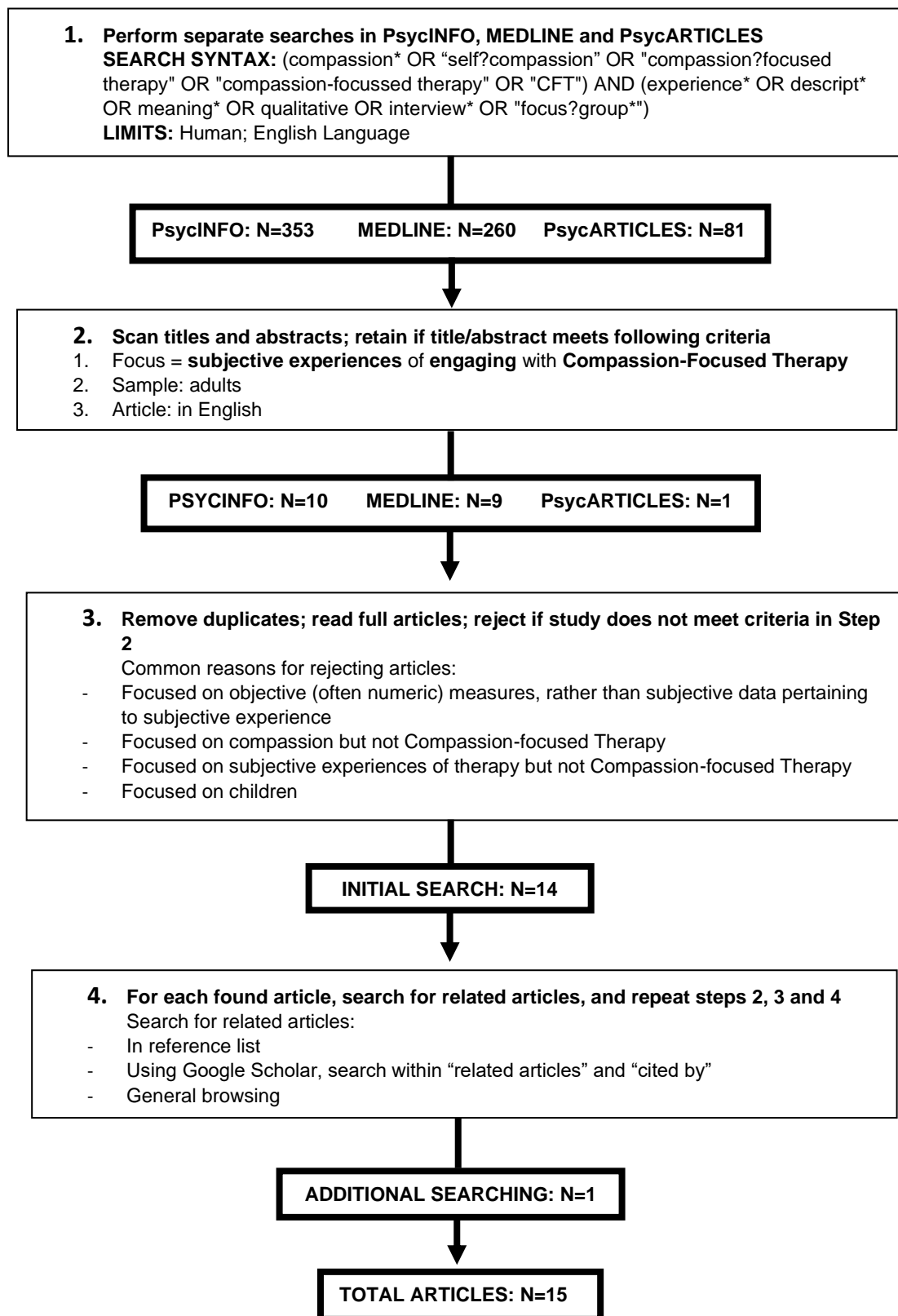
The literature search was conducted within three electronic research databases: PsycINFO, MEDLINE and PsycArticles.

In each database, a search was carried out to retrieve articles focused on (1) subjective experiences of engaging in (2) a CFT-based intervention. In order to maximise the number of relevant articles retrieved, the search syntax included synonyms for these factors (see Figure 1).

The retrieved articles were checked to establish whether they were focused on the subjective experience of adults rather than children. To further maximise the number of articles retrieved, this criterion was not specified in the search syntax.

This searching process, detailed in Figure 1, retrieved 15 articles meeting inclusion criteria for the current review. As two papers (Bell, Montague, Elander & Gilbert, 2019; Bell, Montague, Elander & Gilbert, 2020) are based on the same study and interview data, these are grouped together (see Table 1).

Figure 1. Diagram to illustrate search process



3.2. Critical appraisal of studies

There is an ongoing debate focused on how qualitative studies can be critically appraised. While the majority of researchers argue for the importance of taking the quality of papers into account when conducting systematic reviews of qualitative literature, there is not a general consensus on how this should be operationalised. A sizeable body of literature is dedicated to such difficulties in determining a standardised approach (e.g. Barbour & Barbour, 2003; Cohen & Crabtree, 2008; Long & Godfrey, 2004; Walsh & Downe, 2006).

A recurring theme in such papers is the fact that 'qualitative research' is not an easily-defined entity and numerous approaches are subsumed under this umbrella term. These include a broad range of 'epistemological positions'. For example, some approaches employ an interpretive perspective, assuming that there are multiple realities and these are co-constructed (e.g. Interpretive Phenomenological Analysis; IPA; Smith & Osborn, 2003). Such approaches might be more likely to value reflexivity and rich description as strong indicators of quality. Other approaches employ a realist perspective, which contends that there is one reality which can at least partially known (Maxwell, 2012). With these approaches, there might be a greater emphasis on validity-checking as an indicator of quality.

Furthermore, the process of qualitative data analysis is inherently subjective regardless of the approach used. Critical appraisal tools for qualitative research therefore necessitate a reflection of these differences between, and within, approaches. While there are more tangible ways to critically appraise procedures like sampling, subjective judgments are required when appraising the interpretive aspects of qualitative research. There are a multitude of critical appraisal methods that have been published (e.g. Cohen & Crabtree, 2008) and no universal guidelines

nor evidence base for the selection of these, so researchers are required to identify the procedure(s) that fit the particular needs of their research.

Because it is widely established in qualitative research literature, I chose to use the Critical Appraisal Skills Programme Qualitative Research Checklist (CASP-QRC; <http://www.casp-uk.net>). So that studies adopting a range of epistemological positions could be meaningfully appraised with this method, I took the decision to flexibly use the CASP-QRC with some amendments to the format (see Table 1). It was employed as a list of guidelines that helped to focus attention on different aspects of the studies identified which, depending on the study's approach, could be indicators of quality. The CASP-QRC was designed as a checklist with options between binary choices about quality and this was deemed to unsatisfactorily capture the varied nature of the studies identified, so a subjective judgment component was added to the procedure.

3.2.1. Critical appraisal methodology

There were two stages to the critical appraisal procedure: an assessment structured by the amended CASP-QRC (Table 1) and a holistic, subjective appraisal of quality. The CASP-QRC was used as a helpful set of domains that are relevant to quality depending on each study's approach. In going through these domains, I firstly decided which ones were relevant to the particular study. For all domains that were relevant, I checked whether they were demonstrated by the study. The options for scoring were 'All features present' (given a score of 1), 'Some features present' (given a score of 0.5) or 'No features present' (given a score of 0). Scores for each study were then added together and divided by the number of domains that were deemed relevant and assessed. This resulted in a score between 0 (lowest quality rating) and 1 (highest quality rating). A subjective component was then added to this rating. This was informed by my understanding of qualitative research methodology,

with each study given a 'low', 'medium' or 'high' quality rating. All studies initially identified were included in the review, but these critical appraisal findings were considered in the discussion.

3.3. Analysis

Thematic synthesis (Thomas & Harden, 2008) was used to synthesise the findings. This was chosen because it is a flexible approach that can be applied to studies employing different epistemological positions and data analysis methods. Steps recommended by Braun and Clarke (2006) in their thematic analysis guidelines were also employed within the first two of Thomas and Harden's (2008) three thematic synthesis steps, in order to provide a way of further formalising the data analysis method and generation of initial themes. These steps are detailed below.

As recommended by Thomas and Harden (2008), the results sections of the papers retrieved (including quotations from participants) were imported into NVivo (Version 11: QSR International, 2012) to aid the inductive process of ascribing meanings to the qualitative data. I strove to employ a data-driven approach so that findings located in the data would be privileged over pre-conceptions and pre-established hypotheses. Once this data was imported, I read and re-read the results to immerse myself in the data. Data was deemed relevant if it pertained to the subjective experiences of participants engaging in a CFT-based approach. Data that did not meet these criteria was not coded. I carried out three stages:

1. Line-by-line coding to generate descriptive codes. Most lines had at least one code applied to them, and frequently several different codes were applied to the same line. An iterative approach was adopted, meaning that previously-coded articles were checked for any new codes that I identified. Concepts that were demonstrated in multiple papers but expressed in

different words were identified and associated when appropriate (Thomas & Harden, 2008).

2. Initial themes were developed by grouping and comparing codes in relation to similarities and differences across all the papers. The codes were discussed and finalised with the research supervisor (JK). Codes were then grouped into themes, which were also discussed and finalised with JK. Following this, themes were reviewed against the data several times and the iteratively refined. Themes that were unsupported by the data were taken out, new themes were developed, heterogeneous themes were split into additional and/or sub-themes, and homogenous themes collapsed. After this, I decided that the themes generated reflected the data as closely as possible, and so the process of iterative refinement could be ended.
3. Finally, main 'analytical' themes were created to both organise the themes and to 'go beyond' the studies reviewed (Thomas & Harden, 2008). Descriptive codes and sub-themes were built upon to determine key messages in relation to the research question. While it was deemed important to try to 'go beyond' the data in the studies reviewed, the research question and aim of this review (synthesising findings on people's subjective experiences of engaging with CFT) was broad and exploratory, so I aimed to keep all themes relatively close to the data in the studies reviewed. Sub-themes were included, which were deemed to fall thematically within main themes but to be differentiated enough to warrant inclusion as sub-themes in their own right. All themes were finalised with JK.

Table 1. Critical appraisal guidelines amended from the Critical Appraisal Skills Programme Qualitative Research Checklist (CASP-QRC)

	Domain	Features
1	Clear statement of research aims	<ul style="list-style-type: none"> • There is a clear statement of the research aims
2	Qualitative methodology is appropriate	<ul style="list-style-type: none"> • The qualitative methodology is appropriate • The research seeks to interpret or illuminate actions and/or subjective experiences of participants
3	Research design clear and appropriate for addressing aims	<ul style="list-style-type: none"> • The researchers have justified the research design
4	Recruitment strategy clear and appropriate for addressing aims	<ul style="list-style-type: none"> • There is an explanation of how the participants were selected • There is an explanation of why the participants selected were the most appropriate • There is a discussion of any recruitment issues
5	Data collection clear and appropriate for addressing aims	<ul style="list-style-type: none"> • There is a justification of the setting for data collection • It is clear how data was collected (e.g. focus group, semi-structured interview etc.) • There is a justification of the methods chosen • The methods are explicit (e.g. for interview method, an indication of whether interview schedules were used) • If methods were modified during the study, the researcher has explained how and why • The form of data is clear (e.g. recordings, notes etc.) • Saturation of data has been discussed
6	Adequate consideration of relationship between researcher and participants	<ul style="list-style-type: none"> • The researchers have critically examined their own role, preconceptions, potential biases and influences during various stages of the study, including design, data collection and analysis
7	Ethical issues taken into consideration	<ul style="list-style-type: none"> • Methods used to explain research to participants are clearly presented and in accordance with appropriate ethical standards • There is a discussion of ethical issues raised by the study (e.g. informed consent, confidentiality, effects of the study on the participants etc.) and how these were managed. • There is approval from an ethics committee

8	Data analysis sufficiently rigorous	<ul style="list-style-type: none"> • There is a detailed description of the analysis process (e.g. how themes were derived from the data)
9	Findings clearly stated, contextualised and critically assessed	<ul style="list-style-type: none"> • Findings are explicit • Sufficient data presented to support findings • Justification for why particular pieces of data have been chosen for presentation • Contradictory data presented and taken into account • Exploration of the credibility of findings (for example, through the use of triangulation, respondent validation, external auditing, peer review) • Discussion of the subjectivity of findings (e.g. via detailed contextualisation, consideration of co-creation of findings, analysis of researcher-participant relationship) • Acknowledgment of limitations of findings
10	Findings are valuable	<ul style="list-style-type: none"> • Findings are linked back to the research aims • Discussion of the contribution the study makes to existing knowledge • Discussion of whether/how findings can be applied to other populations • Identification of new areas where research is necessary

Table 2. Summary details of articles included in review

First author	Code	Year	Aim	N	Country	Ages	Gender	Ethnicity	Data collection method	Data analysis method	CASP-QRC (range: 0-1)	Subjective rating
Ashworth	A	2015	To assess the feasibility, safety, and potential value of CFT for Acquired Brain Injury patients receiving neuropsychological rehabilitation	6	UK	21-55	M/F	White British	Semi-structured interviews	IPA	0.8	High
Bell	BE1	2017	To explore the possibility and potential benefit of training therapists to develop a 'compassionate internal supervisor' using CFT	7	UK	27-61	M/F	White British British-Bangladeshi	Semi-structured interviews	IPA	0.9	High
Bell	BE2	2019 and 2020	To explore clients' lived experience of a CFT chair-work intervention for self-criticism To explore self-multiplicity in a CFT chair-work intervention for self-criticism	12	UK	19-53	M/F	White British White Bulgarian White Irish	Semi-structured interviews	IPA	0.9	High

								Asian-British Chinese				
Bratt	BR	2019	To explore participants' experiences of group CFT for parents of adolescents with MH difficulties	11	Sweden	35-57	M/F	NS	Reflective lifeworld research open interviews	Meaning-oriented data analysis	0.9	High
Carter	CA	2020	To investigate the feasibility of CFT as a 12-session group intervention for the reduction in body weight shame for individuals with bigger bodies	5	Australia	18+	M/F	NS	Focus groups	Thematic analysis	0.65	Medium
Clapton	CL	2018	To examine the feasibility and acceptability of group CFT for adults with intellectual disabilities	6	UK	18+	M/F	NS	Focus groups	Thematic analysis	0.75	High
Craig	CR	2018	To assess the feasibility, acceptability, and utility of a CFT intervention for people with dementia with depression and/or anxiety	7	UK	53-88	M/F	White British Black British White European	Semi-structured interviews	Thematic analysis	0.6	Medium
Gale	GA	2017	To explore therapists' experiences of personal practice in relation to CFT, and the impact this has upon them and their therapeutic work	10	UK	25-61	M/F	NS	Semi-structured interviews	Thematic analysis	0.95	High

Gooding	GO	2020	To explore the effectiveness and lived experience of a 12-week CFT group for people who experience persistent pain	4	UK	47-76	M/F	NS	Semi-structured interviews	IPA	0.85	High
Hardiman	HA	2018	To assess the effects of CFT on anxiety in a small sample of adults with intellectual disability	3	UK	31-48	M/F	White British	Semi-structured interviews	IPA	0.55	Medium
Heriot-Maitland	HE	2014	To examine the feasibility of running and evaluating a CFT group adapted for acute inpatient settings	4	UK	18+	NS	NS	Semi-structured interviews	Thematic analysis	0.65	Medium
Lawrence	LA	2013	To explore the process of engaging in CFT for people who have received a PTSD diagnosis	7	UK	30-54	NS	NS	Semi-structured interviews	IPA	0.95	High
Lucre	LU	2013	To explore how CFT affected self-criticism and self-attacking thoughts, feelings, and behaviours, as well as the general symptoms of anxiety, stress, and depression of a group of people who have received personality disorder diagnoses	8	UK	18-54	M/F	White British	Reflective journal	Content analysis	0.55	Low
Mullen	M	2019	To explore participants' patterns of relating to self and others before and after attending a CFT group intervention focused on eating disorders	13	Ireland	19-58	NS	NS	Semi-structured interviews	Thematic analysis	0.7	Medium

4. RESULTS

Table 2 shows some basic information about the 14 studies that the search strategy retrieved. There was a relatively small range of sample sizes (N=3 to N=12). Twelve of the 15 studies were conducted in the UK, with the other three conducted in Ireland, Sweden and Australia, respectively. Most of the papers did not specify the ethnicity of their participants. Of the six that did, three reported that participants solely identified as White British and three reported participants identifying with a range of ethnicities (White British, Black British, British Bangladeshi, White Bulgarian, White Irish, Asian-British and Chinese). As specified by this review's inclusion criteria, all participants were adults. There was a broad range of ages across the studies that reported this (18 to 88). All studies that reported gender included a mixture of participants identifying as either men or women, respectively. While the majority of the studies used semi-structured interviews for their data collection, there were some other methods used (focus groups, reflective journals and reflective lifeworld research open questions). Thematic analysis and Interpretative Phenomenological Analysis were the most-used data analysis approaches, though Meaning-oriented Data Analysis and Content Analysis were also used.

There was significant variety to the formats of the CFT-based approaches across the studies. For example, some of the participants took part in individual sessions and others took part in CFT groups. Furthermore, different approaches placed different levels of emphasis on particular strategies (e.g. chair work was the main focus of some studies, but not included at all in some of the others). The main inclusion criteria across different studies were also markedly different (e.g. people who had suffered from a traumatic brain injury, people who had received a diagnosis of an eating disorder, and trainee therapists).

Five main themes and nine sub-themes were generated by the synthesis. Table 3 provides a summary of these themes and shows their distribution across the studies. While the themes are differentiated, many of them are also inter-related. For example, some of the data was coded in support of both the *Non-blaming attitude* and *Insight* sub-themes, as participants talked of insight into the nature of their difficulties being closely intertwined with being able to take a non-blaming attitude towards themselves. In the section below, I will describe each of these themes separately for the sake of clarity, but similarities will be acknowledged. Quotations from the studies reviewed will be included (in italics) to demonstrate the themes and the corresponding studies will be identified at the end of each quotation. In some cases I have inserted connecting words (within square brackets []) and ellipses (...) in the place of superfluous parts of longer quotations, for ease of reading.

Table 3. Distribution of themes in studies reviewed.

Main themes	Sub-themes	A	BE 1	BE 2	BR	CA	CL	CR	GA	GO	HA	HE	LA	LU	M	
1. New ways of relating to self		[Red bar]														
	1.1. Stepping back from difficulties	[Light red bar]														
	1.2. Non-blaming attitude	[Light red bar]														
	1.3. Insight	[Light red bar]														
	1.4. Common humanity	[Light red bar]														
	1.5. Compassionate behaviours	[Light red bar]														
2. Flows of compassion		[Green bar]														
3. Importance of therapeutic relationships		[Yellow bar]														
4. Ongoing process		[Pink bar]														
5. Blocks		[Blue bar]														
	5.1. Internal blocks	[Light blue bar]														
	5.2. External blocks	[Light blue bar]														
	5.3. Overcoming blocks	[Light blue bar]														
	5.4. Room for improvement	[Light blue bar]														

Key: Direct evidence for the corresponding theme in a study is indicated by filled squares. Code letters for each study correspond to the code letters in Table 1.

1. New ways of relating to self

In all of the studies reviewed, there were participants who described their engagement with a CFT-based approach helping them to develop new ways of relating to themselves. Many participants expressed surprise and pride at these changes they had achieved. While there was a rich variety of descriptions of these new ways of relating to themselves, there were some common themes in participants' accounts, and these have been developed into the five sub-themes outlined below.

"I really feel like I have gained some control back for myself, not through medication or negative actions but real self control over my feelings. I have learned things that I am sure I will keep with me for the rest of my life. Of course I'm not saying that I am now healed... but I can feel positive about things and believe that I can improve."

(Lucre & Corten, 2013, p. 396)

"I think it gives me... the freedom to be, to be kind of the best parts of me... that's part of me now... what it means is – I suppose caring for yourself, letting other people care for you and then caring about other people." (Mullen, Dowling, Doyle & O'Reilly, 2019, p. 259)

1.1. Stepping back from difficulties

Nine studies reported participants talking about learning to take a step back from, or 'make space' for, their difficulties. This was seen as a process of taking more of an accepting, 'observer' stance towards difficulties they were facing, as opposed to feeling over-identified with them, trying to avoid awareness of them and/or trying to achieve absolute control over them. This process of stepping back seemed to be valued by participants across many different settings. Mindfulness was often talked about as one of the strategies that participants found helpful in strengthening their capacity for this.

“I just allowed it to happen really and became more of an observer of it rather than getting immersed within it in a sense really.” (Bell, Dixon & Kolts, 2017, p. 8)

“It helps if I’m really stressing or flapping...I think it can just help ground me and calm me down more so than relaxation does I think. Because I think sometimes relaxation can feel like I’m just trying to pretend everything is ok when it is clearly not all of the time, whereas mindfulness it’s like ‘yeah, it’s rubbish that I’m late for work but that’s ok’ and just be in the moment sort of thing.” (Gale, Schröder & Gilbert, 2017, p. 177)

1.2. Non-blaming attitude

All but one paper included descriptions of how participants had been more able to take a non-blaming attitude towards themselves through engaging with a CFT-based approach. Many participants talked about this in terms of being kinder towards themselves, showing understanding towards their difficulties, and having more flexible standards for themselves. For a lot of participants, this was in stark contrast to their tendencies to be very self-critical towards themselves and to blame themselves for any difficulties they encountered.

“After session I try and get that little voice in my head telling me ‘yeah that’s ok and you’re not going to have all the answers and you tried your best’. I just give myself a little bit more reassurance and I’m a bit more, easier on myself.” (Bell et al., 2017, p. 9)

“...cause often I have a few good days and then I will have a bump or whatever, a slip up, and beforehand if I had a slip up I would just totally spiral and go in the other direction like just—it was like one slip up would just undo all the good work that I have done in the last few days so now I try to look at it more that erm just be more rational kind of moderated and not freak out, you know it’s natural to make a mistake

and to just think about it more bit by bit than looking at it in black and white". (Mullen, Dowling, Doyle & O'Reilly, 2019, p. 260)

1.3. Insight

Participants in 12 of the studies talked about increased insight being one of the key components of developing new ways of relating themselves. This often went hand-in-hand with taking a non-blaming attitude: for many participants, having a better understanding of factors that have influenced their difficulties helped them to not locate so much blame within themselves. Some participants reflected on realising that their self-critical tendencies had served a function for them at certain times in their lives and had been an understandable response to difficult experiences, but now these tendencies were no longer so necessary nor helpful.

"My angry thoughts and words that I believed protected me from attack from others, have kept me trapped and now I don't need them anymore." (Lucre & Corten, 2013, p. 395)

"The next best thing was the way they explained the mind and how it was working ... you understood a bit more of why you might be feeling the way you were feeling." (Gooding, Stedmon & Crix, 2020, p. 37)

1.4. Common humanity

Another theme found in 12 of the studies was the experience of a sense of common humanity, in terms of participants feeling less alone in difficulties, realising that others might be experiencing similar struggles, and seeing suffering as a shared part of the human condition. Although each person's experience is unique, many participants reported finding it very powerful to hear others talk about going through difficulties with striking similarities to their own. This experience seemed to be especially well-facilitated by CFT-based approaches offered in group formats. In

Lawrence and Lee's (2013) paper on CFT focused on trauma, one participant who had engaged in individual therapy reported feeling more isolated at the start of therapy, and reflected on the potential benefits of getting support from people with similar lived experience.

"It's also super useful to get to listen, too. Some people's experiences were identical with my own. So it's really, really nice to hear other parents who have problems, that you're not alone, not different in any way. It's made me open up to others, too. And it's so helpful, instead of being ashamed that we're doing the way we are, to talk about it and then you see that loads of people have these problems—but maybe they just haven't sought help with them." (Bratt, Svensson & Rusner, 2019, p. 5)

"I think the most helpful thing was hearing other people going through the same thing yeah definitely yeah... cause I never did a group before and that was a really big thing I was terrified... yeah it felt good that people were all in the same boat and then you were kind of listening to people going "oh yeah, well I do that and oh she does that too" so it wasn't—so yeah you didn't feel alone which was nice." (Mullen, Dowling, Doyle & O'Reilly, 2019, p. 257)

1.5. Compassionate behaviours

Eleven papers reported compassionate behaviours as being another important part of the new way in which participants were relating to themselves. As mentioned in the next theme, participants also talked about engaging in more compassionate behaviours towards others. The self-compassionate behaviours reported took many shapes: some participants described being more assertive in relationships (e.g. learning to say 'No') while others described engaging in activities that brought them joy and confidence. These behaviours seemed to be intertwined with, and to reinforce, the changes that participants reported in relation to how they thought and felt about themselves.

“I’m very generous with myself now and you know I wouldn’t have gone anywhere as well. I had this thing about not, not, not being compassionate. Not taking myself off to the theatre and I love the theatre.” (Lawrence & Lee, 2013, p. 500)

“I just had a rule like I had a certain body type so I couldn’t wear, I could only wear certain types of clothes or whatever so I went and bought jeans and certain trousers and so that—that was a big change yeah I got my first tattoo as well—which is something that I would have put off until I had my ideal body shape... but then I just went and did it and it was actually, that was really nice as well that gave me a boost.” (Mullen et al., 2019, p. 260)

2. Flows of compassion

The second main theme was the multiple flows of compassion which were facilitated by engaging with a CFT-based approach. Participants in many of the studies described finding that they were helped to not only become more self-compassionate, but also more able to give and receive compassion from others. The ways in which these flows of compassion were strengthened varied across participants. For example, some therapists in Gale et al.’s (2017) study described how engaging in the CFT-based strategies that they use in their work with clients made them realise how challenging it might be for their clients to try out these strategies. Some therapists said this would help them to have empathy for clients and to be more attuned to potential barriers in therapy. In other studies, participants talked about how being self-compassionate meant that their own difficulties felt more manageable and they therefore had more capacity to shift their attention outwards and be compassionate towards others.

“I do think it’s helped to have a deeper level of compassion towards other people and I think there’s no doubt about that really, I think it’s been there but I think it’s

more so because I think the more you are compassionate with yourself the more you feel able to be that way with other people.” (Bell et al., 2017, p. 10)

“Don't be afraid to seek help from other[s] because sometimes we do need that ... This process will let us feel better. And if you feel better then you will get happy and have a good mood. And if you have a good mood you can have enough energy to encourage others, just like you.” (Carter, Gilbert & Kirby, 2020, p. 9)

3. Importance of therapeutic relationships

The third main theme is the importance of therapeutic relationships, which was identified by participants in nine of the studies reviewed. As well as many participants benefiting from being with other participants in group settings, they also often highly valued the relationships developed with their therapists and group facilitators. It seems that in many cases that participants felt that the way therapists/facilitators related to participants modelled the compassionate approach they were trying to develop, which provided a supportive relational context that helped them engage with the approach, as well as demonstrating a way of relating that they could gradually internalise and offer to themselves and others. As will be outlined in the fifth main theme, it was sometimes very difficult for participants to receive compassion from others and from themselves, and a therapeutic relationship was perhaps especially crucial in these cases as it meant that difficulties could be explored and worked through.

“One of the strongest things was the actual therapists themselves. Erm they were so kind. Erm the kindness was amazing. Erm not only as doctors but as human beings. Their generosity was, I'd never come across that level of kindness before and, and their empathy erm at the same time they were very challenging and they made us work hard.” (Lawrence & Lee, 2013, p. 500)

“The encouragement that we got and the whole approach of [the facilitators] was so compassionate... and it was so, it was done in such a caring way and a sensitive way that it just kind of left it wide open for you to engage with it. There was no barriers unless you put them up yourself... it was just so compassionately done, so I think probably what helped me the most.” (Mullen et al., 2019, p. 257)

4. Ongoing process

The fourth theme, identified in nine of the studies reviewed, is that developing self-compassion is an ongoing process. Participants acknowledged that while they had made significant progress, being compassionate towards themselves still did not necessarily come naturally to them, and it is a way of relating that requires ongoing practice. This was sometimes described in relation to the insight they had gained into their difficulties (e.g. the ways in which difficult experiences had played a part in them developing harsh ways of relating to themselves, and how anxiety is to some extent part an inevitable part of life). Some participants expressed frustration at their realisation that this would be something they would have to continue to devote time and energy to, but many nonetheless saw this as a worthwhile endeavour that they intended to take forward.

“Learning to take a step back, to look into this, take care of myself and not only my professional or my parental role. I also have to be myself. Otherwise, I won’t be of much help ... So, I’m working on that too ... finding new patterns. It’s going to take a while. I end up in the ditch every day, but if I realize, ‘this is what I feel’, then I’ve succeeded. Then, take care of the green circle again, balance this effort. The last years have certainly taken a lot of effort.” (Bratt et al., 2019, p. 5)

“I catch myself out daily using the ‘I should have / could have/ ought to have..’ type phrases and swiftly remind myself to ‘be compassionate!’ and often catch myself telling others to do the same thing.” (Lucre & Corten, 2013, p. 356)

5. Blocks

The fifth and final theme identified in this analysis was blocks that participants experienced when trying to engage in CFT-based approaches, which came up in ten of the studies reviewed. Although most of the studies reviewed seem to report mostly positive feedback from participants regarding their experience, participants also reported encountering many difficulties and some did not feel that the approach was helpful at all. This is elaborated upon in the sub-themes below.

“This was completely focused towards me and my well-being and I found that difficult to get used to, to start with because I was wanting to put out [compassionate] but it’s drawing it in really and accepting that it’s for me.” (Bell et al., 2017, p. 7)

“I didn’t want to be kind to myself. Because I still felt I didn’t deserve to be happy or to have nice thoughts or to be kind to myself. I thought that by [being compassionate], there were things that would make me smile and I felt, well, I know it sounds silly, as if I wasn’t allowed to smile.” (Lawrence & Lee, 2013, p. 499)

5.1. Internal blocks

In nine of the studies, participants described internal blocks to engaging in a CFT-based approach. For some, there was a deeply-felt belief that they did not deserve to receive compassion from themselves or others. This seemed to be a particularly pervasive theme in Lawrence and Lee’s (2013) paper, in which the participants had suffered from traumatic experiences. Participants also talked about struggling to believe that becoming more self-compassionate was possible, because it was in such stark contrast to their usual ways of relating to themselves that the gap seemed unbridgeable (*“It’s like being an atheist and someone trying to convert you”*; Lawrence & Lee, 2013). Other participants talked about concerns that becoming self-compassionate carried the the risk of them disengaging with the demands in

their life and absolving themselves of all responsibility. For some of these participants, self-criticism seemed like an important motivator that they could not afford to do without.

The internal blocks participants described sometimes related to particular exercises used, which could elicit intense emotions experienced as overwhelming and embarrassing. The language used in approaches also elicited variable reactions from participants. For example, in Bell et al.'s (2017) study the approach was talked about in terms of developing a compassionate 'internal supervisor', which for some participants led to a strong negative reaction due to associations they had with that term and with authority more generally (see second quote below). Participants in some of the studies had significant memory impairments, and this posed another block to taking in their experience of a CFT-based approach.

"I didn't want to be kind to myself. Because I still felt I didn't deserve to be happy or to have nice thoughts or to be kind to myself. I thought that by [being compassionate], there were things that would make me smile and I felt, well, I know it sounds silly, as if I wasn't allowed to smile." (Lawrence & Lee, 2013, p. 499)

"That was my barrier, I don't like the term, I'd rather it be something like helper or something, you know not a term that's got authority written all over it." (Bell et al., 2017, p. 8)

5.2. External blocks

Five of the studies reported that participants had talked about various external blocks to getting something out of the CFT they had engaged in. Participants talked about difficulties finding the time to practice strategies and balancing these with pressures they were experiencing from their work and/or studying, as well as their personal lives. In Gale et al.'s (2017) study, some of the therapists engaging in CFT felt their continued practice was impeded by not having supervisors who used this

approach. It was also sometimes a challenge to find a setting that was conducive to practicing self-compassion – participants described different forms of disruption (e.g. noise) and a lack of access to suitable equipment to play recordings (Bell et al., 2017). Some participants worried that without a therapeutic relationship supporting them, they would not be able to maintain the progress they had made. Participants also talked about wider-level external blocks, such as shaming societal messages about health-related behaviours (Carter et al., 2020).

“I guess on a personal level, yes, I sort of took it away and read through the literature and then was thinking about how I would apply it to my clinical practice but at the time that I did the training I wasn’t supervised by anyone really using CFT and I didn’t have the chance straight away to use it in practice.” (Gale et al., 2017, p. 156)

“It’s [a] comfort back here [in a therapeutic group setting], I know what I’m doing, I know where I am and if I go forward I’m not really sure what I’m going to [do].” (Gooding et al., 2020, p. 37)

5.3. Overcoming blocks

In 10 of the studies reviewed, participants talked about a process of overcoming blocks they faced when engaging with CFT. While some blocks are inevitably harder to overcome than others (and some participants did not feel that it was possible to overcome blocks they encountered) a lot of participants did find that it gradually became easier to engage in CFT and develop new ways of relating to themselves and others. This was often talked about in relation to some of the previous themes, such as self-compassion being an ongoing process and the importance of therapeutic relationships. For example, many participants mentioned the importance of consistent practice, and developing a way of practising that works for the individual (e.g. being flexible with oneself about whether strategies need to be

practiced at the same time every day or this can be adjusted to fit with other demands). Participants also described how the presence of a therapist/facilitator helped them to become unstuck when they felt that they were struggling to engage with the approach. For several participants, their negative pre-conceptions about self-compassion were gradually modified by learning more about it and trying to integrate it into their lives.

“. . . the being kinder part was nice because somebody else saw that in you, that you know is already there but you just can't access it . . . I think sometimes you just need to be shown a couple of times, and then it depends on how your head is. Maybe you can carry it through.” (Clapton, Griffith, Williams & Jones, 2017, p. 11)

“Learning the value of what you need and not being afraid to—because before like I just associated self-compassion with being sort of like, “Oh if I am being self-compassionate to myself I will become self-indulgent and cocky and lazy and erm become a bad person cause I will just—I will let myself go and I will lose sense of what's right” but now that I remember that it's something that I actually need and it's not necessarily something that is earned when you have like a great achievement.” (Mullen et al., 2019, p. 259)

5.4. Room for improvement

Six of the studies reviewed included participants suggesting that there was some room for improvement in the CFT-based approach they had engaged in. Some participants had a clear idea of what they would have liked to be done differently, such as having more time to process the content they are learning and more one-to-one support around this. One participant described not being very interested in the didactic elements of the CFT they engaged in, and instead preferring more time for group discussions. Some participants talked about valuing the support but wanting more tailored information specific to their difficulties (e.g. memory). Other studies did

not report specific changes participants had suggested, but did report that there had been participants who had not felt they had benefited from the approach. One participant in Gale et al.'s (2017) study (see second quote below) wondered whether participants were keeping more negative perspectives/feedback regarding CFT to themselves, and perhaps felt pressured in some way to only share positive reflections.

“When the teacher was writing lots of the...I wasn’t that interested. I was more interested with the discussion, you know.” (Heriot-Maitland, Vidal, Ball & Irons, 2014, p. 90)

“I don’t know if everyone else kept the more negative reflections that they had about the exercises inside because there is obviously someone teaching about the model who is obviously really passionate about the model and so people’s reflections were quite positive, kind of, overtly about it and I don’t know if maybe there were things that they weren’t sure about that they kept inside.” (Gale et al., 2017, p. 176)

5. DISCUSSION

While CFT has emerged as an approach that has been found to be helpful for a broad range of difficulties, there is a relative dearth of qualitative research exploring people’s subjective experience of engaging with it. The current research literature on CFT is predominantly comprised of studies looking at changes in scores on quantitative outcome measures. While this is important data, future developments in CFT would arguably benefit from being able to draw on qualitative data which might help efforts to understand important factors such as mechanisms of change, barriers people could face with this approach, and ways in which it could be improved. This review therefore aimed to review the current literature on people’s subjective experience of engaging with CFT-based approaches.

Data from 15 studies were synthesised using a thematic synthesis approach (Thomas & Harden, 2008). There were five main themes: *New ways of relating to self*, *Flows of compassion*, *Importance of therapeutic relationships*, *Ongoing process* and *Blocks* (see Table 3). Many of the themes and sub-themes seemed to converge with CFT literature and purported aims of the approach, particularly the sub-themes under *New ways of relating to self*. Others (particularly the sub-themes under *Blocks*) offer useful information about some of the difficulties of engaging with this approach. These findings will be discussed in relation to current literature, particularly with a view to shed light on the employment of CFT in different settings, mechanisms of change and the ways in which these findings might inform the continued development of CFT-based approaches.

It is noteworthy that there was variety in the relative contribution that different papers had to the themes identified in this thematic synthesis (see Table 3). Many of the studies that contributed to the smallest number of themes were ones given lower quality ratings (see Table 2), which could be partly explained by the fact that papers given a low quality rating often had less rich descriptions in their results sections and fewer direct quotations from participants. The paper with the fewest themes (five) corresponding to it was Ashworth, Clarke, Jones, Jennings and Longworth's (2014) study on CFT following a traumatic brain injury, which had a high quality rating but only a small portion of its results section was focused on participants' experiences of engaging with CFT. It may be more pragmatic for subjective appraisals of a study's quality to take into account the study's relevance and potential contribution to a systematic review's research question, instead of/as well as the study's overall quality. Nonetheless, I believe it was helpful for this review to have relatively broad inclusion criteria as this brought valuable diversity to the settings from which researchers and participants were speaking.

5.1. Core aspects of compassion

The findings from this review offer encouragement that CFT can be of use to clients in multiple settings. The studies varied greatly in their inclusion criteria (e.g. trainee therapists, people with a traumatic brain injury, and parents of children with mental health difficulties), but there were many striking similarities and recurring themes in the data across most of the studies. For example, the sub-themes under *New ways of relating to self* show that there were participants in most of the studies who told researchers about how they had become more able to take a step back from difficulties, have a non-blaming attitude towards themselves, gain insight into the nature of their difficulties, see their suffering as part of a shared human existence and to engage in compassionate behaviours. This suggests that these ways of relating to the self are integral to the mentality that CFT-based approaches help people to cultivate. Indeed, these five sub-themes fit closely with the five core elements of compassion identified by a major review by Strauss, Lever-Taylor, Gu, Kuyken, Baer, Jones and Cavanagh (2016, p. 19):

“...we propose a new definition of compassion as a cognitive, affective, and behavioral process consisting of the following five elements that refer to both self- and other-compassion: 1) Recognizing suffering; 2) Understanding the universality of suffering in human experience; 3) Feeling empathy for the person suffering and connecting with the distress (emotional resonance); 4) Tolerating uncomfortable feelings aroused in response to the suffering person (e.g. distress, anger, fear) so remaining open to and accepting of the person suffering; and 5) Motivation to act/acting to alleviate suffering.”

For example, the first element of recognising suffering could be seen to map onto the sub-theme of *Stepping back from difficulties*, which participants often described in relation to having a mindful awareness of difficult thoughts and feelings. The second element of understanding the universality of suffering in human experience could be seen as the very definition of the *Common humanity* sub-

theme. The third and fourth elements do not map quite so neatly onto a sub-theme, partly because they are other-oriented whereas the sub-themes are related to the way participants related to themselves. Nonetheless, the *Non-blaming attitude* sub-theme alludes to this empathic and accepting stance. The fifth and final element – motivation to act/acting to alleviate suffering – maps onto the *Compassionate behaviours* sub-theme in that both refer to a more action-oriented dimension of compassion.

Interestingly, although much of the current CFT literature is focused on self-compassion and benefits of this, the *Flows of compassion* theme outlined how participants also described how self-compassion was often closely entwined with feeling more able to offer compassion to others and receive compassion from others. This ties in with literature on compassion which has outlined three different directional flows and orientations of compassion: compassion for others, compassion from others, and self-compassion (Gilbert et al., 2017).

These flows and orientations of compassion are connected. For example, findings from Hermanto and Zuroff's (2018) demonstrated that high caregiving combined with the ability to receive care from others was predictive of self-compassion, while high care-giving combined with low care seeking from others was predictive of poor self-compassion. As Gilbert et al. (2017) note, this ties in with Bowlby's notion of compulsive caregiving and how caregiving can serve a submissive and defensive function. Research has also found that openness to receiving compassion from others can buffer the impact of self-criticism on depression (Hermanto et al., 2016). Given the personal and social benefits of multiple orientations of compassion, Gilbert et al. (2017) suggest that compassion should be seen as a social mentality.

5.2. Mechanisms of change

The current review provides data for some hypotheses about possible mechanisms of change in CFT. Change is arguably both a conscious and unconscious process, and people will not always be conscious of changes that continue to take place nor necessarily be able to fully articulate these. Nonetheless, exploring people's conscious subjective experience of engaging in an approach does still provide meaningful information about what was going on for them and what factors might have had some significance.

As touched upon in the introduction, self-compassion has been found to be associated with improvements in various mental health difficulties (Gilbert, 2007; Neff et al., 2007) and it seems that the core aspects of compassion/ways of relating detailed above could be one possible mechanism of change. Developing a compassionate social mentality could help and provide a way of being that is associated with various psychological and physiological benefits, which might be particularly beneficial for highly self-critical people (Leaviss & Uttley, 2015).

The necessity of therapeutic approaches including specific ingredients remains up for debate. Research comparing the effectiveness of various therapies has often arrived at a 'Dodo bird verdict' that outcomes are roughly equivalent across multiple approaches despite supposedly different mechanisms of change (Wampold & Imel, 2015). In Wampold and Imel's (2015) contextual model, it is posited that the three routes to psychotherapeutic change are:

"a) the real relationship, b) the creation of expectations through explanation of disorder and the treatment involved, and c) the enactment of health promoting actions" (Wampold, 2015, p. 270)

This is not to say, though, that the approach used is irrelevant. If one of the main routes to psychotherapeutic change is the creation of expectations through explanation of difficulties and the approach involved, it seems important that the

approach involved is a good 'fit' for the difficulties people are seeking help with. This would tie in with Leaviss and Uttley's (2015) finding that CFT seems to be particularly beneficial for highly self-critical clients.

The significance of the enactment of health-promoting actions fits with this review's theme of *Ongoing process* (as well as the *Compassionate behaviours* sub-theme), which emerged from many participants stressing the need for continuous practice in order to overcome barriers and maintain the progress they had made from engaging in a CFT-based approach.

Similarly, the role of 'the real relationship' (meaning the therapeutic relationship) is borne out by this review's *Importance of therapeutic relationships* theme. It seems that the relational context of a supportive relationship with a professional is often experienced as a crucial part of people's experience of therapy. With many therapy services and organisations increasingly developing online approaches (such as the one this thesis will be focused on), this is an important factor to consider. Although there are many good reasons for offering approaches in different formats (e.g. offering something to people who may not want to/be able to commit to attending one-to-one or group sessions), it is important to acknowledge that for many people there is a loss of one of the main pathways to therapeutic change when they do not have a real relationship with a professional. This relationship might be especially integral with people whose difficulties are more long-standing and/or severe.

One of the striking findings from this review was the level of positive feedback regarding attending CFT-based approaches in a group format, particularly in terms of the sense of *Common humanity* people gained from getting a sense of suffering being a shared experience with others. For many people this was a powerful realisation that was a welcome antidote to their painful sense of isolation.

This points to another potential key mechanism of change that is important to hold in mind when developing CFT-based approaches. Indeed, a recent systematic review showed that there is significantly more evidence supporting the effectiveness for group CFT than there is for individual and self-help CFT interventions (Craig, Hiskey & Spector, 2020).

There are various possible benefits that a group format might offer. For example, it could offer increased chances to cultivate different flows/orientations of compassion and could provide a fertile environment for Wampold and Imel's (2015) common factors (e.g. it could help to increase a sense of hope and it could help to increase motivation for enacting health-promoting behaviours). Although Yalom's (1985) work on therapeutic factors in a group setting refers to group psychotherapy, some of the factors highlighted seem applicable to what participants described experiencing in CFT-based groups. In particular, they described a sense of universality (feeling that you are in the same situation as others), altruism, catharsis and group cohesiveness. There is, of course, also a risk that a group dynamic will not be conducive to positive change. Furthermore, many clients would not want to engage in a group format for numerous reasons (e.g. less scope for individual meaning-making; Craig, Hiskey & Spector, 2020).

5.3. Barriers to change

The 'Blocks' theme in this review shed light on some of the many potential blocks people might experience when engaging with a CFT-based approach. Some of these were specific to CFT, while others were blocks that might be experienced when engaging in many types of therapeutic approaches. Although 'internal' and 'external' blocks were separated in the results section for ease of reading, the internal and external blocks are of course intertwined in some cases. For example, participants who felt that they did not deserve to receive compassion (detailed in the

Internal blocks sub-theme) had often suffered from abusive interpersonal relationships. This 'external' relational context is arguably closely interconnected with their 'internal' reality.

The nature of the blocks most frequently talked about in studies varied to some extent according to the presenting difficulties of the participants recruited. For example (as touched upon in the results section), in Lawrence and Lee's (2013) study which recruited participants who had suffered from traumatic experiences, many participants seemed to have a deep-rooted fear of compassion and sense that they did not deserve to receive compassion from others nor themselves. In Craig et al.'s (2018) study on participants who had received a diagnosis of dementia, their blocks seemed to often be more related to their memory difficulties which made it hard to retain what they were learning. This demonstrates the need for CFT-based approaches to be tailored to the particular needs of individuals and groups. It also suggests that CFT might of course not always be the most helpful approach for people for whom alternative forms of support might be better-suited to their needs. It was encouraging that many participants were able to eventually overcome barriers but this was sometimes not possible and, even when it was, the level of struggle and support from others should not be underestimated.

For many participants, there were more practical barriers to engaging with the approach, such as lack of time, equipment, a suitable setting and the headspace required to committing to engaging with the approach. Although the therapeutic relationship was seen by many participants to be an important part of the change process, these practical barriers do suggest that there might be a place for CFT being offered in alternative formats that people could access in a more flexible way (e.g. online formats that people could access in their own time).

5.4. Limitations

This review had several limitations. Only 15 of the studies retrieved by the systematic search met the inclusion criteria for the review, which means that the analysis was limited to a relatively small body of research. Furthermore, the majority of the studies were conducted in the UK. Although there is great heterogeneity of cultures within the UK, the studies did not contain much discussion of how this approach might be impacted by different cultural beliefs and practices. It would be interesting and helpful for future research to look at the how culture might impact people's engagement with this approach, and how applicable this approach might be outside of the UK.

Another limitation of the review was the variable quality of the studies retrieved, although the standard was generally high (most papers were either rated as 'Medium' or 'High' in quality). I believe that one area for improvement in the studies reviewed was a lack of acknowledgement/discussion of the researcher's own position in relation to the research and the interviews they were conducting. The impact of the researchers' position (particularly in relation to the feedback participants gave) was alluded to by one of the participants, who questioned whether a CFT group facilitator's passion for the approach had led to participants feeling the need to hold back more critical feedback they might have regarding the approach.

It would have also been helpful for this review to also look more at data that did not converge with the main themes, and to explore the tension between different participants' accounts of their experience of engaging with CFT-based approaches. It is hoped that the themes generated in the thematic synthesis do still represent the diversity of ways in which CFT-based approaches can be experienced, with their highlighting of barriers people can face as well as the positive changes that can be experienced.

5.5. Conclusions

The findings from this review suggest that CFT-based approaches are often experienced by participants as powerful and helpful, with a notable impact on the way that they relate to themselves and others. The qualitative feedback from participants in the studies reviewed augments the findings from quantitative studies which have demonstrated positive effects on a multitude of outcome measures. It was particularly striking and encouraging that the benefits people can gain from this approach seem to extend to how they relate to others, which offers hope of a social ripple effect.

The themes generated tie in with current research that seeks to identify core aspects of compassion, which supports the idea that compassion is something that can be successfully embodied and cultivated in psychotherapeutic approaches. Possible mechanisms of change can be hypothesised in many ways. The discussion looked at some possible mechanisms with reference to Wampold and Imel's (2015) contextual model, which emphasises the therapeutic relationship, an explanation for difficulties and the approach used, and health-promoting behaviours. Leaviss and Uttley's (2015) systematic review supports the prospect that CFT is particularly well-placed to provide a targeted route of offering these factors to people suffering from high levels of self-criticism.

The process of engaging with this approach and maintaining progress is often challenging for participants. People who had benefited from the approach often emphasised how they had struggled to overcome barriers, and they highlighted the necessity of ongoing practice once their sessions had come to an end. The presence and support from therapists/group facilitators, as well as fellow group members, played an integral role for many. For varying reasons, some participants did not feel they had benefitted from the approach. This flags the

importance of carefully assessing the suitability of the approach for particular individuals, tailoring the approach to different needs and trying to ensure support is in place for people who understandably struggle to overcome barriers they are facing.

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Part 2: Empirical paper

**‘A way of being in the world’: an exploration of the
experience of developing self-compassion through online
training**

1. ABSTRACT

Introduction: *Compassion-focused Therapy (CFT; Gilbert, 2005) has increasingly been shown to have a positive impact for people experiencing a range of difficulties, and online self-help formats could provide a way of increasing its accessibility and scalability. This study explored adult participants' subjective experiences of engaging with online self-compassion training drawn from Compassionate Mind Training (based on the CFT model).*

Methods: *Semi-structured interviews were conducted with 15 participants who had completed online self-compassion training, and the interview data was analysed using reflexive thematic analysis (Braun & Clarke, 2006).*

Results: *The analysis generated four main themes and 17 sub-themes. The four main themes generated were 'A way of being in the world', 'Old habits die hard', The learning process, and Context and resources. These themes showed that while the process of developing self-compassion was often challenging, most participants described experiencing positive changes in their ways of relating to themselves and others. Participants identified many facilitators and barriers to change, including factors related to the training format and their wider social contexts.*

Discussion: *These findings support previous research into CFT, particularly in relation to some common positive changes people experience and some of the difficulties with this process (e.g. fear of compassion). Participants' descriptions offer promise that approaches based on the CFT model can be experienced as acceptable and helpful by people engaging through an online self-help format as well as through individual and group-based interventions. The facilitators and barriers to change that participants described indicate the strong influence of people's contexts and the need for these to be considered when designing and implementing approaches.*

2. INTRODUCTION

Compassion towards oneself and others has consistently been shown to have a positive impact on people's wellbeing and quality of life (e.g. Craig, Hiskey & Spector, 2020; Van Dam, Sheppard, Forsyth & Earleywine, 2011; Zessin, Dickhauser & Garbade, 2015). A recent meta-analysis of 21 randomised control trials (Kirby, Tellegen & Steindl, 2017) found that although methodological rigor was undermined by small sample sizes, compassion-focused interventions led to significant improvements in overall wellbeing, mindfulness, self-compassion, psychological distress, anxiety and depression. Research has also found that self-compassion is associated with various health-promoting behaviours, including diet, exercise and sleeping patterns (Sirois, 2015).

Given the pervasiveness of shame, self-criticism and self-hatred among people experiencing mental health difficulties (Gilbert, 2010), these findings are encouraging. Self-criticism is frequently associated with aversive emotional states (Gilbert, 2010) and is thought to be a central psychological process influencing people's vulnerability to mental health difficulties (Hewitt & Flett, 2002). Its presence is not exclusive to any particular diagnostic category and the burgeoning focus on reducing self-criticism and increasing self-compassion fits with a transdiagnostic approach, which highlights the frequency with which mental health 'disorders' are co-morbid and have considerable overlap, blurred boundaries and shared causal factors (Newby, McKinnon, Kuyken, Gilbody & Dalgleish, 2015). Whilst some research findings have suggested that self-criticism and self-compassion do not form a neatly dichotomous construct (e.g. Halamová, Kanovský, Pačutová & Kupeli, 2020), it is essential that therapeutic approaches offer ways of helping people build more compassionate relationships with themselves.

2.1. Definitions of compassion

Though the prevalence of compassion-focused therapeutic approaches is a relatively recent development in the Western world, compassion is not a new concept and it is integral to many schools of Buddhism (Pauley & McPherson, 2010). Buddhist schools often describe it as a state of mind or mentality, and it has been defined by the Dalai Lama (1995, p. 2) as an “openness to the suffering of others with a commitment to relieve it”. It is not necessarily a single, unitary construct (Wilson, Mackintosh, Power & Chan, 2018) and Buddhist scholar Geshe Thupten Jinpa, who created the ‘Stanford compassion cultivation training’, defined it as:

“...a multidimensional process comprised of four key components: (1) an awareness of suffering (cognitive/empathic awareness), (2) sympathetic concern related to being emotionally moved by suffering (affective component), (3) a wish to see the relief of that suffering (intention), and (4) a responsiveness or readiness to help relieve that suffering (motivational)” (Jazaieri et al., 2013, p. 1113).

Kristin Neff is a pioneer in the operationalisation of defining and measuring self-compassion (Neff, 2003a; Neff, 2003b). Her well-established psychometric measure (Self Compassion Scale; Neff, 2003b) includes three positive and three negative scales. The positive subscales are self-kindness, common humanity and mindfulness, and the negative subscales are self-judgment, isolation and over-identification. The multi-faceted nature of self-compassion is highlighted by differing relationships being found between these subscales and other psychological variables. Neff (2016) found that improvement trends in positive subscales predicted increased well-being, and for the negative subscales predicted reduced psychopathology in a randomised control trial of Mindful Self-Compassion Therapy. In a different study, the negative subscales had stronger associations with psychopathology than the positive subscales (Muris & Petrocchi, 2017). Neff’s scale has been widely used in compassion-related research and there have been many

promising correlational findings, including consistent negative correlations between self-compassion and measures such as anxiety, self-criticism, depression and rumination, and positive correlations with traits such as optimism and happiness (Neff, 2003a; Neff, Kirkpatrick & Rude, 2007). Leary et al. (2007) posited that self-compassion might provide a psychological buffer from difficult life experiences.

Paul Gilbert is another pioneer in compassion-related research and practice, and his definition of compassion is similar to the Dalai Lama's: "sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it" (Gilbert et al., 2017, p. 1). In contrast to Neff, Gilbert's conceptualisation of compassion (2005) puts more emphasis on the role of attachment and evolution in people's ways of relating to themselves and others. From an evolutionary perspective, Gilbert (2009) emphasises the mammalian affiliative system and the neuroscience underpinning three mutually-interacting emotion regulation systems: threat, drive and soothing. He argues that humans and other mammals have evolved basic motivational systems which facilitate seeking out resources and avoiding harm. The under- and over-activation of these systems can be one way of explaining difficulties people have, including those related to shame and self-criticism. For example, although the threat system is important for detecting and responding to threats, its over-activation can result in being overwhelmed by feelings such as anxiety and anger (Gilbert, 2014). From an attachment-based perspective, many people suffering with high levels of self-criticism and shame have had cold, harsh and/or abusive attachment histories (Schore, 1998). Gilbert (2010) has hypothesised that negative attachment experiences could play a part in people having an under-activated soothing system and an over-activated threat system. Similarly, Gillath, Shaver and Mikulincer (2005) posit that comfort from attachment figures in early life is crucial to developing the ability to self-soothe, so this ability may be underdeveloped if comfort was absent or inconsistent.

2.2. Compassion-focused Therapy

Paul Gilbert's conceptualisations of compassion underpin Compassion-focused Therapy (CFT; Gilbert, 2005), which is an integrated, science-based approach to human suffering and wellbeing which he developed to help people build more compassionate ways of relating to themselves. It was originally designed to work with people experiencing pronounced self-criticism and shame, who might not benefit from conventional approaches (e.g. traditional CBT) (Gilbert & Procter, 2006). One of the main aims of CFT is for people to become more able to reach a balance between the three emotion regulation systems, particularly in relation to developing the ability to activate the soothing system. The soothing system is thought to help people manage negative thoughts and feelings through the promotion of positive self-repair behaviours and social bonding (Gilbert, 2009).

Multiple ideas and strategies are drawn upon to support clients to relate to themselves and the challenges they face in a more compassionate way (Kolts, 2016). Gilbert and Irons (2015) explain that some of the facilitators for this include building a positive therapeutic relationship which supports people in engaging with challenges and developing skills to manage them; building compassionate and non-blaming understandings of suffering; building the ability to cultivate and experience compassionate attributes; and building the feeling of compassion towards others and towards oneself, as well as being open to receiving compassion from others. The skills and strategies in CFT form Compassionate Mind Training (CMT), and include attention training, mindfulness, soothing rhythm breathing, compassionate letter-writing and compassionate imagery (e.g. imagining the presence of a compassionate friend). It is hoped that such strategies can enrich and strengthen the soothing system, at the same time as withdrawing/switching from the threat-focused system (Wright et al., 2014). This can also facilitate people activating their

drive system in a way that helps them move towards valued goals (Wright et al., 2014).

2.3. Compassionate Mind Training

CFT incorporates Compassionate Mind Training (CMT), which includes some of the skills and strategies mentioned above. As well as sometimes forming part of CFT, CMT can sit outside of therapy without the common aspects of therapeutic relationships such as boundary-setting, transference, counter-transference, formulation-making and goal-setting (Irons & Heriot-Marland, 2020).

CMT starts with psychoeducation focused on the definition of compassion, common blocks and fears, and the idea of compassion having three 'flows' (self-compassion, self to other and other to self). It then explores the evolutionary roots of many difficulties people experience, with an emphasis on a non-blaming understanding of these leading us to have 'tricky brains'. People learn about the three emotional systems and how the cultivation of the soothing system can help to regulate distress (Gilbert, 2014). People are then encouraged to try a range of practices that are ultimately aimed at cultivating a compassionate self-identity. This 'compassionate self' is associated with qualities such as strength, wisdom and caring motivation, and it is used to manage daily struggles (Irons & Heriot-Marland, 2020).

2.4. Clinical evidence

A recent systematic review by Craig, Hiskey and Spector (2020) found that Compassion-focused Therapy (CFT; Gilbert, 2005) can have significant positive effects for people with a broad range of mental health difficulties, often leading to increased self-compassion and reduced mental health symptoms (Craig et al., 2020). This review also found that compared to self-help and individual formats, group CFT has significantly greater evidence indicating its effectiveness. Leaviss

and Uttley's (2015) systematic review suggested that it is particularly helpful for highly self-critical clients. As well as being effective as a standalone approach, it has been shown to be effective as an adjunct to other approaches. Beaumont, Galpin and Jenkins' (2012) study found that compared with stand-alone trauma-focused CBT, combined CFT and CBT led to significantly greater increases in self-compassion and non-significant reductions in trauma symptoms.

There have been similarly promising results from studies testing the effectiveness of CMT sitting outside of full CFT. Irons and Heriot-Marland (2020) found that participants in the general population who completed an eight-week CMT group had significant increases in self-reassurance, positive emotions, wellbeing, compassion and social rank, alongside reduced self-criticism. Numerous other studies have also found CMT exercises to lead to significant improvements in measures such as stress, rumination, depression, self-compassion and self-reassurance (Arimitsu, 2016; Matos et al, 2017; McEwan & Gilbert, 2016).

While the majority of research into CFT and CMT has a quantitative focus (e.g. measuring pre- and post-intervention change in outcome measures), researchers are increasingly exploring people's subjective experiences of engaging with compassion. Pauley and McPherson (2010) conducted interviews with people (all of whom had received a diagnosis of a depressive or anxiety disorder) about their experiences of and perspectives towards compassion and self-compassion. These participants described compassion as an active and kind process which they considered meaningful and potentially helpful for their difficulties, but they also reflected that it was hard to engage in and they were worried that their mental health difficulties would get in the way of this. For many, self-compassion seemed to be the opposite of what they experienced when depressed or anxious.

These findings followed previous research which had similarly highlighted fear, doubt and resistance towards compassion in a group of people experiencing chronic mental health difficulties (Gilbert, McEwan, Matos & Rivis, 2011; Gilbert & Procter, 2006). Fears were related to “whether compassion was deserved, or a weakness, unfamiliarity with compassion, unresolved grief of wanting love and kindness but often feeling lonely and rejected, and simply ‘never considering the value of self-compassion’” (Gilbert et al., 2011, p. 243). These aversive reactions to compassion inevitably have significant implications for therapeutic practice and they are often explicitly explored in CFT. Indeed, Gilbert et al. (2011) developed a scale – now often used in compassion-focused research and practice – specifically for measuring fear of compassion from others, for others, and for oneself.

Other qualitative studies on participants’ experiences of engaging in CFT have added further support to the finding that compassion can elicit conflicting responses from people. Lawrence and Lee’s (2013) CFT study interviewed participants who had suffered from traumatic experience, and many described feeling that there was an unbridgeable gap between self-compassion and their usual ways of relating to themselves. However, participants in that and other studies have also described being able to overcome barriers they faced in trying to become more self-compassionate (Clapton, Griffith, Williams & Jones, 2017; Lawrence & Lee, 2013; Mullen, Dowling, Doyle & O’Reilly, 2019). In a number of qualitative CFT studies, having a supportive relationship with therapists and/or group facilitators has been described as essential to this process of overcoming barriers and developing self-compassion (e.g. Ashworth, Clarke, Jones, Jennings & Longworth, 2014; Bratt, Svensson & Rusner, 2019; Lawrence & Lee, 2013).

Studies have also highlighted more positive aspects of participants’ experience of this approach, such as becoming more able to step back from difficulties, taking a non-blaming attitude to oneself, gaining insight into difficulties,

engaging in compassionate behaviours and seeing their difficulties as part of a shared human experience (e.g. Bell, Dixon & Kolts, 2017; Gale, Schröder & Gilbert, 2017; Mullen et al., 2019). Gilbert (2014) has written about compassion being a social mentality and this has been supported by participants reporting an increased sense of 'common humanity' that Neff (2003) emphasises in her conceptualisation of self-compassion. The integrity of this social dimension to CFT is further supported by the number of participants who have described CFT helping them develop a new way of relating to others as well as themselves (Bell et al., 2017; Carter, Gilbert & Kirby, 2020). As already mentioned, group CFT approaches currently have the most evidence supporting their effectiveness and they are perhaps especially well-suited to helping facilitate participants feeling less isolated with their difficulties, and experimenting with new ways of relating to others in a supportive environment.

2.4. Self-help applications

While there is a significant body of research supporting CFT in one-to-one and group formats, there is a paucity of research looking into its application in self-help formats which could increase the scalability and accessibility of CFT (Chamberlain, Heaps, & Robert, 2008; Cuijpers & Schuurmans, 2007). We are in an era in which self-help formats are receiving increased attention from healthcare providers, and other approaches such as CBT are routinely offered via online guided self-help programmes in the NHS. Reviews and multi-analyses have shown that self-help interventions can have positive effects on various mental health difficulties such as depression and anxiety (Cavanagh, Strauss, Forder & Jones, 2014; Cuijpers & Schurrmans, 2007). Findings suggest that guided self-help interventions (i.e. involving some support from a practitioner) are more effective than unguided self-help interventions (Cuijpers & Schurrmans, 2007, Gellatly et al., 2007).

The small number of trials researching CFT-based self-help interventions have had some encouraging results showing positive effects on emotional well-being, self-compassion and depressive symptoms (Halamová et al., 2020; Kelly & Carter, 2015; Kelly & Waring, 2018; Shapira & Mongrain, 2010; Sommers-Spijkerman, Trompetter, Schreurs & Bohlmeijer, 2018). These studies have mostly had specific target populations (e.g. people who have received a diagnosis of an eating disorder) and have had various methodological limitations, such as small sample sizes and a lack of follow-up. Halamová et al.'s (2020) study was the first to test the effectiveness of CMT delivered as an online self-help intervention for a non-clinical sample. The findings showed significant reductions in negative thoughts and feelings related to self-criticism for the CMT group, which were still present at a two-month follow-up. Interestingly, there was no significant effect on self-compassion and self-reassurance, which highlights the need to not necessarily see self-compassion and self-criticism as opposite ends of the same construct.

2.5. Study aims

CMT self-help interventions are clearly at an early stage of their development, albeit with some encouraging findings in the handful of studies that have piloted such an approach. To my knowledge, there have been no qualitative studies on this topic yet so there is an important gap in the literature that this study will be focused upon.

This study will be piloting online self-compassion training developed for the general population by CI, who is a prominent researcher and practitioner in the CFT field (e.g. Gilbert & Irons, 2005; Gilbert & Irons, 2015; Irons & Beaumont, 2017). As detailed in the methodology section below, it is a joint project with CN. While CN's thesis (Northover, 2021) will have a quantitative focus (i.e. analysing pre- and post-intervention change on various outcome measures), mine is focused on the exploration of participants' subjective experiences of engaging in the self-

compassion training. Though there have been some qualitative studies exploring experiences of engaging with CFT (e.g. Bell, Montague, Elander & Gilbert, 2019; Lawrence & Lee, 2013), this study will be the first qualitative study focused on participants' experience of engaging in a CMT self-help intervention.

This approach is currently at a piloting stage so an inductive approach was chosen, based on semi-structured interviews and a reflexive thematic analysis of the interview data. The research reviewed in this introduction offers promise that this intervention could be experienced as helpful by participants, but it also seems likely that challenges will be encountered. Many participants in qualitative CFT studies have stressed the importance of a supportive relationship with practitioners or fellow group members, so it remains to be seen how the lack of this might be experienced.

Broad research questions were agreed upon in order to maximise the extent to which the interviews would be open to what participants brought to the interviews, though the methodology section below will outline some ways in which my role as a researcher will inevitably have influenced the data collection and analysis process.

Research question 1: What are participants' subjective experiences of engaging with the self-compassion training?

Research question 2: What are the clinical implications of the subjective experiences described by participants?

3. METHODS

3.1. Joint project responsibilities and emphases

This was a joint project with my fellow DClinPsy trainee, CN. CN and I paired up on this study so that we could divide responsibilities and generate both quantitative and qualitative findings regarding participants' experiences of the self-compassion training developed by CI. While CN and I completed many parts of the project

together (i.e. project planning, setting up the training on Qualtrics and recruitment), we had different emphases in our respective analyses. CN completed quantitative analyses of outcome measures, whereas I conducted semi-structured interviews with a sub-sample of participants and a reflective thematic analysis of the interview data. As such, this paper will be specifically focused on the subjective experiences described by participants I interviewed. For the sake of remaining within the word count and staying relevant to my research aim, I will not describe quantitative questionnaires that participants completed for CN's project (Northover, 2021).

3.2. Setting

Due to COVID-19 restrictions, all recruitment and data collection was conducted online. CN and I developed surveys using the Qualtrics platform (www.qualtrics.com) which included questionnaires and the self-compassion training materials described below. Videos and handouts were embedded into the surveys, and there was a link to audio exercises on the SoundCloud platform (www.soundcloud.com). Semi-structured interviews took place over video calls on Microsoft Teams (<https://www.microsoft.com/en-gb/microsoft-teams/group-chat-software>).

3.3. Self-compassion training

The self-compassion training content was developed by CI and based on CMT, which is drawn from CFT theory, practice and outcome research (e.g. Gilbert 2009; Irons & Beaumont, 2017; Matos et al., 2017). The training lasted four weeks, each with a different emphasis. On a day of the week agreed with each participant, they were emailed a prompt and a Qualtrics link to access:

- A video (approximately 30 minutes) in which CI explained CFT-based ideas and exercises.
- A 1-2 page handout summarising the content of the videos.

- An audio exercise to practise throughout the week.

Below is a summary of what each week covered:

Week one: This session provided some definitions of self-compassion, explored why self-compassion is important and described how to lay foundations for self-compassion by understanding Gilbert's (2009) affect regulation model in CFT (i.e. three systems: the threat, drive and sooth systems). CI then encouraged participants to engage in an exercise called soothing rhythm breathing, which is aimed at accessing and developing the parasympathetic nervous system. This has been found to be associated with threat regulation and social connection (Kirby et al., 2017). Participants were asked to practice soothing rhythm breathing every day over the next week. They were also asked to try to notice which of the three systems they found themselves in, and to ground themselves using the soothing rhythm breathing.

Week two: This session explored the concept of building a compassionate self. It focused on qualities this compassionate self might have: caring-commitment, wisdom, strength and courage. CI talked about how to begin directing this sense of compassion and goodwill to oneself. This practice has been found to be linked with increases in self-compassion, and reductions in shame and stress (e.g. Kim et al., 2020; Matos et al., 2017). Participants were asked to practice with an audio exercise focused on holding a caring intention towards oneself, as well as linking this back to the affect regulation model introduced in the previous week.

Week three: This session involved CI introducing compassion as a relational concept and guiding participants to try to deepen their compassionate relationship with themselves through 'compassionate other' imagery (Gilbert & Irons, 2004; Gilbert, 2009; Irons & Beaumont, 2017). Participants were asked to think about the qualities that a 'compassionate other' would embody and to hold this image in mind,

particularly in terms of how their presence would feel. CI encouraged participants to practice this as well as moments of 'CARE' (C = connect with your compassionate self; A = allow yourself to slow down for a moment; R = reflect on how you are in this moment; and E = extend a sense of care and kindness to yourself).

Week four: The final session was focused on helping participants to think about how they could apply self-compassion in their everyday lives CI emphasised the need for practice and talked about steps people could take in in trying to switch from their 'threat mind' to their 'compassionate mind'. He also described how self-compassion can be embodied in compassionate letter-writing, which utilises adaptations to expressive writing to help people build a more compassionate relationship with themselves (Gilbert, 2010). Participants were encouraged to practice both strategies, as well as continuing to draw upon ideas and strategies covered in the previous weeks.

3.4. Participants and procedure

As the self-compassion training was being piloted and at this stage does not have a particular target demographic, we chose to recruit adults from the general population, using convenience sampling and snowballing techniques. We advertised the study through social media (Facebook and Twitter) on various community groups and our own profiles (see Appendix 3 and Appendix 4 for posters), with the aim of reaching a diverse range of people. In order to try to maximise the number of participants that could take part, we chose broad inclusion criteria: participants had to be over 18 years old, have regular access to the internet and be able to read English fluently.

People could self-identify themselves as potential participants by responding to the advert we posted. They were then sent an information sheet with details of the study and asked to opt-in by completing and returning a consent form. Participants

were randomly assigned to either the 'intervention' or 'waiting list' condition. Those in the intervention condition started the self-compassion training immediately, while those in the waiting list condition started a month later. In each condition, participants were asked to complete various questionnaires at three time points. These measured constructs such as self-compassion, self-criticism, mental wellbeing, shame, fear of compassion and experiences of close relationships. Participants' answers to these were analysed by CN and written up in her thesis (Northover, 2021).

When signing up for the study, participants were asked to specify whether they would be willing to take part in a follow-up interview about their experience of the training. Once enough time had passed to ensure that many people in the intervention condition would be coming towards the end of the training, I emailed an interview information sheet (Appendix 5) and consent form (Appendix 6) to all participants who had consented to be contacted. The only addition to the inclusion criteria for the interviews was that participants needed to have completed the training by the time they engaged in an interview. Out of the 72 participants invited to take part of an interview, 15 consented and all of these were interviewed. There was no response from the other participants contacted, so their reasons for not wishing to take part in an interview are unknown.

Participants were given the option of providing demographic details on the consent forms they returned (see Table 1 for responses). The age of participants who provided this information ranged from 27-51, and the majority (13 out of 15) identified as women. In terms of ethnicity, nine identified as White British, one as White Latvian, one as White Irish, one as White Greek, and three did not specify their ethnicity. Most of the participants reported having completed some form of post-graduate qualification such as a Master's, PhD or doctorate.

Though there is not a general consensus on the number of participants that should be recruited in qualitative research, Braun and Clarke (2013) suggest 6-15 as a 'rule of thumb' for a medium-sized thematic analysis project (including doctoral theses). I provisionally agreed with my co-researchers to reach the higher limit of this suggestion in order to try to provide a rich amount of data to analyse, and after 15 interviews had been conducted we agreed that this had been achieved. While interviewing participants in the waiting list condition could have provided useful information about what it was like to have a delayed start to the training, 15 interviews already conducted were deemed sufficient for the research aim of exploring participants' subjective experiences of the training and there was limited time available to further extend data collection.

Table 1. Participant demographics.

Participant	Age	Gender	Ethnicity	Highest level of education
1	41	W	White British	Doctorate
2	27	W	White Latvian	Master's
3	39	W	White British	Master's
4	41	W	White British	PhD
5	29	W	White Irish	Doctorate
6	28	W	White Greek	Degree
7	NS	W	NS	NS
8	42	M	White British	Degree
9	NS	M	White British	NS
10	33	W	White British	Degree
11	NS	W	NS	Doctorate
12	51	W	White British	Master's
13	30	W	White British	Degree
14	49	W	White British	Post-graduate diploma
15	NS	W	NS	PhD

Key: W=woman, M=man and NS=not specified

3.5. Ethical approval and considerations

Ethical approval for the study was obtained from University College London Division of Psychology and Language Sciences Ethics Committee (see Appendix 2). There were no serious ethical issues raised by the study. Some participants I interviewed described the training eliciting difficult emotions but these were felt to be manageable. Participants were provided with CI's email address in case they had any concerns about the training, and the debrief page of the survey included details of some organisations in case participants wished to seek out further support.

3.6. Data collection

Interviews were conducted on Microsoft Teams and recorded on two Dictaphones. The recordings were then immediately transferred to a password-protected USB stick, deleted from the Dictaphones and uploaded to an online transcription service (Trint.com). Once I had corrected and saved these anonymised transcripts (done within 7 days), I permanently deleted the interview recordings from Trint and the USB stick.

A semi-structured interview schedule (see Appendix 7) was developed based on my research question and in line with relevant methodological guidelines (e.g. Braun & Clarke, 2013). The process of the interview schedule's development was:

1. Establish research questions.
2. For each research question, develop possible topics to explore.
3. For each topic, develop questions to include.
4. Develop an order of topics/questions that will support building a rapport and the exploration of potentially-difficult topics (e.g. barriers to engaging with the training).
5. Pilot interview schedule with friends and adjust according to feedback.

6. Use interview schedule with participants and adjust according to feedback.

I chose a semi-structured approach in order to strike a balance between participant-driven and researcher-driven content. Though I spoke with my co-researchers about some broad areas it would be helpful for the interviews to cover in trying to meet the research aims, I did not want to rigidly impose these on the interview space. The interview schedule was therefore used as a loose aide memoire regarding some areas relevant to the research aims. In an attempt to try to minimise bias, I mostly used open questions and tried to create a relatively informal, comfortable atmosphere in which participants felt empowered to speak openly (Roulston, 2010).

I started each interview by asking the same broad open question ('Please could you tell me a bit about your experience of the training?') and then strove to be led by participants' responses in asking questions about what they described.

However, when participants did not have anything else they wanted to add, I chose to ask open questions that were relevant to my research aim (e.g. 'What barriers, if any, did you encounter?'). It is therefore important to acknowledge the co-construction of the themes generated (both at the data collection and data analysis stages), rather than seeing these as simply 'emerging' from the interviews and data (Braun & Clarke, 2019).

3.7. Data analysis

3.7.1. Reflexive Thematic Analysis

I chose to analyse the data using reflexive thematic analysis (Braun & Clarke, 2006). While many authors have contended that thematic analysis should be considered as a process used by various qualitative approaches (e.g. Holloway & Todres, 2003), others have asserted that it is a distinct method in itself (King, 2014; Willig, 2013).

Braun and Clarke (2019) have recently specified different approaches to thematic analysis, and now refer to their popular approach (Braun & Clarke, 2006) as 'reflexive thematic analysis'. Reflexive thematic analysis approaches are distinguished by their emphasis on qualitative philosophical assumptions (e.g. rather than 'coding reliability' approaches which might have a positivist emphasis on calculating inter-coder reliability), meanings being seen as contextual, research subjectivity being seen as a resource and the researcher having an active role in co-producing knowledge (Braun & Clarke, 2013; 2019).

Reflexive thematic analysis offers a flexible approach for providing rich and detailed accounts of data, and it can be utilised from various epistemological positions. It can be used effectively to examine similarities and differences between research participants' perspectives, to summarise key features of large data-sets, and to inductively generate themes from the data (Nowell, Norris, White & Moules, 2017; Saldaña, 2009). For these reasons, I decided that it was well-suited to my aim of inductively exploring participants' subjective experiences of the self-compassion training, and my aim of writing up the findings in a way that would identify shared patterns of meaning as well as differences within the data. As somebody who is relatively new to using qualitative methodology, I also valued the way in which the guidelines on key phases (Braun & Clarke, 2006) help towards a well-structured approach being taken in the analysis and presentation of data (Nowell et al., 2017).

The analysis went through the following phases, in a recursive process which involved moving back and forth between them (Braun & Clarke, 2019):

Familiarisation with the data: I read and re-read the data in order to become immersed and intimately familiar with its content.

Coding: I generated codes that identified features of the data that seemed relevant to answering the research question. I coded the entire dataset and then collated all the codes and relevant data extracts for the next stages of analysis.

Generating initial themes: I examined the codes and collated data to develop broader patterns of meaning (possible themes). I then collated data related to the possible themes, in order to review their viability. A colleague on the DClinPsy (MVW) independently coded two of the interviews and we reviewed the similarities and differences between our coding in relation to the possible themes, in order to facilitate further theme generation and testing of viability.

Reviewing themes: I checked the possible themes against the dataset, to gauge whether they told a convincing story of the data and answered the research question. In this phase, themes were refined, which involved them being combined, split or discarded. In line with Braun and Clarke's (2019) definition, themes were seen as a "pattern of shared meaning underpinned by a central concept or idea" (p. 845). The reviewing and refining of themes were discussed with one of my research supervisors (JK).

Defining and naming themes: I developed a detailed analysis of themes, working out the scope and focus, and determining their 'story'. I also decided on an informative name for themes.

Writing up: In this final phase, I weaved together the narrative with data extracts, and contextualised the findings of the analysis in relation to existing literature.

3.7.2. Reflexivity

Qualitative research tends to emphasise researchers considering the role of their involvement in influencing and informing studies (Braun & Clarke, 2013). There are two main types of reflexivity described by Willig (2008): epistemological and

personal. 'Epistemological reflexivity' involves researchers describing their philosophical perspectives on knowledge and the world, and how the design of their study might shape its findings. 'Personal reflexivity' involves the researcher reflecting upon the possible influence of their own interests and experiences. By engaging with these forms of reflexivity, it is possible to move towards an increased awareness of the researcher's role in co-constructing knowledge (Fassinger & Morrow, 2013).

Epistemological reflexivity

I adopted a critical realist position in this study, positioned in between constructivism and positivism. This reflects my assumption that the world is objective and real, but it is not possible to make direct contact with this reality and our perceptions of it are shaped by factors including beliefs, language, previous experiences and social contexts (Bhaskar, 1989; Danermark, Ekstrom, Jakobsen & Karlsson, 2002; Willig, 2008). As such, a crucial assumption of critical realism is the fallibility of knowledge (Bhaskar, 1989). I believe that this epistemological position is well-suited with reflexive thematic analysis, and it will have influenced the way in which I conducted the research. For example, I conducted bracketing interviews and reflexive journals throughout the data collection and analysis. This was aimed at helping to take a sceptical and contextualised perspective towards the way I was conducting interviews and analysing the data, rather than trying to altogether 'remove' the influence of my subjectivity. I did not consider this possible nor desirable, but this might be an aim in research adopting a more positivistic epistemological position. Furthermore, the concept of 'saturation' was not used when deciding sample size. This concept typically refers to collecting data until there is no new information being generated (e.g. Ando, Cousins & Young, 2014; Guest, Bunce & Johnson, 2006). From a critical realist position that assumes the partial and co-constructed nature of knowledge, it is arguably not possible to reach a point of theoretical 'knowingness'

(Braun & Clarke, 2019) where it can be confidently assumed that no further information will be generated. As such, I do not claim that my 15 interviews reached a 'saturation' point but this number was deemed to strike a good balance between providing a rich amount of data while being manageable within the timeframe available to complete the study.

Personal reflexivity

CFT (Gilbert, 2005) ideas have been something I have drawn upon a lot in my clinical work, and I have generally found that clients often find them tremendously helpful. In particular, some of the more embodied and experiential exercises (e.g. compassionate friend imagery and compassionate letter-writing) have been described as emotionally powerful and have helped foster a 'felt' change in people's way of relating to themselves. I have also drawn upon some of the ideas myself when I have been particularly self-critical, and I have sometimes found them helpful.

Despite this positive stance towards CFT, I was also sceptical of how helpful clients would find an online delivery of CMT without any tailoring to the particularity of individuals, nor any scope to get support from someone when trying out the ideas and exercises. This scepticism was partly informed by the fact that clients have frequently described initially finding it hard to integrate these ideas (e.g. they have found themselves taking a critical tone in their compassionate letter-writing), and also by concern about the trajectory of mental health services increasingly offering clients the most 'cost-effective' approaches at the expense of prioritising factors that are known to be crucial, such as a therapeutic relationship. This is a concern I have had since working in an IAPT service pre-training and while it is a concern that persists, I believe that I can sometimes lose sight of the fact that there are many people for whom online and self-help formats can be valuable.

These were experiences and beliefs that I reflected upon throughout the data collection and analysis process by conducting bracketing interviews with a colleague (CG) and keeping a reflexive journal. These factors will inevitably have influenced the ways in which I conducted interviews and analysed the data, even if I strove to hold in mind my pre-conceptions and conduct the process inductively (i.e. in a way that was led by participants' responses). Indeed, inductive coding does not make the researcher a 'blank slate', it just takes data (rather than existing theories or concepts) as the starting point of the analysis (Terry, Hayfield, Clarke & Braun, 2017).

3.7.2. Quality and trustworthiness

I considered and consulted various guidelines when designing the research (e.g. Braun & Clarke, 2013; Yardley, 2000) in an attempt to maximise the quality of the study. I aimed to be "consistent with the philosophical position (paradigm) and aims informing the research methods" (Fossey, Harvey, McDermott & Davidson, 2002, p. 273) and conduct the study in line with Braun and Clarke's (2006; 2019) criteria for 'good' reflexive thematic analysis. The four broad principles suggested by Yardley (2000; 2008) for assessing qualitative research quality were also consulted:

Sensitivity to context: As recommended by Yardley (2000), I completed an in-depth review of the existing literature to situate and contextualise the study. I reflected on my epistemological and personal position in relation to the research throughout the process (see reflexivity section) and was open to feedback from participants and co-researchers. I strove to be sensitive to participants' experiences and perspectives by staying alive to potential ethical concerns and asking open questions that facilitated personal expression (Braun & Clarke, 2013).

Commitment and rigour: I showed commitment and rigour by carefully choosing the study's methodology, engaging in reflexivity throughout the process, analysing

the data line-by-line and producing a rich description of the dataset. I also ensured that I collaborated with my co-researchers and colleagues (e.g. with bracketing interviews and co-coding).

Transparency and coherence: I have shown transparency and coherence through a clear explanation for the study's design and the phases that I have moved between in the analysis. I have provided excerpts of the interviews to illustrate the themes that were generated, I have disclosed epistemological and personal influences, and I have specified the role my co-researchers had in the process. I strove to present a coherent 'story' of the data by highlighting similarities and differences in the data and themes, and presenting the findings in a way in which later-presented themes meaningfully build upon earlier-presented themes.

Impact and importance: CFT and online interventions are both burgeoning areas within psychology, and I believe this study has importance in shedding further light on participants' subjective experiences of a newly-developed way of offering CFT. Combined with CN's quantitative analysis, our joint project provides a well-rounded account of participants' experiences of engaging in this approach. It also has broader implications for other online interventions.

4. RESULTS

The reflexive TA I carried out generated four main themes and 17 sub-themes. As outlined below, the four main themes generated were '*A way of being in the world*', '*Old habits die hard*', '*The learning process*', and '*Context and resources*'. The themes are visually represented in Figure 1, and the distribution of themes among the 15 participants is represented in Table 2.

The way in which themes are visually represented in Figure 1 requires some explanation before the themes are elaborated upon below. The two-headed arrows between the first three themes in Figure 1 illustrate how these themes seemed to be

mutually-interacting. For example, the '*A way of being in the world*' theme speaks to participants' descriptions of the training helping them to develop a compassionate mentality across different areas in their life. This related to the '*Old habits die hard*' theme in that the development of this mentality often gradually facilitated the overcoming of difficulties participants faced, but these challenges also impacted participants' ability to develop this way of being to varying degrees. For some participants, the challenges were too strong to overcome. Similarly, '*The learning process*' and its sub-themes illustrate participants' descriptions of aspects of the training which they felt to help or hinder their ability to take in and embody its ideas and strategies. These factors affected both the extent to which participants could develop a compassionate way of being, and the extent to which the training was experienced as challenging. In turn, their ability to develop self-compassion and their challenges doing so affected their experience of the learning process (e.g. self-compassion helped participants to tailor the training to their own needs, and challenges with prioritising time for the training got in the way of the need to practice). Finally, the *Context and resources* theme provides the frame to the other themes in order to illustrate the way in which it speaks to wider-level factors (e.g. cultural values and previous relationships) which played a part in participants' ability to engage with the training.

In order to give emphasis to participants' own descriptions of their experiences with the training, I have presented two verbatim excerpts from interviews corresponding to each theme. I have chosen excerpts based on how well I believe they illustrate their corresponding themes, and I have tried to include themes that highlight different aspects of the same theme. Ellipses (...) are used when parts of interviews are omitted, and I have inserted text within square brackets [] to provide some clarifications. I have used participant numbers in order to preserve confidentiality.

Figure 1. Visual representation of themes.

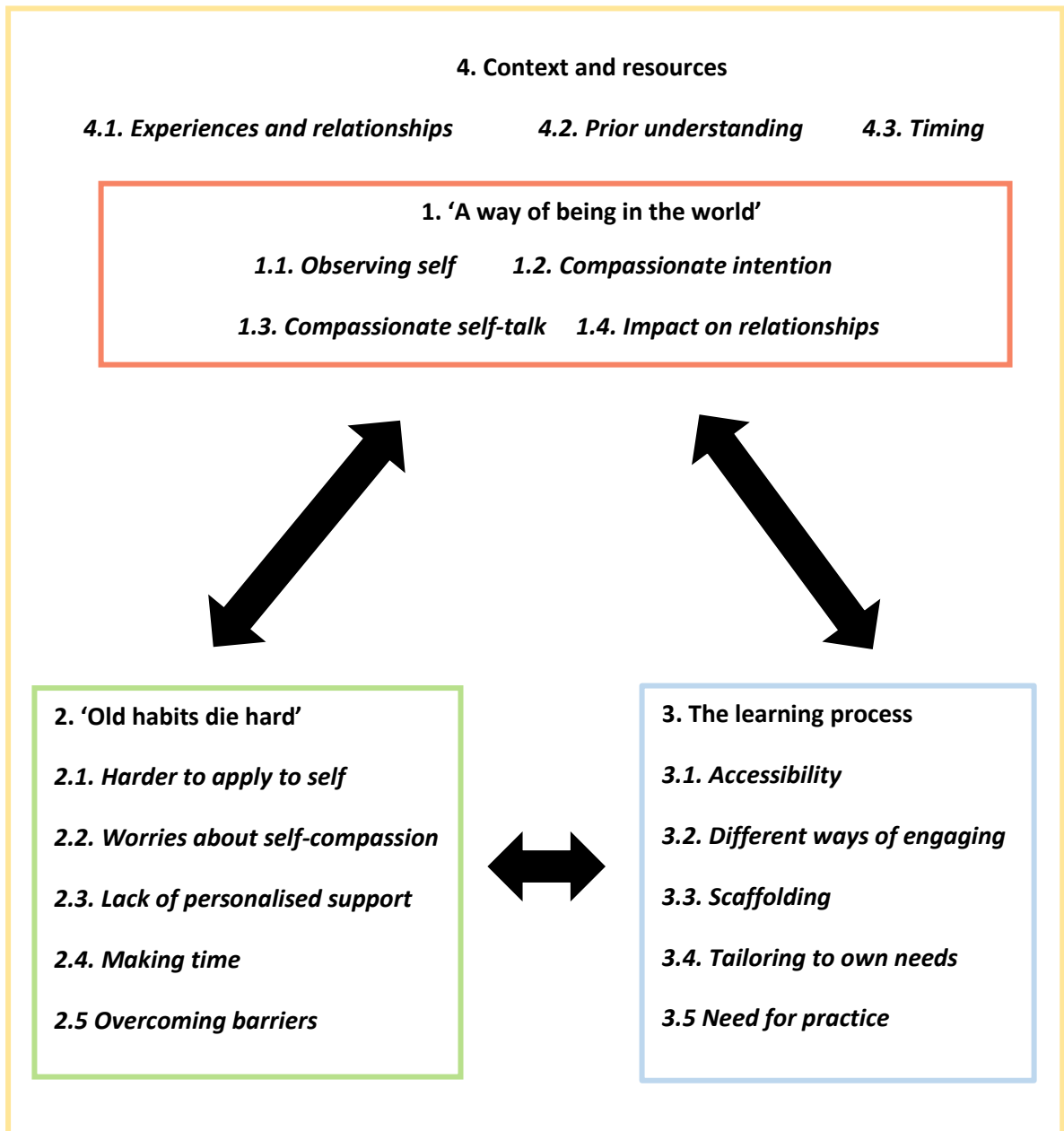


Table 2. Distribution of themes among participants.

Main themes	Sub-themes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1. 'A way of being in the world'																	
	1.1. Observing self																
	1.2. Compassionate intention																
	1.3. Compassionate self-talk																
	1.4. Impact on relationships																
2. 'Old habits die hard'																	
	2.1. Harder to apply to self																
	2.2. Worries about self-compassion																
	2.3. Lack of personalised support																
	2.4. Making time																
	2.5. Overcoming barriers																
3. The learning process																	

3.1. Accessibility										
3.2. Different ways of engaging										
3.3. Scaffolding										
3.4. Tailoring to own needs										
3.5. Need for practice										
4. Context and resources										
4.1. Experiences and relationships										
4.2. Prior understanding										
4.3. Timing										

Key: Filled squares indicate that there was direct evidence for the corresponding theme in an interview with a participant. Participant numbers correspond to those in Table 1.

1. 'A way of being in the world'

One of the main themes generated by the analysis was the idea of self-compassion as 'a way of being in the world'. This theme was supported in different ways by all but one of the interviews, and speaks to the fact that the ideas and strategies were seen not only as tools that can be applied reactively, but a mentality or worldview that one can bring to oneself and others across different areas of life (e.g. in friendships, romantic relationships and at work). The sub-themes below specify some of the aspects of this mentality that many of the participants described, including particular forms of attention, intention, self-talk, choices and relationships. Table 2 shows that this theme and its sub-themes were not supported by the interview with Participant 12, though she did have a positive experience of the training. She talked instead of the training giving her some tangible ways of putting ideas she was already familiar with into practice, and how the compassionate friend imagery reduced her sense of aloneness with her difficulties.

"I suppose the thinking has got to be that it is not a reactive cure to a bad thing. It should be sort of a way of being in the world." (Participant 13)

"I think it is making a difference, just through the day. What surprises me is that it's not feeling like a chore and it's not feeling like a thing that might go away. I actually feel like it's quite embedded." (Participant 14)

1.1. Observing self

Out of the 15 participants, 12 talked about the training helping them to become more able to take a step back and observe their difficulties without feeling so consumed by them. For a lot of participants, this ability helped them to be able to gain insight into some of their automatic responses to difficult situations (e.g. blaming

themselves or acting irritably towards others) and to feel more able to think about how they might break out of these patterns in the moment. This was not described as an easy process, and many participants emphasised the fact that this awareness of their thought processes or emotional experience usually lagged behind their automatic responses. Participants were sometimes able to 'catch' themselves in the moment, but sometimes it was only afterwards that they were able to reflect on their internal and external responses. Nonetheless, the self-compassionate mentality seemed to offer participants a sense of warmth and openness that helped them tune into their experience.

"This is pausing and then just kind of just a note to myself, you know, that this is a difficult situation and it's not like this is an ideal situation and that there is a perfect way to respond. It's kind of acknowledging that, acknowledging that there's something that's difficult that's going on in that moment, I guess." (Participant 1)

"Sometimes I noticed that I wasn't being my compassionate self. And I was like, 'Oh, that wasn't very compassionate of me'. That critical self was the opposite of what I was meant to do. But I suppose that exercise [compassionate self exercise] was really helpful. It helped me stop and think, like, 'Am I being my compassionate self in this situation?'" (Participant 2)

1.2. Compassionate intention

In six of the interviews, participants described bringing a compassionate intention to their everyday lives. This was closely linked with the previous sub-theme, in that participants' observation of themselves were often compared with their intention to be relating compassionately to themselves and others. This meant that when participants observed that they had become caught in an unwanted way of relating, this would often be followed by asking themselves 'How can I respond more compassionately in this situation?'. For the participants who talked about this

compassionate intention, it seemed to be an important part of developing a new 'way of being in the world' as it speaks to a certain stance that one is striving to take, and this stance is perhaps requisite for then embodying compassion in the choices one then makes (see sub-theme 1.4.). Similarly to the previous sub-theme, though, participants described this intention as being something that is not a constant. Instead, it is something that easily slips out of awareness and there is a continuous oscillation between other things dominating one's mind and then re-discovering this intention.

"When I noticed I'm in that unhelpful place of being self-critical with how I'm thinking, is thinking, 'OK, what would the wise, strong and caring me say in this situation, or how can I engage that way of thinking instead?' Even if I don't believe it, at the same time trying to access it more." (Participant 15)

"Sometimes I found that I'd start the day with the intention but then as the day went on, the thought kind of fizzled out yet. So I suppose maintaining it sometimes was hard." (Participant 2)

1.3. Compassionate self-talk

Compassionate self-talk was one of the main ways in which participants described putting into practice some of the ideas and strategies that the training introduced, and acting upon their compassionate intention. This was talked about by 11 of the participants, and often took the form of noticing self-critical thoughts and generating a more compassionate alternative to these. Participants described certain exercises being particularly helpful for this, such as a 'compassionate other' imagery exercise in which they were asked to build an image of a compassionate other (which could take a human or non-human form) and to imagine what it would be like to be in their presence. Participants also talked about finding it helpful to imagine what they might say to a friend who was in their shoes, and to try to turn this more compassionate

response towards themselves. The compassionate self-talk often seemed to comprise a non-blaming acknowledgement of what they were experiencing, and a validating re-frame of a self-critical thoughts (e.g. 'It's understandable that you feel like this' or 'You've tried your best').

“So yeah I was imagining talking to others and then doing that to myself was really, really helpful. You know, I felt warm and I stopped being so harsh. I expect a lot of myself but sometimes you need to be, you know, self-compassionate.” (Participant 6)

“I think even today, I found myself thinking 'It's understandable that it would be difficult because the IT has gone down, it's the middle of the pandemic and I've got loads to do'. So it's giving me permission. A little bit of 'Well, just see what we can do. And that's all we can do really.’” (Participant 14)

1.4. Impact on relationships

Another striking aspect of participants developing a more compassionate way of being was the impact of this on their relationships with others as well as themselves. This took many different forms, with several participants described carrying their compassionate intention into their interactions and noticing that this prevented misunderstandings and disagreements from turning into arguments. There seemed to be an increased sense of prioritising the relationship over proving a point. Another participant talked about how they had been a 'people-pleaser' throughout their life and they were gradually becoming more able to value their own needs as much as others. Other participants talked about how they had found their compassionate self-talk so powerful that they tried to offer the same kind of responses to their colleagues, which had a positive knock-on impact on the participant as well as their colleagues receiving these compassionate responses. Two participants had used CFT in their work with clients and said that the training had enhance their

appreciation of how difficult it can be to internalise and integrate these ideas, which they felt would lead to them having more understanding and flexibility in their clinical work.

“It's given me the thought 'How can I respond helpfully and compassionately?'. And that's also kind of helped me to calm down in situations and then it's helped the communication and most of the time they've been helpful outcomes. I can't think of a time when I've been compassionate towards someone and it's been unhelpful. So it's definitely been positive.” (Participant 2)

“So being able to be more kind to myself, I think that would be the basis of it. Being able not to fall into that kind of cycle of negative thinking about myself about being to blame. It also helped us to get out of the interpersonal dilemma. The fact that I didn't spiral it in my mind meant it didn't spiral so much between us.” (Participant 15)

2. 'Old habits die hard'

While most participants described noticing tangible benefits from engaging in the training, they also all described experiencing challenges in their attempts to become more self-compassionate. This theme is titled 'Old habits die hard' because it a phrase that a couple of participants said, and a phrase that I think captures the sentiment of what was described by many others. Perhaps unsurprisingly, most of the participants interviewed were drawn to the training because they identified self-compassion as something that they were lacking, and it is clearly often hard to develop when it seems so incongruent with people's typical ways of relating to themselves. The sub-themes below and in the final two main themes elaborate some of the specific challenges participants faced, such as certain fears participants had about self-compassion, difficulties developing it on their own terms and upbringings fostering a more self-critical approach towards oneself.

“I guess old habits die hard. So there's something there thinking maybe I can motivate myself by being more critical, by using anxiety just because that's been a pattern that I've probably used a lot of my life.” (Participant 10)

“Because if you've got sort of a mediocre opinion of yourself, then admitting you've got a mediocre opinion of yourself is doing the opposite of what you... I don't know why I don't want to be kinder to myself.” (Participant 7)

2.1. Harder to apply to self

One of the most frequently-described challenges that participants described (10 out of 15) was that compassion is harder to apply to oneself than it is to apply to others. Some participants said that they felt they were able to be compassionate towards others, and friends and therapists had asked them why it was so hard for them to turn this towards themselves or receive it from others. The possible contributors to this difficulty are undoubtedly overdetermined, but some will be touched upon in subsequent themes. It seemed that it was often hard for participants to prioritise their emotional wellbeing enough to direct a compassionate intention towards themselves and, when they did manage to do this, some worried that it would have negative consequences on their relationships and performance at work (e.g. people would stop liking them and/or they would stop making an effort). The participants who had used CFT in their work described there being a considerable gap between understanding these ideas on an intellectual level and using them with clients, and being able to engage with them on a more personal and emotional level in applying them to yourself.

“I guess this is the whole thing about self-compassion - when I speak to friends who are going through a difficult time, I'm really understanding, I'll really talk them through it, I'm really kind. But the moment I've done something that I don't think is

good, or I've made a bad decision or something, I'm instantly very critical.”

(Participant 9)

“And so I think what you know yourself is knowing about something intellectually and, you know, being able to argue for its benefits and looking at the research and everything... But actually applying that to yourself is a very different thing.”

(Participant 1)

2.2. Worries about self-compassion

Eight of the participants described worries about self-compassion making it hard for them to try to engage with the training. As mentioned in the previous sub-theme, some worried that it would resemble a form of self-indulgence and they would end up disengaging from responsibilities. One participant described worrying that if they were to become more self-compassionate, this might jeopardise their relationships as they were so used to taking a passive role that prioritised the needs of others at their expense of their own. A different participant saw self-criticism as a way of protecting others from the anger they experienced in difficult situations and they worried that if they were to become more self-compassionate, the anger they usually directed inwards would be turned outwards and their relationships would not be able to survive this. This participant experienced this barrier as too strong to overcome, and they felt that self-compassion might be an idea they would only be able to prioritise once they felt more able to understand and manage some of their other difficulties.

“I do sort of worry that if I have enough soothing, then the drive might disappear and it might be that I don't really register threats anymore. But also, I won't have the get up and go either.” (Participant 11)

“If I don't allow myself to do that [become self-critical], then I have to do other alternatives, just kind of get angry and then being angry is bad. I'm so... just avoidant of being angry.” (Participant 7)

2.3. Lack of personalised support

Another thing that made it hard for some participants to develop self-compassion was the lack of personalised support. The self-help format of the training, with all participants accessing the same materials independently, meant that there was no opportunity for individual meaning-making, support from a professional nor peer support. The fact that developing self-compassion can be such a challenge meant that for seven of the participants, it felt that the training would have been improved by the offer of some support. The support they said they would have liked included a check-in before starting to help think about why self-compassion might be important for them personally, a check-in between sessions to help overcome any barriers and to remind/prompt them to practice exercises, and a follow-up conversation to help them think about how they would take the training forward. Several participants reflected that it was hard to maintain the motivation to continue practicing the ideas and exercises, and that having somebody check in with them would have brought more accountability and given them an extra incentive to carry on. A couple of participants did say, though, that CI's delivery of the training videos had a personal and genuine feel to it that made the training feel personal despite the fact that it was not tailored to individuals.

“You're just kind of left with all of it on your own and definitely being able to talk to somebody who understands like what you did would be good. Somebody who understands what that might have been like.” (Participant 2)

“I suppose at the end of the day, nothing really beats having somebody doing it on a personal level with you, who's listening to your story and tailoring it to you, because I

guess with the online training, there's no background to it. Like, you know, I can acknowledge that self compassion is important, but there's no 'Why is the self-compassion important for you? What other things might need to be put in place to make sure that it's most effective?'" (Participant 3)

2.4. Making time

Difficulties with making time to practice self-compassion were talked about by 10 of the 15 participants, many of whom described it as the thing they found most difficult about the training. When sending participants the link for each weekly session, we asked them which day they would like to receive this and suggested that they try to establish a routine of doing it on the same day each week if possible. However, they had no other contact with us and as mentioned in the previous sub-theme, for some participants this brought a lack of accountability which made it harder for them to prioritise the training. While for some participants their sense of lacking self-compassion acted as a motivator to regularly practice, others described feeling that it was something that got in the way as it inherently made it harder for them to prioritise themselves. A lot of the participants led busy lives and when they were able to make time to engage with the training, this often necessitated having flexibility in how they fitted it into their schedules and how they prioritised exercises they found most helpful.

"I obviously found it, as a as a working person with children... it's finding the time. Cause at the start you asked about what day I'd do it and I initially said Tuesday but then that turns into Wednesday and then Thursday... it's just actually finding that time when I'm able to sit down. Cause you can't do in the lounge. You've got to be somewhere quiet. So that is a barrier, I guess the time." (Participant 8)

“Because this is a thing you do for you, it goes go to the bottom of the pile, because there's nobody demanding it. And if your self compassion is low you're definitely not going to prioritise it.” (Participant 3)

2.5. Overcoming barriers

While old habits do indeed seem to die hard when it comes to developing self-compassion, several of the participants talked about finding ways to overcome some of the barriers they experienced. The fact that they experienced barriers did not always mean that they were not able to benefit from engaging with the training, and some participants said that they saw the challenges they faced as proof that self-compassion was probably an important area for them to be working on. For the participants who overcame worries about self-compassion, they talked about the training helping them to re-frame self-compassion as something that is not simply ‘letting oneself off the hook’, but rather something that can motivate them towards their goals and values in a more warm and supportive way than their typically self-critical and perfectionistic ways of relating to themselves. Some participants who struggled to make time for the training talked about creatively finding ways of establishing their own practice, such as finding shorter versions of self-compassion audio exercises online and using the training’s exercises as and when they felt the need for them. A couple of participants who had reflected on the lack of personalised support also reflected that this helped them to establish more of an intrinsic motivation for doing the training, which Participant 10 referred to as *“Doing it for me”*.

“So at first it almost felt to me like a bit of a burden. So a bit of frustration kind of came with that. But I was able to slow down and kind of prioritise myself.”

(Participant 10)

“And for me and I guess the process of change, I would expect requires some degree of working through some negative emotions. If it was just positive, I'm not sure I would have been doing what I needed to do to get benefits from it . . . And implicitly, somewhere in my goals for it, I was hoping that it would bring up difficult feelings so that I truly am making a change in what's causing me difficulty in day-to-day life. But no more difficult feelings than other situations in my life. So it's not like it was causing distress that I wouldn't have otherwise had in certain moments. And it was giving me ways to overcome some of the things causing me those upsetting feelings.” (Participant 15)

3. The learning process

The third main theme generated was the learning process of engaging with the training and trying to develop self-compassion, which all participants touched upon in their interviews. They described their experience of certain factors which seemed to influence the extent to which they could take in, and take forward, the training's ideas and exercises. Some of these factors will be elaborated upon below, including the training's accessibility, use of different types of materials, ideas being gradually introduced and the need for participants to find ways of tailoring the training to their needs as well as maintaining practice on an ongoing basis. As will be outlined in the final theme, participants came to the training from different positions (e.g. different levels of prior understanding of self-compassion and different levels of motivation for developing it). This theme and its sub-themes touch upon some of the things that seemed to have mediated between these different positions and people's engagement with the training.

“I think that's something that's been particularly powerful for me which has been interesting, actually, because I've struggled in the past with visualisation exercises. Some people, I think, find those easier than others. But there's something about the

way in which the exercises are set up. And, you know, it's kind of done slowly and it's imagining the various qualities that allowed me to build a picture up in my mind. And I found that very helpful.” (Participant 1)

“I used to be quite a perfectionist, which I'm not anymore, I don't really think I am much. Initially going through that process was like, well, ‘I have to do it really well and I have to get it right. And there must be a solution. And it was a must be one solution. That's my solution that works for me’. When actually... It doesn't matter if it doesn't work first time, but try different things.” (Participant 3)

3.1. Accessibility

All but one participant talked about the accessibility of the training. For the most part, participants found the training highly accessible and few reported difficulties understanding the training's materials. As outlined in subsequent themes, they valued the fact that there were different ways of engaging and that the sessions built upon one another. A few of the participants talked about generally finding meditation exercises difficult, but experiencing the exercises in this training (e.g. soothing rhythm breathing) as easier and more helpful than they expected. Though it was often difficult to make time, many participants felt that four weeks of 30-minute sessions was a reasonably manageable commitment. Several participants found that the online survey format was easy to use. However, many participants also talked about there being some ways in which the study's accessibility could be improved. A couple of participants suggested that though they could understand the terminology in the training, other people might need certain terms to be explained in more detail and more time to digest concepts before moving on to the next ones. There were also some issues with how the study was set up online, such as not being able to easily access materials that people had seen before clicking on to subsequent pages on the online survey if they had not downloaded them. This latter

issue relates to how the study had to be set up for research purposes of data collection and participant anonymity.

“I liked the fact that it was short. Like I wouldn't have liked it to be longer, maybe because it would be even more time to find. And the fact that they gave us to read what was in the video, I found very helpful because I can go back and read them.”
(Participant 6)

“There was a bit, I think probably in the first session and maybe it's in one of the meditations when it talks about soothing rhythm breathing and studies showing that that can lead to increased activity in the parasympathetic nervous system. I wonder if maybe that required a bit more explanation, because I know that language like that can be quite confusing for some people. And I think people who are quite self-critical, if they didn't understand that, that might send them off down a route of thinking ‘Well, this isn't for me, it's too complicated’ and what have you.” (Participant 1)

3.2. Different ways of engaging

The training's use of various formats (30-minute videos, written handouts and brief audio exercises) was something that seven participants said they valued about the training. This was seen to help them digest the ideas and tailor their engagement with the training to their own needs (see sub-theme 3.4.). For example, several participants found that CI's delivery of the videos gave it a personal touch, the written handouts provided a way of reminding themselves of the ideas without having to re-watch the videos, and the brief audio exercises provided an accessible way of practising tuning into a compassionate stance. Many participants also found that they did not click with one of the formats, so the use of multiple formats meant that this did not pose an issue and they could choose how to make use of the materials they found most helpful (e.g. some people focused on practicing audio

exercises, and one participant took photos of the handouts on their phone so that they could easily tap into the ideas while they were out of their home).

“But the pictures and the reading was, like, really simple, straightforward. So, for example, though the video sometimes felt long, then I went on to the reading and stuff and I thought, ‘Oh, that’s everything he said’. And that was really straightforward and quick, but the video is really helpful just because hearing him say it in a really calm voice is really helpful.” (Participant 2)

“And it was varied as well, which was good. So there was a bit of a taught component and then there was some exercises and then there was some reading as well to do. So I guess it tailors to the different ways in which people learn.” (Participant 10)

3.3. Scaffolding

Another key part of the learning process for nine of the participants was the way in which the learning was scaffolded. Some participants were not familiar with many of the concepts in the training and those who were had often not spent much time trying to apply the concepts to themselves, so it was helpful to have the material gradually introduced and built upon throughout the four weeks. The fact that the various materials had relatively short lengths was helpful too, as this allowed people to easily to return to what was covered in previous weeks and also helped them to not feel overloaded by the amount of information they were taking in. Participants also talked about feeling reassured by CI’s comments about certain exercises (e.g. that it is normal for the mind to wander during audio exercises), as these made them less likely to take a self-critical stance towards how well they were doing the exercises.

“I liked the way it started off with just the soothing rhythm breathing. And then it introduced other exercises along the way and they all kind of coupled together,

merged together. And so it was a helpful, gradual way of learning about the different techniques and how to incorporate them together.” (Participant 2)

“I thought that the pacing was very calm, I liked that you could look at things again. You know, you didn’t have to go ‘Well, I don’t remember that model, it’s gone now’. You know, I did look over the transcript at the end. And I did go back to the exercises a couple of times when I couldn’t really remember what I was supposed to be doing. So that suited me, it suited my learning style.” (Participant 11)

3.4. Tailoring to own needs

Ten participants described how the learning process involved tailoring the training to their own needs in various ways, some of which have been mentioned in previous themes. For example, for some participants it was not realistic to complete the training on the same day(s) each week so they had flexibility with themselves in terms of when they could fit it into their schedules. One participant said that the 10-minute audio exercises felt too long for her so she instead found a shorter version online which had similar content but was easier to make time for each day. Some exercises elicited markedly different responses across participants, who sometimes described not ‘clicking’ with them. Rather than disengaging with the training altogether, though, they tended to decide to develop their own practice built from the exercises they found most beneficial. This flexibility seemed to be an important part of participants’ process of integrating the training into their everyday lives.

“I like that the aspect that you could pick the tools that worked for you and maybe leave some of the others - whatever you didn’t like or you didn’t benefit from.”

(Participant 5)

“Like sometimes if I was feeling really exhausted, it was really good to be in meditation and choosing when I was going to do it myself . . . So I actually learnt

that that flexibility was actually probably what I needed rather than rigidly saying do this every day, in spite of my initial concerns.” (Participant 1)

3.5. Need for practice

The last sub-theme generated under ‘*The learning process*’ is the need for practice. This was described by eight of the participants and is interconnected with many of the themes already outlined, such as the ‘*Old habits die hard*’ and its sub-themes which showed how challenging it can be for people to develop self-compassion. The process therefore necessitates a lot of practice and for the intellectual understanding of concepts to be embodied in the choices people make in the ways they are relating to themselves and others. While some participants were pleased to report feeling that self-compassion was gradually becoming more internalised and that they noticed automatically responding compassionately to difficult situations, they also expressed worries that they would struggle to maintain the changes they had managed to make. Rather than being seen as a way of being that is achieved and easily retained, participants described the compassionate stance as something that fluctuates and has to be striven towards on an ongoing basis.

“I appreciate how much regularity and persistence and the sort of the repetition of these things has an effect. We are our habits, literally, what you subscribe to, what you surround yourself by... it reinforces who I am and what I am. And so if I am bad habits, then that will reflect in my life. So for me, I appreciate the need to... To be well, I need to practise and it's not just sort of, you know, 'Go get a tablet'. It's something you've got to work on. And it's like 24/7, 365.” (Participant 13)

“I think my worry is that I might lose that skill now if I haven't got those prompts. And what I'm hoping to do is download all the recordings and stuff and all the reading. And so I think I just need to commit myself to keep revisiting them. Obviously, I think that all the commitments will get in the way and slowly that will fade away. Well, if it

was something that was offered more of, it's something I definitely would like to do.”
(Participant 2)

4. Context and resources

The final theme generated by the analysis pertains to the role of participants' contexts and resources in their engagement with the training, which was described by eight of the participants. As touched upon previously and elaborated upon in the subsequent sub-themes, participants' experience of the training was shaped to some extent by factors such as family backgrounds, cultural beliefs, work environments, prior familiarity with concepts, previous therapy and their emotional states. These factors had varied effects and levels of impact, and though it is inevitably hard to determine these with any precision, it was clear from the interviews that they were an important part of the picture for many participants.

“I think for me personally, compassion is something that you... you actually need to be strong to practise compassion. People see that as a weakness but actually, you're only able to have that if you are actually quite strong and confident in yourself. And it's the people who are that are able to offer that... I think especially men are socialised to be very defensive, and see that as a weakness.” (Participant 13)

“It's almost a societal thing rather than just an individual thing, I think. We're all - for whatever reason - programmed to be quite critical, particularly towards ourselves. So I think when you've spent however many years being critical, rewiring your brain takes time. And I like he says in the video, you know, it takes practise. It's not going to happen overnight. So yeah I think there are wider issues. And I think as well as being critical of yourself, you might think 'Oh God they're going to judge me, they're going to think this'.” (Participant 9)

4.1. Experiences and relationships

Seven participants talked about previous experiences and relationships having an impact on how they experienced the training. In particular, some talked about how self-compassion was not something that had been encouraged within their families and they felt that a more self-critical way of relating to themselves had been internalised from a young age. A few participants reflected that they felt that their generation (including siblings and peers) were more open to the idea and had been trying to promote it, but that some members of their family in an older generation were more likely to see self-compassion as self-indulgent. This highlights social and historical differences in perspectives, which was also touched upon by a couple of participants who spoke of rigid gender roles and stereotypes contributing to men feeling less able to show vulnerability and compassion. The impact of relationships was sometimes felt to be positive, too: A few participants talked about previous therapy helping them to already have made significant progress with self-compassion, and others talked about feeling grateful for having family, friends, partners and colleagues who were supportive of their efforts to do this.

“My childhood was probably typical of everybody of that generation in that sort of, you know, we work hard and we must always work harder and we must do better and we're never good enough. That's a very common theme, I think, and I like to hope there's a bit of a switch now where we don't all do that thing of ‘The busier you are, the better you are’. That people take more time for other stuff and value things over and above work and achievements.” (Participant 3)

“If that's not something that you're that familiar with from your close family you're sort of a bit defensive against that, and then doing that yourself can actually almost bring up like a sense of loss and grief that ‘This is new, this is novel, I haven't experienced this before. How lovely would it have been to have that?’” (Participant 4)

4.2. Prior understanding

Another part of participants' contexts and resources that influenced their experience was their level of prior understanding of self-compassion and the concepts related to it. This theme was supported by 10 of the interviews. Many participants reflected that their familiarity with self-compassion (e.g. from previous therapy experiences or from using it in their work) helped them to already see it in a favourable light and to readily understand the ideas being introduced in the training. The fact that some participants' familiarity with it involved an expectation that it might be a difficult process helped them to not lose hope when they experienced challenges, and to be patient with themselves in trying to engage with it. For several of the participants, the training was part of a multi-pronged approach (e.g. participants mentioned also benefiting from things such as individual therapy, couples therapy, yoga, mindfulness and running) and it helped them to build on changes they had already been trying to make. Some participants wondered whether the training might have been harder to understand and practice without their prior understanding as a resource. Although most of the participants for whom this was the case did not report this being a significant barrier, a couple of them did say that they felt that they would have liked more time to grasp certain ideas (e.g. building an image of a 'compassionate other').

"For me, it's part of a broader picture of all the different things that are interlinked, that they're all important and it's part of that. So for me, it's part of learning to be more giving, less ego, all that kind of thing, like a softening up." (Participant 13)

"And I feel like more spaces in between him going on to the next point would have been helpful for me and, I imagine, for other people as well, because it's such a... It will be quite alien for the people who have to struggle with this, and it felt like it

moved on quite quickly, and then you just get lost and a bit frustrated with the whole thing.” (Participant 10)

4.3. Timing

The final sub-theme was about the timing of the training for participants, which nine of them spoke about. One of the ways in which timing mattered for participants was in relation to their mood and the impact on their level of motivation for engaging in the training. For example, some participants felt that the training came at exactly the right time for them (e.g. they were taking stress-related sick leave from work and they wanted to use this time to become more self-compassionate), which fostered a sense of urgency and commitment to get something out of the training. Others who had periods in which they were struggling while completing the training felt that their difficulties were too all-consuming for them to be able to engage with it. A few participants reflected that that they were generally feeling good in themselves when they engaged with the training, and this meant that it was harder for them to muster motivation as there did not seem to be such a burning need. Other participants who felt good in themselves felt that this was something that helped rather than hindered their motivation. This sub-theme also related to the previous one, in that some participants felt that they would not necessarily have been able to complete the training on their own terms if they had come across it at an earlier point in their lives (e.g. before personal therapy). There were also some more practical issues in relation to timing, in terms of the other demands in people’s lives (see *Making time* sub-theme) and how possible it was to fit in the training around these.

“I’ve had some really challenging times, so I guess that’s what I meant by it came at just the right time when, you know, compassion is the only thing that I can offer myself at the moment and is exactly what I needed.” (Participant 1)

“I think it's almost like I think if I wasn't in the best place when doing the training, I wouldn't have been looking after myself as well. I wouldn't set up that routine. That would be my worry is that sometimes, you know what you need to do but when you're not feeling great, that's when it's tested. That's when it's harder to put into place.” (Participant 9)

5. DISCUSSION

This study was aimed at exploring participants' subjective experiences of engaging in online self-compassion training based on CMT and developed for the general population. To my knowledge, it is the first qualitative study on this topic and it provides helpful insights for further developing the relatively new research area of CMT- and CFT-based self-help approaches, as well as more broadly for online interventions.

The reflexive thematic analysis (Braun & Clarke, 2006) generated four main themes (and 17 sub-themes) pertaining to different aspects of their experience: *‘A way of being in the world’*, *‘Old habits die hard’*, *The learning process* and *Context and resources*.

This section will integrate these findings and link them with research literature. While many of the findings converge with previous research, findings also offer fresh perspectives which are important to consider. This section will conclude with limitations and recommendations for future research.

5.1. A social mentality

The *‘A way of being in the world’* theme and its sub-themes synthesise participants' descriptions of compassion as a mentality that was increasingly brought to multiple areas of their lives. Though the training was explicitly focused on self-compassion, the *Impact on relationships* sub-theme shows that many participants noticed the effects of a more compassionate mentality ripple into their interpersonal

relationships. This took many different forms, including striving to have relationships on more equal terms, trying harder to understand reasons for people's actions, and offering more validation and encouragement to colleagues. These findings tie in with Gilbert's (2014) view of compassion as a social mentality and research on the interconnectedness of different 'flows' of compassion: for others, from others and for oneself (Gilbert et al., 2017). Irons and Heriot-Marland's (2020) study found that an eight-week CMT group led to stronger correlations between these three flows of compassion, and the frequency with which other qualitative CFT research (e.g. Bell, Dixon & Kolts, 2017; Carter, Gilbert & Kirby, 2020; Gale et al., 2017) has also found that participants describe a positive impact on their relationships suggests that this a significant strength of CFT-based approaches. It is encouraging that this impact can be achieved via a self-help format as well as individual and group CFT formats.

Participants described also developing more of an *Observing self*, bringing *Compassionate intention* to their everyday lives and engaging in more *Compassionate self-talk*. These sub-themes fit closely with CFT literature on the two mindsets or 'psychologies' of compassion: "engagement with, and the alleviation/prevention of, suffering" (Gilbert, 2014, p. 26). While the training was grounded in the CFT model (Gilbert, 2005), it is interesting to note that these sub-themes map onto two key components of Neff's (2003a; 2003b) conceptualisation of self-compassion. Participants' descriptions of developing their capacity to observe their difficulties map onto Neff's emphasis on mindfulness, and their descriptions of deliberately engaging in compassionate self-talk map onto her emphasis on self-kindness. This suggests that despite divergence of emphases between different compassion-focused researchers and approaches, there is some convergence around shared core processes. These findings add weight to previous qualitative CFT research which has similarly found that participants described improvements in their capacity to step back from their difficulties and relate to themselves in kinder,

non-blaming ways (e.g. Bratt, Svensson & Rusner, 2019; Gooding, Stedmon & Crix, 2020; Mullen, Dowling, Doyle & O'Reilly, 2019).

5.2. Facilitators and barriers to change

Several of this study's themes pertain to facilitators and barriers to change that participants described encountering when trying to develop a more self-compassionate way of being. These ranged from the accessibility of the training materials to wider-level factors such as the impingement of other demands in their lives, previous experiences which had influenced their typical ways of relating to themselves, and cultural beliefs around self-compassion.

While self-compassion is a multi-dimensional process and not just a behaviour, Michie, van Stralen and West's (2011) COM-B model of behaviour change could be used as a contextualised framework for understanding the broad range of facilitators and barriers participants described, as well as their clinical implications. Their model's components are relevant and applicable to the training's focus of helping people achieve change in their way of relating to themselves, even if this change comprises other dimensions in addition to behaviour (e.g. awareness and intention; Jazaieri et al., 2013).

Their model posits that:

"... at any given moment, a particular behaviour will occur only when the person concerned has the capability and opportunity to engage in the behaviour and is more motivated to enact that behaviour than any other behaviours." (West & Michie, 2020, p. 1)

Michie et al. (2011) explain that capability and opportunity act as 'gates' that must be open for there to be motivation to generate a behaviour, with levels of capability and opportunity generally corresponding with levels of motivation.

Behaviours then feedback to these precursors and can create positive or negative feedback cycles (e.g. practicing learning to drive might improve capability and in turn motivation to engage in further practice, whereas eating might temporarily lower the drive to engage in further eating). Motivation is considered as a quantity attached to behaviours, with a constant competition between different behaviours. Capability is broken into two forms: physical capability (i.e. having the physical capacity to engage in a behaviour) and psychological capability (i.e. having the psychological capacity to engage in the thought processes required). Opportunity is divided into physical opportunity (i.e. the opportunity that the environment provides) and social opportunity (i.e. the cultural milieu dictating the ways in which we think about things, such as the words and concepts forming our language).

The learning process and its sub-themes of *Accessibility*, *Different ways of engaging* and *Scaffolding* could be seen as reflecting different ways in which the training was thought to provide the physical opportunity to develop self-compassion. For most participants, the training was experienced as accessible and the gradual introduction of concepts through multiple forms of media (i.e. videos, audio exercises and written summaries) strengthened their motivation to continue engaging. The participants interviewed had a relatively high level of education, and some wondered whether the training would need to be made more accessible (e.g. through greater explanation of certain concepts) to be used by the general population. These aspects of physical opportunity clearly interacted with participants' psychological capacity to understand and apply certain ideas, which for some was bolstered by *Prior understanding*.

The sub-themes of *Tailoring to own needs* and *Need for practice* point to differing levels of motivation for the training as a whole and its specific strategies. Levels of motivation and participants' ways of tailoring the training to their own needs were often based on physical opportunity (e.g. what they could fit into their

schedules) and psychological capability (e.g. which exercises they felt most able to understand). Participants' sense of there being a need for practice provides support to many previous qualitative CFT studies which have found that self-compassion is experienced as an ongoing process requiring continuous effort rather than being something that is easily retained (e.g. Bell et al., 2017, Heriot-Maitland, Vidal, Ball & Irons, 2014; Lucre & Corten, 2013).

The *Context and resources* theme and its *Experiences and relationships* sub-theme highlight the influential role of participants' relational and cultural contexts, which through the COM-B (Michie et al., 2011) lens links to the extent to which they have the physical and social opportunity to achieve change. Some participants felt that previous relationships and experiences facilitated their efforts to become more self-compassionate, while others saw these as one of their main barriers. This was particularly emphasised in relation to family beliefs (e.g. compassion being weak or self-indulgent) and cultural expectations (e.g. to work as hard as possible) that were not conducive to internalising a sense of oneself as deserving compassion. These findings support research findings which have found associations between people's life experiences and their ways of relating to themselves. For example, being able to recall parental warmth has been found to be negatively correlated with self-criticism, whereas recall of parents being overprotective and rejecting has been positively correlated with inadequacy and self-hating self-criticism (Irons, Gilbert, Baldwin, Baccus & Palmer, 2006).

The *Timing* sub-theme maps onto psychological capacity, physical opportunity and motivation. Participants most frequently talked about timing in relation to their mood during the four weeks of engaging with the training, which had differing effects on their experience. Feeling low could mean that they did not have the psychological capacity to engage with the training, but it could also provide them with extra motivation to prioritise the training over other demands. Others reported

feeling good in themselves during the four weeks, which for some meant they felt they had an increased psychological capacity to engage, and for others meant they had little motivation to do so. Participants also described long working hours, lack of childcare and/or sick leave having varying effects on their ability to engage with the training, which demonstrates the importance of people having the physical opportunity to engage in efforts to make changes.

The global COVID-19 pandemic and UK lockdowns were mentioned by numerous participants as a broader context which influenced their wellbeing and ability to engage. People's social and material living conditions and their differing levels of access to power/resources do not always get sufficiently incorporated into therapeutic approaches, and Smail (2015) argued that there is a danger of services and practitioners being excessively individualistic and 'voluntaristic' (i.e. suggesting that people can will their way out of difficulties). He called for there to be greater emphasis on therapeutic work including careful exploration of people's access to power and resources (e.g. through 'power mapping'; Hagan & Smail, 1997) and appreciation of wider-level factors that can help or hinder people's difficulties, such as access to community support, supportive relationships, secure housing and employment. Gilbert (2002) suggested that we should "have a 'Defeat abuse', rather than 'Defeat depression' campaign" (Boyle, 2003, p. 30)

The danger of therapeutic approaches being offered in a de-contextualised way is perhaps particularly pertinent to self-help approaches. This was captured by some participant descriptions which came under the *Lack of personalised support* sub-theme. Most participants reflected that some guidance would have been helpful with the training, particularly in terms of helping them overcome barriers, maintain motivation and think about how they would be able to take the training forward once they had finished the four weeks. As outlined in the *Timing* sub-theme, people's mood levels and the other demands in their life were sometimes experienced as too much

to overcome and it seems probable that personalised support would improve many people's ability to experience benefits from an approach. This is backed up by other research findings which have showed guided self-help interventions to be more effective than unguided self-help interventions (Cuijpers & Schurrmans, 2007, Gellatly et al., 2007).

The '*Old Habits Die Hard*' theme and its other sub-themes capture some of the ways in which the training was experienced as challenging by participants. The *Harder to apply to self* sub-theme showed how for several participants felt that compassion was something they were more than capable of offering others, but it seemed that there can be a significant gulf between this and offering the same to oneself. Participants' descriptions had similarities to the ones captured in the *Experiences and relationships* sub-theme, in that it seemed as though relationship patterns and cultural expectations had a pivotal role. For some, it seemed that a lack of social opportunity played a part in this as they reflected feeling that self-compassion was not encouraged on a societal level when they were growing up. This was particularly emphasised by participants aged 30 or older, and participants expressed hope that there continues to be a gradual shifting of societal values (in the UK) towards greater emphasis on relating to oneself in a kinder way. The issue of *Making time* sometimes had a clear relation to the fact that several participants had busy schedules which provided little psychological capability and physical opportunity, but some participants also commented on this being linked to the extent to which they were invested in the idea of developing self-compassion and therefore committed to prioritising time for it.

Though there were clearly many barriers to change experienced by participants, it is important to note than a lot of these were possible to overcome. The *Overcoming barriers* theme captured various ways in which participants managed this, such as gradually shifting their perspective on self-compassion,

developing a greater sense of intrinsic responsibility for implementing the ideas in their everyday lives, and experimenting with the ideas and strategies they found most helpful. The fact that this was possible despite there being no personalised support suggests that the presence of barriers does not necessarily negate the training's acceptability and effectiveness for the general population. While these barriers should not be understated, it could be argued that for some people the self-help format could be an empowering way of emphasising CFT's view of people as the experts on matters pertaining to their own lives (Kolts, 2016). The possibility for overcoming barriers when engaging in CFT-based approaches is supported by numerous other qualitative CFT studies in which participants have also described being able to do this (e.g. Bell, Montague, Elander & Gilbert, 2019; Gooding et al., 2020; Lawrence & Lee, 2013).

5.3. Fear of compassion

The sub-theme *Worries about self-compassion* demonstrates the fact that self-compassion can elicit ambivalent reactions for people attempting to engage with it. Many participants had a sense of self-compassion being something it would be worth trying to develop when they signed up for the study, but they also described a range of other reactions towards this prospect. These included worries that it would have a negative impact on their relationships and work, a feeling that they did not deserve self-compassion, and sadness when they realised how different self-compassion was from what they usually experienced from themselves and others. This latter experience has echoes of what psychoanalyst Patrick Casement (1992) calls the pain of contrast. This term refers to how painful it can be for people to find something that has been previously experienced as missing (e.g. comfort), and to get a glimpse of how it could have been to have had available when it was most needed.

These findings add further support to fear of compassion now being a well-established phenomenon that has been repeatedly found in compassion-related research (e.g. Gilbert et al., 2011; Gilbert & Procter, 2007; Lawrence & Lee, 2013; Pauley & McPherson, 2010). Worries about self-compassion map onto multiple parts of Michie et al.'s (2011) COM-B model, including psychological capacity (e.g. whether anxiety about receiving compassion from oneself might undermine the ability to engage with the ideas), physical and social opportunity (e.g. whether self-compassion is supported by people's support networks and wider cultures) and motivation (e.g. whether self-compassion is seen to be worth choosing over alternative ways of relating to oneself).

The prevalence of fears around compassion also suggests therapeutic approaches could benefit from having some explicit emphasis on a meta-cognitive level (i.e. the way people think about their ways of thinking). CFT practitioners frequently make use of Gilbert et al.'s (2011) fear of compassion scale to facilitate working with clients on this level and a similar emphasis has been elaborated upon in other approaches. Though compassion is usually conceptualised as comprising more than just a cognitive dimension (Jazaieri et al., 2013), metacognitive theory and Metacognitive Therapy (MCT; Wells, 1995; Wells & Matthews, 1994) offer some insights which could be complementary when working with worries people might have about becoming more self-compassionate. MCT is based on a transdiagnostic model which proposes that mental health difficulties are caused by a perseverative style of thinking (Wells, 2009). Certain metacognitive beliefs are thought to be a central part of this, and are broadly grouped into positive metacognitive beliefs, often associated with necessity (e.g. "I need to be self-critical in order to perform") or negative metacognitive beliefs, often related to uncontrollability and dangerousness (e.g. "I will never be able to stop criticising myself"). MCT is a 'third-wave' CBT approach which, unlike 'traditional' CBT, sees the main mechanism of change as

people's relationship to their thoughts rather than the content of their thoughts. As well as the potential benefits of a meta-cognitive approach/being mindful of fears of compassion, fear of compassion could be considered in a similar way to other fears, with exposure to this fear an important first step. Compassion-focused approaches could be seen to inherently serve this function, and studies have found reductions in fear of compassion (e.g. Jazaieri et al., 2013).

5.4. Clinical implications and future research

One of the most promising findings of this study is that self-compassion training offered in a self-help format can be experienced as helpful by the general population. Most participants interviewed described having a positive overall experience of the training and they gave rich descriptions of ways in which the training made a difference in various areas of their lives, particularly in terms of their 'way of being' with themselves and others. Given the number of research studies which have demonstrated links between self-compassion and wellbeing (e.g. Craig, Hiskey & Spector; 2020; Neff, Kirkpatrick & Rude, 2007; Van Dam, Sheppard & Forsyth, 2011), it is encouraging that self-help formats could offer a route to increasing the accessibility and scalability of compassion-focused approaches for the general population.

However, the findings also demonstrate significant diversity in people's experience of the training, particularly in terms of possible facilitators and barriers to change. Careful thought should therefore be given to people's individual differences and wider contexts when thinking about the potential helpfulness of this approach. Some of the features of the training that participants experienced as facilitators to change were a gradual learning process (i.e. ideas and concepts slowly introduced and built upon), a personal delivery style in the training videos (e.g. using 'you' language and normalising potential difficulties), different media formats (e.g. videos,

audio exercises and written handouts) and the scope to tailor the approach to your own needs (e.g. flexibility with frequency of practice and which exercises people focus on).

A common reflection from participants interviewed was that they would have liked direct contact with a clinician offering personalised support (e.g. through phone calls or email). Many participants felt that this would have been especially helpful when they faced barriers to engaging the training, such as having worries about self-compassion, struggling to understand certain exercises or not knowing how to maintain practice after completing the training. It would be interesting for future research (both qualitative and quantitative) to compare the experience and effectiveness of unguided and guided CMT. While online guided self-help is now well-established in many NHS services, healthcare providers and other organisations offering such an approach would inevitably have to weigh up the benefits of guided support with the costs of the extra resources required. It would be helpful if both guided and unguided versions of the self-compassion training could be offered, with the selection guided by people's preferences and circumstances (e.g. levels of distress, ambivalence towards compassion and prior levels of understanding). It would also be beneficial to ensure that unguided approaches include some guidance for how people might be able to take their training forward.

5.5. Limitations

Given the fact that most participants invited to an interview did not respond, it is possible that the interview data only comes from those who were particularly committed to the training and/or had more positive experiences of the training. However, online-based interventions are known to often have high rates of attrition (Eysenbach, 2005) and it is hard to determine the extent to which attrition rates are related to participants' experience of this specific training or other factors. The

experiences described by participants should not be devalued for this reason, but it should also not be assumed that they represent the experiences of all participants who engaged with the training.

Another limitation related to the sample is its composition of mostly white British participants with high levels of education. Generalisability of findings is generally not aimed for in qualitative research as much as it is in quantitative research, as small samples preclude representativeness, and its focus is instead on rich detail of the phenomena being explored. Nonetheless, the lack of diversity in the sample indicates that some voices are inadvertently being privileged over others. More research is needed to explore how the training is experienced by participants from a broader range of cultural contexts. While CN and I attempted to reach people from a broad range of backgrounds through our advertising of the study, we still relied on convenience sampling and this may not be appropriate for the purpose of improving representativeness in research. A number of participants expressed having some prior familiarity with the training's ideas through their education or work, and the accessibility of the training could have posed more of an issue for participants without this prior familiarity.

This study also lacked any follow-up interviews, which could have shed light on the extent to which the training had a lasting impact for participants and what it was like for people to try to continue on their own terms. Given the number of participants who expressed concern about maintaining their practice once the training had finished, it might be expected that this would have been challenging for many participants and it would be worthwhile to explore how this was experienced.

Whilst I strove to be led by participants in my questioning and encouraged them to speak openly, it is possible that my position as a researcher and my way of relating to participants influenced participants' descriptions (e.g. demand

characteristics). For example, participants might have felt that my position as part of the research team suggested I was invested in them having a positive experience of the training or, conversely, that my encouragement to speak openly meant I was particularly hoping for constructive negative feedback that could be used to improve the training. It is also inevitable that my subjectivity influenced the way in which I conducted the analysis (e.g. my critical realist epistemological position could have heightened my attention to relational contexts). I tried to increase awareness of the possible impact of my subjectivity through reflexive journaling and bracketing interviews, but I do not believe it would have been possible for me to 'remove' this from the data collection nor data analysis stages and no researcher can be free from preunderstanding (Dahlberg & Dahlberg, 2019). I hope that the results show that participants were able to express a rich range of perspectives and feelings about their experience and that their voices have been centred in the write-up of this study.

5.5. Conclusions

This has been the first qualitative study exploring participants' experience of engaging in an online self-help approach based on CMT, drawn from the CFT model. The findings show that the self-compassion training was experienced as helpful by participants, many of whom described developing a compassionate mentality that had a positive impact on their ways of relating to themselves and others. This provides support to the growing body of literature demonstrating the effectiveness of CMT and CFT-based approaches, and adds weight to Gilbert's (2014) suggestion that compassion should be seen as a social mentality. The potential for a social ripple effect seems to be a particularly striking strength of CFT-based approaches. The fact that participants experienced similar benefits to those described in studies of CFT offered in individual and group formats indicates that online approaches could provide a way of increasing the accessibility and scalability

of CMT and CFT. More broadly, these findings also have encouraging implications for other online approaches.

While the training was generally experienced positively, participants described encountering a diverse range of difficulties with the process. Some of these difficulties consolidated existing CFT literature (e.g. on fear of compassion; Gilbert et al., 2011), while others provided fresh perspectives that have not been explored in previous studies (e.g. in relation to the self-help format). The diverse range of facilitators and barriers to change highlight how differently approaches can be experienced by people, and suggest a need for a contextualised approach to be taken by healthcare providers when determining the potential suitability and helpfulness of approaches. With self-help approaches, there is perhaps a particularly pressing need to consider ways of increasing the personalisation of the support (e.g. options for guided support and/or more attention given to facilitating people to think about how they could overcome barriers and take the training forward). Numerous participants described their social contexts influencing their experience of the training, which suggests that there is also a need for wider-level changes in order to better facilitate people developing more compassionate relationships with themselves.

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Part 3: Critical appraisal

Reflections on managing the research process

Despite some previous research experience, I did not have much confidence in my ability to carry out a research project when I began this process. I feel a lot more comfortable working clinically than I do conducting research, and I was daunted by aspects of the project that I had no experience with, such as completing a literature review and conducting one-to-one semi-structured interviews. As well as choosing a research area that I found interesting, one of my concerns when choosing a research project was a desire to find one with a set-up that would make the inevitable stress feel more manageable than I was anticipating.

Working on a compassion-focused project felt especially attractive because I have found Compassion-focused Therapy (CFT; Gilbert, 2005) helpful in my clinical work with clients, and I felt that it would be a personally helpful area to be reading up on during a process which can amplify trainees' self-doubt and self-criticism. I was also drawn to the fact that the research was supervised to my clinical tutor, JK, who has been such a supportive presence throughout my training journey.

The initial research idea was focused on CN and I undertaking a joint project to pilot the use of a virtual reality-based self-compassion intervention for adolescents, and we had got as far as getting our ethics approved and recruiting schools to take part in this project. Our plan was for CN to conduct a quantitative analysis of pre- and post-intervention measures, while I would interview adolescents about their experience and conduct a qualitative analysis of the interview data. This project unfortunately had to be scrapped in the summer of 2020 because lockdown restrictions meant that face-to-face research would not be possible, and CN and I were feeling panicked about having such a short time-frame to start all over again with a new research project.

Thankfully, MW linked us in with CI, who was serendipitously putting together a CFT-based online self-compassion training that he wanted to be piloted with the general population. This meant that although we would need to start again with all the paperwork and recruitment, we would still be able to complete a compassion-focused project with our different emphases providing both quantitative and qualitative findings about participants' experience of the intervention (Northover, 2021).

It is difficult to overstate how much of a difference it made to be doing a joint project with a friend, particularly at these stages of the project in which we have encountered difficulties. The fact that it was a shared experience made me less likely to assume that difficulties were down to me lacking competence with research, and being able to step in for each other when the other person had other things to contend with meant that there was more space for us to balance the multiple demands of training. In addition to this peer support, we were fortunate to have internal and external supervisors who struck a good balance between being responsive while also showing faith in us autonomously finding our way over hurdles in the research process.

Another thing I have held in mind throughout the research process is Yalom's (2001) story about Abraham Lincoln saying that if he had eight hours to cut down a tree, he would spend several of those sharpening his axe. Yalom talks about in relation to taking breaks in between sessions with clients, and I have found it helpful to apply this to taking a paced approach to research that facilitates thinking space and the re-charging of energy levels. As well as striving to 'sharpen my axe' by making sure I have been living in line with values and interests outside of the course, I have found it beneficial to keep a reflexive journal. Externalising my thoughts and feelings about the research process has felt containing, and has also

helped me to take fresh perspectives without being so quick to 'marry' my initial hypotheses (Cecchin, 1987).

Methodological and conceptual challenges of the literature review

One of the challenges I faced when conducting the literature review was attempting to measure studies' quality despite having relatively little personal experience of qualitative research. I felt as though I was not in a position to do this, and that it was somehow imposturous to be giving some studies a 'low' rating while initially feeling so unsure of how I would be able to put together my own qualitative study. Using the Critical Appraisal Skills Programme Qualitative Research Checklist (CASP-QRC; <http://www.casp-uk.net>) helped to provide a framework for measuring the quality of studies, which I could then use as an anchor when determining about my (more) subjective rating to add to the rating determined by CASP-QRC ratings. The process of thinking about the different aspects of a study that might influence its quality rating turned out to be helpful when designing my own study and writing it up, as it familiarised me with key areas to consider, as well as highlighting a number of things I might not have otherwise thought to include.

I also encountered difficulties when trying to generate 'analytical' themes in my thematic synthesis (Thomas & Harden, 2008), in order to organise and 'go beyond' the data in the studies reviewed. My aim for the literature review was to stay close to participants' voices and take an inductive approach, and I felt concerned about a risk of analytical themes moving too far away from participants' voices. At the same time, I was aware of a risk of the thematic synthesis resembling a content analysis-type approach if I stayed too close to the data, and having 'domain summaries' rather than themes: *"a summary of an area (domain) of the data; for example, a summary of everything the participants said in relation to a particular topic or interview question. Unlike themes, there isn't anything that unifies the*

description of what participants said about this topic . . ." (Braun & Clarke, 2021, p. 3). I managed this dilemma with varying degrees of success through a long process of reviewing the themes against the data and iteratively refining them. Some themes (e.g. 'Blocks') potentially sound like a domain summary but it did not seem possible to generate alternative titles that went 'beyond' this without moving too far from the corresponding data.

A final dilemma that stood out in the literature review process was choosing which excerpts to include with their corresponding themes. On the one hand, I wanted to choose the excerpts that best illustrated the themes and would hopefully enrich the findings by illustrating different aspects of the same theme. On the other hand, I noticed that there was a significant imbalance between the papers in terms of the frequency with which I was drawn to including excerpts from them. There were a handful of papers that I nearly always felt included the best possible excerpt for each theme, and a few from which I rarely felt impelled to include excerpts. This imbalance partly reflected the studies' variable quality. Although most of the studies were of relatively high quality, there were some disparities, particularly in relation to how much their results sections included rich interview data. The imbalance also, however, reflected the nature of the difficulties that participants experienced in different studies. For example, participants in some studies were experiencing significant memory impairments, which might be expected to understandably have an impact on their ability to recount and describe their experience of engaging with CFT. I felt concerned that it would be unethical to not give voice to participants with such difficulties in my literature review, but I also wanted to ensure that the excerpts I included were sufficiently illustrative. Including two excerpts for each theme helped me to manage this dilemma and strike a balance between these two concerns, but I believe that this dilemma highlights issues about whose voices are privileged and/or marginalised in research.

Reflexivity

In qualitative research there is an increasing expectation for researchers to consider their influence throughout the research process (Braun & Clarke, 2013), and I have done this through bracketing interviews and reflexive journaling at all stages of the research. Reflexivity refers to the reciprocal influence between the research process, participants and findings on the one hand, and the researcher on the other (McLeod, 2011). It involves exploring one's assumptions, feelings, values, experiences and theoretical leanings, and how these may interact with the research process (Berger, 2015). With reflexive thematic analysis (Braun & Clarke, 2006), the researcher is not expected to 'remove' the influence of their subjectivity, but it is nonetheless seen as an important endeavour that helps the researcher to think about, and acknowledge, the co-constructed nature of findings.

When conducting semi-structured interviews, one of the challenges I faced was striving to remain led by participants while also ensuring that the interviews were focused on the research questions (i.e. people's subjective experiences of the self-compassion training). Having drawn upon CFT in my clinical work and completed a literature review on qualitative studies on CFT-based approaches, I was aware of having some assumptions about how people would describe their experience and I was worried about imposing these in the interview space. I found it interesting to explore qualitative CFT research for my literature review but also felt that there was a danger of an over-familiarity with previous findings making it harder to be open to different perspectives. Discussing these assumptions in bracketing interviews and exploring them in reflexive journaling helped me to catch myself sometimes prematurely assuming that a participant was saying something I might have expected them to say. I tried to minimise my influence in this regard by designing a very brief interview schedule aide memoire that left space for participants to bring what they wanted to conversations, as well as asking open

questions and staying with participants' own language. Although I do not think it would be possible (nor desirable) to fully achieve this, when trying to limit my intrusion on the interview space I tried to hold in mind Bion's psychoanalytic principle of entering the conversations "without memory, desire or understanding" (Bion, 1970, p. 43).

Another challenge I faced when conducting interviews was trying to maintain a researcher 'stance'. I found that interviewing people about their experiences of a therapeutic approach sometimes meant that my role could become blurred, and I felt a pull to take on a stance of someone who was helping them to plan how to take their training forward, rather than exploring their experience of the training. Indeed, my initial drafts of interview schedules bore some resemblance to 'staying well plans' I would work through with clients at the end of therapy when I worked in an IAPT setting (to help them think about the main things they took from therapy, barriers they might face going forward and how they might be able to overcome these). It was a great help to be able to send many drafts to AW, who helpfully pointed out the fact that I had planned so many questions that it was likely the interview data would simply reflect all the topics I had packed in. Through emails with AW and then pilot interviews with friends, I gradually simplified the interview schedule and created one that left much more space for exploration for participants' experience. I then further refined this along similar lines after conducting my first couple of interviews and realising how much could emerge that I had not anticipated, and how important it would be to allow ample room for this. This tendency to try to take an overly 'helpful' stance has been something that I have also been reflecting on with my supervisors in my current psychoanalytic placement which sometimes involves being able to survive as a 'bad' (or even hated) object for patients (Winnicott, 1969), and my experience working psychoanalytically has

helped me to notice and re-adjust my internal and external stance when I felt that it had drifted from the research focus.

Implications for my clinical practice

One of my main home take-home messages from completing a literature review and empirical study on CFT-based approaches is how it seems to be capable of consistently having an impact on people's ways of relating to others as well as themselves. Different flows of compassion (i.e. from others, towards others and towards ourselves) are often emphasised in a lot of CFT literature (e.g. Gilbert, 2014) and this is borne out by the qualitative research into people's experiences of engaging with it. CFT is an approach that I had already found helpful for clients in multiple settings prior to conducting this project, but this research has further strengthened my resolution to try to integrate it into my practice going forward.

The positive feedback from participants in the empirical study has challenged some of my pre-conceptions about online and self-help approaches. Although I had a lot of faith in CFT before conducting this research, one of the main themes in the literature review was the importance of therapeutic relationships (e.g. Lawrence & Lee, 2013). I was not convinced that an online self-help format would lead to similarly positive results, and I anticipated that the relational context of supportive relationship with a therapist would perhaps be necessary for people to feel able to deeply engage with, and benefit from, the ideas and strategies. This self-compassion training would not necessarily be offered in NHS services, but online interventions also hold some negative connotations for me in relation to the continuous pressure for NHS services to be as 'cost-effective' as possible and for understandings of/responses to mental health difficulties to be disproportionately individualised. The findings of this research have made me more open to the potential helpfulness of self-help approaches.

While many participants did report benefiting from the training, one of the invaluable things about having interviews with participants was that it was possible to gain a detailed understanding of some of the facilitators and barriers to change. Despite participants having a positive overall experience, several of them did mention a desire for more personalised support with it and nearly all participants described experiencing barriers of some kind. The frequency with which participants described their contexts and resources (e.g. work pressures, child care and relationship difficulties) influencing their engagement with the training highlighted the importance of a contextualised approach being taken to supporting people. While many practitioners do this anyway, I believe that the implications of people's social contexts are often insufficiently acknowledged and worked with.

The findings in this study led me to do some more research into some ways in which I can ensure I incorporate this into my clinical work, such as Hagan and Smail's (1997) 'power-mapping', which can be seen as a theoretical framework but also a tool for unpacking the influence of different forms of power and resources on people's distress and wellbeing. Smail (1996) details different forms of power, from proximal influences (e.g. personal relationships, family and education) to more distal influences (e.g. politics, culture and media). In line with community psychology approaches (e.g. Kagan, Burton, Duckett, Lawthorn & Siddiquee, 2011), Hagan and Smail argue that there should be more of an emphasis on transforming oppressive living conditions rather than taking an 'assistentialist' (Freitas, 2000) approach that disproportionately emphasises people adjusting to their living conditions.

"Empowerment', therefore, is a matter not of instilling a 'sense' of power, but of obtaining power. This assertion is in complete opposition to some psychotherapeutic notions, where change in the real world is seen as an avoidance of painful 'inner' work, a form of 'acting out'." (Hagan & Smail, 1997, p. 262)

Conclusions

Despite my initial lack of confidence and the curveballs we encountered along the way, I have enjoyed the challenge of completing this research project and it has taught me a lot. In particular, it has made me aware of some of my assumptions about what is or is not helpful for clients, issues around whose voices are privileged or marginalised in research, the diversity of people's experiences of engaging in particular forms of support, and some ways of working that I want to ensure I strive towards in my clinical practice. I have been lucky to be able to have a friend as a co-researcher and to have such supportive supervisors throughout this process, which has underlined the value of peer support and collaboration.

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Appendices

Appendix 1: Outline of joint project contributions

As described in the Method section (p. 67), this was a joint project with my fellow DClinPsy trainee, CN. CN and I completed many parts of the project together: project planning, setting up the training on Qualtrics and recruitment. However, we had different emphases in our respective data collection and data analysis processes. CN collected scores on various outcome measures and completed quantitative analyses of pre- and post-intervention changes in these, whereas I conducted semi-structured interviews with a sub-sample of participants and a thematic analysis of the interview data. All parts of our theses were written separately.

Appendix 2: Ethics approval

Ethics Application Form for Non-Invasive Research on Healthy Adults

SECTION A APPLICATION DETAILS


A1	Project details
	Project title: Developing self-compassion online
	Date of submission: 15/7/2020
	Proposed start date: 1 st August 2020
	Proposed end date: 31 st July 2025 (this can be up to 5 years from start date):

A2	Principal researcher																
	<i>(Note: A student – undergraduate, postgraduate or research postgraduate – cannot be the principal researcher for ethics purposes).</i>																
	Full name: Dr Chris Irons																
	Position held: Hon. Associate Professor																
	Research Department: Clinical, Educational and Health Psychology																
	The principal researcher must read and sign (electronic signature or scanned pdf with signature are acceptable) the following declaration. Please tick the box next to each of the statements below to acknowledge you have read them and provided all required information.																
	<table border="1"> <tr> <td> <ul style="list-style-type: none"> I will ensure that changes in approved research protocols are reported promptly and are not initiated without approval by the Departmental Ethics Committee, except when necessary to eliminate apparent immediate hazards to the participant. </td> <td style="text-align: center;">x</td> </tr> <tr> <td> <ul style="list-style-type: none"> I have completed a risk assessment for this programme of research and hereby confirm that the risk assessment document will be discussed with any researcher/student involved in this programme of research (currently or in the future). I will ensure that all researchers/students sign the risk assessment form following this discussion. Risk assessment forms for projects can be downloaded from the Ethics section of the PaLS Intranet. </td> <td style="text-align: center;">x</td> </tr> <tr> <td> <ul style="list-style-type: none"> I have completed the Information Governance training provided by ISG </td> <td style="text-align: center;">x</td> </tr> <tr> <td> <ul style="list-style-type: none"> I have obtained approval from the UCL Data Protection Officer stating that this research project is compliant with the General Data Protection Regulation. My Data Protection Registration Number is: Z6364106/2020/07/23 You can find a data protection registration form at: http://www.ucl.ac.uk/legal-services/research Note: your data protection number could cover a whole programme of research. It is not always necessary to request a data protection number for each individual project. </td> <td style="text-align: center;">x</td> </tr> <tr> <td> <ul style="list-style-type: none"> I have included examples of the Information Sheet and Consent Form for the proposed research. It will be made clear to the participants that they can withdraw from the study at any time, without giving a reason. </td> <td style="text-align: center;">x</td> </tr> <tr> <td> <ul style="list-style-type: none"> I will ensure that all adverse or unforeseen problems arising from the research project are reported in a timely fashion to the UCL Research Ethics Committee. </td> <td style="text-align: center;">x</td> </tr> <tr> <td> <ul style="list-style-type: none"> I will undertake to provide notification when the study is complete and if it fails to start or is abandoned. </td> <td style="text-align: center;">x</td> </tr> <tr> <td> <ul style="list-style-type: none"> I have met with and advised students on the ethical aspects of this </td> <td style="text-align: center;">x</td> </tr> </table>	<ul style="list-style-type: none"> I will ensure that changes in approved research protocols are reported promptly and are not initiated without approval by the Departmental Ethics Committee, except when necessary to eliminate apparent immediate hazards to the participant. 	x	<ul style="list-style-type: none"> I have completed a risk assessment for this programme of research and hereby confirm that the risk assessment document will be discussed with any researcher/student involved in this programme of research (currently or in the future). I will ensure that all researchers/students sign the risk assessment form following this discussion. Risk assessment forms for projects can be downloaded from the Ethics section of the PaLS Intranet. 	x	<ul style="list-style-type: none"> I have completed the Information Governance training provided by ISG 	x	<ul style="list-style-type: none"> I have obtained approval from the UCL Data Protection Officer stating that this research project is compliant with the General Data Protection Regulation. My Data Protection Registration Number is: Z6364106/2020/07/23 You can find a data protection registration form at: http://www.ucl.ac.uk/legal-services/research Note: your data protection number could cover a whole programme of research. It is not always necessary to request a data protection number for each individual project. 	x	<ul style="list-style-type: none"> I have included examples of the Information Sheet and Consent Form for the proposed research. It will be made clear to the participants that they can withdraw from the study at any time, without giving a reason. 	x	<ul style="list-style-type: none"> I will ensure that all adverse or unforeseen problems arising from the research project are reported in a timely fashion to the UCL Research Ethics Committee. 	x	<ul style="list-style-type: none"> I will undertake to provide notification when the study is complete and if it fails to start or is abandoned. 	x	<ul style="list-style-type: none"> I have met with and advised students on the ethical aspects of this 	x
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	project/programme of research.	
	<ul style="list-style-type: none"> I am satisfied that the proposed research complies with current professional, departmental and university guidelines. 	x
	Signature: <i>[Handwritten Signature]</i>	Date: 6/7/20
A 3	Contact details	
	Principal Researcher	
	Full name: Dr Chris Irons	
	Position held: Hon. Associate Professor	
	Research Department: Clinical, Educational and Health Psychology	
	Email: chris@balancedminds.com (waiting for UCL email address)	Telephone: 07894472861
	Additional applicant 1	
	Full name: Dr John King	
	Position held: Associate Professor	
	Research Department: Clinical, Educational and Health Psychology	
	Email: john.king@ucl.ac.uk	Telephone: 020 76795993
	Additional applicant 2	
	Full name: Dr Michelle Wilson	
	Position held: Doctoral student	
	Research Department: Clinical, Educational and Health Psychology	
	Email: m.c.wilson@ucl.ac.uk	Telephone: 020 7679 1897
	Additional applicant 3	
	Full name: Clare Northover	
	Position held: Doctoral Student	
	Research Department: Clinical, Educational and Health Psychology	
	Email: clare.northover.18@ucl.ac.uk	Telephone: 020 76795993
	Additional applicant 4	
	Full name: Jack Deacon	
	Position held: Clinical Tutor	
	Research Department: Clinical, Educational and Health Psychology	
	Email: j.deacon.17@ucl.ac.uk	Telephone: 020 76795993

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(Add further details on a separate sheet if there are more applicants to be covered by this form)

A4	Approval from the Departmental Ethics Committee	
	<i>(Approval cannot be given by the principal researcher of this project – if necessary the application must be sent to an Ethics Officer from a different Research Department, or to the College Ethics Committee, for approval)</i>	
	<p>Declaration by the Research Department Ethics Chair:</p> <p>I have reviewed this project and I approve it. <input checked="" type="checkbox"/></p> <p>The project is registered with the UCL Data Protection Officer and a formal signed risk assessment form has been completed.</p>	
	<p>Allocated Departmental Project ID Number for the approved application:</p> <p>CEHP/2020/581</p>	
	<p>Name of the Research Department Ethics Chair (type in): Jean-Baptiste Pingault</p> <p>Date: 01/08/2020</p>	

SECTION B	PROJECT DETAILS
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B1	Summary of Research
	<p>It is particularly important to provide sufficient detail of the research protocol and the measures that will be used, to enable evaluation of the application on ethical grounds. It is also important to clearly demonstrate that the proposed measures are 'innocuous' and fall within PaLS Ethics remit.</p> <p>Please provide a brief summary of the project/programme of research including</p> <ul style="list-style-type: none"> • Background • Aims • Participants and recruitment • Procedure (including whether face-to-face or online study) • Measures • Examples of measures (tests, questionnaires, interviews etc.) as per RD guidelines <p>NB When providing examples of each measure you plan to use, please select the most emotive/distressing examples so that the Ethics Chair can judge the potential for causing any distress.</p>

This programme of research aims to explore the impact of brief online or app based programmes based on the principles and practices of Compassion Focused Therapy (CFT) and Compassionate Mind Training (CMT). The research will focus on healthy adult samples. Measures will include commonly used questionnaires measuring compassion, self-compassion, self-criticism and shame (amongst others). Questions for focus group and any qualitative elements will be guided by experts in CFT, along with published research.

Example Study

Study 1. Developing self-compassion online: Assessing the effectiveness and acceptability of a brief online intervention.

Background

The corona virus outbreak has caused a time of heightened anxiety and uncertainty, and it appears that it has never been more important for us to learn to be kinder and more compassionate towards ourselves. Compassion is defined as "a basic kindness, with a deep awareness of the suffering of oneself and of living things, coupled with a wish and effort to relieve it" (Gilbert, 2009). At present, there is a growing body of evidence demonstrating the positive impact of cultivating compassion, both for improving physical health (e.g. immune system effectiveness, Klimecki et al., 2012) and general psychological wellbeing (Neff & Germer, 2013). Researchers have also found that cultivating self-compassion can lead to higher levels of compassion for others and greater motivation to alleviate others' suffering (Condon et al., 2013).

Compassion-Focused Therapy (CFT; Gilbert, 2000) was developed for high shame and self-critical people with complex mental health problems, for which there is good evidence of effectiveness (e.g. Kirby 2016; Leaviss and Uttley 2014). It focuses on our common humanity by understanding that the way that the human brain has evolved makes us very vulnerable to rumination, self-critical self-monitoring and negativity bias (Baumeister et al. 2001; Gilbert 2009). Such insights shift attention from blaming and shaming the self for these difficulties to how to work with them compassionately (Gilbert and Choden 2013).

Compassionate Mind Training (CMT), an aspect of CFT, has been found to increase self-compassion through education on compassion, the teaching of self-soothing techniques and by providing tools to challenge self-criticism and self-judgement (Gilbert, 1997; Gilbert, Clarke, Hemel, Miles & Irons, 2004). Additional benefits to developing self-compassion include increased emotional resilience (Gilbert & Procter, 2006), increased resources to manage stress (Leary, Tate, Adam, Allen & Hancock, 2007) and lower levels of self-critical judgement, which in high levels, has been found to be positively correlated with burnout and negatively correlated with psychological wellbeing (Beaumont, Durkin, Hollins Martin and Casron, 2016).

While CFT requires an intensive face-to-face treatment delivery in order to target clinical conditions, a brief CMT intervention may be particularly useful to target public health concerns and promote mental well-being among the general population (Matos et al., 2017). Mental health prevention and promotion initiatives should aim to be flexible, accessible, and sustainable (Christensen & Hickie, 2010; Kazdin & Blase, 2011) and, "light-touch" approaches, such as CMT, can provide a cost-effective and time efficient means of engaging a broad range of people.

Studies of CMT have demonstrated effectiveness in reducing clinical psychological symptoms (Beaumont and Martin 2013; Braehler et al. 2013; Gilbert and Procter 2006; Mayhew and Gilbert 2008) and more recently studies have started to assess the effectiveness of CMT in nonclinical populations (Matos, et al., 2017; Matos, et al., 2017; Kim, et al., 2020), demonstrating that even interventions as short as a couple of weeks can significantly reduce both self-reported symptoms and increased neurophysiological

biomarkers of the parasympathetic nervous system response: the “self-soothing” system.

Due to the social distancing restrictions in place because of the corona virus outbreak, developing online interventions seems more relevant than ever. There have now been several pilot studies, using a pre-post intervention design, which have shown promising benefits of accessing brief compassion focused interventions online in a variety of populations; including university students (McEwan & Gilbert, 2016), psychology trainees (Finlay-Jones, Kane & Rees, 2016), health care professionals (Rao & Kemper, 2017) and mothers of infants (Mitchell, Whittingham, Steindl & Kirby, 2018). There has been a lack of research, however, using more rigorous designs. Krieger, et al., (2019) conducted a randomised control trial of an 8-week compassion focused online intervention for those suffering with high levels of self-criticism, and Halamová, Kanovský, Varšová & Kupel (2018) developed an online intervention design to be accessed over 14 consecutive days. Both studies showed significant improvements in self-reported outcomes measures of those that completed the interventions but neither of these have assessed that participants’ experiences of the intervention more thoroughly in order to improve its acceptability and reduce the likelihood of drop out and non-compliance.

Based on these considerations, we aim to develop a brief, online self-compassion training programme that will be short and accessible for the general population. The research project will be interested in exploring the initial outcomes of this new programme and conducting a process evaluation to explore the feasibility and acceptability of it. The Medical Research Council’s (MRC) guidelines for complex interventions emphasises the importance of assessing feasibility as part of piloting interventions to prevent evaluations being undermined by issues of acceptability, compliance, intervention delivery, recruitment and retention (Moore et al., 2014). As advised by the MRC, the current research project will combine quantitative and qualitative methods to examine the programme’s feasibility (implementation and delivery of the intervention) and acceptability (how participants engage with the intervention, experiences of change etc.). In doing so, it is hoped that the research project will help to explain the interventions outcomes and identify ways to optimise its design and/or replicate it. Furthermore, it will explore initial outcomes i.e. whether the online training contributes to an increase in self-compassion and well-being in the participants and a reduction in their experience of self-criticism, shame, anxiety, depression and stress symptoms.

Aims

1. To develop a new brief online self-compassion programme with follow-up exercises (i.e. guided audio based self-compassion exercises) for the adult general population.
2. To carry out a process evaluation of the programme and follow-up exercises, which will involve consideration of:
 - a. The feasibility of delivering a brief online compassion intervention with follow up exercises for the adult general population considering:
 - i. Compliance with the follow-up exercises
 - ii. Fidelity of the intervention delivery.
 - b. The acceptability of a brief online self-compassion intervention with follow-up exercises, for the adult general population considering:
 - i. Subjective experiences of the programme and follow-up exercises (e.g. what participants found helpful / could have been different, whether participants feel they can make use of them in their lives)
 - ii. Subjective experiences of change through the workshop and follow-up exercises (e.g. whether the participants feel as though they led to any changes and if so what changes occurred and what factors contributed to / hindered these changes).
3. Explore initial outcomes and effectiveness of the workshop and follow-up exercises by examination of the outcome measures, i.e.
 - a. To evaluate whether this online intervention and follow-up exercises can effectively improve levels of self-compassion and mental wellbeing and decrease levels of self-criticism, shame, depression, anxiety and depression in the adult general population.

Participants and recruitment

As this is a new programme, we want to use an adult sample from the general population. We will then be able to use the results from the research to make adaptations for more specific groups in the future.

Participants will self-identify themselves by responding to an advert for the study on social media and emailing one of the research team. They will be sent an information sheet (appendix 1) about the research study and asked to opt-in with a consent form (appendix 2). Those who give their consent to participate in the study will then be emailed a link to the questionnaires in the survey (appendix 6). Participants will be asked to generate a unique code for themselves at the start of the survey – this will allow us to track their engagement with the programme and their responses across the three outcome measure time points. The code will be first three letters of their mother's maiden name and the last three numbers of their mobile phone – information that the researchers will not have access to and therefore will not be able to use identify participants by. As such, the code will be non-identifiable so the trainees' responses will remain anonymous, however they will be able to easily remember it each time they complete the outcome measures. Participants will then be randomly assigned to either the "intervention" condition or the "waiting list" condition. Those in the intervention condition will then complete the online training. The waiting list group will complete the intervention after the third outcome measure time point.

Procedure

The content for this online training has been drawn principally from CFT theory, practice and outcome research (e.g. Gilbert 2009; Matos et al., 2017; Irons & Beaumont, 2017). A link to each session will be emailed to them each week. This will be through Qualtrics and participants will have to enter their unique code to access them.

Session 1 - this session will explore how to lay the foundations for self-compassion by understanding the affection regulation model in CFT (Gilbert, 2009). It will then lead to participants engaging in an exercise called soothing rhythm breathing which is linked to accessing and developing the parasympathetic nervous system (which has been found, amongst other things, to be related to threat regulation and social connection - see Kirby et al., 2017)

Session 2 - this session will explore the concept of developing a compassionate self, and to begin to direct a sense of compassion and good will to oneself. This practice has been found to be associated with reductions in shame and stress, and increases in self-compassion (see Matos et al., 2017 and Kim et al., 2020).

Session 3 - will involve learning to switch from a threat mind, to a compassion mind, and further develop self-compassion through compassionate imagery (see Gilbert & Irons, 2004; Gilbert, 2009; Irons & Beaumont, 2017)

Session 4 - this final session will explore self-compassion principally through compassionate letter writing, which utilises adaptations to expressive writing to help participants develop a more compassionate relationship with themselves (Gilbert, 2010).

Following the completion of each session, they will be emailed a link where they can download the follow-up guided audio exercises and reading materials. This will be via the online survey platform Qualtrics. Participants will enter their self-generated code in order to access these. This will allow us to track which participants opted to access the follow-up exercises. One week after each session (before they access the next session) we will ask participants to complete the Compassionate Mind Practice Recording Diary (taken from Matos et al., 2017) to assess how much they have practiced the exercises during that week.

One week after the last session of the programme (Time Point 2), participants will be sent a final link to Qualtrics to complete the package of outcome measures, the final Compassionate Mind Practice Recording Diary (taken from Matos et al., 2017) and some brief open-ended questions to learn more about their experience of participating in the training programme and follow-up exercises. The email will also ask them whether they would like to be contacted for further follow-up qualitative interviews to explore their experiences of the online programme and follow-up exercises in further detail (see Appendix 3).

Lastly, participants will be sent a link to complete the outcome measures one month after completing the online programme (Time Point 3). Again, they will access the survey using their self-generated code. The final page of the survey will redirect them to a separate survey. This survey will have one question on it asking them if they would like to enter themselves into a prize draw for a high street voucher or donation to charity for having participated in the study.

These responses are stored completely separately from their questionnaire responses and so cannot be linked to them at all. All of the participants will be provided with a debriefing sheet following this. Participants who expressed an interest in taking part in the qualitative interviews at Time Point 2 will be contacted via email to invite them to an interview via videocall (using the platform Microsoft Teams). They will be provided with an information sheet (Appendix 4) and consent form (Appendix 5) prior to the interview (again using Qualtrics). Interview data will be collected via an audio recording of the interview using a Dictaphone. These will be immediately transferred to a password-protected memory stick and removed from the Dictaphone. Anonymised transcripts will be made within seven days of the interviews. Once the transcripts are completed, the audio recordings will be deleted. Transcripts from interviews will be anonymised and stored using a password-protected account with NVivo. This qualitative feedback will be used to further explore feasibility, acceptability and facilitators/barriers to change.

All of the participants will be provided with a debriefing sheet following completion of the study.

All participants' email addresses will be deleted at the point that they exit the study.

Measures – Please see Appendix 6 for copies of these

Demographic measures

The first questionnaire will ask participants to fill out some brief demographic details. The categories of personal data used in the study will be as follows:

- Gender
- Age
- Ethnicity
- Highest level of education
- Occupation
- Previous experience of therapy
- Where they saw the study being advertised

Feasibility measures

In order to assess feasibility, data will be collected regarding compliance with follow-up exercises and drop-out rates across different time points. Participants will be asked to complete the Compassionate Mind Practice Recording Diary (taken from Matos et al., 2017) each week in order to assess how often they practice the exercises.

Acceptability measures

In order to assess acceptability, we will conduct interviews to explore participants' subjective experience of the intervention. The majority of existing research into self-

compassion interventions is focused on quantifiable change through outcome measures, and there is a lack of emphasis on people's experience of the process. It is hoped that this will provide invaluable complementary data that will help to shed some light on various important areas such as mechanisms of change, barriers to developing self-compassion, helpful aspects of engaging in the intervention, and ways of improving the experience in further developments. Please see Appendix 7 for an outline of the interview schedule.

Outcome measures

The participants in this study will also be asked to complete a package of outcome measures at the three time points listed previously, i.e.: pre online-programme, post online-programme, and one month after the programme. These measures will be used to explore the effectiveness of the intervention. The package of outcome measures are:

The Self-Compassion Scale - Short form (SCS-SF; Raes, Pommier, Neff & Van Gucht, 2011): a 12-item measure of the level of self-compassion within an individual.

Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (FSCRS; Gilbert, Clarke, Hempel, Miles & Irons, 2004). 22-item self-report questionnaire to measures trait self-criticism and self-reassurance.

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS; Tennant et al, 2007): a 14-item scale, which measures subjective well-being and psychological functioning.

B2	Will the results be disseminated outside the standard academic outlets?	Yes X	No
	If you answered 'yes', please specify:		
	<p>The research outcomes will be disseminated in the following ways:</p> <ul style="list-style-type: none"> • Jack Deacon and Clare Northover will each be writing a thesis, which will report the research outcomes. This will be read and discussed by the DClinPsy course academic staff members and students. • A summary of the results will be shared with the participants. • The aim is to write a paper for publication in a psychology journal. 		

B3	<p>Please outline any ethical issues that might arise from the proposed study and explain how they will be addressed.</p> <p><u>Informed consent</u></p> <p>An information sheet will be provided to all participants detailing the purpose of the study, what it will involve, any possible risks and benefits, as well as an explanation of confidentiality and data protection. Participants will also have the opportunity to ask questions and discuss the study with the researcher and will be able to withdraw from the study at any time without having to provide a reason or incurring any penalties. They will be asked to sign a consent form.</p> <p><u>Confidentiality and data security</u></p> <p>The data collected from all participants will be anonymised and handled in accordance with the Data Protection Act 1998 to ensure confidentiality.</p> <p><u>Harm to participants</u></p> <p>We do not anticipate any harm coming to participants. There is the potential for us to become aware of risk of harm to self or others during the post-training interviews. If this happens the researchers would work with the Principal Researcher to best-support the person and ensure they are aware of support services they could access.</p> <p><u>Waiting list control design</u></p> <p>Half of the participants will be randomly allocated to a "waiting list" control group which means that they will have to wait before they have access to the online training. However, as we are using a general population sample, and not a clinical sample, then participants would not otherwise be receiving such an intervention. Furthermore, participants will be clearly told that they might be assigned to this group when they consent to take part.</p> <p><u>Participants' wellbeing</u></p> <p>There is a risk that questions about self-criticism and internal and external shame could be distressing for some participants. Three steps will be taken to address these risks:</p> <p>(1) participants will be clearly informed what the study is about and what information will be sought in each section of the measures, to ensure they are fully informed before deciding to take part</p> <p>(2) it will be stressed at the beginning of the questionnaire that participants may at any point cease participation and close their web browsers. Only responses where the participant has clicked the 'submit' button at the end of the survey will be accessed and included in the analysis. Participants will be able to ask for their data to be removed from the study if they wish by providing the researchers with their self-generated code.</p> <p>(3) At the end of the study we will provide a debriefing form which will include information normalising self-criticism and difficulties with self-compassion and wellbeing, as well as a link to an NHS web page of confidential support lines for those participants who may wish to explore further support options.</p>
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SECTION C

PARTICIPANT DETAILS

C1	Participants to be studied		
	Number of volunteers:	100	
	Upper age limit:	N/A	
	Lower age limit:	18	
C2	Payment		
	<p>Will payment or any other incentive (e.g. a gift voucher or free services) be made to any research participant?</p> <p style="text-align: right;">Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Participants will not be individually paid for taking part in the questionnaire-based part of the study (i.e. for completion of the outcomes measures). We will however offer participants the option to be entered into a random prize draw to win a £10, £15 or £25 high street voucher of their choice / donation to a charity following completion of the one month follow-up questionnaire completion (i.e. Time Point 3). They will do this by being redirected to a different survey on Qualtrics where they will provide their email address for entry into the prize draw. This data will be separate from their questionnaire responses and will not make their questionnaire responses identifiable to the researchers. Once the prize draw has taken place, the email address will be deleted.</p> <p>We will offer high street vouchers / donations to charity at the value of £10 for any participants opting to engage in the semi-structured follow-up interviews.</p>		
C3	Recruitment		
	<p>(i) Describe how potential participants will be identified:</p> <p>(ii) Describe how potential participants will be approached and recruited:</p> <p>Potential participants include anyone in the general population that is over 18 years old, has regular access to the internet and can read English fluently.</p> <p>The study will be advertised on various social media sites with the aim of reaching a diverse population, i.e. through community groups rather than university groups. The advert will ask whether the reader is someone who "struggles with being too hard on themselves" and whether they are "interested in learning how to be more self-compassionate". Potential participants will self-identify themselves by clicking the link to read the full information sheet and consent form.</p>		
C4	Will the participants participate on a fully voluntary basis?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	Will UCL students be involved as participants in the research project?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Participants will not directly be recruited from UCL but there is the possibility that a UCL student will volunteer to take part.		
C5	Deception		
	Will any form of deception be used that raises ethical issues? If so, please explain.		
	No		

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C6	Will you provide a full debriefing to the participants?	Yes	X	No
	If 'No', please explain why below.			

C7	Information Sheets And Consent Forms			
	<p>You must attach the final information sheet and consent form for your participants with this application. This will already have received approval from the Data Protection Team. Templates are available on the PaLS intranet (please note that these changed at the end of 2017, so as to be compliant with new Data Protection regulations [GDPR]). The information sheet needs to contain sufficient detail to enable informed consent. However, the information must be provided in lay language and should look different from the summary of research provided in section B1.</p> <p>The template information and consent forms should give you an idea of the level of detail required. NOTE THAT MAILING AND E-MAIL ADDRESS SHOULD BOTH BE INCLUDED IN RESEARCHER CONTACT DETAILS. All information sheets and consent forms should include a) Institutional headed paper, b) information regarding the RD Ethics Chair who approved your study, c) project ethics ID. N.B. Where consent will be obtained online, the information sheet and consent form should be accurate to reflect that.</p> <p>When applying for an ethics approval for a broader research programme, you should provide an example information sheet and consent form for a representative study/experiment. You do not need to provide further examples, unless future studies/experiments substantially depart from the proposed programme of research</p>			

Appendix 3: Poster for social media



UCL

DEVELOPING SELF-COMPASSION ONLINE



Giving yourself a hard time?

Interested in contributing to new research on how to help people become more compassionate with themselves?

Our study will involve:

- Engaging in online self-compassion training
- Less than 10 minutes of daily practice over 4 weeks
- Completing some questionnaires
- Telling us about your experience of the training
- Random prize draw to win a high-street voucher or donation to a charity (£10, £15 or £25)

To find out more, please contact researchers Dr Clare Northover (clare.northover.18@ucl.ac.uk) and Jack Deacon (j.deacon.17@ucl.ac.uk). Supervised by Dr Chris Irons, Director of Balanced Minds and Honorary Lecturer at UCL.

By responding to this advert you are consenting for us to email you with information about the study.

Appendix 4: Additional poster for social media



UCL

DEVELOPING SELF-COMPASSION ONLINE



Giving yourself a hard time?

Interested in contributing to new research on how to help people become more compassionate with themselves?

Our study will involve:

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- Less than 10 minutes of daily practice over 4 weeks
- Completing some questionnaires
- Telling us about your experience of the training
- Random prize draw to win a high-street voucher or donation to a charity (£10, £15 or £25)

To find out more, please contact researchers Dr Clare Northover (clare.northover.18@ucl.ac.uk) and Jack Deacon (j.deacon.17@ucl.ac.uk).
Supervised by Dr Chris Irons, Director of Balanced Minds and Honorary Lecturer at UCL.

By responding to this advert you are consenting for us to email you with information about the study.

Appendix 5: Interview information sheet

Self-compassion training interview: participant information sheet

UCL Research Ethics Committee Approval ID Number: CEHP/2020/581

Study title: *Developing self-compassion online: Assessing the effectiveness and acceptability of a brief online intervention*

Department: Research Department of Clinical, Educational and Health Psychology

Name of the researchers: Dr Chris Irons, Dr John King, Dr Michelle Wilson, Dr Clare Northover and Jack Deacon

Name of the Principal Researcher: Dr Chris Irons, Clinical Psychologist and Director at 'Balanced Minds'. If participants wish to contact Dr Chris Irons they can do so via email (chris@balancedminds.com).

You are being invited to take part in an interview to explore your experience of taking part in the online self-compassion training. Before you decide to take part in this interview, it is important for you to understand why it is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish to. Feel free to ask us if there is anything that is not clear or you would like additional information.

Interviews about your experiences of online self-compassion training: The content for this online training was based on the Compassion-Focused Therapy approach and designed by an expert in this area. The aim of the training was to help develop self-compassion in individuals. You are being invited to participate in an interview to explore your experience of engaging with the training.

Purpose of the interview: Broadly, this research study aims to evaluate the feasibility, acceptability and effectiveness of the online self-compassion training. The interview you are being invited to take part in is aimed at finding out about your experience of the training, as well as any changes you feel it may have led to. We consider participants' feedback invaluable in helping us to think about how this approach is offered to the general population and how it could be improved upon.

Why have I been chosen? You are being invited to take part in this interview because you agreed to be contacted regarding an interview when you first signed up for the study.

Do I have to take part? Participation in the study is voluntary. You do not need to agree to participate in an interview, and you can withdraw from the study at any stage without giving a reason and without any negative consequences.

What will happen to me if I take part? If you decide to take part in the interview, you will be invited to speak with one of the researchers in a video interview. Before the interview starts, the researcher will clarify the plan and double-check that you consent to take part. The researcher will try to answer any questions you may have about the interview and, where possible, the broader evaluation study.

The interview should last approximately 1 hour and will take place online via Microsoft Teams. The researcher will try to arrange the interview at a time that suits you. The interview will be conversational, and the researcher will help you to talk about your experiences of the intervention and any subsequent changes in your own words. The researcher will ask you about things such as what you found helpful or unhelpful about the online self-compassion training, whether you feel as though they led to any changes, and whether you felt there were any factors that facilitated or hindered these changes. You will be able to stop the interview at any time, and you can do so without giving any reason.

The interview will be recorded via Dictaphones. Once the interview has been completed, the audio recording will be transferred to a password-protected USB stick and the recording will be deleted. The recording will be stored using codes (i.e. a participant number) created to protect your anonymity. Any and all identifiable information will be removed from the transcripts and any quotes used from the interviews will be referred to using participant numbers.

After completing the interview, you will receive either a £10 Amazon gift voucher or a £10 donation to a charity of your choice to thank you for your time.

Are there possible disadvantages and/or risks in taking part? We do not anticipate any disadvantages or risks to taking part in an interview. In the unlikely event that completing the interviews becomes distressing, you will be able to talk with the researcher about this and/or contact the Principal Researcher to discuss what action might be helpful.

What are the possible benefits of taking part? After completing the interview, you will receive either a £10 Amazon gift voucher or a £10 donation to a charity of your choice to thank you for your time. Your feedback will be used to explore the feasibility and acceptability of the online self-compassion training, as well as facilitators and barriers to change. We hope this will help us to improve the training and its future delivery for the general population.

What if something goes wrong? If you wish to make a complaint about this evaluation study, please contact the Principal Researcher at chris@balancedminds.com. If you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk. If something happens to you during or following your participation in this evaluation study that you think might be linked to taking part, please contact the Principal Researcher. If you have any concerns about the compassion based workshop and follow-up audio exercises, please also discuss this with the Principal Researcher.

Will my taking part in this study be kept confidential? Any responses you give are completely confidential and anonymous and will be stored according to the Data Protection Act 1998. Only the research team will have access to the data, which will be stored on the UCL secure drive. The information you provide will be stored using codes generated to protect your anonymity. You will not be identifiable in any ensuing reports or publications.

Limits to confidentiality: It will not be possible to identify you from the interview transcripts because they are anonymous and confidential. Any identifiable information will be removed from the transcripts and will be excluded from any ensuing reports or publications. However, if you do discuss any of your responses with us and there is a risk to self or others, then the Principal Researcher for this evaluation study may need to agree that confidentiality needs to be breached in order to safeguard yourself or others. If this were to happen, we would try to discuss this with you before we need to share any information. Confidentiality will therefore be respected unless there are compelling and legitimate reasons for this to be breached.

What will happen to the results of the study? Results of this study will be used to inform future studies and your feedback will help us in further developing this compassion based intervention. The study will enable us to gauge the feasibility and acceptability of the delivering the intervention for the general population and will therefore provide key insights for follow-up studies. Dr Clare Northover and Jack Deacon will write up the results for their DClInPsy theses. We will also aim to publish the results in a peer-reviewed journal within the next year. You can contact the researchers directly using their contact details at the start of this information sheet, to ask for a copy of any publication on the data. You will not be identifiable in any report or publication.

Local Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in research studies, click [here](#)

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used in the study will be as follows:

- Gender
- Age (through broad categories)
- Ethnicity (through broad categories)

- Highest level of education
- Occupation
- Previous experience of therapy
- Where you saw the study being advertised

The lawful basis that will be used to process your personal data are: 'Public task' for personal data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

As stated above, you have the right to withdraw from the study at any time and to request that all your data are immediately destroyed.

Who is organising and funding the research? The study is being organised by the Research Department of Clinical, Educational and Health Psychology, University College London (UCL).

Complaints: If you wish to complain about our use of personal data, please send an email with the details of your complaint to the UCL Data Protection Officer so that they can look into the issue and respond to you. Their email address is data-protection@ucl.ac.uk. You also have the right to lodge a complaint with the Information Commissioner's Office (ICO) (the UK data protection regulator). For further information on your rights and how to complain to the ICO, please refer to the ICO website: <https://ico.org.uk/>

Ethical review of the study: This study has been ethically approved by the UCL Division of Psychology and Language Sciences ethics committee.

Contact for further information: If you have any further questions about this study before or after participation, please feel free to contact us and we will be happy to answer any questions:

Dr Chris Irons (Clinical Psychologist and Director at 'Balanced Minds')

Email: chris@balancedminds.com

Jack Deacon (Trainee Clinical Psychologist)

Email: j.deacon.17@ucl.ac.uk

Thank you for reading this information sheet and for considering taking part in an interview.

Appendix 6: Interview consent form

Self-compassion training interview – consent form

Please complete this form after you have read the information sheet and asked the researcher any questions you may have regarding the interview.

Study Title: *Developing self-compassion online: Assessing the effectiveness and acceptability of a brief online intervention*

Department: Research Department of Clinical, Educational and Health Psychology

Name of the Researchers: Dr Chris Irons, Dr John King, Dr Michelle Wilson, Dr Clare Northover and Jack Deacon

Name of the Principal Researcher: Dr Chris Irons, Clinical Psychologist and Director at 'Balanced Minds'. If participants wish to contact Dr Chris Irons they can do so via email (chris@balancedminds.com).

Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts
(email: data-protection@ucl.ac.uk)

This study has been approved by the UCL Research Ethics Committee: Project ID number: CEHP/2020/581

Thank you for considering taking part in this study. The participant information sheet provides detailed information about this evaluation study. If you have any questions arising from the Information Sheet, please ask the researcher directly or contact the Principle Researcher, Dr Chris Irons (chris@balancedminds.com) before you decide whether to participate.

I confirm that I understand that by ticking all the boxes below and returning this form to the researcher, I am consenting to participate in an interview. If I do not consent to all the below elements of the study, I should not return this consent form.

Statement

**Insert an
'X' next to
each
statement
to give
consent**

I confirm that I have read and understood the information sheet

I have had an opportunity to consider the information and what will be expected of me

I have also had the opportunity to ask questions which have been answered to my satisfaction

I consent to participate in an interview regarding my experience of the online self-compassion training

I understand that my responses during the interview will be used for the purposes explained to me

I understand that according to data protection legislation, 'public task' will be the lawful basis for processing

I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. Any and all identifying information will not be removed from the transcripts and excluded from any ensuing reports and publications.

I understand that confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached. If this were the case I understand that I would be informed of any decision that might limit my confidentiality

I understand that my data gathered in this study will be stored anonymously and securely. The interview recordings and transcripts will be saved using codes generated to protect my anonymity

I understand that my information may be subject to review by responsible individuals from the university for monitoring and audit purposes

I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the study

I understand the benefits of participating

I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researchers undertaking this study

I understand that I will receive either a £10 Amazon voucher or a £10 donation to a charity of my choice for participating in this study. I also understand that I will not benefit financially from any outcomes the research study may result in in the future

I agree that my anonymised data may be used by others for future research. [No one will be able to identify you when this data is shared.]

I consent to my interview responses being stored anonymously, using password-protected software and being used for analyses, quality control, and research purposes

I hereby confirm that I understand the inclusion criteria as detailed in the information sheet

I hereby confirm that I understand why I have been invited to take part in this evaluation study and I am eligible to take part

I am aware of who I should contact if I wish to lodge a complaint

I would be happy for the data I provide to be archived at University College London

Name

Date

Please continue to final page.

We are collecting some basic demographic data to help us think about who our recruitment strategy is reaching/receiving responses from. There is no obligation to provide this information but if you are happy to, please provide the information below.

Gender

Age

Ethnicity

Highest level of education

Appendix 7: Interview schedule aide memoire

Interview schedule aide memoire

a) Introduction

- Thank you very much for agreeing to take part.
- Recap of interview focus.
- Recap of timing – the interview will last up to 1 ½ hours. Feel free to ask for breaks and/or multiple shorter interviews.
- Recap of confidentiality – your information will be anonymous, unrecognisable and well-protected.
- Recap of recording – I will be making an audio recording of this interview to enable transcribing. All recognisable info will be removed and after transcription, your recording will be deleted.
- If there is anything I ask you for examples of but there are none you can think of, you are free to say so.
- Do you have any questions?

b) General experience/helpfulness. Aim: to get a sense of people's general experience of the training and its helpfulness.

Main question 1: How would you describe your experience of the online self-compassion training?

c) Applying the training. Aim: to explore an example of people's attempts to apply the training.

Main question 2: Please could you describe a situation in which you have tried to apply the self-compassion training?

Possible sub-question areas (use flexibly to help fulfil the stated aim of the question):

- Motivation
- Specific ideas applied
- Helpfulness/impact
- Barriers/facilitators

d) Suggestions. Aim: To find out whether people have any suggestions for how the training could be improved.

Main question 6: What suggestions do you have for how this experience might be improved?

Possible sub-question areas (use flexibly to help fulfil the stated aim of main question):

- Bits to be changed
- Bits to be taken out
- Bits to be added

e) Debriefing

- How did you find the interview?
- Do you have any questions about anything we discussed?
- Has anything we discussed left you feeling unsettled or concerned in any way?
- Is there anything we discussed that you would like more information about?
- Do you have any questions about what will happen to your information or the research project more generally?

Appendix 8: Excerpt of interview data supporting theme

Worries about self-compassion New way of relating to self and Tailoring to own needs

<Files\\2020 12 11 15 33 39 interview 2> - 5 1 reference coded [0.93% Coverage]

Reference 1 - 0.93% Coverage

P [00:19:17] Yeah, I think I need to... I think reconnect with why I'm doing it rather and then seeing it as a chore. And kind of embedding it as part of a routine, either whether I do it faster in the morning or before bed time.

<Files\\2020 12 15 10 28 28 interview 3> - 5 3 references coded [6.86% Coverage]

Reference 1 - 1.35% Coverage

P [00:06:03] Erm, no the breathing stuff is probably OK, because I do actually feel physical benefit of have done that a lot because I feel like I get the, you know, whatever it does physiologically to your brain does actually work. And I know that when I'm very stressed, I do breathe quite shallow and I sigh a lot. So I kind of like the breathing stuff I think actually works a little bit because I do actually notice the difference to how it actually makes me feel. But anything that involves just thinking thoughts is not for me.

Reference 2 - 2.98% Coverage

[00:17:39] I mean time is an issue but time is always an issue. And I've had like a big deadline in the last few weeks as well. And I also had one week where mentally I

Appendix 9: Excerpt from co-coded transcript

P [00:15:29] Yeah.

I [00:15:31] And and how would you describe the impact that it's had on you, if any?

P [00:15:39] I think it had a positive impact. It's something that's constantly at the back of my mind now. And although I'm not constantly walking and breathing compassion, it's definitely more ingrained, I think, and I'm constantly trying to be more mindful of it, so I think I found that really helpful. Because I was aware of CFT before, but I was always focused on the patient and how I can deliver it to the patient, how I can support them. And I never thought about myself. And the programme helped me to reflect on myself and how I can do more than actually really need it and how hard it can be. And that's helped me to appreciate some of the expectations that I can have of my clients and other people of how hard compassion actually can be. So, yeah, I think it's definitely something that's with me now all the time for me and for other people.

I [00:16:51] Yeah, great. And how do you think you might be able to kind of take it forward from here?

P [00:17:05] Yeah, I think one worry is that when the training finishes I'll kind of stop the practices. In a sense, I didn't want it to finish because I almost wanted somebody to email me every week. They'd like, do this, do that. And so I think my worry is that I might lose that skill now if I haven't got those prompts. And what I'm hoping to do is download all the recordings and stuff and all the reading. And so I think I just need to commit myself to keep revisiting them. Obviously, I think that all the commitments will get in the way and slowly that will fade away. Well, if it was something that was offered more of, it's something I definitely would like to do.

Martha

Self compassion as lingering in background

Martha

Removal of self in patient work; gap between client and clinician

Martha

Connection with difficult of clients

Martha

Impact on relationship to self and others

Martha

Needing reminders to be compassionate. Needing external reinforcement.

Martha

Shrinking of self-compassion. No room for self-compassion.

Appendix 10: Example of initial codes and themes

Self-compassion

File Home Import Create Explore Share

Paste Copy Merge Clipboard Properties Open Memo Link Add To Set Create As Code Create As Cases Query Visualize

Quick Access

- Files
- Memos
- Nodes

Data

- Files
- File Classifications
- Externals

Codes

- Nodes
- Relationships
- Relationship Types

Cases

Notes

Search

Maps

Output

Nodes

Name	Files	Referen
Tailoring to own needs	10	19
Scaffolding	9	14
Overcoming barriers	9	14
Timing	9	24
Different ways of engaging	8	11
Compassionate choices	8	15
Need for practice	8	19
Worries about self-compassion	8	12
Impact on relationships	8	17
Context	8	18
Accessibility	8	12
Some exercises don't click	8	13
Flexibility	7	14
Insight	7	11
Techniques - compassionate letter	7	15
Lack of personalised support	7	18
'Doing it for me'	7	12

In Nodes

JD 133 Items