Exploring how individuals experience self- compassion within acceptance and commitment informed therapy for chronic back pain. An Interpretative Phenomenological Analysis.

Thesis submitted in part fulfilment of the degree of Doctorate in Clinical Psychology (DClinPsy)

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Declaration

I confirm that this piece of work, that consists of the literature review, the research report and the appendices, is my own work. I have not submitted it for any other academic award. It is submitted in part for the fulfilment of the degree of Doctorate in Clinical Psychology (DClinPsy). I confirm that I have checked that the following thesis is complete prior to its submission.

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April 2019

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Exploring how individuals experience self-compassion within acceptance and commitment informed therapy for chronic back pain.

Thesis abstract

The thesis comprises of two parts, the literature review and the research report. Summaries for both are included below:

Literature review

The aims of the literature review were to explore the experience of compassion focused therapy (CFT) and explore which elements of CFT were experienced as helpful or not in enabling individuals to become compassionate. A systematic research process was employed to search five academic databases (PsychInfo, Scopus, MedLine, Cinahl, Web of Science). Seven articles were identified and were critically reviewed. A metasynthesis of the findings of the seven studies was conducted. The findings suggested that individuals appear to experience blocks and resistances towards becoming compassionate during the initial stages of the therapy. Different elements of therapy were perceived as helpful in overcoming those blocks. Overall CFT was reported as having a positive effect on different aspects of the participants' lives.

Research report

Interpretative Phenomenological Analysis was used to explore the experience of self-compassion of six participants prior, during, and after taking part in an acceptance and commitment based therapy group (ACT) for chronic back pain. Two super-ordinate themes were produced (Transformed relationship with their self in pain, The social self in pain). Each superordinate theme had two and three sub-ordinate themes respectively (From disownership to ownership of the self in pain, Protecting the self in pain) and (The isolated self, You can survive it, Experience of difference in the group). Participants appeared to have experienced a more positive emotional response and relationship with their sense of self, indicating an increased experience of self-compassion. The findings were considered in light of the existing research literature. Their clinical significance and implications, as well as recommendations for future research were also discussed.

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*Denotes the mandatory appendices

PART ONE: LITERATURE REVIEW

An exploration of the experience of compassion focussed therapy. A critical review and metasynthesis.

(Guidelines to authors for the journal targeted for literature review is included in Appendix A)

Abstract

Introduction: Compassion focused therapy (CFT) has been found to be an effective intervention for a number of mental health difficulties, leading amongst others to a decrease in self-criticism and shame. Nevertheless, research has shown that individuals encounter a number of blocks and difficulties in relation to developing compassion during CFT therapy. Therefore, the aims of the current review are to explore the experience of CFT and explore which elements of CFT are experienced as helpful or not in enabling individuals to become compassionate.

Method: A systematic research process was employed to search five academic databases (PsychInfo, Scopus, MedLine, Cinahl, Web of Science) to identify suitable articles. Seven articles were considered to meet all the inclusion criteria and were subjected to quality assessment using both the Critical Appraisal Skills Program (CASP)(CASP, 2014) and the framework by Meyrick (2006). A metasynthesis of the findings of the seven studies using the framework proposed by Sandelowski and Barroso (2007) was conducted.

Results: Three main themes were generated: blocks individuals encounter towards developing compassion, elements of CFT that enabled individuals to overcome them and the transformative effect that CFT had on their lives.

Conclusion: Individuals appear to experience blocks and resistances towards becoming compassionate during the initial stages of the therapy. Different elements of therapy are perceived as helpful in overcoming those blocks. Overall CFT was reported as having a positive effect on different aspects of the participants' lives. Clinical implications and limitations of the findings were explored.

1. Introduction

Compassion focused therapy (CFT) is part of the third wave of CBT therapies (Carvalho et al., 2017). It has been found to be an effective and acceptable intervention for a wide range of mental health difficulties, leading to a decrease in depression, anxiety, shame, self-criticism, and an increase in overall functioning (Braehler et al., 2013; Gilbert & Procter, 2006; Hunot et al., 2013; Judge et al., 2012; Mayhew & Gilbert, 2008; Stewart & Holland, 2011). However, the evidence for its effectiveness has been inconsistent and individuals appear to encounter a number of blocks and difficulties in the course of CFT therapy (Gilbert, 2014; Gilbert, 2009; Gilbert & Procter, 2006; Shapira & Mongrain, 2010). Furthermore, previous reviews of its effectiveness have highlighted a lack of rich qualitative data exploring the experience of CFT and its palatability to clients (Beaumont & Hollings, 2015). Exploration of clients' experiences of CFT therapy might assist us to gain a better understanding of how CFT is experienced at an individual level and identify which elements of CFT are experienced as helpful or not in enabling individuals to become compassionate.

1.1. Compassion Focused Therapy

In contrast to other CBT-based interventions that primarily attempt to diminish threat-based appraisals, CFT suggests that the development of skills that enable individuals to experience affiliative emotions and motives is of equal importance (Gilbert, 2010a; Gilbert, 2014). CFT can be delivered as a group or individual therapy and outlines the significance of adopting a compassionate tone and manner throughout the various components of therapy (Gilbert, 2009). CFT utilises evidence-based theories from neuropsychology, attachment and social psychology to inform its theoretical underpinnings (Gilbert, 2009).

Within CFT, early life experiences of neglect, trauma or primary attachments saturated by threat-based emotions are proposed to lead to the development of psychological distress through the development of an unbalanced emotion regulation system and the internalisation of the negative feelings experienced during difficult early life experiences (Gilbert, 2010a; Gilbert 2010b; Gilbert, 2014). In CFT compassion is

broadly conceptualised as the development of certain skills that can lead to the rebalancing of the emotion regulation system and the development of the ability to access positive affiliative emotions and self-soothing skills (Gilbert, 2009; Gilbert, 2010a). This is achieved through developing distress tolerance skills, empathy, sympathy, sensitivity and non-judgement towards oneself and others (Gilbert, 2009).

CFT combines elements from various evidence-base interventions, including psycho-education, mindfulness, behavioural exposure experiments, cognitive restructuring, memory re-scripting, imagery exercises and trauma work (Gilbert, 2014). Psycho-education is a pivotal element of CFT, primarily aiming to help individuals experience less shame (Gilbert, 2014). It introduces the concept of common humanity, seeing one's difficulties as a rational result of being an imperfect human being (Gilbert, 2009). It also presents the concept of the 'tricky mind', proposing that the evolution of the human brain is imperfect, leading to the perpetuation of problematic reactions to difficult events (Gilbert, 2010a; Gilbert, 2010b; Gilbert, 2014; Lee & James, 2012). Compassionate mind training (CMT) is another element of CFT that encapsulates the various exercises for the development of self-soothing skills and self-nurturance (Gilbert, 2014).

1.2. Difficulties encountered during therapy

Even though several studies suggest that numerous individuals have found CFT to be a beneficial experience, clinical experience and research findings seem to indicate that people encounter numerous difficulties and blocks throughout its duration (Gilbert, 2010a; Gilbert, 2014; Gilbert & Procter, 2006).

Paul Gilbert has highlighted that individuals appear to experience several obstacles and barriers within CFT that can negatively influence its effectiveness (Gilbert, 2010; Gilbert et al., 2011). It has been found that for individuals with an early history of abuse, neglect or shame, and high self-criticism, the generation of self-compassionate feelings in the initial stages of therapy can evoke intense emotions of fear, threat, and be experienced as something extremely alien or aversive (Gilbert, 2009; Gilbert, 2010a; Gilbert & Procter, 2006; Liotti, 2007). Compassion for ones' self has been

suggested as activating metacognitive beliefs of unworthiness of kindness or of eliciting feelings of hopelessness and mourning, due to the realisation of the extent of detachment from ones' self, as well as a compelling desire to discontinue from therapy (Gilbert, 2010a; Lucre & Corten, 2013). Experiencing feelings of warmth through receiving compassion from others, such as the therapist, has also been reported as potentially leading to the experience of grief for not having received compassion from significant others and a consequent heightened awareness of loneliness that can again lead to disengagement from therapy (Gilbert et al., 2010a).

1.3.Evidence on the effectiveness of CFT

The evidence for the effectiveness of CFT for a wide range of mental health difficulties is ever increasing, but is not consistent. CFT for personality disorders has been found to significantly improve psychopathology and reduce depression and shame, although the changes in the levels of self-compassion were inconsistent (Laithwaite et al., 2009; Lucre & Corten, 2013). A study of CBT enhanced with CFT for eating disorders found improved overall functioning while highlighting the need for qualitative research of individuals' experience of CFT for improved therapy development and increased understanding of the obstacles the participants encountered during therapy (Gale et al., 2014).

CFT for individuals facing heterogeneous chronic mental health difficulties in community-based settings (Gilbert & Procter, 2006; Judge et al., 2012; Mayhew & Gilbert, 2008; Stewart & Holland, 2012) and non-clinical populations (Kelly et al., 2009; Shapira & Mongrain, 2010) was found to lead to a significant reduction in depression, anxiety, shame and self-criticism. Gilbert and Procter (2006) and Judge et al. (2012) reported that participants disclosed an initial fear of compassion, and that at the end of therapy self-correcting self-criticism was not reduced. Mayhew and Gilbert (2008) reported that at a one-year follow-up a number of participants described difficulties in being self-compassionate. A need for further exploration of the mechanisms of change within CFT was highlighted (Gilbert & Procter, 2006; Judge et al., 2012; Mayhew & Gilbert, 2008; Shapira & Mongrain, 2010). This was considered

as having the potential to lead to a better understanding of the aspects of CFT that contributed to its effectiveness, or lack of.

1.4. Previous literature reviews

Two reviews of CFT were conducted in 2015 highlighting the early stages of the research area and the increased interest for this comparatively new therapy.

Leaviss and Uttley (2015) conducted a systematic review of the evidence for the effectiveness of CFT. The review suggested that CFT is a promising intervention for mood disorders and highlighted the need for more research and consequent systematic reviews of the emerging evidence prior to its consideration as evidence-based practice (Leaviss & Uttley, 2015).

A narrative review of research studies employing CFT for various mental health difficulties also suggested that CFT is an effective therapeutic intervention (Beaumont & Hollins, 2015). However, it was proposed that there is a need for rich qualitative data that can explore the palatability of CFT at an individual level and explore the experience of different aspects of CFT, such as imagery exercises, that were reported as well-received in some studies and as difficult in others.

1.5 Rationale for current review

This review aims to build on the findings and recommendations of the previous reviews and research on CFT and bring together the existing qualitative research on the experience of CFT. Previous reviews have focused on the effectiveness of CFT but there seems to be a lack of reviews on the experience of CFT. A number of studies have also highlighted the need for the exploration of the experience of CFT to understand why certain aspects of CFT therapy are experienced as helpful or not by different individuals and to expand our understanding of how individuals are able, or not, to overcome any obstacles or difficulties they encounter during CFT.

To the author's knowledge, the research literature on the experience of CFT has not been previously appraised. The current review looks at the qualitative research

literature in order to understand the lived experience of individuals having experienced CFT. A qualitative approach was elected given that qualitative research methods provide a rich in-depth understanding of the lived experience of individuals (Dixon-Woods et al., 2006).

The literature review addresses the following questions:

How are compassion focused therapy interventions/strategies experienced by those receiving the intervention?

Within compassion focussed therapy interventions/strategies, what is perceived as helpful or not helpful in becoming compassionate?

2. Method

2.1 Search process

A systematic search strategy was utilised in order to ensure that an exhaustive and replicable search of the current literature was conducted. The first stage included a scoping exercise to determine the range and depth of the relevant available literature. This informed the objectives and the search terms used in the next step. Google scholar and the Google search engine were used to search the grey literature. The Compassionate Mind Foundation, Self-compassion, Good Therapy and the National Institute for Health and Excellence websites (see Appendix B, Table 3.) were also explored. In order to identify any significant previous reviews on the same or similar topic the Cochrane Library was searched. No eligible reviews focusing on qualitative research on the experience of CFT were identified.

Five databases (PsychInfo, Scopus, MedLine, Cinahl, Web of Science) were searched in July 2018 to ensure that a wide-ranging literature from the fields of psychology, clinical science and wider healthcare sciences was searched (Appendix B, Table 4. includes the rationale for the databases selection). The search terms used were keywords identified in the scoping exercise. The search terms were kept broad to ensure that all relevant studies were identified. They were focused on the intervention (compassion focused therapy and compassionate mind training) and the studies being of qualitative format (Dalhouse University, 2018). The scoping exercise uncovered that studies investigating compassion fatigue and compassion satisfaction were beyond the scope of this study and the search terms were appropriately adapted. The search terms used are included in Appendix C.

2.2 Inclusion/ exclusion criteria

Inclusion criteria were applied to the studies identified during the above search process. Studies were included if they were in English, had human participants, and had been published in peer reviewed journals. No limit to the date of publication was used due to the limited literature identified in the initial scoping exercise. Additionally, CFT was

firstly introduced in 2009 (Gilbert, 2009) and therefore any published studies were expected to be quite recent. The CHIP tool for qualitative studies (Shaw, 2010) was utilised to create further inclusion criteria to ascertain that the search of the existing literature was done in a methodical manner that attended to all the various aspects of the research question. The use of the CHIP tool entails the consideration of the identified articles in regards of the following four aspects: The Context of the study, How the study was conducted, the Issues of Interest of the study and the Population that took part in the study (Shaw, 2010). Following from the above, papers were included if their context was a compassion focussed therapy based intervention (Context). Papers that the intervention used was compassionate mind training were also included as it is a significant part of CFT and were therefore considered relevant for the purposes of this review. Papers were also included if they had a qualitative methodology (How), they focused on the experience of compassion focused based therapy (Issues of Interest) and the participants had received CFT or CMT based interventions (Population).

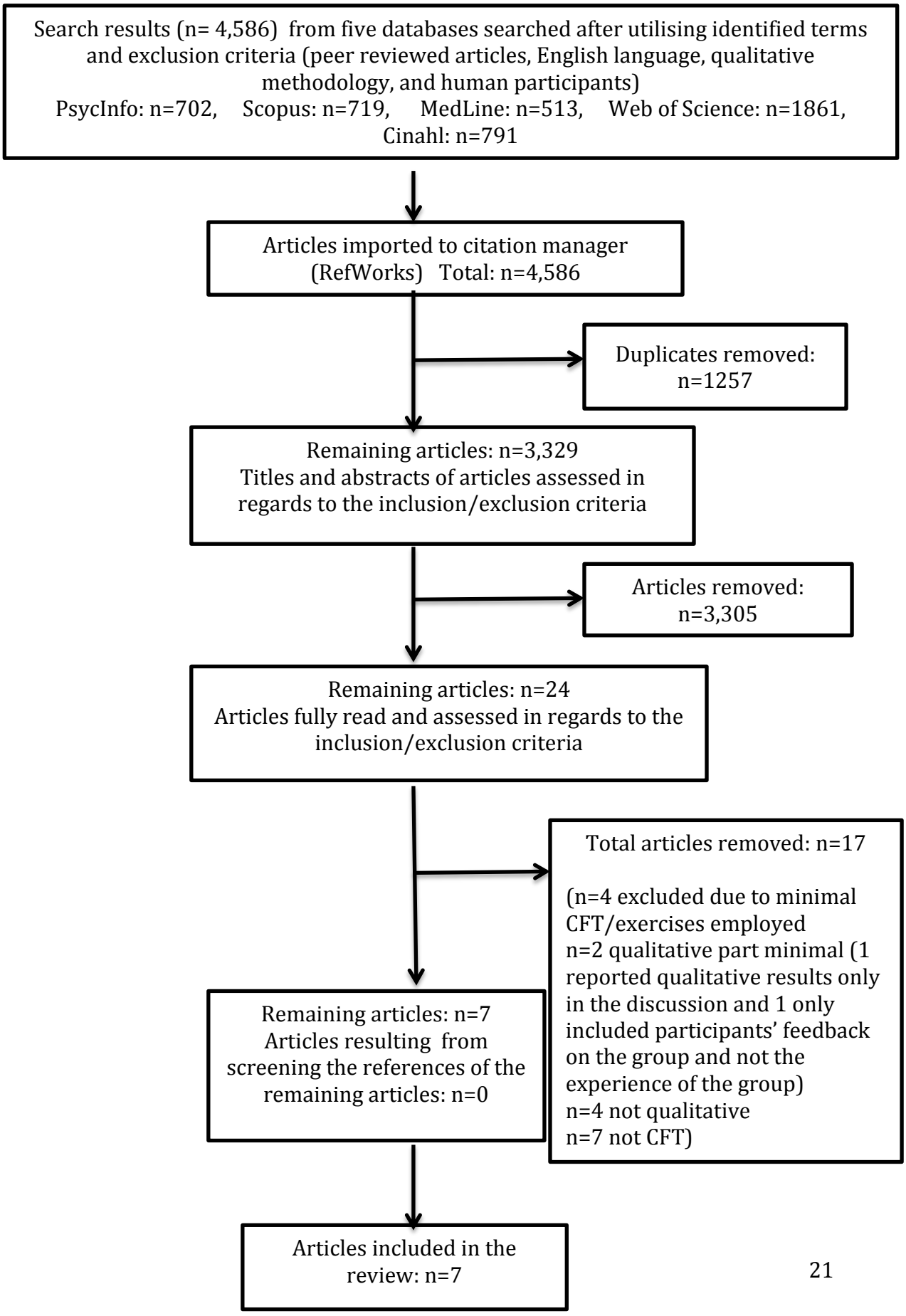
Papers were excluded if their intervention was quite minimal, for example including only limited one-off exercises from CFT, given that it was not considered to adequately represent the experiences of individuals that had undertaken CFT based interventions. Papers were excluded if they did not utilise a qualitative methodology. Papers that employed both qualitative and quantitative methodology were included if the qualitative findings were reported separately from their quantitative findings.

2.3 Selection of relevant papers

The search of the five included databases utilising the identified search terms and the inclusion/exclusion criteria produced a total of 4,586 articles. These were imported in a reference management software (RefWorks) and duplicates were removed (n=1,257). The titles and abstracts of the remaining articles (n=3,329) were assessed in regard to the inclusion/exclusion criteria. N=3,305 articles were removed as they did not fit the study's inclusion criteria. The remaining n=24 articles were read in full and assessed again in regards to the inclusion/exclusion criteria. Seven articles were seen as meeting the inclusion/exclusion criteria and were included in this review. No further articles

were found from screening the references of the above articles. The above is depicted in Figure 1.

Figure 1. Flowcharts of papers shortlisting process



2.4 Quality assessment

The quality of the seven selected studies was assessed using both the Critical Appraisal Skills Program (CASP)(CASP, 2014) and the framework by Meyrick (2006). CASP is a qualitative checklist that is frequently used for the critical appraisal of NHS qualitative research (CASP, 2014). Given that merely utilising a checklist when appraising the quality of research is not recommended (Barbour, 2001), the Meyrick (2006) framework was also used. It was selected due to its focus on the transparency and systematicity of qualitative research and its applicability to studies adopting a wide range of epistemological and ontological stances.

2.5 Data extraction, analysis and synthesis

The meta-synthesis method proposed by Sandelowski and Barroso (2007) was utilised for the data analysis and synthesis stage of this review, with a critical realist epistemological position adopted by the researcher for the analysis and synthesis stage of this review (please see Appendix D for further information). A taxonomic based analysis was the basis of the analysis and synthesis, that aimed to capture the conceptual range of findings, while also maintaining that qualitative meta-synthesis consists of leaps of imagination that the researcher can only aim to describe as best he or she can (Sandelowski & Barroso, 2007). Taxonomies have been suggested as being able to demonstrate the conceptual range of findings, whether those are implicitly or explicitly present within the findings (Sandelowski & Barroso, 2007). Given that the research question was focused on the participants' experience, only the findings from from the articles' result sections were utilised (Ludvigsen et al., 2015). The stages of the analysis consisted of an in-depth reading of the selected papers and line-by-line coding of the findings section of the selected articles. The identification of themes that captured the experience of CFT was attempted by endeavouring to identify not the frequency of occurrence of the findings but rather the conceptual relationships of the findings. This was done by creating a table of the identified findings; the merging of the above findings into new conceptual clusters that were then renamed into themes; the revisiting of the selected papers for the identification of any further findings and

clusters of findings; incorporating any newly identified clusters into to the previously identified themes, where appropriate, and lastly reporting all of the above new themes.

3. Results

A summary of the selected studies, the findings from their quality appraisal and meta-analysis are included in the following section.

3.1 Summary of selected studies

The overarching aim of all the seven selected studies was to explore their participants' experience of CFT. All of the selected studies were conducted in the UK. The mental health or physical difficulties faced by the participants included in the studies varied significantly: Ashworth et al. (2015) recruited individuals with acquired brain injury, Bell et al (2017) trainee therapists, Clapton et al. (2018) and Hardimman et al. (2018) adults with a diagnosis of an intellectual disability, Heriot-Maitland et al. (2014) individuals in an acute inpatients setting, Lawrence and Lee (2014) individuals with a diagnosis of posttraumatic stress disorder, and Lucre and Corten (2013) individuals with a diagnosis of a personality disorder. The characteristics of the 7 selected studies are included in Appendix E, Table 5. The therapeutic modalities utilised in the studies were all based on CFT principles. However, the format of therapy (individual or group), number of sessions, duration of sessions, overall duration of therapy, training and background of the therapists, as well as information about the supervision of the therapists delivering the intervention varied significantly. The above are included in Appendix E, Table 6.

3.2 Methodological qualities of the studies

The quality and rigour of the selected studies were appraised using the CASP (please see Appendix F, Table 7) and the Meyrick (2006) (please see Appendix F, Table 8) proposed framework. The results of the above process are included in Appendix G. This process was primarily done to confirm that papers were of sufficient quality to be included. However, further details do not seem to be necessary given that the results of the appraisal did not seem to impact upon synthesis.

3.3. Meta-synthesis

The findings from the meta-synthesis process are presented below (please see Appendix H).Figure 2. depicts the above findings.

Figure 2. Superordinate and sub-themes

1. Blocks Towards compassion

2. Elements of therapy that assisted participants in becoming more compassionate

- 1.1. Realisation of not being alone/common humanity
- 1.2. Empathic affiliative interactions
- 1.3. Feeling understood
- 1.4. Therapeutic relationship

3. The transformative effect of CFT

3.3.1 Blocks towards compassion

In five of the studies participants discussed the blocks and resistances they experienced at the beginning of therapy (Bell et al., 2017; Clapton et al., 2018; Heriot-Maitland et al., 2014; Lawrence & Lee, 2014; Lucre & Corten. 2013). These occurred when participants were introduced to the concept of compassion and during their first attempts to develop it.

> *"It's hard to be kind to yourself when you're always used to not being kind to yourself", participant, Clapton et al (2018), page 145.*

Participants disclosed an initial fear towards the notion of warmth and kindness aimed at themselves (Lawrence & Lee, 2014; Lucre & Corten. 2013). This was rationalized by disclosing an internal association of compassion with inactivity and self-indulgent behaviour (Clapton et al., 2018; Lawrence & Lee, 2014).

> *"I always thought this compassion stuff would make me weak.. pathetic", participant, Lucre & Corten (2013), page 395.*

For some participants self-criticism was perceived as an integral part of their identity. The notion of relinquishing it in order to become more compassionate induced the fear of losing part of their self and resulting in the amplification of their self-critical thoughts (Lawrence & Lee, 2014).

> *"You have to push yourself, you have to. And then if you don't push yourself well you're just a bad person. You must be a high achiever because if you are not you are nothing. To start off with there was a vacuum and it was well that vacuum shows that I am nothing. I am worthless", participant, Lawrence and Lee (2014), page 499.*

Certain participants reported that at the start of therapy they found engaging with compassion exercises difficult (Bell et al., 2017; Clapton et al., 2018; Lucre & Corten, 2013). They described that during those initial stages of therapy they experienced receiving compassion only at a cognitive level whilst they struggled to experience it at an emotional level (Bell et al., 2017).

> *Compassion was also initially experienced as strange and uncomfortable on a 'felt' level, or, in turn, was 'intellectualized' without emotional connection. researcher, Bell et al. (2017), page 638.*

A number of participants described compassion as an uncomfortable emotional experience (Bell et al., 2017; Clapton et al., 2018). Several participants believed that they did not deserve compassion and reflected that the strong aversive emotional responses of dread and fear they experienced during the initial therapeutic sessions were due to their resistance towards becoming compassionate towards themselves (Lawrence & Lee, 2014; Lucre & Corten, 2013). Participants highlighted that compassion triggered feelings of hopelessness, producing fears that they would never be able to feel compassion towards themselves. This led to a strong desire to disengage from therapy (Lawrence & Lee, 2014).

> *"There's no way that I'm going to think what you're telling me I am gonna think (laugh). There is no way at the end of 6 months that I am gonna think like this at all. I thought I might as well go home now". participant, Lawrence and Lee (2014), page 499.*

A number of participants described the importance of implementing a regular practice for overcoming the blocks and obstacles towards compassion early during therapy (Bell et al., 2017; Clapton et al., 2018; Lucre & Corten, 2013). Participants described that recognising and working with the internal blocks and fears of compassion during therapy was also an important step in helping them overcome them (Bell et al., 2017; Heriot-Maitland et al., 2014).

> *Another participant, who described having found it difficult his entire life to be compassionate to himself, reported how they felt it was through repeated practice that they began to overcome these initial difficulties, and thus become more self-compassionate. researcher, Clapton et al. (2018), page 145.*

3.3.2. Elements of therapy that assisted participants in becoming more compassionate

All of the studies included themes that depicted different elements of CFT that participants described as assisting them to become more self-compassionate.

3.3.2.1.Realisation of not being alone/common humanity

Participants reported a realisation that other people within their group were facing comparable problems to their own. This was described as leading them to form a view of their current difficulties as an understandable reaction to adverse life experiences.

> *The comfort of shared group experiences Many groups members echoed the sentiment I am not alone: knowing that others struggle as they do seems to have been a key component of the group. researcher,* Lucre and Corten (2013), page 395

This realisation helped participants shift from self-blame to being more compassionate (Heriot-Maitland et al., 2014; Lawrence & Lee, 2014; Lucre & Corten, 2013). They reflected that they valued the disclosures from other group members about their life experiences. They perceived them as serving as an internal de-shaming process. They reported that it helped them achieve an increased sense of common humanity (Clapton et al., 2018; Hardiman et al., 2018; Heriot-Maitland et al., 2014).

> *"[It is] nice to have a group that you can express how you feel, and talk about how, you know, what compassion means …to know a bit more of what other people think about caring, and what I think about caring." participant, Heriot-Maitland et al. (2014), page 88.*

3.3.2.2 Empathic affiliative interactions

Participants described as important the process of becoming more compassionate towards themselves, finding safeness and gaining strength from other group members (Ashworth *et al.*, 2015; Heriot-Maitland et al., 2014).

> *Patients described finding security in their relationships with members of staff, their therapist, and within the group. They also describe finding a sense of*

> *safeness within the environment at the neurorehabiliation centre. They describe the development of affiliative relationships between themselves and others, which were reported as important in approaching change*. researcher, *Ashworth et al. (2015), page 154.*

Some participants significantly valued receiving empathy within a group setting and gaining a sense of belonging. Experiencing empathetic affiliative interactions with other group members enabled them to become more compassionate (Ashworth *et al.*, 2015; Heriot-Maitland et al., 2014; Lucre & Corten, 2013). Being part of a group was further reported as assisting some participants in developing a sense that they can work on their difficulties as a team rather than having to deal with them alone (Ashworth et al., 2015).

3.3.2.3. Feeling understood

The same effect of a positive sense of common humanity was not as pronounced in individual therapy. In those instances, participants emphasised the importance of feeling understood by their therapist in overcoming their sense of not being the only ones' in facing problems similar to their own. Feeling understood and accepted by their therapist was perceived as assisting them to become more self-compassionate (Lawrence & Lee, 2014). Utilising the concepts of CFT that described the human brain from an evolutionary point of view as being faulty enabled some participants to view themselves as not being to blame for their difficulties (Ashworth et al. 2015; Clapton et al., 2018; Hardiman et al., 2018).

> *All patients described their experience of formulation as a powerful and helpful one. They described the importance of drawing from neuropsychology along with other psychologies to establish a non-blaming understanding explicitly remembering some of the evolutionary concepts such as the 'tricky brain'" researcher, Ashworth et al. (2015), page 155.*

3.3.2.4 Therapeutic relationship

In the majority of the studies, both those researching group and individual therapy, the importance of the therapeutic relationship in the process of becoming more compassionate was highlighted (Ashworth *et al.*, 2015; Clapton et al., 2018; Hardiman et al., 2018; Lawrence & Lee, 2014).

> *"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." participant, Clapton et al. (2018), page 145.*

Participants disclosed that feeling safe, believed, accepted and understood within the therapeutic relationship enabled them to shift from being self-critical to being more self-compassionate (Ashworth *et al.*, 2015; Clapton et al., 2018; Hardiman et al, 2018; Lawrence & Lee, 2014). Participants further reported that establishing a secure therapeutic relationship enabled them to change from cognitively knowing that they were not to blame for their difficulties to experiencing it at an emotional level (Bell et al., 2017; Lawrence & Lee, 2014).

> *"You need that kind of person steering you and guiding you through the process and actually just, just keep saying to you that it is okay to feel like this. It is okay to want to cry. It is okay to be nice to yourself. It is a good thing to be good to yourself." participant, Lawrence and Lee (2014), page 500.*

3.3.3 The transformative effect of CFT

Positive discourses appeared when participants discussed the experience of becoming more compassionate. All of the studies reported that participants experienced changes in their cognitions, affect, behaviours and interpersonal relationships as a result of their increased compassion.

Participants reported that becoming more compassionate enabled them to develop a novel way of firstly, relating and secondly, comprehending their selves (Ashworth et al., 2015; Clapton et al., 2018; Hardiman et al., 2018; Lawrence & Lee, 2014). They described that increased self-compassion resulted in them becoming more empathetic towards their own difficulties. They experienced the positive change of their inner dialogue becoming less critical (Bell et al., 2017; Clapton et al., 2018).

Participants recognised that they were able to increase their engagement with self-soothing techniques that gave them a sense of control over the focus of their attention from negative to more positive aspects of their everyday experiences, identifying self-critical thoughts and finding strategies to deal with them (Ashworth et al., 2015; Bell et al., 2017; Lucre & Corten, 2013).

> *"I'd have just continually kept working until I had to do something like going making my tea or something like that, something that I felt I had to do. Whereas this has definitely helped me just be a little bit more compassionate to myself in terms of my time management and put a few more boundaries in places… just looking after myself a bit more."participant, Bell et al. (2017), page 644.*

They further disclosed a shift in how they related to their own selves by giving themselves permission to engage in more self-caring behaviours (Ashworth et al., 2015; Bell et al., 2017; Clapton et al., 2018; Heriot-Maitland et al., 2014; Lawrence & Lee, 2014) as well as activities they enjoyed (Ashworth et al., 2015; Bell et al., 2017; Lawrence & Lee, 2014).

Through becoming more compassionate, participants recognised that they developed more constructive ways of coping with past and present difficult emotions. Participants described that they felt more able to contain them and accept them instead of avoiding them (Bell et al., 2017; Heriot-Maitland et al., 2014).

> *While CFT highlights the importance of becoming more sensitive to suffering and distress, this is only in so far as helping people tolerate rather than avoid the*

> *difficult emotions and memories. The change process itself involves cultivating and engaging capacities for experiencing and behaving in compassionate ways. researcher, Heriot-Maitland et al. (2014), page 89.*

Participants' identified that their increased ability to control threat-based emotions led them to a heightened ability to tolerate and manage experiences that evoked them (Ashworth et al., 2015; Bell et al., 2017; Clapton et al., 2018; Hardiman et al., 2018; Heriot –Maitland et al., 2014). As a result participants described experiencing more frequently comforting, soothing affiliative emotions (Bell et al., 2017; Clapton et al., 2018; Heriot-Maitland, 2014). Participants described an important shift in their emotional response to their future and their life, moving from feeling hopeless to being hopeful (Lawrence & Lee, 2014).

> *"My whole outlook is different. I feel like I've got a future now, which I didn't feel, well I've never felt like that really. No, so I feel like I've got a future now, which I didn't feel like 6months ago." participant, Lawrence and Lee (2014), page 501.*

Similarly, participants disclosed a shift on how they related to other individuals. Participants disclosed that they were better able to accept others through being able to be empathetic and accept themselves (Ashworth et al., 2015; Clapton et al., 2018; Hardiman et al., 2018; Heriot-Maitland et al., 2014).

4. Discussion

This review aimed to examine, firstly, how individuals receiving CFT experienced the intervention. Secondly, it aimed to explore which elements of the intervention were perceived as helpful or not helpful in assisting individuals to become more compassionate. This review aimed to develop a better understanding of the palatability of CFT at an individual level and to comprehend the experience of overcoming, or not, of any obstacles or difficulties individuals encounter during CFT. A systematic endeavour to find and critically appraise relevant peer-reviewed studies was attempted. The meta-synthesis of the findings revealed three main themes that will be considered in relation to previous research findings.

The findings from the first theme fit well with previous research reporting that individuals described numerous blocks towards becoming compassionate while also experiencing resistances during the initial stages of therapy (Gilbert & Procter, 2006). Gilbert et al., (2011) and Pauley & McPherson, (2010) identified that compassion initially evoked extremely aversive emotions. Gilbert, (2014) highlighted the importance of recognising and working with the fears and blocks encountered during therapy, and of regular practice of compassion exercises.

The second theme depicted the different elements that individuals reported as assisting them in developing compassion. The findings that being part of a group can assist individuals to gain a sense of common humanity fits with previous findings that shared group experiences can aid in the acceptance of personal difficulties (Cheng, 2014) and initiate a de-shaming process (Gilbert & Procter, 2006; Haslam et al., 2010). An important novel finding was the discrepancy between gaining a sense of common humanity between group and individual therapy. For individual therapy, a pivotal step towards developing compassion was feeling understood and accepted by the therapist and utilising CFT concepts on 'the faulty' human brain. The significance of the therapeutic relationship in developing compassion was underlined in both group and individual therapy. This fits with previous findings of the pivotal part that the therapeutic relationship can play in accomplishing therapeutic change (Greenberg, 2007).

The third theme described the positive transformative effect of developing compassion. Previous research has similarly indicated that the experience of CFT and the development of the capacity of compassion appears to have led to reduced self-criticism, an increased ability to self-sooth and cope with difficult emotions (Braehler et al., 2013), increased positive emotions (Shapira & Mongrain, 2010) and a more positive outlook on life (Laithwaite et al., 2009).

Another point that might be important to highlight is that no themes made reference to elements of CFT that were not experienced as helpful or depicted the experience of individuals that might not have been able to develop compassion. One interpretation of the above can be that the number of papers included in this review was quite small, and therefore only covered a limited population whose overall experience of CFT was perceived as beneficial. Therefore, those elements that were experienced as not helpful could have been quite scarce and did not emerge within the meta-synthesis. Another factor influencing the above could be that the selected studies did not include the experiences of individuals that discontinued from therapy. Similarly, the majority of the studies utilised a purposive and/or opportunist sampling that did not account for the inclusion of adequate discrepant cases. This could potentially have also contributed to the lack of themes reporting the experience of unhelpful elements of therapy or the experience of not developing compassion.

Similarly, the sample of the selected papers was not representative of the general population with approximately two thirds being female. The participants were also primarily White-British or their ethnicity was not reported. Religion, culture, educational and socio-economical background of the included participants was also not explored. No consideration was therefore made on the impact of the above characteristics on the experience of CFT and its palatability. Culture, gender and ethnicity have been found to affect not only access to therapy but also the experience and engagement with therapy (Bernal et al., 2009) as well as individuals meaning making of the experience of therapy (Morrow, 2005). It might be beneficial if future research explored how the above characteristics affect the experience of CFT. Examining the socio-political and cultural context within which therapy takes place might also be of great importance (Morrow, 2005; Qu & Dumay, 2011)

Compassion has been highlighted as one of the six core values that should permeate the care provided by the National Health System (NHS) (NHS Commissioning Board and Department of Health, 2012). Yet, inadequate staffing levels, disproportionate workloads, lack of job security due to potential privatisation of the NHS or financial penalties if NHS Trust targets are not met, have been found to negatively influence not only the well-being and the levels of burn-out of the NHS staff, but also their ability to form compassionate relationships with their service-users and negatively impact the quantity and quality of the care provided (Henshall et al., 2018). Exploring how the above influences the experience of therapy might assist in not only better understanding the palatability of CFT but potentially gaining an important insight into the overall care provided for service users. If the above is not explored, it is the authors' opinion that it could be an oxymoron to invite individuals to become more compassionate when they are situated within a system that cannot provide compassion for its service users or employees.

4.1. Strengths and Limitations of current review

One of the main strengths of this current review is that to the authors' knowledge it is the first review to explore the existing qualitative accounts of how individuals experience CFT.

On the other hand, a number of limitations should be acknowledged. The participants included in the selected studies had received a range of diagnoses for their experiences. The form, duration of CFT and the training and supervision of the therapists utilised by the different studies was also quite diverse. Consequently, the results with regards to the experience of CFT might have been overtly influenced by the variability both in the difficulties experienced by the included participants and/or the delivery of therapy. This may have led to the meta-synthesis providing a partial understanding of their experience of therapy.

Additionally, the epistemological stance and the reflexivity of the researchers (of whom a large number were therapists) was not explored in the majority of the selected studies. Future research might benefit from addressing the above sampling and analysis limitations. It might also be beneficial for future research to explore the experiences of individuals that might not have been able to develop compassion, that disengaged from therapy or were not able to overcome the initial blocks encountered in the beginning of CFT. Given that within the first theme it was described that an initial aversive reaction to compassion elicited a desire to disengage from therapy, further research on the above might be beneficial. This might shed some light in the palatability of CFT and the conflicting findings highlighted in the review by Beaumont and Hollins (2015) with regards to how different element of CFT are experienced.

The quality of the included papers were considered of being of adequate quality. Nevertheless, it was considered that the studies included were quite heterogeneous in regards to both the population and the setting within which they were conducted. This has the potential to have significant implications for the coherence and potential future utility of this study's findings. Fore example, individuals with a learning disability (included in two of these studies) might not have been as able to understand, conceptualise and therefore successfully implement the potentially cognitively demanding compassion exercises that can enable them to experience enhanced self-compassion. It might have also affected their inclusion in the selected studies, with the experiences of individuals with significant learning disabilities not being included and therefore considered.

4.2. Clinical implications

The great variability of the clinical presentations of the included population, the therapeutic modalities and therapists' training and supervision included in the selected papers indicate that no firm conclusions can be drawn. Nevertheless, some potentially significant clinical implications of the findings can be tentatively outlined. Therapists' awareness of a potential initial aversive emotional reaction of their clients towards compassion can be seen as beneficial. Addressing and exploring those reactions within therapy, as well as exploring the blocks and difficulties encountered during the initial

stages of therapy could perhaps assist individuals to not become overwhelmed and disengage from the therapy. Normalising those feelings and barriers can also assist clients to develop their compassion. Highlighting the importance of regular practice of compassion exercises might further assist in its development.

Another part of the findings that can potentially have significant clinical implications is that participants receiving group CFT were more able to gain a sense of common humanity compared to those receiving individual CFT. It could be useful if therapists were aware of the potential influence that they could have on the way individuals view their current difficulties. An awareness on behalf of the therapist of the important role the therapeutic relationship can play in providing a sense to clients of feeling understood and accepted could potentially counterbalance the above. Additionally, emphasising CFT concepts on the 'faulty' human brain could similarly prove beneficial in assisting individuals to develop compassion. Future research on additional ways that common humanity can be developed within individual CFT might also be beneficial.

Lastly, the positive experience of developing compassion on different aspects of the participants' lives could potentially mean that incorporating methods and exercises that promote the above in other psychological therapies might be useful.

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PART TWO: RESEARCH REPORT

Exploring how individuals experience self-compassion within acceptance and commitment informed therapy for chronic back pain. An Interpretative Phenomenological Analysis.

(Guidelines to authors for the journal targeted is included in Appendix A)

Abstract

Aim: Existing conceptualisations of self-compassion have been suggested as corresponding and overlapping with the psychological flexibility model that guides acceptance and commitment therapy (ACT). Research on ACT and self-compassion seems to be limited but exponentially increasing, with self-compassion being suggested as a significant implicit element of change within ACT. Nevertheless, there seems to be a lack of research on the experience of self-compassion within ACT. The current study aimed to explore how individuals experience self-compassion within ACT for chronic back pain and how their experience of self-compassion changes within ACT for chronic back pain.

Method: Six semi-structured interviews were conducted with individuals that had taken part in an ACT based group for chronic back pain to explore their experience of self-compassion prior, during and after the group. Interpretative Phenomenological Analysis was used to analyse their interview data.

Results: Two super-ordinate themes (Transformed relationship with their self in pain, The social self in pain) with two and three consequent sub-ordinate themes (From disownership to ownership of the self in pain, Protecting the self in pain) and (The isolated self, You can survive it, Experience of difference in the group) were produced.

Conclusion: Participants appeared to have experienced a more positive emotional response and relationship with their sense of self, indicating an increased experience of self-compassion. The findings were considered in light of the existing research literature and considerations for future research were made. The study's findings seem to indicate the positive influence of a group setting on the experience of self-compassion. Being in a group setting seemed to assist individuals to feel less isolated and experience an enhanced sense of common humanity.

1. Introduction

The healing properties of self-compassion have been documented numerous times over the centuries, but only recently has the concept been incorporated in Western psychological sciences (Gilbert, 2009; Neff, 2003). Self-compassion has been found to be negatively correlated with shame, self-castigation, depression, anxiety and positively correlated with increased mental well-being and psychological health (Gilbert & Procter, 2006; Mayhew & Gilbert, 2008). Research has explored the different ways that individuals can be aided in becoming self-compassionate and examined different psychological therapies that although initially not intended to alter self-compassion, were gradually seen as increasing it (Barnard & Curry, 2012; Gilbert & Procter, 2006; Neff et al., 2007). Research on self-compassion can be seen as aiming to better understand presently unacknowledged mechanisms of change associated with therapy efficacy and to improve current psychological therapies (Barnard & Curry, 2012).

1.1. Self-compassion

In the academic literature numerous conceptualisations of compassion have been proposed. Compassion within Buddhism is conceptualised as being open towards one's own and other people's pain (Neff, 2003). Gilbert (2010) conceptualised compassion and self-directed compassion, i.e. self-compassion, using evolutionary terms that linked it to attachment and affiliation.

Based on the Buddhist concept of compassion, Kristin Neff (2003) further defined the concept of self-compassion to include three separate components: mindfulness, self-kindness, and common humanity. Self-kindness entails an individual's stance of forgiveness, empathy and positive affect towards one's sense of self (Neff, 2016). Common humanity describes a sense of self that is not perceived as separate from others. Rather, there is an internal recognition that each and every human being is inherently similar to other human beings in regards to the universality of emotional or

physical experiences of pain, personal limitations and weaknesses (Neff, 2008). Mindfulness includes directing one's attention to the present moment and a stance of warm and open acceptance of one's present experience (Neff, 2003).

Both Gilbert's and Neff's conceptualisations focus on the self-to-self relating, emphasising how an individual's experience of self-compassion is linked to their feelings and thoughts towards their self, as well as the conceptualisation and relationship with their sense of self (Gilbert, 2010; Neff, 2008). Self-compassion entails an integrated sense of self where an individual is aware and accepting of the different parts of their personal experience, their perceived weaknesses, and is refraining from social comparison of their self within their social relationships (Gilbert, 2010; Neff, 2003; Neff, 2008). It also entails a sense of self that is not separate from others due to the recognition of the shared nature of the human condition and the interdependence of the human experience (Neff, 2008).

Nevertheless, it appears that neither Neff nor Gilbert make an explicit reference to the definition of the sense of self they use when they utilise the term within their conceptualisations of self-compassion. Yet, they explicitly state that they operate within a post-modern constructivist conceptualisation of a sense of self, suggesting that the structure of the language used can unearth individuals' construction of their sense of self (Gilbert, 2008; Neff, 2008). A post modern constructivist perspective can be seen as offering a conceptualisation of the self as being in continuous change, consisting of the construction of separate selves (Gergen, 2011; Harre, 1991) while simultaneously postulating the experience of a universal stable sense of self (Williams, 1999). The definition used for an individual's self to self relating described that individuals' self-to-self relating entailed the levels of concern they demonstrated for their well-being and the level of attunement and tolerance that they utilised towards their distress that was seen as being influenced by their level of understanding of the origin of their distress and their ability to accept that distress (Gilbert & Procter, 2006). The self-to-self relating was suggested as being demonstrated by an individual's self-talk and the way the individual interacts with different aspects of one's self (Gilbert & Procter, 2006).

1.2. ACT and self-compassion

The existing conceptualisation of self-compassion by Kristin Neff (2003) has been proposed as corresponding and overlapping with the psychological flexibility model that guides ACT (Yadavaia, Hayes & Vilardaga, 2014). ACT assists individuals in developing psychological flexibility by aiming to activate six main processes: present moment awareness, acceptance (of both bodily sensations and emotions), cognitive diffusion, self as context (developing a sense of self that is separate from self-identity and self-image), committed action (behaviour that is consistent and self-directed) and values (chosen behaviour is internally reinforced by self-chosen qualities and directives) (Yadavaia, Hayes & Vilardaga, 2014).

From the above core processes, the first three are components of mindfulness. They have been proposed as being one of the three core elements of self-compassion according to Neff's (2003) conceptualisation of the term; they also actively affect the development of the remaining two core elements of self-compassion, common humanity and self-kindness (Barnard & Curry, 2012; Forman et al., 2007; Neff, 2003; Yadavaia, Hayes & Vilardage, 2014). The fourth process, self as context, assists individuals to recognise that self-judgements are discreet to reality, leading to their reduction and promotion of active self-compassion (Yadavaia, Hayes, & Vilardage, 2014). Similarly, the fifth process involves individuals adopting behaviours that are consistent with their values, thus inviting them to be more self-compassionate by focusing on developing the sense of self they want instead of on their self-perceived personal failings (Barnard & Curry, 2012).

1.3. Acceptance and commitment therapy for chronic pain

Acceptance and commitment based therapeutic modalities (ACT) are emerging as effective therapies for assisting individuals experiencing chronic pain in gaining higher quality of life and experiencing less psychological distress (Veehof et al., 2016). Total pain relief is often considered an unattainable therapeutic goal for the majority of people with chronic pain (Turk et al., 2011). ACT therefore aims to assist individuals to accept their pain, as well as their thoughts and feelings about pain in an effort to

support them in ceasing to continuously avoid or try to reduce pain; this aims to enable them to develop patterns of constructive actions in order to pursue their life goals and lead a life guided by their values (Costa & Pinto-Gouveia, 2011).

Empirical evidence has shown the effectiveness of ACT for a wide range of psychological distress and specifically chronic pain, having been found to have similar outcomes to the gold-standard therapies (Bluett et al., 2014; Luoma & Platt, 2015; Ruiz, 2010; Veehof et al., 2011). Nevertheless, ACT has been found to outdo them only occasionally (Burn, 2016). It has been suggested that gaining a better understanding of any unidentified underlying processes of change within ACT for chronic pain might further help us enhance ACT's positive outcomes and maximise the impact of those processes (Burn, 2016; Luoma & Platt, 2015).

Increasing numbers of studies have explored the association between ACT and self-compassion (Stafford-Brown & Pakenham, 2012; Graham, 2016). A study exploring the effectiveness of ACT for assisting clinical psychology trainees to increase their levels of self-compassion, as measured by Neff's 26 item Self Compassion Scale, demonstrated an increase in the outcome measure of self-compassion (Stafford-Brown & Pakenham, 2012). Similarly, in a randomised control waitlist-controlled trial utilising a treatment group with 20 adults diagnosed with a substance use disorder and a waitlist-control group exploring the efficacy of a 6 week ACT treatment, significant improvements were found in the levels of both self-compassion and psychological flexibility in the treatment group compared to the control group (Graham, 2016).

Furthermore, two studies have suggested that self-compassion might be a mediator of outcomes within ACT. A study exploring the relationship between the constructs of psychological flexibility, self-compassion and emotional well-being conducted in a sample of 144 university psychology students, suggested a statistically significant correlation between self-compassion and psychological flexibility (Marshall & Brockman, 2016). More importantly, it was found that self-compassion contributed to the unique variance in the concept of emotional well-being that was not mediated by psychological flexibility. It was suggested that there is a need for future research to

explore in more depth individuals' experiences of self-compassion within ACT and its processes of change during therapy.

Similarly, in an open trial for chronic pain, self-compassion was found to be a strong mediator of anxiety, depression and disability above and beyond psychological flexibility (Vowles et al., 2014). The study was conducted with a sample of 117 participants that took part in an interdisciplinary programme of ACT based rehabilitation for chronic pain. The findings were interesting given that self-compassion was not specifically targeted within the therapeutic modality. It was suggested that self-compassion might be an underlining mechanism within ACT. The study highlighted the need to gain a better understanding of individuals' experiences and mechanisms of change of self-compassion in ACT in order to increase the focus of self-compassion within it in the hope that it might lead to the increased effectiveness of the therapy (Vowles et al., 2014).

1.4. Study's rationale

The findings of these studies suggest that self-compassion, although not directly targeted within ACT, might be a significant mediating factor within ACT and specifically ACT for chronic pain. Additionally, while there is quantitative research examining self-compassion as an aspect of therapeutic change within ACT, there seems to be a lack of qualitative research exploring how the process of developing self-compassion occurs within ACT (Yu & McCracken, 2016). The current study therefore aims to explore both how clients experience self-compassion in ACT based therapeutic modalities for chronic pain and how changes in self-compassion occur within the therapy by examining their self-to self-relating through the utilisation of post-modern constructivist conceptualisation of a sense of self.

Understanding the processes that lead to psychological change and the experience of therapy are seen as important in developing more effective interventions (Higginson & Mansell, 2008, Kazdin, 2011). Based on the absence of previous research in the area, the present study aims to provide a better understanding of how self-compassion is experienced within ACT for chronic pain and what meaning individuals ascribe to it. Therefore the present study aims to answer the following research questions.

1.5. Research questions

* How do clients experience self-compassion within ACT for chronic pain?

* How does self-compassion change over the course of ACT for chronic pain?

2. Method

2.1. Design

A qualitative methodology was chosen as it facilitates the understanding of individuals' experiences and processes (Harper & Thompson, 2011). Interpretative Phenomenological Analysis (IPA) was selected as it aims to explore the meaning that individuals ascribe to their experiences without any predefined notions derived from scientific theory (Smith, Flowers & Larkin, 2012) and due to its suitability for the exploration of experiences around participants' self-to-self relating and sense of self (Eatough & Smith, 2009) that was perceived as 'fitting' with the conceptualisation of self-compassion that focuses on the self-to self-relating (Gilbert, 2010; Neff, 2008). IPA's double hermeneutics methodology offers a way to interpret and understand the participants' lived experience of self-compassion within ACT for chronic pain (Harper & Thompson, 2011).

Additionally, the study utilised a theoretical lens of a post-modern constructivist conceptualisation of a sense of self to examine the above (Gilbert, 2010; Gergen, 2011 Harre, 1991; Neff, 2008). The use of a theoretical lens with an IPA methodology, while not considered to be a standard practice, can be used to apply a particular theoretical lens following the implementation of an inductive phenomenological analysis (Langdridge, 2007). A post-modern constructivist conceptualisation of a sense of self postulates that the structure of the language can be seen as pivotal in unearthing an individual's conceptions of their senses of self. An individual's use of personal

pronouns, such as 'I', 'you', in their narrative fore-structure can be perceived as suggesting the participants construction of separate selves (Gergen, 2011; Harré, 1991). At the same time it has been suggested that individuals might also experience a universal stable sense of self that is not solely based on their linguistic or social relations (Williams, 1999). Participants might also experience a sense of self that is based on their inhabiting a biological body that pre-exists their linguistic or social relations (Williams, 1999). The self-to-self relating of the participants was explored by looking into how they discussed their concerns about their well-being as well as the level of attunement and tolerance that they described towards their distress, that was seen as being influenced by their level of understanding of the origin of their distress and their ability to accept that distress (Gilbert & Procter, 2006). Furthermore, the participants' self-to-self relating was explored by looking into the participants' self-talk and the way they appeared to interact with the different aspects of their selves (Gilbert & Procter, 2006).

Further information on the rationale for the chosen methodology framework are included in Appendix I.

2.2. Position of the researcher

The researcher adopted a critical realist stance for this study. Critical realism suggests an ontological realism whilst postulating a form of epistemological constructivism and relativism (Maxwell, 2012). The researcher's selection of a critical realist stance was influenced by the belief that there is an objective reality that the researcher's own socio-educational-vocational and cultural background influences the researcher's perception of it. More specifically, the researcher is a non-British, white, female who is training to become a clinical psychologist. The researcher has an interest in self-compassion as a practising clinician and believes it is useful within therapy. The researcher's own cultural background that influenced the researcher's beliefs about how individuals should relate to themselves, might consequently influenced the researcher's understanding and interpretation of the participants' experiences of self-compassion. The researcher reflected that the interpretations of the participants' experiences might have been different from the participants' understandings and interpretations of those experiences, that could have been influenced by their own

cultural beliefs about how individuals should relate to themselves, and their actual experiences. The above stance of knowledge production and understanding of reality was seen as being in accordance of a critical realist epistemological stance.

Further information around the rationale for its selection included in Appendix D.

2.3. Participants

A purposive sampling method was chosen. This provided access to a specific perception of phenomena instead of being statistically representative (Smith, Flowers & Larkin, 2012). A sample of six participants was utilised, with an emphasis placed on the richness of the collected data, the homogeneity of the sample (Larkin & Thompson, 2012; Smith, Flowers & Larkin, 2012) and the basis that they could provide 'access' to the phenomena under study (Smith, Flowers & Larkin, 2012). This is in line with recommendations for a doctoral thesis using IPA (Larkin & Thompson, 2012; Smith, Flowers & Larkin, 2012). Participants were recruited from an ACT based chronic back pain group guided by the guidelines proposed by Vowles and Sorrell (2007) and delivered in a NHS hospital in the UK. The group ran on a three hours weekly basis for 9 weeks, with a follow up two hours session offered three to six months after its completion. The group was delivered four times every year and was facilitated by a clinical psychologist, a physiotherapist and an occupational therapist.

Participants were included in the study if they: had capacity and were willing to provide informed consent; were aged over 18 years of age; and could speak English, as a translator could not be provided. To ensure the homogeneity of the sample, participants were included if they had completed the group within the last year. Participants were also excluded if they had not attended at least 50% of the group's sessions. A summary of the participants' demographic information is provided in Table 1.

Table 1. Participants' demographic information

Pseudonym*	Age	Gender	Nationality	Time since completion of the group	Length of duration of pain
Grace	53	Female	White British	8 months	9 years
Kathy	61	Female	White British	1 month	7 years
Lucy	45	Female	White British	1 month	1 year
Amy	56	Female	White British	6 months	20 years
James	52	Male	White British	6 months	8 years
Hannah	54	Female	White British	8 months	2 years

2.4. Ethical approval

Ethical approval from the NHS Health Research Authority (HRA), the local Research ethics Committee (REC) and the local Research and Development department (R&D) where the study was conducted was requested and granted (Appendices J &K). Sponsorship approval was also provided by the University of Leicester (Appendix L). The appropriate confidentiality and safety procedures stipulated by the above organisations were adopted throughout the study. Participants were given the opportunity and were encouraged to ask questions in regards to the study and their potential participation. They were informed that they could withdraw from the study at any point without having to provide an explanation. Prior to their participation,

*the names of the individuals have been changed and the location of the group is not disclosed in order to guard the participants anonymity.

participants provided signed informed consent (Appendix M). At the end of their participation participants were given the time and space to discuss any potential emotional distress they might have experienced during the interview. A list of local and national support organisations was also made available to them (Appendix N).

2.5. Procedure

The study was conducted over a period of approximately two years. The chronology of the study is outlined in Appendix O.

Individuals taking part in the ACT group for chronic pain are routinely asked to provide consent to be contacted in the future to take part in research studies. The clinical psychologist delivering the ACT based chronic back pain group provided individuals that had provided the above consent and met the study's inclusion criteria with the study's information sheet (Appendix P). Potential participants interested in taking part in the study were informed that they could complete a contact details form (Appendix Q) containing information about the way they would like to be contacted by the researcher or directly contact the researcher to seek further information about the study. The researcher contacted participants that expressed an interest to take part in the study at least 48 hours after being given the study's participant information sheet.

One-to-one semi-structured interviews were conducted with each participant using a topic guide. The interview topic guide provided an opportunity to collect rich data, within a purposeful conversation, that was not extensively limited by specific interview questions (Smith, Flowers & Larkin, 2012). It also enabled the development of rapport between the interviewer and interviewee that invited the participants to give a reflective in-depth description of their experiences. The topic guide and interview questions used were developed following the review of the relevant literature alongside the researcher's supervisor and are included in more detail in Appendix R.

All participants requested for the interviews to be conducted in their homes. The interviews were digitally recorded and their duration varied from 50 to 90 minutes. The tape-recorded interviews were then transcribed verbatim. Pseudonyms were used in the

verbatim transcription of the interviews, with any participant identifiable information suitably removed, to ensure the participants anonymity.

2.6. Transcription and analysis

The researcher transcribed verbatim the audio recordings of the participants' interviews, incorporating both verbal and non-verbal nuances, while acknowledging that according to IPA guidelines, the researcher's immersion and interpretation of the data commenced during this stage (Smith, Flowers & Larkin, 2012). Data analysis was conducted according to IPA guidelines proposed by Smith, Flowers and Larkin, (2012). The following steps are described in a linear manner but the researcher moved back and forth to different steps throughout the analytic process in a cyclical manner as per the above guidelines (more details included in appendix S). Each interview transcript was read numerous times to ensure the researcher's familiarity with the data and the researcher recorded her initial comments on the transcript to uncover any presuppositions about the subject. Those initial comments were put aside before creating a table for each interview that consisted of three columns, with the middle column containing each participant's interview transcript. Line-by-line coding of descriptive, linguistic and conceptual interpretations of participants' experiences were written in the right column. Emergent themes were then developed that reflected both the participant's original quotes and the researcher's interpretation of them. These were included in the left column. The next stage entailed clustering emergent themes into tentative higher order themes. The above were revisited numerous times, within the researcher's supervision, through personal reflection and the attendance at a peer supervision group with other researchers using IPA. The tentative themes were then reviewed to produce subordinate themes.

The above process was repeated for each interview. Patterns across all of the participants' subordinate themes were sought out and organised into superordinate and subordinate themes across all participants. Participants' representation in each superordinate and subordinate theme is demonstrated in Appendix T .

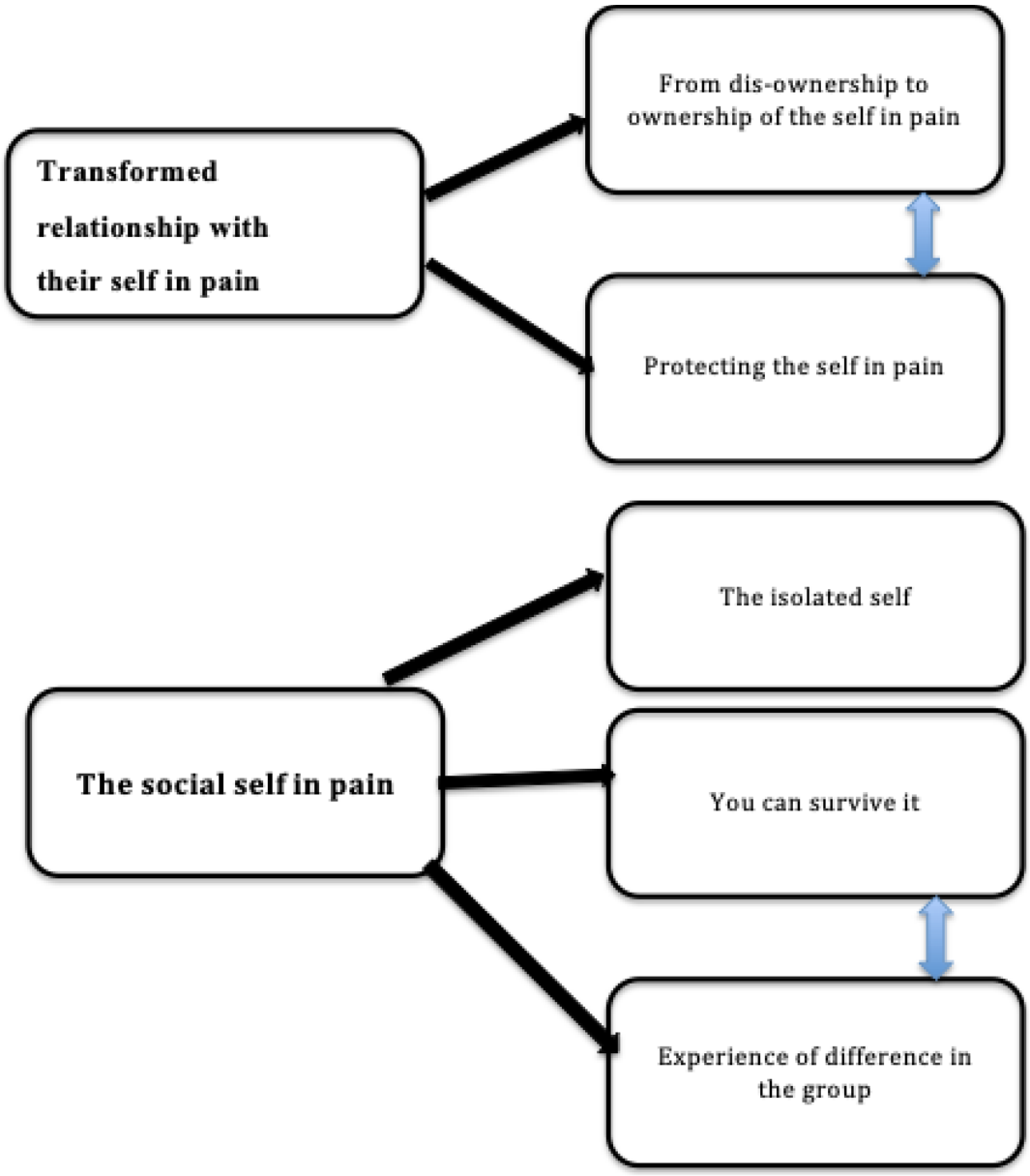
2.7. Reflexivity and Quality checks

The principles proposed by Yardley (2000) (sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance) were adopted in order to ensure the quality and validity of the research process. Further information on the above is included in Appendix U. Reflexivity was attended to throughout the whole research project and the researcher kept a reflective diary (an extract is included in Appendix V).

3. Results

The analysis generated two super-ordinate themes that each contained two and three subordinate themes respectively, depicted in Figure 3, with the blue double-ended arrows depicting the themes that share some quotes due to the word limitations of this thesis.

Figure 3. Depiction of the structure of the Super-ordinate and sub-ordinate themes across all of the participants



3. 1. First super-ordinate theme: Transformed relationship with their self in pain

This super-ordinate theme highlighted how participants' perception and relationship with their sense of self and their experience of pain changed following their participation in the group. This theme conveyed how participants developed a new,

more positive perception and relationship with themselves and the part of their sense of self that experienced pain.

(Pain) is part of me. Kathy

I am kinder to myself, because of what I have learnt. Grace

Participants described that prior to the group they had formed a negative perception of themselves (*I felt useless, Kathy).* They described their experience of pain as being separate from their sense of self, further disowning the part of them that experienced pain. Following the completion of the group, participants appeared to describe an acknowledgement of their experience of pain.

The shift in their relationship to themselves was reflected in the structure of the language participants used throughout their interviews. It significantly changed when they described their personal experiences of pain prior, throughout and after the group. Their alternation between personal pronouns (i.e. I, you, it) during their interviews was interpreted as being indicative of their conceptualisation of separate selves when experiencing pain and the changing internal relational processes of and with the different aspects of those separate selves.

This super-ordinate theme includes two subordinate themes (From dis-ownership to ownership of the self in pain and Protecting the self in pain) detailing participants' relationships with different parts of themselves.

3.1.1. From dis-ownership to ownership of the self in pain

For the majority of the participants, the experience of pain and the immense effect it had on their lives was distressing and overwhelming. The narratives of five participants contained accounts that before the group they perceived their experience of pain as outside of their sense of self. Their use of language when describing the above is noteworthy and was mirrored in the accounts of five participants.

'I tried to block the pain out'. James

'I couldn't see an end to the awful pain.' Lucy

Participants described that prior to the group they attempted to disengage from or deny the different aspects of their experience of pain and the part of themself that experienced it. The use of language of five participants seemed to change when describing their experience of pain during and after the group,

'*You realise you still haven't got rid of your pain but hey ho'. James*

'My back pain'. Hannah

The participants' use of language seem to indicates a shift from 'disowner-ship to ownership' of their experiences of pain, suggesting a new relationship with the part of themselves that experiences pain. Kathy's quote 'it is who I am' suggests a new relationship with the part of herself that experiences pain. She acknowledges it, becomes attuned to it but does not over-identify with it (*I try not to dwell on it*. Kathy).

Kathy's use of language when describing the above is noteworthy and mirrored the accounts of four participants. In the first and second quote she describes her experience of pain before the group and, during and after the group, respectively.

'It wasn't any life to live like and like I can't do anything, I am useless is probably, you know you feel like I mean I run a business for 20 years and I just was re-training to do new things and like everything was taken from me you know […]. I mean I've been through this for as long as I have, it has been nine years and having led such a full life before it's like taking everything away […] grieving for what you had.' (Kathy, line 77)

'You've got a choice, you either carry on or give up and it is the carry on bit that is easier[…] I mean it is part of me, it is who I am [] I try not to dwell on it and doing things, I mean I try and walk more, I think that helps I don't think sitting around all

day did my pain any good […] and doing more believing I can do more.' (Kathy, line 452)

Kathy's quote offers multiple layers of interpretation, included in this and the following theme. Her use in the first quote of the words 'it' and the phrase 'I have been through this' indicates that before the group she conceptualised her experience of pain as being a separate entity from her sense of self. Her use of the word 'taken', used twice in the first quote, suggests that the external experience of pain performed the removal of the valued sense of achievement in her life. By externalising the experience of pain, Kathy disowns the part of herself that experiences it.

Kathy's use of the words 'you' in her second quote (you have a choice, you carry on, you give up) portrays her adoption of a stance of having two senses of self when experiencing pain; one that experiences pain and one that is observing and responding to that self. Dissimilar to her first quote, in the second quote her use of language conveys a sense of agency (you have a choice). Kathy's perception of the observing part of herself changes after the group to it having more control, being able to acknowledge the part of herself that experiences pain without over-identifying with it and then being able to shift her attention towards other experiences.

3.1.2. Protecting the self in pain

Prior to the group, five participants described that their experiences of pain affected their ability to take care of themselves and complete everyday activities. They related how the 'achieving self', an important, valued part of their sense of self that provided them with a positive self-perception and constituted their lives as worthwhile, was taken from them. This loss of the 'achieving self' led to their complete devaluation of their selves.

' (I) considered myself useless.' Kathy

'I couldn't move my arms, I couldn't wash my hair […] I couldn't drive and I couldn't work you know I couldn't support myself and everything[…] I did feel absolutely worthless.' Lucy

Participants described that prior to the group they had a negative emotional response towards themselves for not achieving/recovering according to specific self-imposed standards. The value of their sense of self seemed to be conceptualised and influenced by the performance of the part of their self that was achieving. There seemed to be a lack of a sense of inherent value that was not externally or internally imposed by societal or personally constructed standards. Other parts of their selves that were not linked to achievement were not considered when contemplating their own sense of personal value.

A change was captured in their use of language when participants began to talk about their experiences during and after the group.

self-love really, that was a huge part […] I say to myself I need to just make sure I am not pushing myself too hard. […] If I can't walk that distance one day I won't beat myself up about it, […] I think that is the thing, not being too hard on myself physically and emotionally or mentally. Hannah

I have been going through feeling unworthy […] that changed […] I learnt to be kinder to myself that it is okay to make arrangements and then not being able to keep them. Grace

For Kathy and Hannah, achieving as a value was still quite important, but they both seemed to describe a reconceptualization of what achievement looked like that accounted for their personal limitations. This led them to positively re-evaluate not only the 'achieving part' of themselves but their entire sense of self. Participants described the emergence of a sense of self that took care of their needs and was more kind, describing a more self-compassionate internal process of relating to themselves. Kathy also described a new sense of self that believed in her ability to achieve things, whereas Hannah described a more positive emotional response (self-love) towards herself and a more positive relationship as a whole with herself. Grace on the other

hand described a move from achievement being a way of valuing herself to a new way of interacting with herself that accounted for her personal limitations and her needs.

3.2. Second super-ordinate theme:The social self in pain

This superordinate theme includes three subordinate themes (The isolated self, You can survive it, Experience of difference in the group). It highlights how participants' construction and relationship with their sense of self was influenced by their social interactions.

Because they were in that same kind of pain they knew how you felt and I know how they felt and we could all sort of sympathise and acknowledge the same thing you know we all go through that other people in the outside world haven't got a bloody clue. *Amy*

Prior to the group, five participants conveyed that through negative social interactions or by not being able to inhabit their past social roles, when they experienced pain, they had constructed an isolated sense of self. The participants' interactions with other group members they perceived as facing similar but different experiences of pain enabled them to shift the above towards a sense of self that can endure and survive the experience of pain. It also led to their re-evaluation and re-conceptualisation of their experience of pain. For one participant, perceiving other group members' experiences of pain as dissimilar to her own led her to become less engaged to the group's teachings.

3.2.1. The isolated self

Prior to the group, five participants described feeling alone when they experienced pain. This was further influenced by the negative responses individuals within their social network had towards their experience of pain or their own perceived inability to inhabit their past social roles.

'My family did get to the stage where one of my sons would say 'oh, come on mom, pull yourself together'.' Hannah

'I have been going through being frustrated and feeling unworthy[…]I felt I cannot contribute to society anymore' Grace

They described that the above resulted in a sense of disconnection from those around them, culminating in an isolated sense of self. For four participants, other people's minimising attitudes towards their pain was in stark contrast to their personal awareness of how difficult the experience of pain was. This led them to view their problems as unsurpassable. All the above resulted in their adoption of negative responses in their interaction with themselves when in pain.

3.2.2. You can survive it

During their social interactions within the group, gaining an awareness that other individuals were facing similar difficulties to their own had an immense effect on five of the participants' sense of self and relationship with their self.

'Less anger and frustration […] because they got similar symptoms to what I have, they felt the same as I felt and it gave you sort of relief and hope as well. […] You can survive, you can survive it […] (before the group) it was a constant battle with your other self with who you used to be.' James

'It is like oh somebody's the same as me and if she's managing so can I.'Kathy

For James, seeing his personal experience of pain being mirrored in the experiences of the other group members resulted in a reconceptualization of his sense of self that experiences pain. He moved from the rejection of that part of himself to gradually accepting it. That sense of acceptance centred on his new perception of his self as being able to survive the experience of pain that allowed him to stop striving to return to his old sense of self that did not experience pain. It also brought about a more positive

relationship with his self that entailed less anger and frustration. For Kathy seeing other group members managing their experience of pain allowed her to re-conceptualise the perception of herself as being able to 'follow in their footsteps'.

Hannah, further described how connecting with group members influenced her own view and relationship with herself.

'That connection with people within the group it does make you feel normal and then that has an effect of you being able to then to ease off a little bit and not put yourself under too much pressure and know that you are going to get better but at a different rate in a different pace and there is always somebody worse off than yourself and to be there for that one person ehm I found really helpful.' Hannah

For Hannah connecting with other group members rather than simply witnessing their experience of pain was critical. Prior to the group, her sense of isolation and lack of connection within her social environment led her to perceive herself as abnormal and to relate to herself in a punitive way. The formation of social connections within the group changed her perception of herself to that of being normal. This shift positively altered her relationship with herself. It provided Hannah not only with a sense of how recovery and adaptation to the pain looks like but also with a sense of self that has the capacity to manage her experience of pain in a way that causes her less distress.

3.2.3 Experience of difference in the group

Gaining an awareness that other individuals in the group were facing comparable or dissimilar difficulties to their own had an immense effect on all of the participants' sense of self and relationship with themselves.

The account of one participant that took part in the group twice highlights the influence of participants' perceptions of differences in other group members' experiences of pain.

'I think the previous time I did it (participation in the group) everyone appeared to be walking well and I was like the only one with sticks and I felt different even in that group everyone was in pain I felt different so that made a big difference this time because I didn't feel different […] Because like I said I wasn't paying as much attention (in the previous group), as I said before I just considered I was different right from the off and maybe didn't respect their pain if you see what I mean […] so I was the lame of that one wasn't I?' Kathy

In her description of her first participation in the group, Kathy uses the word 'different' four times. This highlights the influence that her perception of her experience of pain as being different to that of other group members had on her experience of the group. It leads her to perceive herself as being dissimilar to the other group members, resulting in her distancing her self from the teachings of the group, from other group members and from the experience of the group as a whole. Kathy described considering the group with deference due to it being irrelevant for the experiences of her sense of self that endured more severe pain than that of the other group members. During her second participation, experiencing a sense of sameness in her experience of pain with that of other group members enabled Kathy to overcome her perception of her sense of self as being separate from other group members. It also enabled her to actively engage with the group.

Five participants described that seeing other members in the group experiencing pain gave them an awareness of the range of pain intensity people can experience. It led them to position their own difficulties within that range, compared to before the group when they perceived their pain as being in the most intense range. This seemed to positively alter their perception, emotional response and relationship with their self.

'It is really sad in a way but seeing people who were a lot worse than me helped a bit to think well actually it could be worse which is a little bit of a shame for the isn't it really that I have somehow benefitted from seeing them being in so much pain […] I

suppose that their misfortune made me feel a little bit better about my own situation which sounds awful.' Lucy

For Hannah, witnessing other group members' experiences of pain and being able to perceive herself as being able to assist them stirred a more active sense of self that is portrayed by her use of the word 'I' (found that helpful), instead of her continuous use throughout her quote in the previous theme of the passive word 'you'. Lucy acknowledges that becoming aware of the part of her self that witnessed other members more severe difficulties led her to experience contradictory feelings. She experiences shame and sadness, describing her self's act of noticing as 'awful'. At the same time, she recognizes the positive emotions that her sense of self experienced as a result of observing the other participants' experiences of pain.

4. Discussion

The current study explored how individuals experienced self-compassion within ACT for chronic back pain. It aimed to achieve the above by exploring the participants lived experience of relating to their sense of self during the therapy. This was seen as having the potential to explore their experience of self-compassion and how it changed over the course of the therapy. The findings are discussed in relation to the wider literature on self-compassion and in regards to their clinical utility.

4.1. Links to the literature

4.1.1. Transformed relationship with their self in pain

Participants described that during the group they were able to adopt a more compassionate stance towards themselves by becoming more aware and accepting of their own personal limitations, adopting a more-kindness oriented way of relating to their selves and a new self-perception that was not primarily focused around their sense of achievement. These findings seem to imply an adoption of intrinsically based sense of self-worth that is in accordance to the experience of self-compassion, i.e. guided by the recognition and acceptance of one's own personal limitations and consequent experience of self-kindness when faced with those limitations (Neff, 2016).

Participants described that prior to the group their experiences of pain were so aversive that they tried to disengage from the different aspects of that experience and the parts of themselves that experienced it. They described that taking part in the group led them to be able to be more aware of their difficult experiences of pain, observe both the experience of the pain and the part of their self that experiences it, and consequently becoming able to shift their attention to other experiences. This may point to participants adopting a more mindful awareness of their personal experiences in line with Neff's definition of self-compassion (Neff, 2003; Neff, 2008; Neff, 2016). According to Neff, self-compassionate individuals have an integrated sense of self (being aware and accepting of the different parts of their personal experience) and are

able to observe their negative experiences, thoughts and emotions, without making an effort to deny or suppress them, thus being able to become disentangled from a negative reactivity.

4.1.2. The social self in pain

Following from Neff's definition (2003) the experience of self-compassion involves an individual refraining from criticising their self for any personally perceived failure to meet their own or societal standards. It instead postulates the acceptance and adoption of a warm emotional response towards oneself when faced with personal flaws or inadequacies. For participants, prior to the group, societal and personal values around achievement played a pivotal role in invoking negative emotional responses towards their selves and resulting in a negative self-evaluation, indicating a lack of a compassionate approach towards themselves. Participants seemed to not have an inherent sense of self-worth that was not linked to achievement. This has been proposed as being negatively linked to the experience of self-compassion (Neff, 2003; Purdie & Morley, 2016).

Participants' social context and social interactions seemed to have an immense influence on their sense of self, and consequently their experience of different elements of self-compassion. Prior to the group, negative social responses to the participants' experiences of pain and the loss of their social roles within their social relationships seemed to have led participants to develop a sense of self that was isolated and separate from others. This was interpreted as participants experiencing a diminished sense of common humanity, that entails viewing one's own difficulties as abnormal when contrasted to those of other individuals (Neff & Davidson, 2016). These findings also seem to be in accordance to Gilbert (2010) proposing that the experience and maintenance of a more compassionate relationship with one's sense of self is heavily influenced by one's social interactions (Gilbert, 2010). To the researcher's knowledge, current research has focused on the importance of the social context for the development of self-compassion for individuals that had limited prior experiences of self-compassion (Gilbert, 2010). There doesn't seem to be any literature on the harmful effects of negative social interactions on the maintenance of self-compassion, and the

influence of changing and evolving social interactions on that experience of self-compassion. The findings of this study are seen as shedding some light to the above.

Participants' social interactions within the group seemed to give rise to them experiencing more self-acceptance and less negative emotional responses towards their selves. These findings detail the seemingly conflicting influence that the social interactions within the group setting had on the participants' experience of self-compassion. Seeing other group members facing similar difficulties to their own, on the one hand resulted in participants starting to view their difficulties as being part of the common human experience, suggesting the experience of a sense of self that was less isolated and consequently suggesting the experience of self-compassion (Neff, 2008). One the other hand it resulted in them starting to form and focus on a more positive performance evaluation of their selves, something that seems contradictory to the experience of self-compassion. More specifically, according to Neff, Kirkpatrick and Rude (2007) positive self-acceptance that is associated with self-compassion is irrespective of one's performance evaluations of the self and does not stem from comparing one's self with others. This can be seen as highlighting the seemingly contradictory influence that elements of therapy can have on the experience of self-compassion.

Lastly, participants described experiencing a sense of feeling connected with other group members. This seems in accordance to Neff (2016) suggesting that the experience of self-compassion is linked to an individual's recognition of their interconnectedness with other individuals. More specifically, the recognition that other individuals face difficulties similar to one's own and the adoption of a stance that aims to help others' suffering (Neff, 2016). Three participants reported this. The influence participants' perceptions of their experiences as being different to that of other group members have also been highlighted. Both Lucy and Kathy described that perceiving too much difference in their own experiences compared to that of other group members resulted in their sense of interconnectedness and equality with others group members diminishing. For Kathy, it seemed to exacerbate her sense of separateness from other group members, resulting in her disengagement from the group teachings. This seems to have not been previously highlighted in the literature and seems to have clinical implications. It seems to suggest that therapists, to the extent that this is feasible,

should be aware of the disparity in the levels of pain within a group in order to potentially safeguard the disengagement of participants that their experience of pain appears to be dissimilar to that of the rest of the group members. The importance for the therapist to be aware of the level of heterogeneity within group settings as well as the group members' personal attribution and perception of their disability in comparison to both the therapist and the other group members has been previous highlighted (Brabender et al., 2004; Leszcz et al., 2007). More specifically, it has been suggested that it might be beneficial for the therapist to be aware of the personal meaning and perception that each member of the group adopts in regards to their disability, as too much perceived heterogeneity in the group members' self perceptions of their and other group members' disability might potentially lead to their limited participation in the groups or even disengagement from the group setting.

4.2. Strengths and limitations

This study was seen as having a number of strengths. It is the first study to explore the experience of self-compassion within acceptance and commitment based group therapy for chronic back pain. A further strength of the study is its transparency in regards to its methodological process, the explicit exploration of the epistemological stance of the researcher and the assessment of its quality according to the principles stipulated by Yardley (2000). The chosen methodology, IPA, was considered as having the potential to provide the researcher with the opportunity to examine a previous un-explored research area in order to potentially make meaningful contributions to the improvement of existing psychological interventions, while also permitting for links to be made to the current literature (Bradding, 2015). The richness of the participants' interviews was seen as a further strength that enabled the researcher to further explore their experiences. Another strength is the use of a number of methods to ensure that the findings were grounded in the participants' data, such as the attendance of peer and one-to-one reflective supervision, the attendance of an IPA workshop and the keeping of a research journal.

On the other hand the study appears to have a number of limitations. The researcher's concurrent status as a trainee clinical psychologist could potentially have led participants to construct a more positive account of their experiences and effectiveness of therapy (Chenail, 2011). Another limitation is the participant recruitment process, with the groups' lead clinician approaching individuals that had completed the group. This might have led to only participants that had benefited from the group and had a positive experience during the therapy opting to take part in the study. The above two reasons might explain the homogeneity of the participants accounts around the positive experience of their participation in the group. Future research might be useful to explore the experience of self-compassion for participants that did not find the ACT based back pain group beneficial.

Additionally, the researcher had no experience of chronic back pain and therefore the ensuing discussions during the interviews might have been affected by the researcher's capacity to relate to the participants' experiences of pain. It might also have influenced the participants' experience of feeling understood by the researcher. Similarly, it is important to recognise that the researcher explored the participants' experience of self-compassion by focusing on their sense of self and self-to-self relating.

4.3. Clinical Implications

Participants seemed to have experienced a more positive emotional response and relationship with their sense of self, indicating an increased experience of self-compassion. They reported being more able to be mindfully aware of their painful thoughts and feelings. Participants further reported that they were able to redefine their sense of achievement to accommodate their personal limitations and difficulties, thus experiencing a more kindness-oriented relationship with their sense of self. The present study also indicated the positive influence that the social interactions between group members had on the promotion of the participants' experience of both self-kindness and sense of common humanity. The above seems to indicate that the experience of self-compassion could be an underlying process within ACT group therapy for chronic back pain. Future research that explores the transferability of the above findings to other populations is recommended.

The study's findings also seem to indicate the positive influence of a group setting on the experience of self-compassion. Being in a group setting seemed to assist individuals to feel less isolated and experience an enhanced sense of common humanity. Nevertheless, the study's findings highlighted the importance of a balance in the homogeneity of the group participants' experience of pain. While, it is not always feasible, due to economic and service structure constraints, it might be useful if clinicians were attentive of the level of difference in group participants' levels of pain. While some difference in the levels of pain was perceived as beneficial, too much difference could potentially lead to the disengagement of participants in the more extreme level of pain. This recommendation is a tentative one, given that other group members' levels of pain were based on the participants' perceptions and might have not been an accurate reflection of the other group members' experiences of pain. Therefore a clinician might not always be aware of how individuals' experiences of pain will be perceived within a group setting. More research exploring the experience of self-compassion and the process of change within ACT for chronic pain might assist in the further improvement of the therapy and shed more light in this study's findings. Additionally, further research on how individuals might be helped to refrain from engaging in the evaluation of their self according to their abilities to achieve their personal goals might be useful in helping individuals to experience more self-compassion during therapy.

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Appendices

Appendix A*. Guidelines to authors for the journal targeted for literature review

Author Guidelines

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and **Registered Reports**. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

• Research articles: 5000 words
• Qualitative papers: 6000 words
• Review papers: 6000 words
• Special Issue papers: 5000 words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via **Editorial Manager**. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the **terms and conditions of submission** and the **declaration of competing interests**. You may also like to use the **Submission Checklist** to help you prepare your paper. If you need more information about submitting your manuscript for publication, please email Vicki Pang, Editorial Assistant at **papt@wiley.com** or phone +44 (0) 1243 770 410.

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5. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

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• The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

• Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (**http://www.consort-statement.org**).

• Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (**http://www.prisma-statement.org**).

For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association.

6. Multiple or Linked submissions

Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

7. Supporting Information

PAPT is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at **http://authorservices.wiley.com/bauthor/suppmat.asp**

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Colour figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures at Early View publication, they will be invited to complete a colour charge agreement in RightsLink for Author Services. The author will have the option of paying immediately with a credit or debit card, or they can request an invoice. If the author chooses not to purchase colour printing, the figures will be converted to black and white for the print issue of the journal.

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Visit **http://authorservices.wiley.com/bauthor/** for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

13. The Later Stages

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from the following web site: **http://www.adobe.com/products/acrobat/readstep2.html**. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

14. Early View

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Further information about the process of peer review and production can be found in this document. **What happens to my paper?** Appeals are handled according to **the procedure recommended by COPE**.

Appendix B. Details of websites searched during scoping exercise

Table 2. Websites searched

Compassionate Mind Foundation	http://compassionatemind.co.uk/
Self-compassion	http://self-compassion.org/
Good Therapy	https://www.goodtherapy.org/
National Institute for Health and Excellence	https://www.nice.org.uk/
Google search engine	www.google.co.uk
Google Scholar	https://scholar.google.co.uk/

Table 3. Rationale for selected databases

PsycInfo	It was selected due to being one of the most extensive and well-known databases containing published peer-reviewed research in the fields of psychology, behaviour and social sciences.
Scopus	It was selected as it is considered one of the most extensive databases of published peer-reviewed research on a wide range of sciences, encompassing amongst others medicine, humanities and social sciences.
MedLine	It was chosen as it is considered to be one of the most extensive and comprehensive databases of published peer reviewed research on biomedical sciences and life sciences.

Cinahl	It was selected as it contains extensive published peer-reviewed research from a wide range of health disciplines, including health sciences and allied health disciplines.
Web of Science	It was selected as it contains a wide range of published peer reviewed research from a vast number of scientific disciplines.

Appendix C. Search terms used

(compassion* OR compassion-focused OR CFT OR compassionate-mind OR CMT OR self-compassion*)

AND

(interview* OR focus group* OR focus-group* OR narration* OR qualitative research OR (((semi-structured OR semistructured OR structured OR unstructured OR informal OR “in-depth” OR indepth OR “face-to-face” OR “face to face” OR guide OR guides) AND (interview* OR discussion* OR questionnaire*))OR (“focus group” OR “focus groups” OR qualitative OR ethnograph* OR fieldwork OR “field work” OR “key informant”)))

NOT

(“compassion fatigue” OR compassion-fatigue*)

NOT

(“compassion satisfaction” OR compassion-satisfaction*)

Appendix D*. Statement of epistemological position taken for the study

Within qualitative research, it is widely recognised that the researchers' epistemological stance, the researchers assumptions and understandings of the relationship between participants' accounts and reality, can heavily influence the researcher's interpretation of the participants' experiences (Smith, Flowers & Larkin, 2012). Being explicit about the above is considered essential in order to safeguard the transparency of the research process and to position the research findings within a specific context, thus increasing the quality and utility of these findings (Mitchell, 2017).The following epistemological position was adopted for both the literature review and research part of this study.

Prior to the commencement of this thesis a scoping exercise of the available literature exploring the experiences of self-compassion within psychological therapies was conducted. The researcher became aware that individuals' experiences of self-compassion within therapy were extremely under-researched. There seemed to be plethora of research adopting a quantitative research methodology, with an implicit positivist epistemological stance, that aimed to measure changes in individuals' levels of self-compassion within psychological therapies. This highlighted a lack of research that did not adopt a reductionist perspective that an individual's sense of self and self-to-self relating can be solely reduced to and measured based on pre-determined statements on the individual's knowledge of the self (Cromby, 2004). Available research also seemed to not acknowledge post-modernism conceptualisations of self and self-to-self relating suggesting that an individual's sense of self is influenced by their cultural and societal context, while simultaneously, the individual is an active agent attaching meaning to their life experiences (Cox & Lyddon, 1997; Warren, 2002).

A critical realist stance proposes that ontology cannot be equated to epistemology (Fletcher, 2017). It maintains that individuals' perceptions and experiences are subjectively constructed, while simultaneously acknowledging that aspects of reality are in existence regardless of people's representation of it (Bradding, 2015). More specifically, critical realism is part of a constructionist epistemology postulating that as humans we construct meaning from our experiences. A critical realist position argues

that the world is an objective reality but that our relationship to it and our understanding of it are both constructed and shaped by our own social position and personal history (McEvoy & Richards, 2006). This is considered to be in contrast to discursive social constructionist approaches that don't believe in an objective reality but rather that each individual constructs their own interpretation of reality, so there is relativism. Critical realism aims to not isolate generalizable rules but rather to gain a richer understanding of a phenomenon, through the combination of an interpretative epistemology with that of a realist ontology (Gale, Schroder & Gilbert, 2017). A critical realist stance was therefore seen as having the potential to enable the researcher to focus on individuals' reflections and sense making of their experience of self-compassion within therapy, further focusing on their sense of self and self-to-self relating in order to investigate the research question.

A critical realist epistemological stance was also seen as being in accordance to the adoption of an IPA framework for the research part of this thesis, given that IPA is a phenomenological method suggesting that an individual's knowledge of their reality is based on their experience of that reality (Smith, Flowers & Larkin, 2012). More specifically, it proposes that the generation of knowledge is idiosyncratic and any form of analysis should adopt an interpretative engagement with the research data (Gorski, 2013). Both IPA and a critical realist stance recognise that the researcher interpretation of the participants' experiences is subjective and heavily influenced by the researcher's own life experiences and personal beliefs (Smith, Flowers & Larkin, 2012).

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Appendix E. Details of the selected papers

Table 4. Characteristics of selected papers

Citation	***Title***	***Aims of qualitative part of the study***	***Participants***	***Inclusion – Exclusion criteria for the study***	***Inclusion-Exclusion from the therapy***	***Research method***	***Analysis method***	***Rag-rating***
Ashworth et al. (2015)	*An exploration of compassion focussed therapy following acquired brain injury*	*An exploration of any psychological change and its nature with compassion focussed therapy for patients with an acquired brain injury facing emotional difficulties in a neuropsychological rehabilitation service.*	*6 participants*	*Patients with an acquired brain injury attending a neuropsychological rehabilitation outpatient programme.* .	*Patients were excluded if they had a diagnosis of a personality disorder or had an alcohol or drug addiction*	*mixed methods: self-report measures and semi-structured interviews*	*IPA (interpretative phenomenological analysis)*	*Green quality*
Bell et al. (2017)	*Developing a compassionate internal supervisor: Compassion-focussed therapy for trainee therapists.*	*The exploration of potential benefits of training therapists to develop a compassionate internal supervisor using adapted versions of compassion-focussed therapy interventions.*	*7 participants*	*Participants were CBT trainees that had not previously received CFT therapy.*	*Participants were excluded if the did not complete the entire CFT programme.*	*Semi-structured interviews*	*IPA (interpretative phenomenological analysis)*	*Green quality*
Clapton et al. (2018)	*'Finding the person you really are… on the inside':*	*Exploration of the experience of compassion focused therapy*	*6 participants*	*Participants had to have a diagnosis of an intellectual disability, be over 18 years of age, have*	*Participants were excluded if they were experiencing*	*Mixed methods: self-report measures*	*IPA (interpretative phenom*	*Amber quality*

	Compassion focused therapy for adults with intellectual disabilities	*for adults with intellectual disabilities.*		*received a score of at least 13 in the Psychological Therapies Outcome Scale for intellectual disabilities (Vlissides, 2014), have been assessed to be displaying self-criticism and have the ability to consent.*	*either psychosis or mania or were assessed as not having the capacity to consent to take part in the study.*	*and 2 focus groups*	*enologi cal analysi s)*	
Hardima n et al. (2018)	*CFT & people with intellectual disabilities.*	*Exploration of the experience of compassion focused therapy for adults with intellectual disabilities.*	*3 participants*	*Participants had to have a diagnosis of a mild to moderate intellectual disability and clinical anxiety.*	*Participants were excluded if they were diagnosed with autism or had a diagnosis of a non-affective psychiatric disorder.*	*Mixed methods: self-report questionnai res and semi-structured interviews*	*IPA (interpr etative phenom enologi cal analysi s)*	*Amber quality*
Heriot-Maitland et al. (2014)	*A compassionate -focused therapy group approach for acute inpatients: Feasibility, initial pilot, outcome data, and recommendatio ns.*	*Exploration of the experience of a compassion focused therapy group for individuals in an acute inpatient setting.*	*: 4 participants*	*Participants were recruited from an acute NHS inpatient unit. Participants were excluded if they were assessed by members of staff in the inpatient unit as being at risk to other patients or were deemed as being over sedated.*	*No information provided on additional reasons for exclusion of participants from the study*	*Mixed methods: self-report questionnai res and semi-structured interviews*	*IPA (interpr etative phenom enologi cal analysi s)*	*Amber quality*
Lawrence & Lee (2014)	*An exploration of people's experiences of compassion-focused therapy for trauma, using interpretative phenomenologi cal analysis.*	*The exploration of the experience of becoming self-compassionate within compassion-focused therapy for individuals with posttraumatic stress disorder.*	*7 participants*	*Participants had to have a diagnosis of post-traumatic stress disorder.*	*No further information provided*	*Semi-structured interviews*	*IPA (interpr etative phenom enologi cal analysi s)*	*Amber quality*

Lucre & Corten, (2013)	*An exploration of compassion-focused therapy for personality disorder.*	*An exploration of how individuals with a diagnosis of a personality disorder experienced compassion focused therapy and the aspects of the therapy that they found useful.*	*8 participants*	*Participants had to have a diagnosis of a personality disorder and self-identify as being self-critical.*	*No further information provided*	*Mixed methods: self-report questionnaires and written reflections of the therapy at the end of the group.*	*IPA (interpretative phenomenological analysis)*	*Amber quality*

Table 5. Details of the intervention used in the selected studies

Study	Format of therapy	Number of sessions	Duration of sessions	Duration of therapy	Training of therapist	Background of therapist	Supervisor of therapist	Frequency of supervision
Ashwort et al. (2015)	Both individual and group therapy	Individual therapy: 72 Group therapy: 8	not specified	Individual therapy: 18 months approximately Group therapy: 8 weeks	CFT training	Clinical psychologist	Professor Paul Gilbert	monthly
Bell et al. (2017)	Workshop	5	not specified	5 weeks	not specified	not specified	not specified	not specified
Clapton et al. (2018)	Group therapy	6	not specified	6 weeks	CFT training	not specified	Professor Paul Gilbert	not specified
Hardiman	Individual	12-15	not	12-15 weeks	no formal	counselling	not specified	not specified

et al. (2018)	therapy		specified		training	psychologists		
Heriot-Maitland et al. (2014)	Group therapy	4	40 mins	4 weeks	CFT training	clinical psychologist	CFT specialist	not specified
Lawrence and Lee (2014)	Individual or group therapy	not specified	not specified	not specified	CFT training	clinical psychologist	CFT specialist	bimonthly
Lucre & Corten (2013)	Group therapy	16	not specified	16 weeks	CFT training	cognitive behavioural therapists	Professor Paul Gilbert	bimonthly

Appendix F. Results from the quality appraisal of the selected papers

Table 6. Quality appraisals of the selected papers utilising CASP (2014)

Authors	Aims	Methods	Design	Sampling	Data collection	Reflexivity	Ethical Issues	Data analysis	Findings	Research value
Ashworth et al. (2015)						-				
Clapton et al. (2018)						-				
Bell et al. (2017)										
Hardiman et al. (2018)						-				
Heriot-Maitland et al. (2014)						-				
Lawrence & Lee (2014)										
Lucre & Corten (2013)						-				

✔: Means yes - : Means no

Table 7. Quality appraisal of the selected papers utilising Meyrick (2006) framework

Categories	Subcategories	Ashworth et al. 2015	Bell et al. 2017	Clapton et al. 2018	Hardiman et al, 2018	Heriot-Maitland et al., 2014	Lawrence & Lee, 2014	Lucre & Corten, 2013
Researcher epistemological theoretical stance	Epistemological stance explored	no	no	no	no	no	no	no
	Reflexive	yes	yes	no	no	no	yes	no
Methods	Aims/objectives clear	yes	yes	yes	yes	yes	yes	yes
	Methods appropriate to research question	yes	yes	yes	yes	yes	yes	yes
	Method established through reference to a body of literature	no	no	yes	no	no	yes	no
Sampling	Demographic details of sample provided	yes	yes	yes	yes	no	yes	yes
	Narrative description of sampling strategy provided	yes	yes	yes	yes	yes	yes	yes
	Explicitly describing sampling technique	yes	yes	no	yes	no	yes	no
	Rationale behind sampling technique detailed	yes	no	no	yes	no	no	no
	Data saturation	no	no	no	no	no	no	no
Data Collection	Process described	yes	yes	yes	no	no	yes	yes
	Place of interview reported	yes	yes	yes	no	no	no	yes
	Duration of interview reported	yes	yes	yes	no	no	yes	yes
	Interview questions established following a literature review	yes	yes	no	yes	no	no	no
	Interview questions provided	yes	yes	no	no	yes	no	no
Analysis	Systematic process described	yes	yes	yes	yes	yes	yes	yes
	Specific details on how data analysis was conducted provided	yes	yes	yes	no	no	yes	no
	Reflexivity/objectivity of	yes	yes	yes	yes	no	yes	no

	findings							
	Methodological triangulation	yes	no	yes	yes	yes	no	yes
Results/conclusions	Findings grounded in data	yes	yes	yes	yes	yes	yes	yes
	Findings considered in regards to research question	yes	yes	yes	yes	yes	yes	yes
	Generalizability of results	yes	yes	yes	yes	yes	yes	yes
	Transferability of results	yes	yes	yes	yes	yes	yes	yes
	Limitations considered	yes	yes	yes	yes	yes	yes	yes
Overall quality		high	high	medium	low-medium	low-medium	medium-high	low-medium

Appendix G. Quality appraisal of selected articles

3.2.1. Researcher epistemological stance

The epistemological and theoretical stance was not stated or explicitly explored in any of the included studies.

While six of the studies utilised therapists for either conducting the interviews or the thematic analysis of their findings, the influence the researcher had on the data was explicitly explored in only three studies. Ashworth et al. (2015) acknowledged that the researcher's training in psychology might have influenced their findings. Bell et al. (2017) reported that clinicians practising CBT and CFT conducted the research, with that potentially affecting their findings, while the lead author disclosed her expectation that the participants would find the therapy to be beneficial. Lawrence and Lee (2014) utilised an interview to unearth the researcher's presuppositions in regards to the research subject, while the main researcher documented her experiences of each interview and the process of data analysis on a reflective diary.

3.2.2. Methods

Each of the studies clearly outlined the aims and objectives of their research. Additionally, the methods chosen (discussed below) were deemed as being appropriate with regards to the objectives of the studies. Yet, only two of the studies justified the selection of their research method after considering a substantial amount of literature (Clapton et al., 2018; Lawrence & Lee, 2014), constituting them more robust on that perspective.

3.2.3. Sampling

All of the papers provided a narrative description of their sampling techniques while four papers further provided an explicit description. Two papers (Ashworth et al., 2015; Bell et al., 2017) utilised a purposive sampling. Hardiman et al. (2018) utilised a purposive and opportunistic sampling method while Lawrence and Lee (2014) utilised an opportunistic sampling method. Only two articles made reference to a body of literature for the rationale of the sampling technique chosen (Ashworth et al., 2015; Hardiman et al., 2018). Data saturation was not discussed in any of the studies. Lastly, two of the studies that utilised a mixed method design detailed the sampling method for the quantitative part but not their qualitative part despite the latter being a subsection of the former (Ashworth et al., 2015; Heriot-Maitland et al., 2014). Participants that did not complete the interventions were not included in the studies and adequate discrepant case inclusion was not considered.

Across all of the studies, the complete sample included 47 participants (26 female, 17 male). One study did not report the number of female and male participants within their sample, which amounted to 4 participants (Heriot-Maitland et al., 2014). Only three studies provided information on the ethnicity of their participants, 26 White-British and 1 British Bangladeshi (Ashworth et al., 2015; Bell et al., 2017; Lucre & Corten, 2013). Not one of the studies sought out a sample that was representative of gender and the population being researched.

3.2.4. Data collection

Each of the studies provided information on the methods utilised for data collection, although for two studies (Hardiman et al., 2018; Heriot-Maitland et al., 2014) the information was minimal; therefore making the systematicity and transparency of the data collection process difficult to assess. Five of the

studies utilised semi-structured interviews (Ashworth et al., 2015; Bell et al., 2017; Hardiman et al., 2018; Heriot-Maitland et al., 2014; Lawrence & Lee, 2014). Clapton et al. (2018) used two focus-groups while Lucre and Corten (2013) collected data from written reflections attained at the end of the therapy. The place of the interview and the duration of the data collection were detailed by four studies (Ashworth et al., 2015; Bell et al., 2017; Clapton et al., 2018; Lucre & Corten, 2013) while Lawrence and Lee (2014) only reported the duration of the interview. Three studies (Ashworth et al., 2015; Bell et al., 2017; Heriot-Maitland et al., 2014) included the interview questions utilised, increasing their transparency. Three studies considered a body of literature to establish the interview questions (Ashworth et al., 2015; Bell et al., 2017; Hardiman et al., 2018). As can be concluded, the transparency and systematicity of the chosen studies varied, with Ashworth et al. (2015) and Bell et al. (2017) being on the higher end.

3.2.5. Analysis

Each of the studies provided a detailed presentation of their selected method of analysis. All of the studies used IPA thematic analysis, with four of them using the Smith, Flowers and Larkin (2009) framework (Ashworth et al., 2015; Bell et al., 2017; Hardiman et al., 2018; Lawrence & Lee, 2014; Lucre & Corten, 2013). Clapton et al. (2018) and Lawrence and Lee (2014) used the framework from Braun & Clarke (2006). Four studies had increased transparency by explicitly detailing how they implemented their chosen method of analysis framework (Ashworth et al., 2015; Bell et al., 2017; Clapton et al., 2018; Lawrence & Lee, 2014). Two of the studies utilised more than one researcher in the process of analysing the data in order to ensure the reflexivity of their findings (Ashworth et al., 2015; Clapton et al., 2018); Bell et al. (2017) and Hardiman et al. (2018) utilised a third author for critical feedback; Lawrence and Lee (2014) utilised an peer IPA group feedback therefore achieving further reflexivity. Methodological triangulation by combining qualitative and

quantitative methods was used by five studies (Ashworth et al., 2015; Clapton et al., 2018; Hardiman et al., 2018; Heriot-Maitland et al., 2014; Lucre & Corten, 2013).

3.2.6. Results and conclusions

Each one of the studies utilised participants' quotations in order to verify their findings, hence grounding them in their data. The findings were further considered in regards to the research question. All of the studies considered the limitations of their findings in regards to generalizability and transferability.

3.2.7. Quality of papers

Ashworth et al. (2015) and Bell et al. (2017) were deemed as high quality papers. The rest of the papers fluctuated with regards to their systematicity and levels of transparency, but were all judged as being of satisfactory rigour.

Appendix H. Identified themes

In the following table underlined text denotes a subtheme within the results section, text in bold denotes the representation of that article in the themes within the results section and text in normal form within double apostrophes denotes extracts from the selected articles

Papers	Blocks toward self-compassion	Elements of therapy that assisted participants in becoming self-compassionate	The experience of compassion focussed therapy and its transformative effect on participants
Ashworth et al., 2015		<u>Empathic Affiliative interactions</u> **Finding safeness and gaining strength from other group members important in becoming compassionate. :** "**Developing trust and finding safeness** Patients described finding security in their relationships with members of staff, their therapist, and within the group. They also describe finding a sense of safeness within the environment at the neurorehabiliation centre. They describe the development of affiliative relationships between themselves and others, which were reported as important in approaching change." p. 154	**Becoming more compassionate as enabling to develop a novel way of firstly interacting and secondly comprehending ones' self:** 'A new approach The patients described how CFT gave them a new way to relate to themselves, helped them to revaluate their sense of worth, and provided tools to manage their difficulties. A key part of this process was of understanding and developing empathy for their own situation. They described that this allowed them to make changes to how they relate to others as well as themselves.' p. 155

		Receiving empathy within a group setting and gaining a sense of belonging significantly valued. Empathetic affiliative interactions as enabling one to become more compassionate.: "In it together-security in the group. Five of the patients described finding safeness in the group which allowed group members to draw strength from each other, and feel as though they were in it together: *"We had a lot of these groups between us . . .that was a real help because it can be very isolating, well, always had been for me, very isolating. Jill* *Our group was really strong, it was really nice to get together. Lucy*" p. 155 **Being part of a team helping participants in developing a sense of being able work on their difficulties as a team rather than dealing with them alone.** "In it together-security in the group. Five of the patients described finding safeness in the group which allowed group	**Increased engagement with self-soothing techniques that gave a sense of control over the focus of ones' attention from negative to more positive aspects of everyday experiences, being able to identify self-critical thoughts and finding strategies of dealing with them. :** 'New tools. All patients described how the CFT model allowed them to develop a toolkit/ repertoire, which included soothing rhythm breathing and compassionate self-focusing and allowed patients to develop a more personal sense of control: *With the compassionate mind training, it's much easier to cope. Because I can face a problem head on and go from there. I don't see many problems really, now. Now I'm able to sort them out now and concentrate and focus. Sam* *Without being compassionate to myself, I would still not have had the tools to be able to stop myself going into the deep depression stages. I would have perhaps had tools to not get into the situations so much but, like I said earlier, there are times where you are still going to muck it up and it's how you respond to that, that is where the compassionate mind really comes into*

		members to draw strength from each other, and feel as though they were in it together: *"We had a lot of these groups between us . . .that was a real help because it can be very isolating, well, always had been for me, very isolating. Jill* *Our group was really strong, it was really nice to get together. Lucy*" p. 155 **<u>Feeling understood</u>** **Utilisation of the evolutionary point of view of the human brain being faulty seen as enabling participants to view their self as not being to blame for their difficulties. :** 'All patients described their experience of formulation as a powerful and helpful one. They described the importance of drawing from neuropsychology along with other psychologies to establish a non-blaming understanding: *Then it started to make sense that I could make the connections between what was unexplained in my own reactions, when I*	*its own. Paul' p. 155* **A shift in ones' relationship to themselves by giving ones' self permission to engage in more self-caring behaviours and enjoyable activities.** 'Revaluing self. All patients described how CFT prompted them to show care towards themselves. They explained that they were now much more able to engage in other activities that helped them manage other consequences of their brain injury, such as fatigue management: *I have started caring more about myself and what I want out of life and not thinking so much about others – not saying that I don't care about others, because I do, but I have started to put myself first now, not others. Nicola'* p. 156 **Increased ability to control threat-based emotions leading to a heightened tolerance and ability to manage experiences that evoked them:** '*Without being compassionate to myself, I would still not have had the tools to be able to stop myself going into the deep depression stages. I would have perhaps had tools to not get into*

		lost my temper and the accident. So I could say 'well, *that is reasonable I can see the connection there', and that helped*. Paul *For the first time I could actually look at it and really mean it when I say 'I am not stupid',* *because for so long I thought I was really stupid and really thick*. Jill ' p. 155 **<u>Therapeutic relationship</u>** **Importance of therapeutic relationship in becoming more compassionate:** '*All patients describe developing relationships with the staff at the neurorehabiliation centre and feeling understood by them. For many, their therapist was a primary source of care and comfort, however, affiliative relationships were developed with all of the staff team:* *I think of all my friends from rehab and all the lovely people I met there and that helps me, in a way that I can't really explain, but that helps me a lot, just knowing I have you guys and my*	*the situations so much but, like I said earlier, there are times where you are still going to muck it up and it's how you respond to that, that is where the compassionate mind really comes into its own. Paul*' p. 156 **A shift on ones' relationship with other individuals. Better able to accept others by being able to be empathetic and accepting of ones' self:** 'New way to relate to others. Two survivors described how CFT allowed them to develop a better understanding of others' behaviours and alter their response to their actions or perceived judgments: *For example, if I am driving to work when I get in the car, I have to clear my head and say 'Paul, there is going to be someone today who is going to do something stupid who is going to take your right of way, who is going to do something dangerous'. So I expect it, and in that way I am taking over some of the actions of my frontal lobes because that is what it is doing, it reasons with the old brain.* Paul' p. 156

		friends, just knowing that I have you caring people there for me helps me. Nicola *It was everything that I needed; it was people who really understood me*. Sarah' p. 154 **Feeling safe, believed, accepted and understood within the therapeutic relationship as enabling to shift from being self-critical to being more compassionate.:** 'Developing trust and finding safeness Patients described finding security in their relationships with members of staff, their therapist, and within the group. They also describe finding a sense of safeness within the environment at the neurorehabiliation centre. They describe the development of affiliative relationships between themselves and others, which were reported as important in approaching change.' p. 154	
Bell et al. 2017	**Engaging with compassion exercises was**	<u>Therapeutic relationship</u> **Establishing a secure therapeutic**	**Increased self-compassion resulting from becoming more empathetic towards one's own difficulties. A positive change of inner**

	reported as difficult during the start of therapy. 'Internal Blocks The participants identified a number of internal blocks and resistances to creating, practising and applying the supervisor imagery. Four participants had difficulty in finding and selecting a 'reliable' or stable image, or found imagined supervisors 'competing': *P6. 'Initially it was very difficult, it was, for starters, when imaging a compassionate supervisor I had 4 or 5 different, because I could get faces or people that I've met in the past who sort*	**relationship as enabling the change from cognitively knowing one is not to be blamed for one's difficulties to experiencing it at an emotional level:** 'The qualities of the supervisory relationship were first incorporated through the internalisation of the supervisor's voice and were adopted by the individual as their own.' p. 646	**dialogue becoming less critical:** 'All participants reported that the image of the supervisor, and the caring relationship it offered, could be brought to mind as required (P5.'it's a point of reference that's there'). Participants noted the practice had become an 'embedded' part of their daily thinking and responding. For three participants the supervisor's voice began to be melded and 'integrated' with the participant's own inner dialogue (like a 'script in my head', P2). p. 642 **Increased engagement with self-soothing techniques that gave a sense of control over the focus of one's attention from negative to more positive aspects of everyday experiences, being able to identify self-critical thoughts and finding strategies of dealing with them:** 'The participant's changing imagery matched this shift in focus. After the initial image of a past supervisor was rejected, it was replaced by the booming voice of a powerful deity, before the voice became his own and the focus shifted to inner-dialogue and feeling. The participant reported moving from the role of

	of interchanged. So it was quite difficult to stay focused on one sort of person initially.' p. 638 **During the initial stages of therapy, receiving compassion was only experienced at a cognitive level, struggling to experience it at an emotional level.:** 'Compassion was also initially experienced as strange and uncomfortable on a 'felt' level, or, in turn, was 'intellectualized' without emotional connection.' p. 638 Compassion initially experienced as an		'victim' to a sense of self authority. *P3. 'I wouldn't take it to my supervisor I'd take it to me, after I'd been through this sort of training process, now it's taking it to myself.*' p. 643 **A shift in ones' relationship to themselves by giving ones' self permission to engage in more self-caring behaviours and enjoyable activities:** **'**Whilst the imagery practice had a clinical focus, five participants emphasized an improvement in their 'work-life balance'. This was linked with an ability to 'cut off' from work, again emphasizing a re-focusing away from unhelpful rumination. Participants reported this occurred in a conscious and deliberate manner to allow connection to personal interests and priorities outside of work, motivated by self-care and compassion: *P1. 'I'd have just continually kept working until I had to do something like going making my tea or something like that, something that I felt I had to do. Whereas this has definitely helped me just be a little bit more compassionate to myself in terms of my time management and put a few more boundaries in places… just looking after myself a bit more.*" p. 644

	uncomfortable experience. 'The most prominent internal blocks were experienced by participant 3 and related to negative associations with the notion of supervision. The participant reported the word 'supervisor' acted as 'red light' to progress, a reaction he related to negative personal experiences: *P3. 'For me the connotation of a supervisor puts me off. Everything to do with authority, only in my experience.'* *P3. '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*		**Becoming more self-compassionate, leading to the development of more constructive ways of coping with difficult emotions experienced in the past and the present. Increased capacity to contain them and accept them rather than avoid them:** 'There was also a wider impact on the participant's relationship with colleagues and management of workplace pressures. Sub-themes included an increased resilience to workplace stress, which was linked to reduced personalization of service difficulties and an increased sense of personal empowerment.' p. 643 **Increased ability to control threat-based emotions leading to a heightened tolerance and ability to manage experiences that evoked them:** Participants also reported a reduction in unhelpful comparisons with other therapists and an improvement in personal boundaries and time-management. The workplace themes are best articulated by Participant 3 who utilized the exercises to manage the regular conflict he experienced at work. Notably, this was achieved

	that's got authority written all over it.' The participant associated the supervisor role with power imbalance and perceived dominance, questioning the 'agenda' of his supervisor as representing 'a critical top-down model of things'. A sense of distrust in the supervisor's intentions was matched with an expectation of the supervisor's inefficiency and disinterest. Such associations created a sense of frustration that was evident during the participant's recollection at		in a manner that maintained his values and willingness to advocate on the behalf of his clients, but reduced counterproductive confrontation: *P3. 'Step back take it for what it is which I know what it is, instead of getting roped in to their mess it's not going to help anybody, stick to what I am good at, stick to what I know what I think is the right course of action. Reflecting on what could make matters worse by kicking off with some other worker'*. p. 644 **More frequent experience of comforting, soothing affiliative emotions:** 'All participants also reported a reduction in self-criticism (which they associated with increased self-compassion). This included a reduction in the processes of self-blame and negative self-monitoring. As with the reduction in worry and rumination, participants identified that the reduction in self-criticism increased their ability to think 'freely' and flexibly. Participants referred to the change as a shift in internal self-to-self dialogue'. p. 643

	interview.' p. 639 **Importance of implementing a regular practice for overcoming the blocks and obstacles towards compassion early during therapy:** 'All participants emphasized the importance of repetition and practice, but there was variance in how individuals maintained their own motivation. For some this included the development of a set schedule with phone-alarms to prompt practice, whilst others, who were		

	often more stringent in their initial routine, became more flexible in their practice times and frequency: *P4. 'I just actually made space for it at different times in the day,* *so rather than thinking I have to do it at a certain point, I felt* *like I'll do it when I can, so that's what I did*.' p. 639 **Recognising and working with the internal blocks and fears of compassion during therapy was an important step in overcoming them:**		

	'Whilst all participants initially described blocks in relation to the exercises, all participants were able to engage in personal practice and offered various means by which they overcame their initial difficulties. For many, acknowledging and working with such blocks became the gateway to developing self-compassion and identifying areas requiring reflection and self-care' p.639		
Clapton et al., 2018	**Internal association of compassion with inactivity and self-indulgent behaviour**	**<u>Realisation of not being alone/ common humanity</u>** **Valuing other members' disclosures**	**Becoming more self-compassionate as enabling the development of a novel way of firstly interacting and secondly comprehending one's self:**

	results in fear of compassion: ‘‘It’s hard to be kind to yourself when you’re always used to not being kind to yourself – Fears, blocks and resistances to compassion… Kathy further describes how being able to take in compassion from others, and have it modelled first by the therapist, was crucial in overcoming these fears, blocks and resistances and being able to develop compassion for oneself: *. . . 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*	**about their life experiences. Perceiving them as an internal de-shaming process that was helpful in achieving an increased sense of common humanity.** **‘**We’re not alone’. Participants generally reported that the opportunity to share their stories and experiences of suffering within the CFT group was powerfully de-shaming. This process, aided by core CFT concepts/principles such as ‘not your fault’, appeared to begin to depersonalize suffering and reduce participants’ sense of aloneness, as reflected by Kathy: *It’s like, you’re not, you’re not on your own. You know, there are other people that are going through* *the same thing . . . I’d say [chuckles], I’ve managed to realise that, that I’m not on my own. (Kathy)* These emotional shifts in turn appeared to be related to an increased sense of common humanity.’ p. 143 **<u>Feeling understood</u>** **Utilisation of the evolutionary point of view of the human brain being faulty seen as enabling participants to view**	‘Participants unanimously reported changes in self-to-self relating, but again their verbal accounts were often vague. A number of participants specifically reported that the intervention in general had contributed to a sense of increased self-understanding: *It just . . . helped me understand myself a little bit better . . . urm, how to cope with my inner self, basically. (Anne)’* p. 147 **Increased self-compassion resulting from becoming more empathetic towards one’s own difficulties. A positive change of inner dialogue becoming less critical:** ‘For other participants, developing self-compassion through the compassion practices appeared to lead to increased self-acceptance, reduced shame and self-criticism, and positive changes in how they related to others and general experiences in life: *. . . I’m not that negative like I used to be . . . being kind, kinder to yourself ones help, ‘cos ‘cos I don’t* *think much that I’m a weak link anymore . . . (James)*

	your head is. Maybe you can carry it through . . . (Kathy)'. p. 145 **During the start of therapy engaging with self-compassion exercises was reported as difficult:** 'Many of the participants reported initially finding compassion exercises/practices strange and difficult: *When I first did the breathing, I thought 'what is he [therapist] on?!?' . . . you know, 'this is daft!'*(Kathy)'. p. 145 **Compassion described as an emotionally**	**their self as not being to blame for their difficulties:** 'One participant reported explicitly remembering some of the evolutionary concepts such as the 'tricky brain', but their articulation of this concept was vague and did not explicitly communicate a deeper level of understanding: *Zooey: The way our brain works and that* *Interviewer: Ahhh okay, 'the way our brain works'. How do our brains work?* *Zooey: In many mysterious ways!'* p. 144 <u>**Therapeutic relationship**</u> **Importance of therapeutic relationship in becoming more compassionate:** Kathy further describes how being able to take in compassion from others, and have it modeled first by the therapist, was crucial in overcoming these fears, blocks and resistances and being able to develop compassion for oneself: *. . . the being kinder part was nice because somebody else saw that in you, that you know is*	*. . . and you know you can, you can find it in, in yourself to be nice to yourself, to be nice to other people . . . instead of being the one that . . . beating yourself up . . . (Kathy)*'. p. 147 **A shift in one's relation to themselves by giving one's self permission to engage in more self-caring behaviours and enjoyable activities:** 'The majority of participants were able to report and reflect on how they were attempting to generalize their learning and practices to everyday life' p. 147 **Increased ability to control threat-based emotions leading to a heightened tolerance of and ability to manage experiences that evoked them:** 'For other participants, developing self-compassion through the compassion practices appeared to lead to increased self-acceptance, reduced shame and self-criticism, and positive changes in how they related to others and general experiences in life: *. . . I'm not that negative like I used to be . . . being kind, kinder to yourself ones help, 'cos 'cos I don't think much that I'm a weak link anymore . .*

	uncomfortable experience: 'Many of the participants reported initially finding compassion exercises/practices strange and difficult . In summary, all participants described a journey of initially being sceptical about compassion or finding the practices difficult, to finding their own way to open to compassion and work with the practices, and receiving some benefit.' p. 145 **Importance of implementing a regular practice early during therapy for overcoming blocks**	*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 . . . (Kathy)'*. p. 145 **Feeling safe, believed, accepted and understood within the therapeutic relationship as enabling the shift from being self-critical to being more compassionate:** 'Kathy described how a sufficient level of trust in the therapist and safeness within the group allowed her to explore new things: *But once I, once I let myself do it [the breathing], it was kind of relaxing, and it does help you out in ways you wouldn't even think about. (Kathy)'* p. 145	*. (James)* and *. . . and you know you can, you can find it in, in yourself to be nice to yourself, to be nice to other people . . . instead of being the one that . . . beating yourself up . . . (Kathy)'* p. 147 **More frequent experience of comforting, soothing affiliative emotions:** 'For other participants, developing self-compassion through the compassion practices appeared to lead to increased self-acceptance, reduced shame and self-criticism, and positive changes in how they related to others and general experiences in life' p. 146 **A shift on ones' relationship with other individuals. Better able to accept others by being able to be empathetic and accepting of ones' self:** 'Another participant described how becoming more self-compassionate helped her recognize and validate her own emotions and needs, and develop the courage and confidence to be more assertive in her relationships, something she had previously

	and obstacles towards compassion: ‘Another participant, who described having found it difficult his entire life to be compassionate to himself, reported how they felt it was through repeated practice that they began to overcome these initial difficulties, and thus become more self-compassionate: *Crispin: At first it was a bit hard, but the easier it got, but at first it’s hard . . . Interviewer: Yeah? . . . do you feel like it’s a bit easier to put it all into practice? Crispin: Yeah, like putting a jigsaw together and that!*		felt ashamed of and feared doing: *. . . it felt, it felt like because I had the courage and the guts to say ‘hang on a minute’, you know . . . I thought ‘if you don’t say it now, I’m never gonna do it, and it’s gonna continue to get on my nerves, I’ll beat myself up and I’ll be back to square one’, and I don’t want that to happen again this time. (Kathy)* Kathy went on to describe how compassion practice was further beginning to transform her relationships with others: *. . . Dad . . . he used to hate talking to me ‘cos I, I was like a spoilt three year old . . . he said it’s a joy to speak to me now. He says it’s alm*ost like you’ve grown up overnight. (Kathy)’ p. 148

	But with practice it gets easier.' p. 145		
Hardiman et al. 2018		**<u>Realisation of not being alone/ common humanity</u>** **Valuing other members' disclosures about their life experiences. Perceiving them as an internal de-shaming process that was helpful in achieving an increased sense of common humanity:** 'GP appears to understand the process of therapeutic change as one in which her sense of self has changed from being less than others to being the same as others: GP: *Um I thought I was like cos I've got learning difficulties I thought I was thick kind of thing but then after passing me English I knew that weren't I was not different from anyone else kind of thing cos there was other people in there from nearly the same levels so.*' p. 49 **<u>Feeling understood</u>** **Utilisation of the evolutionary point of**	**Becoming more self-compassionate as enabling the development of a novel way of firstly interacting and secondly comprehending one's self:** 'GP appears to understand the process of therapeutic change as one in which her sense of self has changed from being less than others to being the same as others: *GP: Um I thought I was like cos I've got learning difficulties I thought I was thick kind of thing but then after passing me English I knew that weren't I was not different from anyone else kind of thing cos there was other people in there from nearly the same levels so.'* p. 49 **Increased ability to control threat-based emotions leading to a heightened tolerance and ability to manage experiences that evoked them:** ' MA also describes how he feels different now, compared to before therapy. Change because of therapy appears embodied: *Mark: Mm how will you know when you're getting*

		view of the human brain being faulty seen as enabling participants to view their self as not being to blame for their difficulties: 'Post-therapy, all three participants describe a change in how they view themselves: *GP: Just felt like normal for once like everyone else just walking about kind of thing. I still like keep an* *eye out over my shoulder just in case but not as bad as I was kind of thing.* *Mark: Mm yeah just like everyone else.* *GP: Yeah.* *Mark: What's that like to think about.* *GP: Uh just being like normal kind of thing.* *Mark: So if you're now normal what were you before.* *GP: I just felt different kind of thing like I was stupid from everyone else kind of thing.* For GP, the experience of becoming normal when she previously believed herself to be different to everyone else must have seemed dramatic. MA	*better?* *MA: Uh by um by bit changed.* *Mark: Mm.* *MA: By 'at's easy to tell a bit tense up.* It was clear in context that he was describing an absence of "tense up" as a positive change. "Tense up" appears to have been a constant, regular part of his life pre-intervention. AW also describes an absence of long-running physical symptoms as an outcome of therapy: *AW: Um I in't had them er panic attacks since I started er bit er talking to her and I ain't had that horrible* *eeling in my legs mm I get it in my leg.*' p. 49 **A shift on ones' relationship with other individuals. Better able to accept others by being able to be empathetic and accepting of ones' self:** ' For GP, the experience of becoming normal when she previously believed herself to be different to everyone else must have seemed dramatic. MA described a shell opening, perhaps capturing a sense of previously having been hidden away from the world, perhaps where no one would see him. AW describes feeling more empowered, able to take social risks and speak

		described a shell opening, perhaps capturing a sense of previously having been hidden away from the world, perhaps where no one would see him.' p. 47 **<u>Therapeutic relationship</u>** **Importance of therapeutic relationship in becoming more compassionate:** 'Given its central position in CFT, it was surprising that participants' experience of compassion flowing in any direction (self-compassion, or flowing to or from the therapist) was not more obviously a theme in their narratives. MA discussed the therapist's calmness and that she listened: *MA: She calm she listen you know you got troubles like I had I had a load of trouble I had she phoned* *not phoned up um I been crying she um on the 'puter in a white cap she put word on there.* The therapist's calmness appears to be a key factor for both AW and MA. Maybe calmness is the best term participants can	first: *AW: Um sometimes you gotta speak before they speak to you sometimes.*' p. 47

		find to make sense of their experience of compassion flowing from the therapist towards themselves.' p. 48 **Feeling safe, believed, accepted and understood within the therapeutic relationship as enabling to shift from being self-critical to being more compassionate:** 'All three participants position the therapist as a source of change in their lives and appear to appreciate the experience of being able to both understand and feel understood by someone: *MA: You know you know she she done wonderful.* *GP: Um I just feel different I don't know why I think (the therapist) helped me a lot with the breathing and the room I don't know 'at just felt like a weight lifted off my shoulder kind of thing so when I was walking* *down the road with the kids I just felt I don't know that no one would harm me kind of thing […].*' p. 48	

Heriot- Maitland et al. 2014	**Recognising and working with the internal blocks and fears of compassion during therapy was an important step in overcoming them:** ‘ Compassion involving the opening to, engaging with and moving towards distress and suffering of self and other, are seen as important (Gilbert, 2009; 2014). For example, participants discussed their sense of caring for well-being, becoming more sensitive to their own and others’ distress and needs, and empathy: *I’ve learnt that… there is loads of ways of caring for each*	**<u>Realisation of not being alone/ common humanity</u>** **Realisation that other people within one’s group were facing comparable problems to one’s own, leading to an understanding of current difficulties as an understandable reaction to adverse life experiences. This realisation helpful in shifting from self-blame to being more compassionate:** ‘ 1. Common humanity and affiliative relating: One of core principles of CFT is to create space for affiliative sharing, relating, and learning about self and others. *I want to learn more, and also share my little bit of life outside’. (1)* *‘[It is] nice to have a group that you can express how you feel, and talk about how, you know,* *what compassion means (2)* and	**Becoming more self-compassionate, leading to the development of more constructive ways of coping with difficult emotions experienced in the past and the present. Increased capacity to contain them and accept them rather than avoid them:** ‘ Compassion involving the opening to, engaging with and moving towards distress and suffering of self and other, are seen as important (Gilbert, 2009; 2014). For example, participants discussed their sense of caring for well-being, becoming more sensitive to their own and others’ distress and needs, and empathy’. p. 88 **A shift in one’s relation to themselves by giving one’s self permission to engage in more self-caring behaviours:** ‘ Another participant reflected on how the practice of imagery in the group had helped them in regard to their own life and changes they planned to make as a result: *I think it would be beneficial for me not to sit in the dark all the time. The picture made me kind of realise that. So when I go home I want to try and open the curtains. (4)*’ p. 89 **Increased ability to control threat-based**

	other, so just by, you know, by buying…buying stuff for them, or, you know, offering them support. It could be like, just giving them time, talking to them and, you know, just be there for them, be their ear, just listen then give your opinion, give advice. (2)' p. 88	*to know a bit more of what other people think about caring, and what I think about caring. (3)* Participants reported valuing the opportunity to learn from other group members and relate to people such that they could see their own stories reflected in the stories of others. This is an important de-shaming process linked to the feelings of not being alone (Bates, 2005). ' p. 87 **Valuing other members' disclosures about their life experiences. Perceiving them as an internal de-shaming process that was helpful in achieving an increased sense of common humanity:** ' Indeed, participants felt validated by hearing others' experiences and feelings and were able to acknowledge the normality of their suffering in the breadth of human experience without belittling it.' p. 88 **<u>Empathic Affiliative interactions</u>**	**emotions leading to a heightened tolerance and ability to manage experiences that evoked them:** 'While CFT highlights the importance of becoming more sensitive to suffering and distress, this is only in so far as helping people tolerate rather than avoid the difficult emotions and memories. The change process itself involves cultivating and engaging capacities for experiencing and behaving in compassionate ways.' p. 89 **More frequent experience of comforting, soothing affiliative emotions:** ' All participants mentioned positive emotions linked to the CFT group, particularly feeling comforted or soothed.' p. 89 **A shift on ones' relationship with other individuals. Better able to accept others by being able to be empathetic and accepting of one's self:** 'Participants discussed their sense of caring for well-being, becoming more sensitive to their own and others' distress and needs, and empathy: *I've learnt that… there is loads of ways of caring for each other, so just by, you know, by*

		Finding safeness and gaining strength from other group members important in becoming compassionate: *'[It is] nice to have a group that you can express how you feel, and talk about how, you know, what compassion means (2)* and *' I learned that other people…that some other people have got aspects of compassion within them, which…which is very helpful, because it makes me…it made me richer by listening to them. (3)'*. p. 88 **Receiving empathy within a group setting and gaining a sense of belonging significantly valued. Empathetic affiliative interactions as enabling one to become more compassionate:** ' One participant discussed how the group had led to an increased sense of common humanity: *so I was very angry about the cat dying and stuff so me being here talking about it and having a* *member of staff, talk about her cat passing away and stuff, it really helped.*	*buying…buying stuff for them, or, you know, offering them support. It could be like, just giving them time, talking to them and, you know, just be there for them, be their ear, just listen then give your opinion, give advice. (2)* and *My daughter, she's 4 years old now. Obviously she's at a stage now where she's learning everything new. So by me showing her I love her, care her, care for her, not by just buying her* *88 Charles Heriot-Maitland et al.* *stuff, I talk to her, be her ear, so when she comes up from nursery, ask her 'how was your day' maybe, you know, just like that, things like that, simple things. About my partner as well, ask himhowwas his day, is he ok, does he need to talk about anything, is he upset, have you eaten, you know, simple things.*' p. 88

		(2)' p. 88	
Lawrence & Lee 2014	**Initial fear towards the notion of warmth and kindness aimed at one's self:** '*am I going to like the person that I've become? because I've been like this, with these memories and these thoughts and this for so long' (Participant 4*)'* p. 499 **Internal association of compassion with inactivity and self-indulgent behaviour results in fear of compassion:** ''*You have to push yourself, you have to. And then if you don't push yourself well*	**<u>Realisation of not being alone/ common humanity</u>** **Realisation that other people within one's group were facing comparable problems to one's own, leading to an understanding of current difficulties as an understandable reaction to adverse life experiences. This realisation helpful in shifting from self-blame to being more compassionate:** ''*You think you are the only one and then you realize that you are not alone. There are other people who feel the same and you are not alone. It's just unfortunate that you have been through these experiences' (Participant 6)* *'It can make you feel less desperate. That there are other people that feel like you and you are not the only person who went through that experience. If you are really struggling it could be quite hard to see. Or it could be good to know of other people that have been through it and are doing better in life than you are. So it's quite, I think when you*	**Becoming more self-compassionate as enabling the development of a novel way of firstly interacting and secondly comprehending one's self:** ''*it was like getting a drink of water in the desert. Erm. Once I had kind of given up the addictions of blaming myself it was like this whole guilt trip had gone' (Participant 2*)' p. 500 **A shift in one's relation to themselves by giving one's self permission to engage in more self-caring behaviours and enjoyable activities:** *'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' (Participant 1).*' p. 500 **An important shift in their emotional response to the future and life, moving from feeling hopeless to being hopeful:** *''My whole outlook is different. I feel like I've got a future now, which I didn't feel, well*

	you're just a bad person. You must be a high achiever because if you are not you are nothing. To start off with there was a vacuum and it was well that vacuum shows that I am nothing. I am worthless' (Participant 2)' p. 499 **Self-criticism perceived as an integral part of one's identity and becoming self-compassionate perceived as losing part of that identity. Initial engagement with self-compassion exercises lead to amplification of self-**	*get to know people better, you get to know that actually you all have the same issues, the same anxieties' (Participant 3).*' p. 499 **<u>Feeling understood</u>** **The effect of a positive sense of common humanity not as pronounced in individual therapy. In individual therapy an emphasis on the importance of feeling understood by the therapist in overcoming the sense of being alone in facing similar problems:** 'In contrast to participants who received group therapy, those that had undertaken individual therapy did not reflect on gaining a sense of shared humanity, but all emphasized the value of the therapeutic relationship and contributed to subordinate theme 3.1. The emotional experience of gaining a sense of shared understanding therefore differed between group and individual recipients of CFT. Although they did not witness others' difficulties, it was important to individual members that they felt understood by the therapist.' p. 502	*I've never felt like that really. No, so I feel like I've got a future now, which I didn't feel like 6months ago' (Participant 4)* *'It is still very, very difficult but I can see actually now I've got a future. I need to look towards my future and I deserve to have my future' (Participant 7)'* p. 501

	criticism: *'I felt a bit stupid to start with. You feel a little bit stupid talking to yourself but you kind of, that's the crucial point when you have to push yourself through that phase and then force yourself to do it' (Participant 5)* *'it isn't easy just to feel it [self-compassion] and get it and sometimes I get tired of it. I just think I'm bloody useless and I don't want to feel better. I don't want to think nice things. I don't want to feel good. And sometimes it is hard to do that but most times I can make myself feel that way'*	**<u>Therapeutic relationship</u>** **Importance of therapeutic relationship in becoming more compassionate:** ''*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' (Participant 1)* *'You need that kind of person steering you and guiding you through the process and actually just, just keep saying to you that it is okay to feel like this. It is okay to want to cry. It is okay to be nice to yourself. It is a good thing to be good to yourself' (Participant 7)*' p. 499 **Feeling safe, believed, accepted and understood within the therapeutic relationship as enabling to shift from being self-critical to being more compassionate:** 'Acceptance, non-judgement, feeling valued and understood and feeling believed in were	

	(Participant 7)' p. 499 **Beliefs of not deserving compassion. Strong aversive emotional responses of dread and fear attributed to resistance towards compassion:** '*It's really difficult to start off with. Erm. It doesn't feel right to be kind to yourself. That was the hardest thing. I really sort of railed and struggled against that, because basically I felt that my illness was all my fault' (Participant 2)* '*I didn't want to be kind to myself. Because I still felt I didn't deserve to be*	characteristics of the therapeutic relationship that participants described as helpful and important. Of particular importance to participants was their perception of the therapists as human beings, rather than just professionals, who genuinely cared for them rather than providing them with the tools to feel better. p. 501 **Establishing a secure therapeutic relationship as enabling to change from cognitively knowing one is not to be blamed for one's difficulties to experiencing it at an emotional level:** '*You need that kind of person steering you and guiding you through the process and actually just, just keep saying to you that it is okay to feel like this. It is okay to want to cry. It is okay to be nice to yourself. It is a good thing to be good to yourself' (Participant 7)*' p. 500 'Participants described the process of shifting from believing that they were to blame for their previous traumatic experiences, to the realization that they were not responsible for such experiences. An interesting characteristic of the participants' experiences of this process was that they spoke	

	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' (Participant 7)' p. 499 **Compassion triggering feelings of hopelessness and fear that one will never be able to feel compassion towards one's self, leading to a strong desire to disengage from therapy:** '*There's no way that I'm going to think what you're telling me I am gonna think (laugh). There is no*	of the difference between thinking that they were not to blame and feeling that they were not to blame. They identified the therapeutic relationship as an important means through which this became possible, in that the therapists' belief in them enabled them to shift their beliefs about themselves. The experience of feeling safe in the mind of another was therefore of fundamental importance.' p. 502	

	way at the end of 6 months that I am gonna think like this at all. I thought I might as well go home now' (Participant 4) '*I think I just felt sceptical and the reason for that was it had been going on for so long without feeling any great improvement. You kind of begin to doubt whether you are ever going to feel any kind of improvement. Erm which is where the resistance comes from'* (Participant 5)'		

	p. 499		
Lucre & Corten, 2013	**Experience of fear when introduced to the notion of warmth and kindness aimed at one's self:** 'Fear of compassion featured throughout the group, with many associating warmth and kindness to self with inactivity and self-indulgent/self-destructive behaviour. *I always thought this compassion stuff would make me weak.. pathetic.. but now I feel that it has made me stronger*.' p. 395 **During the start of therapy engaging**	**<u>Realisation of not being alone/ common humanity</u>** **Realisation that other people within one's group were facing comparable problems to one's own, leading to an understanding of current difficulties as an understandable reaction to adverse life experiences. This realisation helpful in shifting from self-blame to being more compassionate:** ' The comfort of shared group experiences Many groups members echoed the sentiment I am not alone: knowing that others struggle as they do seems to have been a key component of the group.' p. 395 **<u>Empathic Affiliative interactions</u>** **Receiving empathy within a group setting and gaining a sense of belonging significantly valued. Empathetic affiliative interactions as enabling one to become more compassionate:** 'The use of semiprecious stones as a transitional object supported the imagery in the early stages of the therapy:	**Increased engagement with self-soothing techniques that gave a sense of control over the focus of one's attention from negative to more positive aspects of everyday experience, being able to identify self-critical thoughts and finding strategies of dealing with them:** 'Participants demonstrated an increased ability to identify when they were engaging their internal critic. Even more importantly, they reported new found strategies for dealing with this self-criticism rather than blaming themselves for its existence. *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.* *The voice in head telling me 'I'm useless, wrong unwanted'(I used to tell it to go away or who do you think you are?) But now I have stopped listening to it, I don't hear it at all*.' p. 395

	with self-compassion exercises was reported as difficult: ‘ *I used to be scared that I would be stuck on a compassionate sofa, going nowhere . . . I never realized that being kind to myself could help me DO things.’ p. 395* **Beliefs of not deserving compassion. Strong aversive emotional responses of dread and fear attributed to resistance towards compassion:** ‘ Fear of compassion featured throughout the group, with many	I still have my stone and use it often to ground my thoughts, sometimes I use it just to remind me that there are others out there who understand. ‘p. 395	

	associating warmth and kindness to self with inactivity and self-indulgent/self-destructive behaviour. Many of the group observed at the follow-up that using self-compassion as a precursor to increased activity had undermined and eroded this key fear.' p. 395 Importance of implementing a regular practice early during therapy for overcoming blocks and obstacles towards compassion.		

Appendix I*. Rationale for methodology chosen

This study aimed to explore the participants' experience of self-compassion within ACT for chronic pain. During the initial stages of the study, Grounded Theory and Narrative Analysis methods were considered, given that both methods aim to gain a better understanding of an individual's life experiences. Grounded Theory was deemed as not appropriate due to its orientation towards capturing the individual's life experiences and actions in the social context in which those are experienced (Harper & Thompson, 2011). While the social context of the participants was deemed as important, it was not considered as the primary aim of the study. The central focus of the study was the participants' subjective experience of self-compassion rather than the social context within which that experience took place.

Equally, Narrative Analysis was also considered. Narrative Analysis focuses on the narratives that individuals employ in order to talk about their lived experiences (Harper & Thompson, 2011). It was decided that Narrative Analysis was not suitable since it primarily focuses on the language used to describe an individual's life experiences. While the language the participants used to describe their experience of self-compassion was deemed as important it was not deemed as the main focus of the study, that was to better understand the meaning individuals ascribes to their experiences.

Given the study's aim to explore the participants' experiences of self-compassion within ACT for chronic pain it was decided that the data would be analysed using Interpretative Phenomenological Analysis (IPA). IPA aims to explore the meaning that individuals ascribe to their subjective experiences and the significance of those experiences for the participants (Smith, Flowers & Larkin, 2012). This was seen as being in accordance to the aim of the study's research question. Additionally, IPA was preferred due to its interest in how meaning is constructed both within the social and personal reality of the participants (Shinebourne & Smith, 2009), something that was seen as having the potential to capture the influence that an individual's social relationships can have on the experience of self-compassion (Gilbert, 2010; Neff, 2008).

During the designing stages of the study, the researcher also considered conducting two interviews that would explore the participants' experiences of self-compassion before and after the group respectively. After consultation with the researcher's supervisor, it was decided that focusing on the participants' retrospective subjective experience of self-compassion following their participation to the group would be more in line with the study's chosen methodology, IPA. IPA postulates the importance of exploring the meaning that a given experience has for the participant rather than focusing on the factual accuracy of the participants' account, aiming at exploring the participants' perception of the past (Harper & Thompson, 2011). It was deemed that this would enable the researcher to focus on the participants meaning-making of their experience of self-compassion during the group, giving a stronger voice to the participants' interpretation of their lived experience rather than the researchers double measuring and interpretation of that experience. The use of a single interview was also in accordance with the methodological design utilised in similar studies to this one, exploring participants' experience of self-compassion in other therapeutic modalities (Ashworth et al., 2015; Boellinghaus et al., 2013; Dorian & Killebrew, 2014; Lawrence & Lee, 2014; L'Estrange et al., 2016). It could perhaps be beneficial if future studies conducted two interviews and their findings were considered in conjuction to this study's findings. This could potentially give us an enhanced understanding of the participants subjective experience of self-compassion.

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Appendix J*. Ethical approval letter from Research Ethics Committee

NHS
Health Research Authority

Yorkshire & The Humber - South Yorkshire Research Ethics Committee

Room 001
Jarrow Business Centre
Rolling Mill Road
Jarrow
Tyne & Wear
NE32 3DT

Tel: 0207 104 8082

09 February 2018

Miss Foteini Oikonomitsiou

[redacted]

Dear Miss Oikonomitsiou

Study title: **Exploring how people experience self-compassion within acceptance and commitment informed therapy for chronic pain.**

REC reference:
Protocol number:
IRAS project ID: [redacted]

The Proportionate Review Sub-committee of the Yorkshire & The Humber - South Yorkshire Research Ethics Committee reviewed the above application on 09 February 2018.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

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

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

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

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

Ethical review of research sites

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

Summary of discussion at the meeting

Social or scientific value; scientific design and conduct of the study

Members stated that the self compassion was not identified anywhere on the application and requested that A6-2 of the IRAS form and the Participant Information Sheet be amended accordingly.

Miss Foteini Oikonomitsiou replied that the definition of self-compassion that I would be used for this study was: "Kristin Neff (2003), drawing for the Buddhist conceptualisation of compassion, further developed the concept of self-compassion to include three separate components: developing mindfulness; adopting a stance of self-kindness towards one's self; and common humanity (i.e. perceiving one's experiences and difficulties in life as part of the larger human experience).
(It was taken from: Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. Self and Identity, 2(2), 85-101.)" An updated Participant Information Sheet was also submitted for review.

The Sub Committee was satisfied with the response given to the issue raised.

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Confirmation of agreement of collaboration]		05 January 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsor insurance or indemnity]		28 July 2017
Interview schedules or topic guides for participants [Interview schedule guide topic]	version 1	26 January 2018
IRAS Application Form [IRAS_Form_24012018]		24 January 2018
IRAS Checklist XML [Checklist_24012018]		24 January 2018
IRAS Checklist XML [Checklist_26012018]		26 January 2018
Letter from sponsor [Letter from sponsor]		19 January 2018
Other [Voucher form]	version 1	10 January 2018
Other [Demographics form]	version 1	10 January 2018
Other [Travel expenses form]	version 1	10 January 2018
Other [List of Support Organisations]	version 1	10 January 2018

Other [Contact Details form]	version 1	10 January 2018
Participant consent form [Participant Consent Form]	version 1	10 January 2018
Participant information sheet (PIS)	Version 2.0	08 February 2018
Research protocol or project proposal [Research Protocol]	version 1	10 January 2018
Summary CV for Chief Investigator (CI) [CV of Chief Investigator]	version 1	10 December 2017
Summary CV for student [CV of Chief Investigator]		10 December 2017
Summary CV for supervisor (student research) [CV of supervisor (Dr Steve Melluish)]		06 December 2017

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

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

18/YH/0060	Please quote this number on all correspondence

Yours sincerely

pp

[redacted]

Enclosures: *List of names and professions of members who took part in the review*

"After ethical review – guidance for researchers"

Copy to: *Dr Michelle Muessel, University of Leicester*

[redacted]

Appendix K*. Letter of ethical approval from HRA

NHS
Health Research Authority

Miss Foteini Oikonomitsiou
[redacted]
Email: hra.approval@nhs.net

09 February 2018

Dear Miss Oikonomitsiou

Letter of HRA Approval

Study title: **Exploring how people experience self-compassion within acceptance and commitment informed therapy for chronic pain.**

IRAS project ID: [redacted]
Protocol number:
REC reference:
Sponsor

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Appendix L*. Letter of University of Leicester Sponsorship approval

Research & Enterprise Division
University of Leicester
Research Governance Office
Fielding Johnson Building
University Road
Leicester, LE1 7RH
Email: uolsponsor@le.ac.uk
Tel: 0116 373 6410 / 223 1660

12 February 2018

Miss Foteini Oikonomitsiou

[redacted]

Dear Miss Oikonomitsiou

Ref: [redacted]
Title: **Exploring how people experience self-compassion within acceptance and commitment informed therapy for chronic pain.**
Status: **Approved** **End Date:** **26/09/2019**
Site: [redacted]

I am pleased to advise you that following confirmation of a Favourable Opinion from an Ethics Committee, HRA and NHS Trust R&D Capacity and Capability confirmation and where relevant regulatory authority agreements have been received, the University are able to confirm sponsorship for the above research at the above site.

I would be grateful if you can forward a copy of this letter to the Principal Investigator for their Site File.

Please note you are required to notify the Sponsor and provide copies of:

- Changes in personnel to the Study
- Changes to the end date
- All substantial amendments and provisional and favourable opinions
- All minor amendments
- All serious adverse events (SAEs) and SUSARS
- Annual progress reports
- Annual MHRA (DSUR) safety reports (if applicable)
- End of study declaration form
- Notifications of significant breaches of Good Clinical Practices (GCP)or Protocol

If your study is adopted onto the Clinical Research Network Portfolio please ensure that your recruitment figures, end dates and study status are the same on the EDGE database and Open Database Platform (ODP) CPMS.

Please copy the Sponsor into all correspondence and emails by using uolsponsor@le.ac.uk.

Please note it is essential that you notify us as soon as you have recruited your first patient to the study.

I would like to wish you well with your study and if you require further information or guidance please do not hesitate to contact me.

Yours sincerely

Dr Michelle Muessel
Research Governance Manager

Appendix M*. Participants' informed consent sheet.

UNIVERSITY OF LEICESTER

Participant identification number for this study:

INFORMED CONSENT FORM

Study Title: Exploring how people experience self- compassion within acceptance and commitment informed therapy for chronic pain.
Name of researcher: Foteini Oikonomitsiou, Trainee Clinical Psychologist

Please read the following statements and **INITIAL** the boxes:

1. I confirm that I have read and understood the participant information sheet (vX.X, DD/MM/YYYY). I confirm that I was given the opportunity to ask any questions about my participation in the study and have had those answered satisfactorily. ☐
2. I understand that my participation in the study is voluntary and that I have the right to withdraw at any point, without having to provide a reason. ☐
3. I understand that any information I provide during this study will remain confidential unless there are any serious concerns about my safety or the safety of others. I understand that the researcher will firstly speak to me before making any disclosures. ☐
4. I consent to the interviews being recorded and understand that the recording will be kept confidential and will be anonymised. I further understand that my personal details and study data will be stored on secure computers or in a secure office at the University of Leicester. ☐
5. I understand that any personal information and research data I provide will be accessed by the main researcher and supervisor (Dr Stephen Melluish) and authorised individuals from the Sponsor, regulatory authorities or NHS Trust for audit and monitoring purposes and I give permission for the above. ☐
6. I consent to take part in the study ☐
7. I would like to receive a copy of the study report. Yes ☐ No ☐

Name of Participant	Date of consent	Signature
Name of Researcher	Date of consent	Signature

When completed: 1 for participant; 1 for researcher site file

[redacted]_Consent Form_v1.0_10/1/2018 Page 1 of 1

Appendix N. List of support organisations provided to the participants.

UNIVERSITY OF LEICESTER

LIST OF SUPPORT ORGANISATIONS

Study Title: Exploring how people experience self- compassion within acceptance and commitment informed therapy for chronic pain.
Name of researcher: Foteini Oikonomitsiou, Trainee Clinical Psychologist

Thank you for taking part in the above named study. Your participation is highly appreciated. If following your participation you have any further questions or concerns in regards to the study, please do not hesitate to contact me on my research mobile number ([redacted]). I will do the best I can to address any issue or concern you may have.

In the event that taking part in the study has been upsetting for you, please contact your GP in order to seek referral to the appropriate mental health service. Additionally, you might find helpful contacting any of the following organisations who may be able to provide you with the necessary support or advice, or further signpost you to the most appropriate organisation.

Organisation Name	Type of Support	Contact Number	Contact Times
Samaritans	Confidential telephone/email/ text support for anyone that is experiencing distress.	National number: 116 123 Email address: jo@samaritans.org National correspondence address: Freepost RSRB-KKBY-CYJK, PO Box 9090, Stirling, FK8 2SA Northampton number: 01604 637637 (local call charges apply) Leicestershire number: 0116 2700 007 (local call charges apply)	24 hours a day, 365 days a year

MIND	Telephone/text advice and support to empower anyone experiencing a mental health problem.	National number: 0300 123 3393 txt: 86463	Open during weekdays (09:00-17:00) and closed during Bank Holidays.
NHS 111	Helpline that provides information and advice for non-emergency health issues	Telephone number: 111	24 hours a day, 365 days a year
Accident & Emergency (A&E)		Call your local GP practice	

Appendix O*. Chronology of the research process.

Date	**Procedure**
December 2016	Development of the first draft of the research questions after review of the literature and following consultation with the research supervisor
May 2017	Submission of the research proposal of the study for internal review from the university of Leicester staff members and honorary colleagues.
June 2017	Attendance of a research review panel at the university of Leicester. Receipt of feedback on the research proposal.
August 2017	Amendments made to the research proposal according to the research review panel feedback. Submission of the amended research proposal to the university of Leicester peer review process.
September 2017	Submission of a lay summary of the research proposal to the Service User Reference Group (SURG) for review and receipt of feedback. Receipt of feedback from the peer review process of the University of Leicester.
October – December 2017	Incorporation of the feedback from the SURG and the university peer review process to the research proposal. Preparation and submission of the ethics application for the study to the relevant ethics authorities: NHS Health Research Authority (HRA), the local Research ethics Committee (REC) and the local Research and Development department (R&D).
February 2018	NHS HRA approval HRA and REC approval. Receipt of sponsorship for the study from the University of Leicester.
March-July 2018	Recruitment of participants and data collection. Commencement of systematic literature review.

August – September 2018	Data transcription. Completion of systematic literature review.
October 2018-December 2018	Data analysis. Submission of systematic literature review for publication.
January 2019-April 2019	Internal submission at university of Leicester of the systematic literature review. Write up of the empirical part of the thesis.
April 2019	Thesis submission.
May 2019-June 2019	Preparation of research article for publication.
July 2019	Research viva.
August 2019	Preparation of research poster for trainee clinical psychologist's research conference.
September 2019	Dissemination of the study's findings in the research conference.

Appendix P*. Participants' information sheet.

UNIVERSITY OF LEICESTER

Participant Information Sheet

Study Title: Exploring how people experience self- compassion within acceptance and commitment informed therapy for chronic pain.

Main researcher: Foteini Oikonomitsiou, Trainee Clinical Psychologist

We would like to invite you to take part in this research study. Taking part in the study is entirely up to you, therefore before you decide it is important that you understand why the research is being done and what it will involve. Please take your time to read the following information and feel free to discuss it with other people should you wish to do that. Please feel free to contact the researcher, Foteini Oikonomitsiou should you require any further information or if you have any questions. Contact details can be found at the end of this Information Sheet.

What is the purpose of the study?

We are interested in understanding how people experience self-compassion within acceptance and commitment informed therapy for chronic pain. Self-compassion in this study is defined as the degree to which people are able to be mindful, adopt an attitude of kindness towards themselves and the degree to which they can perceive their difficulties in life as being part of being a human being. We are also interested in exploring whether people do experience any changes in self-compassion as a result of the above therapy. We hope that this will help us improve both the design and delivery of acceptance and commitment therapy for chronic pain.

Why have I been invited to take part in the study?

You have been invited to take part in the study because you have in the past received or are currently receiving individual or group based acceptance and commitment informed therapy for chronic pain.

Do I have to take part?

No. It is entirely up to you to make the decision to take part or not in this research study. If you do decide to take part in the study you can keep this information sheet. The decision to not participate in the study or to withdraw from the study at any point will not influence your rights in any way and will not affect any ongoing care that you may receive.

What will happen if I say yes?

If you say yes you will be given a form to complete with your contact details and the preferred method of contact for you which you will give to your therapist. Your therapist will then give your contact details to the researcher, who will contact you within 72 hours of you completing the form to answer any questions you might have about the study. Agreeing to be contacted by the researcher does not mean you have agreed to take part in the study and you have the right to not take part in the study even after the researcher has contacted you. You

also have the right to take as much time as you need to consider whether you want to take part in the study. Following the above, if you are still interested in taking part in the study, the researcher will arrange to meet with you at a convenient date and time in order to complete an interview. You can ask any questions about the study at any time, even after the completion of the interview. At the meeting, if you are still happy to take part, before the interview begins you will be asked to give your written informed consent to show that you have agreed to take part in the study. Please keep in mind that even if you do decide to take part in the study and you provide written consent, you have the right to change your mind at any time without having to provide a reason for that decision. In that event, or if you lose the capacity to consent following your interview, we would like to retain any data we have already collected and use it for analysis, unless you explicitly state otherwise. At your request, we will remove and destroy any data we have collected. However, we need to make you aware that this may not always be possible because any data that we collect will be made anonymous as soon as possible and certainly within 1 month of the interview being conducted. This decision will not affect your rights or ongoing care in any way. Before the interview begins you will also be asked to provide some anonymous demographic information about your age, gender, ethnicity and the duration of your pain. You have the right to refuse to provide any of the above information.

Although the length of the interview will vary for each participant it is not expected to take more than an hour. The interview questions will aim to understand your experience of self-compassion within acceptance and commitment informed therapy for chronic pain. It is anticipated that only one interview will be needed, however, if you prefer to split your interview up into more than one interview, this can be accommodated.

What will happen to the information I provide you with?

Any information you provide during the study will be kept strictly confidential.
The information you provide us with during the interview will be recorded on an audio device to make sure that an accurate account of what you have told us is recorded. Audio files will be initially stored on an encrypted USB device before being transferred to a password protected location on a secure computer at the University of Leicester. Following the interview, the researcher will transcribe your interview and make sure that any identifiable information is removed and you will be given a pseudonym. Transcribing services will be used only in highly exceptional circumstances. If a transcribing service is required, only a University of Leicester certified and authorised service will be used and for whom a Confidentiality Agreement will be in place. Pseudonymised quotes from your interview will be used for the write up of the study. You have the right to withdraw your interview audio recording at any time after one month of its completion, without that affecting your rights in any way.

Will any information I provide during the study remain confidential?

The interview data, both the audio recordings and the anonymised transcriptions of the interviews and the demographic information you provide will be kept on a password protected location on a secure computer at the University of Leicester and will be deleted within three months following the completion of the study. Your personal details will not be kept in the same place as your interview transcript and will be destroyed no more than 3 months following the end of the study unless you have indicated that you wish to receive a

copy of the summary of results. In this case, your name and contact details will be retained until the summary of results have been sent to you, then your details will be destroyed. Only the main researcher and her supervisor will have access to the information collected during this study, along with any authorised individuals from the Sponsor, regulatory authorities or host NHS organisations for audit and monitoring purposes. The only exception to the above might be if you disclose any concerns in regards to your safety or the safety of others, in which case the research will need to disclose those concerns to someone else such as the main supervisor and/or your therapist. The researcher will discuss this with you first before making any disclosures.

Are there any disadvantages or risks of taking part?

No risks are anticipated from taking part in the study. In the unlikely event that you find the interview upsetting, the researcher will make sure that at the end of the interview you have the time and space to discuss any matter that you found distressing and consequent support will be provided. You can also request to take as many breaks as you need during the interview and you are not required to answer all questions.

What are the benefits of taking part in the study?

We hope that it will be helpful for you to be given the opportunity to discuss your experience of therapy. We also hope that our findings will be used to improve acceptance and commitment informed therapy. Lastly, by way of a thank you for your participation in the study, you will be offered a £10 voucher after the completion of the interview. It is up to you if you wish to accept it or not. Your travel expenses will be reimbursed up to a maximum value of £10 upon receipt of valid and original receipts.

What will happen to the study's findings once it is completed?

The findings of this study are expected to be available after September 2019. If you like to receive a summary report please indicate this on the consent form. The findings from the study will form part of the researcher's doctoral thesis and they are intended to be made available through publications and presentations. All findings will be anonymised and the participants will not be identifiable in any way.

What if I am harmed by the study?

It is very unlikely that you would be harmed by taking part in this type of research study. However, if you wish to complain or have any concerns about the way you have been approached or treated in connection with the study, you should ask to speak to Foteini or one of her supervisors (contact details below) who will do their best to answer your questions. If you remain unhappy and wish to address your concerns or complaints on a formal basis, you should contact [redacted].

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against University of Leicester but you may have to pay your legal costs. The

normal National Health Service complaints mechanisms will still be available to you (if appropriate).

Who has the responsibility for this research?

The research is funded by the Clinical Psychology Department at the University of Leicester. This study has been reviewed by the University of Leicester as the study Sponsor and all research that involves NHS patient or staff must be reviewed and approved by the Health Research Authority and a Research Ethics Committee. This approval does not guarantee that no harm will come to participants, but it does means that they are satisfied that the study respects your rights, that all risks are as reduced as they can be, and that you have been given enough information to make an informed decision about whether to take part. This study has been approved by the [redacted]. The University of Leicester is the Sponsor for the study. The main researcher is Foteini Oikonomitsiou, trainee clinical psychologist and is being supervised by Dr Stephen Melluish, Consultant Clinical Psychologist.

What do I need to do if I would like to take part in the study or require more information?

- *You can let your therapist or the individual that provided you with this information sheet that you would like to take part in the study and fill in the Contact Details Form. He or she will pass your contact details to Foteini who will ring you to arrange the interview.*

Or

- *You can contact the researcher directly using the details below to indicate that you would like to take part in the study.*

Foteini Oikonomitsiou
[redacted]

Telephone number: [redacted] *(Monday to Friday from 8:30 to 17:30)*

Email address: [redacted]

Main Supervisor: Dr Stephen Melluish
Telephone number: [redacted]
Email address: [redacted]

Appendix Q. Contact Details Form

UNIVERSITY OF LEICESTER

CONTACT DETAILS FORM

Study Title: Exploring how people experience self- compassion within acceptance and commitment informed therapy for chronic pain.
Name of researcher: Foteini Oikonomitsiou, Trainee Clinical Psychologist

If you are thinking of taking part in the study or you have any further questions about the study please fill in the following form and return it to your therapist. Your therapist will give this form to the researcher and the researcher will then contact you according to the contact method you indicated below. Filling in the form does not mean you have agreed to take part in the study and you have the right to change your mind about taking part in the study even after the researcher has contacted you to provide you with more information. Your ongoing care will not be affected by your decision (or not) to take part.

Name:……

I would like to be contacted either by phone:

Please provide your telephone number:……

If a specific time of the day is more convenient for you please indicate:
……
……..

Or by email:

Please provide your email address:……..

Or by letter:

Please provide your address:
……
……
……...

[redacted]_Contact Details Form_v1.0_10/01/2018 Page 1 of 1

Appendix R.

Semi structured interview schedule/ Topic guide.

UNIVERSITY OF LEICESTER

SEMI STRUCTURED INTERVIEW SCHEDULE/TOPICS GUIDE

Study Title: Exploring how people experience self- compassion within acceptance and commitment informed therapy for chronic pain.

Name of researcher: Foteini Oikonomitsiou, Trainee Clinical Psychologist

Introduction

Introductions, presentation of the research and it's rationale, confidentiality and its limitations, information about tape recorder and transcription of interview, questions from participant prior to the interview.

Prior to commencing the interview re-iteration that the participant should feel free to only answer the questions he/she feels comfortable with and refuse to answer any question without having to provide a reason. Invite them to only share information they feel comfortable sharing.

Questions

1. **Invite the participant to tell me a little about themselves and what led them to take part in individual or group therapy.**
2. **First topic (exploring sense of self-kindness versus self-judgement)**

Invite the participant to describe how they relate to themselves when they are facing a difficulty. Invite them to describe what their internal dialogue towards their self looks like when they are facing a difficulty and how they sooth their selves.

Invite the participant to describe whether the above has changed due to therapy or /how they believe therapy has enabled that change.

3. **Second topic (exploring their sense of common humanity versus sense of isolation)**

Invite the participant to describe how they view their difficulties in life. Do they view them as being part of life or as them being alone in facing those difficulties?

Invite the participant to describe whether the above has changed due to therapy or/ and how they believe therapy has enabled that change.

4. **Third topic (exploring their sense of mindfulness vs over-identification)**

Invite the participant to describe whether they feel that they are now more aware of their difficulties. Invite them to describe whether they feel more able to just be (in sense of being aware of) their difficulties or the things that they struggle without necessarily striving to change them has changed.

Invite the participant to describe whether the above has changed due to therapy or /how they believe therapy has enabled that change.

Outline of interview questions used in the semi-structured interviews.

Background/Introduction

I am interested in your experience of your journey through the group. This interview asks about your experiences before, during and after the group.

Before the group

How did your pain difficulties begin?

Before you began the group –how did you face/ react to your pain? Other difficulties in your life?

How did you see or feel about yourself when experiencing pain or during those situations of difficulty?

How did you react towards yourself in those situations?

Did you have an inner dialogue during those situations? Can you explain what that might have looked like?

How did you react when you got things wrong or when you made a mistake?

How did your difficulties affect your sense of connection with other people? Your view of other people?

Can you tell me what led you to decide to take part in the group?

During the group.

When you commenced the group, and over the course of the group, how did your experience of your pain change?

Over the course of the group how did how your feelings towards yourself (and your view of yourself) change?

Over the course of during the group, did your inner dialogue alter? How did it change?

Over the course of the group how did your reaction towards yourself change?

How did how your sense of connection with other people change? Your view of other people?

After the completion of the group

Since completing the group how is your experience of your pain?

How has your reaction to difficulties you were facing changed since completing the group?

How have your reactions towards yourself changed since completing the group?

How have your feelings and your view of yourself changed since completing the group?

How has your inner dialogue changed since completing the group?

How has your sense of connection with other people changed since completing the group?

Appendix S*. A description of the analytic process.

The analytic process was both iterative and inductive (Smith, Flowers & Larkin, 2012). While the different steps taken in the analytic process are for brevity presented below in a linear order, the process was cyclical, and the researcher often revisited different steps of the analytic process at different stages of that process. The analytic process outlined below was flexibly based on the guidelines by Smith, Larkin and Thompson (2012).

Reading of the interview transcripts and initial annotations.

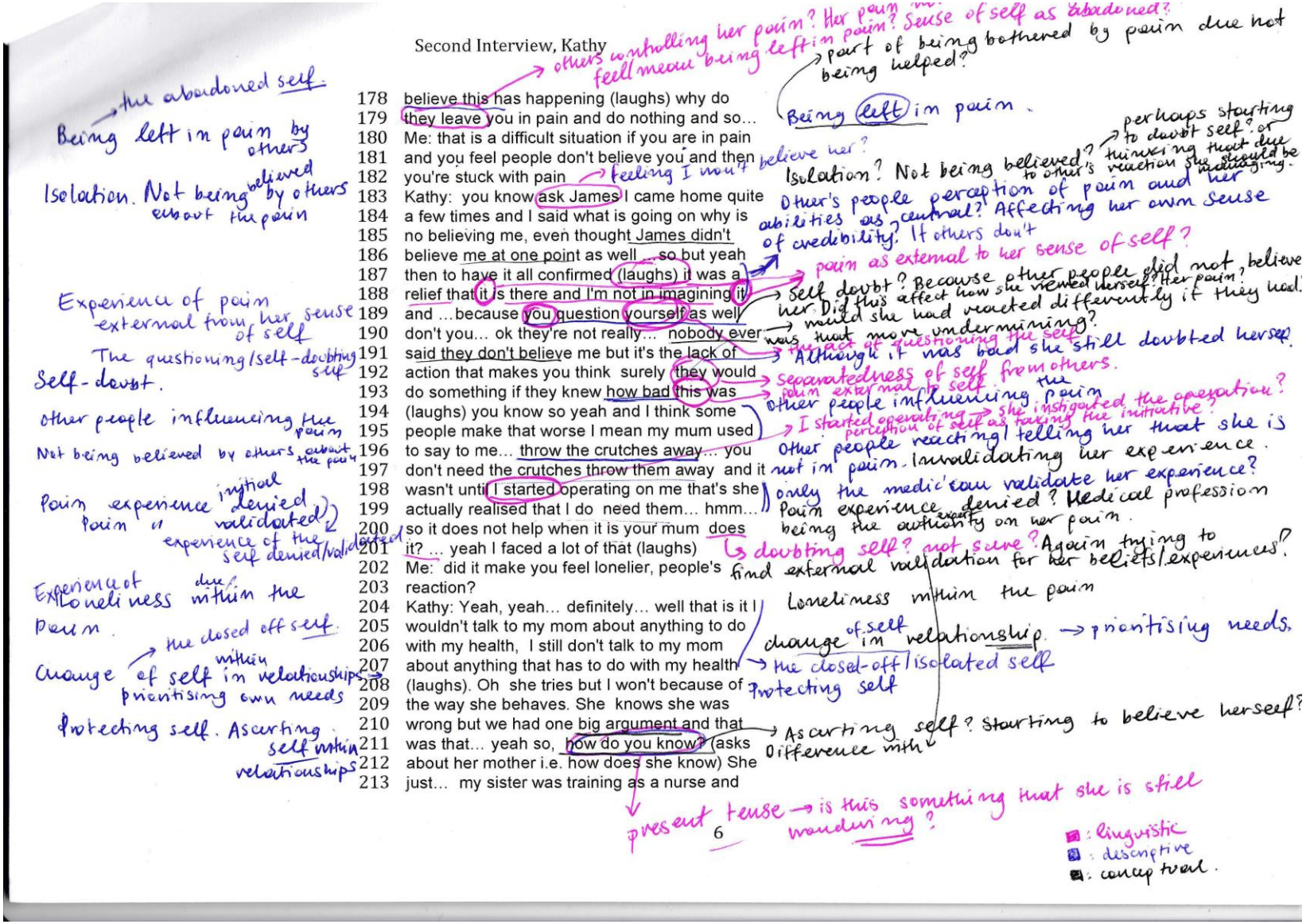
Initially, each interview transcript was read numerous times to ensure the researcher's immersion in the data. Initial notes and comments were written in the interview transcript that included various thoughts, feelings and imagery that the researcher had in response to immersing herself in the participants' experiences. This was considered as having the potential to uncover the researcher's preconceptions about the participants' experiences. It was done in an effort to identify those preconceptions at an early stage of the analytic process and therefore minimise their influence in the above process (Larkin & Thompson, 2012). These initial notes and comments were then 'put aside' before continuing to the next step.

Initial coding of the each interview transcript

A table was created for each interview that consisted of three columns, with the middle column containing each participant's interview transcript. This step of the analytic process entailed the identification of 'patterns of meanings' within each participant's interview transcript (Larkin & Thompson, 2012). More specifically, this process involved the line-by-line coding in the participant's interview transcripts of descriptive, linguistic and conceptual interpretations of the participant's experiences. These comments were written in the right column of the interview table.

Descriptive comments involved identifying and relating the content of the participant's narrative, i.e. describing things/objects/key words/comments in the participant's narratives that were perceived by the researchers as being of specific significance to the participant (Smith, Flowers & Larkin, 2012). Linguistic comments focused on the participant's use of language in an effort to explore the meaning and content of the participant's experiences (Smith, Flowers & Larkin, 2012). Lastly, conceptual comments entailed the researcher's attempt to understand the participant's central understanding and meaning making of their own experiences (Smith, Flowers & Larkin, 2012). Different coloured pens were utilised to code the different exploratory comments, with blue coloured ink used for descriptive comments, pink for linguistic and black for conceptual comments.

The next step of the analytic process entailed the production of emergent themes, written in the left column of the interview table. The emergent themes involved focusing on the comments made on the interview transcript, included in the right column of the interview table, while still remaining anchored at a more abstract level to the participant's data. More specifically, emergent themes were the researcher's attempt to concisely capture in a brief statement her various comments on the transcript (Smith, Flowers & Larkin, 2012). This step of the coding process is depicted in the picture below.



Picture 1. An extract from the coding process

Clustering of emergent themes

The next step entailed an attempt to loosely organise and summarise the identified emergent themes. This was done by looking into the different ways that the emergent themes might 'fit or contrast' together into groups to form tentative themes. An example of the initial clustering of emergent themes that included extracts from the participants interview transcripts, as to ensure that the process was grounded in the participant's data, is in included in Table 9.

Table 8. An example of the initial clustering of emergent themes to form tentative themes

Tentative themes	**Emergent themes with participant quotes**
Influence of pain in their life before the group	Pain causing life disruption '*I would need a couple of weeks off but then get back to work*' line 45 Pain affecting socialisation ' *I can't drive, and the buses I can't get on, because it is that getting up ehm that you know you know ehm it just it affects it (relationships)*' line 209 Pain dictating life frame 'I couldn't do that next week or next month' line 206 Limiting social connections ' *I tried to meet a friend […] but as soon as I started driving I could feel my back pulling , I thought oh no, okay, well I got to go through this, I am in the car now, I have got*

	to get there and I have got to get back' line 159 Loss of previous abilities '*I couldn't carry on doing what I was doing I was making it worse*' line 81
Coping mechanisms for dealing with the pain before the group	Initial reaction to the pain, trying to carry on '*It just got worse and worse and as much as I could carry on, I would need a couple of weeks off but then get back to work'* line 44 Always looking for a solution '*With the pain I was always looking for solutions with it'* line 62 Use of medication '*Codamol […] that is how I was managing it and also realising at that point two and a half years that I couldn't carry on doing what I was doing, I was just making it worse*' line 78 Pushing self to do more '*I always thought that I would get to where I was, back to working, back to shopping, back to carrying stuff, you know, there are a lot o fthings that I can't do now that I used to do, I would always be pushing to do*

	them' line 99

The initial clustering of emergent themes to tentative themes was revisited numerous times. This was done through the lengthy engagement with the produced clusters of emergent themes, during supervision, through the use of a reflective diary and through attending a peer supervision group. By revisiting the clustering of the emergent themes, the researcher aimed to cautiously incorporate her own interpretations in the clustering of the emergent themes, in an effort to capture both the participant's meaning making of their experiences and the researcher's understanding of those experiences (Smith, Flowers & Larkin, 2012). Table 10 below illustrates the evolved clustering of emergent themes into tentative themes for Grace's interview.

Table 9. Evolved clustering of emergent themes into tentative themes

Emergent themes	**Participant's quotes**	**Tentative Themes**
Looking for solutions/ trying to 'get away' from the pain/Un-bearability of pain Continuous use of medication as a way of getting rid of pain/	*'With the pain I was always looking for solutions with it*', line 62 *Codamol […] that is how I was managing it and also realising at that point two and a half years that I couldn't carry on doing what I was doing, I was just making it worse*' line 78	**Ways of coping with the experience of pain**

Battle with the self/ trying to get away from the pain by doing/ denial of the experience of pain Unbearability of being the one that cannot do things due to the pain therefore trying to push self to do things/rejection of the self in pain Pushing self to do things in an effort to deny pain	*I always thought that I would get to where I was, back to working, back to shopping, back to carrying stuff, you know, there are a lot o fthings that I can't do now that I used to do, I would always be pushing to do them'* line 99 *'It would be a mixture of 'I can do this' and I would compare myself with other people you know […], they all got various aches and pains but they keep going, so I think, I should be able to do this'* line 117 *'And yeah, I would push myself'* line 126	
Negative emotional response to the experience of pain	*'I felt annoyed, cross'* line 198	**Emotional response to the pain**

Frustration/ the experience of pain as unescapable	*'I would get frustrated that it didn't seem that anything could be done long term'* line 95	
Loss of independence	*'I went through a stage of feeling loss… of feeling I have lost my independence'* line 133	
Experience of annoyance for not being able to accomplish things	'*It wasn't angry, it was… it was annoyance that I couldn't do it'* line 149	
Annoyance for loss of past abilities	*'(thinking about the past) I can't do that now, so I would be annoyed'* line 158	
Feeling cross/ Loss of past abilities	'*I felt annoyed cross, because I knew that well, that is something else I cannot do now'* line	

	198	
Looking for solutions/ trying to continue accomplish thing/ loss of sense of achievement?	*'I was always looking for solutions with it and that is […] I overdid it'* line 62	**Trying to accomplish same things she could in the past despite the pain**
Trying to accomplish same things as in the past/ influence of pain in her current abilities	*'Being in the car for four hours, I got a brother that lives in (names place) so that journey became difficult'* line 68	
Trying to 'cling to' her past achievements	*'I couldn't carry on doing what I was doing I was just making it worse'* line 81	
Looking at the past/ change in expectations/ pushing self to accomplish what she no longer could	'*I always thought I would get to where I was, back to working, back to shopping, back to carrying stuff, you know[…] I would always be pushing to do them'* line 99	

Pushing self to accomplish what she no longer could/ un-acknowlegment of limitations	*'And yeah, I would push myself* ' line126 and *'I tried to meet a friend […] but as soon as I started driving I could feel my back pull, I thought oh no, okay, well I got to go through this, I am in the car now, I have got to get there and I have got to get back'* line 159	
Pain separate from sense of self/ pain a distinct entity/ sudden nature of pain Pain affecting abilities Pain separate from self/ pain having a function Relationship with	'*It just started… literally it seemed as though it was overnight'* line 28 *'It (pain) affects it (being able to do things)*' line 211 '*It (pain) would be re-evaluating'* line 205	**Pain distinct entity before the group**

pain/ pain distinct from self/'making it worse Trying to 'solve the pain'/ pain being an entity separate from the self Sudden nature of pain/ pain being an entity	'*I was just making it worse'* line 82 '*With the pain I was always looking for solutions with it'* line 62 *'It just went off almost in an instance'* line 57	
Practical about dealing with pain/ pain 'shrinking life/ pain affecting abilities Pain dictating life 'time-frame' Pain affecting plans/ pain limiting what can be done	*'I would be practical I suppose about what I can and cannot do'* line 188 *'(talking about the past) I couldn't do that next week or next month'* line 206 *'My back would have to really good and it has to be a time when I have nothing planned the day before and nothing planned the day after and just make like a*	**Pain shrinking life before the group**

	one-off' line 201	

The next stage of the analytical process aimed to uncover connections between tentative themes to form subordinate themes, i.e. clusters of tentative themes. The identification of subordinate themes was in an effort to generate a structure that would enable the researcher to adequately portray her interpretation of the participant's key aspects of their experience. More specifically, this stage of the analytic process aimed for the researcher to attempt to portray her perception of how the tentative themes fitted together, through examining different ways of clustering the tentative themes (Smith, Flowers & Larkin, 2012). During this step the researcher reconsidered both her emergent and tentative themes, re-organising and re-naming some of them during this process, in an attempt to meaningfully organise them into superordinate themes for each participant. Table 11 illustrates part of that effort for Grace's interview transcript, i.e. the reconsideration of the subordinate themes .

Table 10. Formation of subordinate themes

Emergent themes	**Participant's quotes**	**Tentative themes**	**Tentative themes to sub-ordinate Themes** **(Reconsiderations in regards to naming the tentative themes into themes and their organisation into sub-ordinate themes)**
Looking for solutions/ trying to 'get away' from the pain/Unbearability of pain	'*With the pain I was always looking for solutions with it'* line 62 *'Codamol […] that was how*	**Ways of coping with the experience of pain**	**Denying/ un-acknowledging the experience of pain** *By re-reading and re-engaging with*

Continuous use of medication as a way of getting rid of pain/ Battle with the self/ trying to get away from the pain by doing/ denial of the experience of pain	*I was managing it […] I couldn't carry on doing what I was doing, I was just making it worse'* line 78 '*I always thought I would get to where I was, back to working, back to shopping, back to carrying stuff, you know… you know there are a lot of things that I can't do now that I used to do I would always be pushing to do them'* line 99 '*It would be a mixture of 'I*		*both the interview quotes and transcripts and following the consequent discussion within supervision, it was considered that another level of interpretation would be the participants' attempt to disengage from the experience of pain. It was also identified that there was an underlying un-*

Unbearability of being the one that cannot do things due to the pain, therefore trying to push self to do things/rejection of the self in pain Pushing self to do things in an effort to deny pain	*can do this' and I would compare myself with other people you know […] they all got various aches and pains but they keep going, so I think, I should be able to do this'* line 116 '*And yeah, I would push myself'* line 126		*acknowledgement of the experience of pain from participants in their everyday life, due to their continuous attempt to 'get rid' of the pain*
Negative emotional response to the experience of pain Frustration/ the experience of pain as inescapable	'*I felt annoyed, cross'* line 198 '*I would get frustrated that it didn't seem that anything*	**Emotional response to the pain**	**Frustration for the loss of a sense of self that can achieve** *By re-reading and re-engaging with the both the*

	could be done long term' line 95		*interview quotes and transcripts and following the consequent*
Loss of independence	*'I went through a stage of feeling loss… of feeling I have lost my independence'* line 134		*discussion within supervision a deeper level of the participants' experiences*
Experience of annoyance for not being able to accomplish things	'*It wasn't angry, it was… it was annoyance that I couldn't do it* line 151		*interpretation was considered. It was considered that her frustration was about the loss of a sense of self that can achieve.*
Annoyance for loss of past abilities	*'(thinking about the past) I can't do that now, so I would be annoyed'* line 159		
Looking for solutions/	*'I was always looking for*	**Trying to**	**Pushing self to**

trying to continue accomplish thing/ loss of sense of achievement? Trying to accomplish same things as in the past/ influence of pain in her current abilities Trying to 'cling to' her past achievements Looking at the past/ change in expectations/	*solutions with it and that is […] I overdid it'* line 62 '*Being in the car for four hours, I got a brother that lives in (names place) so that journey became difficult'* line 68 *'I couldn't carry on doing what I was doing I was making it worse'* line 82 '*I always thought that I would get to where I was,*	**accomplish same things she could in the past despite the pain**	**perform according to her past accomplishments**

pushing self to accomplish what she no longer could	*back to working, back to shopping, back to carrying stuff, you know, there are a lot of things that I can't do now that I used to do, I would always be pushing to do them'* line 99		
Pushing self to accomplish what she no longer could/ un-acknowlegment of limitations	*'I tried to meet a friend, but as soon as I started driving I could feel my back pulling, I thought oh no, well I got to go through this, I am in the car now, I have got to get there and I have got to get back'* line 160		
Pain separate from sense	*'It just started… literally it*	**Pain distinct**	**Pain distinct**

of self/ pain a distinct entity/ sudden nature of pain Pain affecting abilities Relationship with pain/ pain distinct from self/'making it worse Trying to 'solve the pain'/ pain being an entity separate from the self	*seemed as though it was overnight'* line 28 *'It (pain) affects it (being able to do things)'* line 212 '*I was just making it worse'* line 82 *'With the pain I was always looking for solutions with it'* line 62	**entity before the group**	**entity from sense of self** *It was considered that the experience of pain before the group it was considered as being distinct from her sense of self hence her use of the adjective 'it' when describing her experience of pain*

Sudden nature of pain/ pain being an entity	*'It just went off almost in an instance'* line 57		

Development of super-ordinate and sub-ordinate themes for each participant

The next step of the analytical process aimed to uncover connections between sub-ordinate themes to form super-ordinate themes for each participant, i.e. clusters of sub-ordinate themes.

The aim of this part of the analysis was for the researcher to endeavour to represent her perception of how the sub-ordinate themes of each participant fitted together for that participant. This step is depicted in Table 12, for the part of Grace's data already included in this section.

Table 12. Clustering of sub-ordinate themes into super-ordinate themes.

Subordinate theme	**Sub-ordinate themes**
Dis-ownership of pain	**Denying/ un-acknowledging the experience of pain**
	Pain distinct entity from sense of self
Negative response to the self in pain	**Frustration for the loss of a sense of self that can achieve**
	Pushing self to perform according to her past accomplishments

Development of super-ordinate and sub-ordinate themes across all participants

Once the above steps were completed for each participant, with sub-ordinate and super-ordinate themes created for each one of them, patterns across all of the participant's sub-ordinate and super-ordinate were sought out. This is depicted in Table 13 below (Smith, Flowers & Larkin, 2012)

This required a significant amount of time and a number of different tables were created in an attempt to capture different potential groupings of each of the participant's subordinate and superordinate themes into superordinate and subordinate themes across all of the participants. The following Table 13. Illustrates the above step. Quotes from each participant, where appropriate, were included as to ensure that the analytic process was grounded in the participants' data.

Table 13. Development of super-ordinate and subordinate themes across all of the participants

Participants' quotes	**Subordinate theme**	**Revised Subordinate Theme**	**Superordinate Theme**
Grace: I pushed my self (when in pain) really, so it took me a lot of time to stop doing that. line 123 *Kathy: It wasn't any life to live like and like I can't do anything. line 77* *Lucy: I mean I did contemplate suicide quite a lot because I thought what is the point of living with this agony. line 83* *James: I went for a walk (when in pain) then the frustration came in cause I realised I can't walk that far […] so I am walking a bit further […] I was gone for two hours, I*	Disownership and disengagement from the self in pain	From dis-ownership to ownership of the self in pain	Transformed relationship with their self in pain

didn't realise it was that length of time. line 250 *Hannah: I had been clutching, get hold of, trying to get back to how I was instead of actually trying to be better and improve. line 320*			
Grace: I could feel my back pulling, I thought, oh no, well I got to go through this, I have to get there and I have to got to go back […] I would be planning really for the next part of when I would get to the village. line 162 *Kathy: I 'd sit and have the telly on all day but it isn't as much watching the telly than the telly is on you are in nowhere land you're watching the telly but you are not really. line 615*	Disengagement from the experience of pain	From dis-ownership to ownership of the self in pain	Transformed relationship with their self in pain

James: I just wanted […] to get lost in my game on my phone so I am not in this reality I am in my own reality in my own little bubble. line 189 *Hannah: try to put on this big image that it has not happened it is not there that it is going to go away within weeks. line 427*			
Grace: With the pain I was always looking for solutions with it. line 62 *James: I tried to block the pain out. line 342* *Hannah: the pain made me so over emotional. line 167* *Lucy: 'I couldn't see an end to the awful*	Disownership of pain- pain external entity from self	From dis-ownership to ownership of the self in pain	Transformed relationship with their self in pain

pain. line 278 *Kathy: It (pain) is like taking everything away. line 251*			
Grace: my pain is my pain if you like. 684 *Kathy: I mean it is part of me, it is who I am, I try not to dwell on it. line 455* *Lucy: I know everyone's pain is their own. line 836* *James: You realise you still haven't got rid of your pain but hey ho. line 801* *Hannah: My back pain. line 480*	Ownership of pain	From dis-ownership to ownership of the self in pain	Transformed relationship with their self in pain
Grace: I say right I can't walk any more (due to pain). line 281	Observing and being aware of the self in pain	From dis-ownership to ownership of the self in pain	Transformed relationship with their self in pain

Kathy: I try not to dwell on it and doing things, I mean I try and walk more, I think that helps I don't think sitting around all day did my pain any good […] and doing more believing I can do more. line 457 *Lucy: I kept saying to myself this too will pass […] I said oh no keep calm don't panic just take it easy and its still not quite right but it is a bit better. line 696* *James: I just say here we go again (pain) what can I do about it. line 823* *Hannah: I had to accept that my body had been twisted up a little bit, of course it was going to be in pain, allow it to recover, allow yourself to recover. line 424*			

References:

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. *Qualitative Research Methods in Mental Health and Psychotherapy: A guide for Students and Practitioners*, 99-116.

Smith, J. A., Flowers, P. & Larkin, M. H. (2012). *Interpretative phenomenological analysis: Theory, method and research*. Los Angeles: Sage.

Appendix T*. Participants' representation in each superordinate and subordinate theme.

Superordinate theme	Subordinate theme	Participants					
		Grace	Kathy	Lucy	Amy	James	Hannah
Transformed relationship with their self in pain	From dis-ownership to ownership of the self in pain	✔	✔	✔	-	✔	✔
	Protecting the self in pain	✔	✔	✔	✔	✔	✔
The social self in pain	The isolated self	✔	✔	✔	-	✔	✔
	You can survive it	✔	✔	✔	-	✔	✔
	Experience of difference in the group	-	✔	✔	✔	✔	✔

Appendix U*. Reflexivity and Quality checks

From the onset of the study, the quality and validity of the research were guided by the adoption of the principles proposed by Yardley (2000) (sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance).

Following from Yardley's principles (2000), prior to the commencement of the study, the existing relevant literature in the field was explored and the researcher reflected on the clinical utility of the research project.

In an effort to promote transparency of the research process, different steps were taken throughout the analytic process. Extracts from the different stages of the process of analysis were recorded in a log. Additionally, participants quotes were included in the result section of this study in an effort to adequately ground the study's findings in the participants' data and to ensure the transparency of the research process.

Reflexivity was enhanced through the researcher's participation in an IPA workshop facilitated by an IPA research expert and in an one-off peer-supervision group. During the above, anonymised extracts of the study's interview transcripts were exchanged and coded between trainee clinical psychologists. This was done in an effort to assess whether the identified themes were 'grounded' in the interview data, to identify other perspectives (triangulation) and to further assess the depth and validity of the analytic process. The researcher also attended continuous supervision and kept a research diary throughout the research process. During supervision different reflections and interpretations of the interview transcripts were considered and the researcher's potential preconceptions potentially influencing her interpretations were explored.

The researcher also attempted to be mindful of her own influence on the research project. The researcher was aware that she was a trainee clinical psychologist that could have been perceived by the participants as a therapist and therefore they might have been reluctant to fully disclose any dissatisfaction or negative

experiences during their participation in the group. The researcher also acknowledged that during the interviews she found it hard to separate her clinical role from her research role. This resulted in her at times offering either an empathetic or reflective response to the participants' disclosures on highly emotional topics that was seen as delineating from a curious stance that could have enabled her to gain a more in-depth understanding of the participants' experiences. The researcher also considered that the socio-cultural-linguistic background of the participants was different to that of the researcher, with English being the researchers second language. Therefore the researcher might have failed to correctly identify socio-economic, cultural and linguistic influences on the participants' experiences resulting in a reduced sensitivity to context.

References:

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*(2), 215-228.

Appendix V*. Extracts from the researcher's reflective diary.

Reflections following the first interview

It was challenging switching between being a trainee clinical psychologist and being a researcher. I found it quite difficult not starting to validate some of the participants' emotions or summarising what she had just told me as a way of reflecting back to her, her own experience. Looking back to the interview, if I hadn't used reflective comments, her interview might have had more depth. Having heard back part of the interview I really think that I should also have asked her to further elaborate on some of the things she had told me.

I also think that I did refrain from asking too many questions. Can this be because I was thinking that this was the initial assessment session and I didn't want to appear too intrusive or ask too many questions? It feels like I had this notion in the back of my head that if there was something that seemed significant but too 'sensitive' I could ask some but not too many questions and then further explore it in my next session with her. It appears as if I acted as if she was a client I was seeing as a trainee and not a research participant. Maybe this is something that I need to be aware of in my next interview? I need to discuss this in supervision.

Reflections following the third interview

This was such a hard interview to conduct. The participant became quite emotional while recounting her own story. I did ask her if she wanted us to stop and at the end I did ask her again if she was okay. Both times she told me that she was okay and that she was finding it helpful to talk about these things. She also said that she found it useful talking about how hard things had been for her, making her realise how far along she had come. I did find myself experiencing immense respect and somewhat sadness for the difficulties that she had been through. Before this interview I had some awareness of how difficult the experience of pain could be but following this interview it

somewhat dawned on me what a profound effect something like that can have on someone's life. I am also grateful for her sharing her story with me, I feel so privileged to be in a position that people can open up to me about their life stories.

I do need to be aware though of not walking into the next interview assuming that I know or understand how difficult the participants' experiences were. I need to put some of my assumptions around 'understanding' their pain 'on the side' and ask them to elaborate on what they are telling me.

Appendix X*. Anonymity and Confidentiality Check Table

	Checked in Executive Summary/Abstract/ Overview (if included in assignment)	**Checked in main text**	**Checked in appendices**
Pseudonym or false initials used			
Reference to pseudonym/false initials as a footnote			
Removed any reference to names of Trusts/hospitals/clinics/services (including letterhead if including letters in appendices)			
Removed any reference to names/specific dates of birth/specific date of clinical appointments/addresses/ location of client(s), participant(s), relatives, caregivers, and supervisor(s). [For research thesis – supervisors can be named in the research thesis "acknowledgements" section]			
Removed/altered references to client(s) jobs/professions/nationality where this may potentially identify them. [For research thesis – removed potential for an individual research participant to be identifiable (e.g., by a colleague of the participant who might read the thesis on the internet and be able to identify a participant using a combination of the participants specific job title, role, age, and gender)]			
Removed any information that may identify the trainee (consult with course staff if this will detract from the points the trainee is making)			
No Tippex or other method has been used to obliterate the original text – unless the paper is subsequently photocopied and the trainee has ensured that the obliterated text cannot be read			
The "find and replace" function in word processing has been used to check the assignment for use of client(s) names/other confidential information			