How do therapists experience clients who struggle with self-compassion? : An Interpretative Phenomenological Analysis

Abstract:

Self-compassion is a burgeoning area of research in healthcare and psychological therapy professions, and has shown potential for benefiting clients, which has prompted the development of specialist frameworks such as Gilbert's (2009) Compassion-Focused Therapy. However there is also a growing body of research bringing attention to the concern of 'compassion fatigue' for those in the caring professions. There is limited qualitative research, compared to the growth in quantitative studies on this subject; this research aims to redress this imbalance, with the assumption that understanding self- compassion at the ground level, by exploring the phenomena from the direct lived experiences of therapists, will compliment our understanding of how the struggle with self-compassion manifests in a relational paradigm of therapy.

Data was collected using semi-structured interviews with three therapists, and analysed using Interpretative Phenomenological Analysis (IPA). IPA was chosen as a method which encourages a deep engagement of both the participant and the researcher; acknowledging the value in the researcher's interpretation as giving meaning to the experience.

Five master themes emerged from the data. Firstly, 'therapist grounding'; the background the therapists held during their work with clients. Secondly, 'therapist presence'; the unspoken elements of the therapist's presence in the room . Thirdly 'cultivating client self- compassion'; the ways in which therapists facilitated the client towards self-compassion. Fourthly, 'clients negative self-image'; how therapists experienced the lack of self- compassion in the

client; and lastly, 'respecting process pace'; how therapists navigated the balance of allowing space and time for the client's struggle. The findings call attention to the importance of the inclusion of self-compassion in therapist trainings, to support therapists in their role. In addition, the nature of self-compassion as having a significant bodily-felt quality is proposed, which has implications for future research.

Contents

Introduction

The concept of compassion is not new; it has been a part of ancient religious and spiritual movements for thousands of years (Goetz, Keltner, & Simon- Thomas, 2010; Kirby & Gilbert, 2017 cited by Kirby et al. 2017), and has been found in Eastern philosophical writings dating back centuries (Germer and Neff, 2013). However the concept of compassion has, hitherto, remained in the background in the scientific community. Within the last 20 years there has been a re-discovery of these ideas, catalysing a dramatic

increase in interest in the potential of compassion and its application in Western paradigms of healthcare, including as health psychology, positive psychology, and psychotherapy (Kirby et al. 2017).

The researcher's attention was drawn to the idea of compassion after reading Paul Gilbert's (2010) 'The Compassionate Mind'. The researcher noticed that the explicit notion of compassion hadn't been included as part of her framework in training, whilst other ideas such as empathy and 'unconditional positive regard' (Rogers, 1961) are prevalent. Upon introspection around her concept of 'therapy', and its purpose, the researcher perceived that there is something fundamental in the reparative potential of therapy that was a motivation in her choice of profession. There is a desire to assist the client towards healing. Choosing to practice as a therapist, and moving towards healing, often entails a willingness to attune to the suffering of others. The researcher suggests that integral to the concept of therapy is compassion; a 'sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it' (Gilbert, 2014). Therefore, compassion is particularly relevant for research interest in the therapy community and other caring professions.

As a therapist working within a relational framework, the researcher became interested not only in how compassion is expressed to others in the external world, but in the relationship that therapists and their clients have with compassion towards themselves, that is, 'compassion directed inward' (Germer and Neff, 2013). Self-compassion has, like compassion, recently received increased research attention; more than 200 journal articles examining the topic have emerged in the past 15 years, since the first seminal articles defining and measuring self-compassion were published by Neff (2003a/2003b) (Neff and Germer, 2012). However the vast majority of these studies were conducted using quantitative methods, and whilst, given current research culture in healthcare disciplines, being conducive in bringing attention to self-compassion as an important factor, these do not tell the whole story.

There is likely something different to be gained from an understanding of the pursuit of knowledge that is grounded on human experience (Greenwood, 2010) which this study hopes to uncover.

The following 'theory' chapter, will begin by defining the terms of the research question, drawing particular attention to the concepts of 'experience' and 'self- compassion'. The extant literature will be explored, providing a grounding of the research question this study within the current research.

The 'methodology' chapter follows the researcher's journey, through the ontological, and epistemological considerations in deciding to utilise a qualitative research method.

The methodology of Interpretative Phenomenological Analysis (IPA) is explored alongside the researchers philosophical and practice orientation, in relation to the meaning of 'experience' and the related concepts of 'phenomenology', 'hermeneutics' and 'ideographic enquiry'. Then the 'method' chapter will report the steps that the researcher took to conduct the study using IPA .

The 'analysis' chapter takes the reader through the progressive steps of the analysis, demonstrating how the researcher adhered to the IPA guidelines as given by Smith and Osborn (2008) to generate the master themes from the transcript coding. The master themes and the superordinate themes that emerged are reported in the 'findings' chapter.

Lastly, the findings of the study will be relocated the extant literature, to examine some areas of potential contribution to the theory of self-compassion. The researcher will use the 'discussion' chapter to critically evaluate the method and draw conclusions as to the quality of the study, and whether the findings meaningfully contribute to this area of research. The researcher will give recommendation for further research, and give a personal reflection on their experience of conducting the research.

Theory

This chapter has two parts; the first aims to define the terms of the questions 'how do therapists experience clients who struggle with self-compassion'. The second part will explore how the researcher came to the research question taking into account the extant literature, providing the reader with an overview of the position of self-compassion in current psychotherapy research. This literature will be re-engaged with in the discussion chapter, where the findings of this study are evaluated by how they fit in with current research, as is specified by the research method of Interpretative Phenomenological Analysis (IPA). In this way, the 'lived experience' (Smith et al. 2009) of participants is brought into context with the surrounding historical, socio-cultural constructions surrounding these concepts, allowing the findings of this study to be grounded back into the relevant theory.

The term 'therapist' is defined as 'a person skilled in a particular type of therapy' (Collins, 2018). Smith et al. (2009) recommends researchers to find a sample that is 'fairly homogenous', which requires some selection criteria for the participant. Therefore the researcher has refined the definition of therapist, for the purposes of this study, to require the therapists to be qualified by the BACP, UKCP or equivalent, and to have been practicing for two years or more. This helps to ensure that a shared therapeutic language is understood between the researcher and the therapist, so that the nuances of experience can be communicated, as an important component of IPA (Tuffour, 2017); while positing a level of experience of the therapist assumes that the therapist has a broader scope of experience with clients to draw upon.

The definition of 'client' is defined as 'a person, company, etc, that seeks the advice of a professional man or woman' (Collins, 2018). The definition of client has a more unique connotation in the psychotherapeutic world; most commonly a client is thought of a person seeking the therapist's professional services on regular basis,

with whom they are in an ongoing therapeutic relationship. For the purposes of this study, the term client is refined to being those who 'struggle with self-compassion' as the area of interest.

The term 'struggle' has two close definitions which are adaptable for the purposes of this study; 'to exert strength, energy, and force; work or strive' and 'to go or progress with difficulty' (Collins, 2018). However whether the client is thought of as falling under the description of 'struggling with self-compassion' will be reliant on the therapist's perspective rather than the researcher's, but may include aspects such as; self-judgement, feelings of isolation, and over-identification with pain, according to categorisations used by Neff(2003a, 2003b) which will be elaborated on later.

The term experience' is central in this study; how it is understood influenced the choosing of the research method of IPA, as well as how the findings of this study were understood. 'Experience' is difficult to define succinctly; it holds multiple meanings, yet underpins central frameworks and concepts within psychotherapy theory. Debates around the nature of experience are central within the existential-humanistic school, which is the modality

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closest to that of the researcher. With Husserl (1913), Heideggar (1962), Merleau-Ponty (1964) Sartre (1956) and many other philosophers developing their own nuances to the concept, it is challenging to hold this definition to one tangible and pragmatic meaning. For the purposes of this study, the researcher has chosen to use Heidegger's (1962) definition, being the conceptualisation with which she feels most philosophically aligned. Experience as *Dasein, as* 'being-in-the-world', means that experience is grounded in the time and place from which it emerges (Heiddeger, 1962). Heidegger (1962) argues that we are *subjective*, *experiencing*, *embodied beings*, and that the present experience is the only reality. This has implications for the status we place on the knowledge and truth that derive from such experiences, which ultimately influences

what meaning emerges from the findings of this study. This will be further explored in the discussion chapter.

In addition, how experience is ultimately defined by the researcher also has an implications for what research method was chosen; IPA derives from an understanding of experience closely aligned with phenomenology and hermeneutics, which will be further explored in the methodology chapter.

The central concept of this study is the definition of the term 'self-compassion'. Interest from the scientific community around compassion has exploded recently, emerging from Eastern philosophical thought and spiritual teachings where the concept has been present for centuries (Germer and Neff, 2013). Paul Gilbert (2014), who developed Compassion- Focused Therapy, takes these influences into account defining of compassion as "the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it" (p. 19). The definition of 'self-compassion' is related to the more general definition of 'compassion' as Germer and Neff (2013) state that self-compassions is 'simply compassion directed inward'. Kirby et al. (2017) highlights the debate as to the nature of compassion with some defining it as a motivational system (Gilbert, 2014), others defining it as an emotion (Goetz et al., 2010) and others as a multidimensional construct (Jazaieri et al., 2013; Strauss et al., 2016).

The concept of self-compassion as distinct from compassion has been most fully expounded by Kristin Neff (2003a, 2003b). Neff (2003a) defined self-compassion based on her interpretations of Buddhist teachings (Kirby et al. 2017), and operationalised self-compassion into three key elements; self-kindness, a sense of common humanity, and mindfulness. Neff (2003b) utilised these elements to developing and validating a scale to measure of self-compassion.
The elements of self-compassion are seen as being in juxtaposition to other concepts which do not promote self-compassion, creating a six factor model. 'Self-kindess' versus self- judgement; self-kindness

means being warm towards oneself especially during experiences of pain or when perceiving personal weaknesses instead of pushing away, ignoring or causing harm towards oneself with self-criticism. Common humanity versus isolation; entails the recognition that such painful experiences are a shared part of human experience. Mindfulness versus over identification; in context with self-compassion, mindfulness involves taking a balances attitude towards the experiences of pain and suffering, perceiving these with equanimity, that is, without exaggerating nor diminishing the present experience but as close to 'as it is' as possible.

Neff (2003a) is careful to distinguish between self-compassion and other concepts, such as 'self-pity' 'self-esteem'. Neff (Ibid.) argues that 'self-pity' is distinct from self-compassion, and reflects a state of mind in which the observer has become too involved or over-identified with the negative experience, which would become an aversive reaction (Bishop et al. 2004). Self-pity 'emphasises egocentric feelings of separation from others and exaggerates the extent of personal suffering' (Neff Ibid.). Neff (Ibid.) argues that self- compassion is also superior to self-esteem, which is also problematic because it is highly resistant to change (Swann 1996 cited by Neff, 2003a), and over-emphasis on evaluating and liking the self may lead to self-absorption, narcissism, self-centeredness, and a lack of concern for others (Damon, 1995 cited by Neff 2003a).

Neff (2003a) compares self-compassion to concepts in other psychological approaches, likening self-compassion to Jordan's (1989;1991) writings on self-empathy, which is described as a process in which the individual practices an attitude of openness and non- judgement toward the self. However Vivino et al. (2009) suggests while empathy and compassion are similar, therapists in their study described compassion 'as broader or deeper than empathy in that it allows a deeper engagement'. Rogers (1961) 'unconditional positive regard' is also regarded as comparable by

Neff (2003a); in the idea of adopting an unconditionally caring emotional stance toward the self.

Though not all researchers agree that Neff's (2003b) scale holds generalisability, (Lopez 2015), Neff (2003a) has given the most thorough definition of self-compassion, developing and validating this term, as well as identifying its place in relation to ideas within relational and humanistic frameworks. It is hoped that the present study will be able to shed light on to the alignment of Neff's (2003a) conceptualisation of self-compassion with therapists lived experience of it.

An exploration of the extant literature in self-compassion, not only how other researchers have defined it, but how research has been conducted follows, providing a basis for how the current study emerged, and where it stands in the current literature.

More than 200 journal articles exploring the subject of self-compassion have emerged from the seminal work of Neff (2003a/2003b)(Germer and Neff, 2013). It has been foundational to a plethora of quantitative research that has begun to show the importance of self-compassion as a factor in predicting outcomes in mental health (Van Dam et al., 2011; Germer and Neff, 2013; Neff and Germer 2012). Self-compassion is positively associated with increased wellbeing for number of factors such as subjective happiness, optimism, wisdom, curiosity, social connectedness, and emotional resilience, whilst indicating lower tendency for self-criticism, rumination, anxiety and depression (Neff, 2003b; Neff et al., 2007; Leary et al., 2007).

From this research self-compassion has become more relevant in modern psychotherapy practice, influencing the development of whole new methods of working, such as Compassion-Focused Therapy (CFT) (Gilbert, 2009) and Mindful Self-Compassion therapy (MSC) (Neff and Germer, 2012) Self-compassion has also become the focus of other related

mindfulness based therapies such as acceptance and commitment therapy (ACT) (Yadavaia, et al. 2014).

Of further interest, cultivation of self-compassion is something that research has shown to be beneficial to those in a caregiving capacity (Shapiro et al. 2007), including therapists themselves (Germer and Neff, 2013); and may be an authentic route to finding common ground within the therapeutic relationship. This is of particular interest to this research, which a more qualitative research method may allow.

These studies have been useful for exploring how self-compassion might be measured, which has been foundational for how self-compassion has been researched in quantitative studies, which make use of these measures in order to demonstrate the efficacy of therapies and find co-occuring phenomena. This form of quantitative study has been abundant, seeking out discrete measurable categories above the richness of 'lived experience' of the participants at a deeper level. Furthermore, much of the established research has built upon the research before, making use of Neff (2003b) and Gilbert et al. (2011a; 2011b) scales. However, Lopez et al's (2015) much larger scale study suggests that the six-factor model could not be replicated, leaving room for further research into the validity of Neff's (2003a) conceptualisation of self-compassion and scale. Because a lot of subsequent research has made use of these scales, this throws into question the validity of these studies also.

In attempts to find other qualitative studies into the phenomena of self-compassion the researcher used the University of Brighton 'OneSearch' (2018) system, with the search terms of 'therapist' 'experience' 'counselling' 'psychotherapy' 'qualitative' 's elf- compassion' 'compassion' and 'IPA'. Literature took the perspective of the influence of mindfulnesss based self-compassion interventions for therapists as a method of self-care (Patsiopoulos and Buchanan, 2011), presence (McCollum and Gehart, 2010) and other- focused concern (Boellinghaus et al. 2014). These are areas

where research has been significantly more focused because of recent concerns of the phenomena of 'compassion fatigue' (Sinclair et al. 2017) in caring professions. Therefore the present study will be taking this into account as an area it might contribute to.

There is a lack of qualitative research into the experience of the therapist with the client who struggles with self-compassion with only two relevant qualitative studies being found. Vivano et al. (2009) conducted a Consensual Qualitative Research (CQR), using 14 therapists nominated by peers as being compassionate, to gain a greater understanding of their perspective into how they would define compassion in psychotherapy and what factors facilitated or hindered their compassion towards clients. Lawrence and Lee (2014) conducted the only IPA research found, though it explored experiences of the clients who underwent CFT, rather than therapist experiences. These papers will be referred back to in the discussion chapter of this study.

This brings us to the comparison of the research which has already been established and the focus of this study. Earlier the definition of experience was explored as a key part of the research question. Keeping this in mind, this study aims to further explore the

relational qualities of self-compassion as experienced by from the therapist's point of view, by exploring the data in depth using a qualitative research method of IPA.

It is hoped that this research will create insight into the experience of the 'average' practicing therapist; one who may, or may not, have heard of the principles of self- compassion but who don't use a specialised modality for working with compassion such as ACT or CFT. How these therapists experience working with clients who struggle with self-compassion is taken from their own perception, rather than being a measured variable using a scaling method. Using this method could add to the understanding of this phenomena established by the previous quantitative research, by uncovering the 'lived experience' of such therapists.

This chapter began by defining the terms of the question, especially noting the nuances in the term 'experience' as important for the choice of the qualitative, IPA method. Neff's (2003a) definition of self-compassion was explored, followed by an overview of the current research literature around this subject, which revealed a heavy bias towards quantitative research, especially those which had built upon the measurement scale of Neff's (2003b) work, which has yet to prove its validity over time. Few qualitative studies were found, which were mostly concerned with how self-compassion has been utilised and experienced by therapists as part of their own process or were an exploration of 'compassion fatigue'. It is hoped that this study will contribute to providing a richer understanding of how self-compassion is experienced in a relational way, as phenomena perceived from the therapists perspective.

The next chapter will look at IPA in depth as a method for exploring how therapists experience clients who struggle with self-compassion.

Methodology

This chapter will introduce the methodology of Interpretative Phenomenological Analysis (IPA), providing a brief background of the ontological and epistemological arguments surrounding its use in research inquiries into experience, including phenomenology, hermeneutics and ideographic inquiry. Using these arguments, the researcher provides the rationale for the use of IPA in the present study.

Phenomenology

The central interest of the research question is to explore the *experience* of the participants. Therefore the researchers understanding of the concept of experience as being most closely aligned with Heidegger's (1962) *Dasein,* played a central role in the selection of the research method in order to reflect this understanding.

There has been a historical philosophical evolution to the notion of experience; from philosophers such as Brentano (1874; cited in Moran, 2002) , who talks about meaning as being driven by the 'intentionality' towards an idea; to Husserl (1913) who took this further that by conceptualising the experience we create as an 'intentional object', which drives subjective experiences and creates the phenomenology of the individual. Phenomenology became a key term in talking about the definition of experience using this perspective, which was developed into existential phenomenology by Heidegger (1962).

A qualitative research design is most compatible with the epistemology that emerged from the influence of phenomenology (Flick, 2014). In addition the post-modern ideas of IPA challenge the common understanding of truth, and question quantitative research. Oevermann et al. (1979) cited by Flick (2014), stated that 'quantitative methods are only research economic shortcuts of the data generating process, whereas only qualitative methods, are able to provide the actual scientific explanations of facts'. It is hoped by using qualitative methods that we gain insight which quantitative studies overlook. The present culture of psychological therapies such as those found in the NHS favour 'Randomised Control Trials', whereas there might also be something different to be gained from 'an understanding of the pursuit of knowledge that is grounded on human experience' (Greenwood, 2010), which may be more influential. Greenwood (2010) uses Freud's classic case studies as an example of qualitative work that illustrates this point and argues for a more balanced approach to research; 'what is important is the potential influence an enquiry might have on current cultural understanding' (Greenwood, 2010). It is hoped that this study will attend to this balance in our understanding of self- compassion using an illustrative point of view (Flick, 2014).

IPA is increasingly recognised as a useful tool in providing valuable contributions to healthcare research (Pringle et al., 2011; Lawrence and Lee, 2014). The suggestion that experience and phenomenology hold value in themselves is akin to the philosophy underpinning

much modern therapeutic theory, and reflects the philosophical stance of the researcher. Thus IPA was was thought to be an appropriate method for use within the present study.

Hermeneutics

Chamberlain (2000) made a critique of qualitative studies, arguing that they focus on 'description at the expense of interpretation'. Heidegger contrasted with Husserl by placing ontology before epistemology, and brought the idea of experience into the relational realm. Influenced by Gadamer and Schleiermacher (Moran, 2002; Smith et al. 2009) Heidegger challenged Husserl's conception of phenomenology as emerging from intentionality, because it positioned consciousness into a detached and autonomous place from the world (Greenwood, 2010). Heidegger's phenomenology placed emphasis on the dynamic and circular process of *Dasein*, which forms a 'hermeneutic circle' (Crotty, 1998 cited by Greenwood, 2010); the process of interpreting and understanding a phenomenon involves questioning, uncovering meaning, followed by further questioning.

IPA has emerged as distinct from other phenomenological methods, such as Giorgi's (2009) descriptive phenomenological analysis, where the researcher attempts to 'bracket' pre- conceptions and assumptions so that the data may be 'truly exploratory and participant- led' (Cassidy et al. 2011).

However in IPA, the researcher accepts that setting aside preconceptions isn't plausible, and so allows the story of the participant's experience to unfold in natural and unexpected directions (Smith and Osborn, 2008). This reflects the view of the researcher of this study, and is the primary divergence of Heidegger from Husserl, entailing the emergence of the interpretive role of the researcher in attempting to understand the participants experience. Heidegger combined his understanding of phenomenology with the theories of hermeneutics, positing that human existence is bound in the environment of the experiencer, in a world of

relationships, culture, language, people and things. (Cassidy et al. 2010)

Thus IPA understands lived experience as inextricably bound with the external world, including the social, cultural and historical perspectives of the participants (Eatough and Smith, 2008)

Smith (2004) refers to the ‘biographical presence’ of the researcher, as essential to understanding the data. Thus the role of the researcher becomes central as the 'double hermeneutic’ (Smith and Osborn, 2003) emerges. The outcome of IPA is a reflection of multiple layers of interpretation, with the researcher’s making sense of the participants meaning-making process (Cassidy et al. 2011).

Idiographic inquiry

The concept of creating ideographic research, which Malim *et al* (1992) considered as

addressing ‘the wholeness and uniqueness of the individual’ echoes what the researcher perceives to be the ideals of the therapy paradigm; IPA, like the therapeutic relationship, privileges the individual.

Smith et al. (2009) advocate small sample sizes to remain consistent with the idiographic approach, recommending three participants for studies undertaken by novice researchers, which was adhered to for the present study. Smith et al. (2009) regard their stepped process as a guideline only, but suggest that the researcher gather rich data, which can be collected from interviews, diaries or group discussions.

Smith and Osborn (2008) suggest that the exemplary method for collecting data is through the use of semi-structured interviews. This form of interview allows an flexible

approach whereby the interviewer is freer to pursue interesting areas that arise, and can follow the participant's interests; the respondent can introduce an issue the researcher had not thought of. The method of questioning advocated by Smith and Osborn is in some ways reminiscent of a therapy session. For example, Smith and Osborn (2008) suggest the researcher try to build a rapport with the participant, and to 'monitor the effect of the interview on the respondent'; being a novice researcher but having experience of using these techniques in her practice was a further reason this method was selected.

Smith and Osborn (2008) recommend using an audio-recording device to record the interview in the data collection phase, the recording is then transformed into a verbatim transcript. Though this process o transcription is lengthy, it allows the researcher to become intimately acquainted with the material to the depth that is required for IPA (Ibid).

Data is then analysed by coding the data. Text is coded for a variety of reasons; when something poignant or was of interest to the researcher, when the content reflected a convergence or divergence from another participant, and when the researcher had a sense that the text was conveying something of interest to the research question. The researcher attempts to understand each case as far as possible, before moving on to the next. (Ibid.). Each case is attempted to be understood within its own right, before a cross-case analysis is conducted and the codes are grouped into into superordinate themes, which are in turn grouped into master themes (Smith et al. 2009).

Unlike Giorgi's (2009) method, which focused solely on convergence, areas of divergence as are also highlighted. In this way, patterns emerge from the data from which can form an overarching theme, whilst each participant's experiences are grounded within their particular conditions (Cassidy et al. 2011). Thus IPA attempts to stay attuned the individual whilst also illustrating more general themes (Smith and Osborn, 2008).

Method

This chapter describes the step-by-step process the researcher undertook to conduct the research including the recruitment of participants, the interview process and data collection, and the data analysis. The researcher followed the guidelines set out by Smith and Osborn (2008).

Prior to commencing the research, the researcher created an ethics proposal which was submitted to the University of Brighton ethics committee. Once the ethics proposal was approved the researcher commenced the recruitment process.

Recruiting participants

A combination of purposive and convenience sampling to find three participants. The participant inclusion criteria were:

- A qualified counsellor or psychotherapist (BACP, UKCP or equivalent)
- Have a minimum of two years practice experience
- Have experience of working with client(s) who struggle with self-compassion and a desire to reflect on this experience.

A participant request document was drafted (see Appendix A). The participant request document was then was circulated by a group email list of two organisations at which the researcher had previously worked. This did not successfully yield any participants.

Following this the researcher compiled a list of therapists that she had previously had a professional relationship with and the participant request form was circulated by email. Three therapists responded, to which a further email containing the consent form (see Appendix B) and information sheet (see Appendix C) was sent.

A phone call was made to arrange time and location of the interview.

Data collection

The interviews took place at the private therapy rooms of the participants. Ninety minutes was allocated for the each interview. Approximately ten minutes was used at the beginning to explain the process and answer any questions regarding the information sheet, and for the participant to sign the consent form. A small audio recording device was set up in between the researcher and participant to record the interview. The interview lasted between fifty and sixty minutes. The interviewer was semi-structured, with a prompt sheet with questions for the researcher to open dialogue should it be needed (see Appendix D). The researcher took a passive stance during the interview in an attempt not to direct or divert the flow of the participant and allow material and content to emerge naturally. After the recorded interview fifteen minutes was allocated to debriefing the participant, and they were given a debriefing document (see Appendix E). The audio files were then downloaded onto the researchers computer where they were coded and password protected, and deleted from the recording device. Once the interviews had been conducted with all participants, the data was transcribed verbatim by the researcher, and then analysed. The details of the analysis are given in the next chapter.

Analysis

This chapter will begin by taking the reader through the progressive steps of the analysis, demonstrating how the master themes were generated from the raw data of the verbatim transcripts.

Coding

The coding process began by the transcripts being created from the audio recordings, during which preliminary notes were made regarding any thoughts that emerged believed to be a part of the interpretation; for example, particular moments of curiosity were noted, times where the tone of voice of the participant were engaging, and possible emerging themes. Each transcript was read through once sequentially, and further notes added. Each transcript was then re-read individually a number of times whilst parts were highlighted and coded.

A column was added to the right of the transcript to note the interpretation. Figure 1 gives an example of this process. (Please see Appendix G for the fully coded transcripts)

Figure 1: Transcript analysis example

P4 H1	My first reaction was well I think thats everybody	The struggle for self-compassion is present in most client work or is a

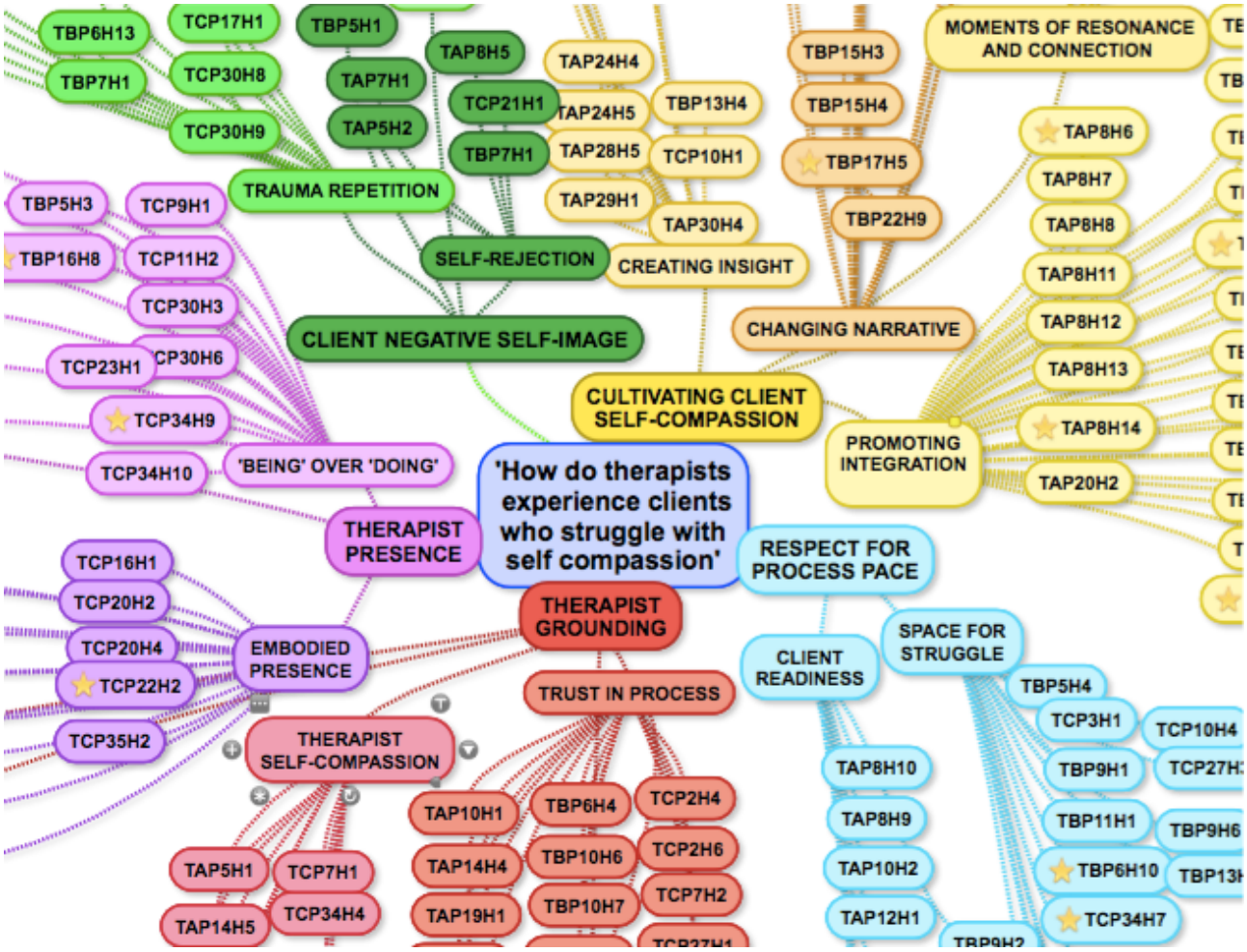
Grouping into themes

A cross-referencing code (left column of Figure 1) was utilised to create a mind-map of the codes which were grouped to create 'superordinate themes', using; 'T' followed by the letter A,B or C denoting the transcript it had originated from; 'P' followed by a number, denoting the section of text in which the participant is speaking; 'H' followed by a number denoting the section which was highlighted. For example the code in Figure 1 would be notated as 'TAP4H1'. Thus each code could be traced back to the text and interpretation. (A full key for the coded transcript can be found in Appendix F) This referencing system will be used in the Findings chapter.

Once these themes emerged, the transcripts were re-read a number of times and more codes were generated, creating a circular process of interpretation, which fed into these themes. The mind-map was completed using 'SimpleMind' (2017) software. Figure 2 illustrates

part of the completed mind-map (see Appendix H for the full mind-map).

Figure 2: Mind-map example



These 'superordinate themes' were then grouped together into ‘master themes’, which attempt represent a balanced account of individual accounts of the participants and the generalised themes which emerged, as encouraged by IPA (Smith and Osborn, 2008). Figure 3 shows a summary of the superordinate themes under their master theme groupings. The number to the right of each theme heading shows the number of codes found to relate to these themes. Overall 258 codes were found in all the transcripts, which emerged into 19 superordinate themes, from which 5 master themes were found.

Lastly, a table was created for each master theme showing what the researcher found to be a representative sample of text and code for each superordinate theme from each transcript. Figure 4 shows an example of this table (all tables can be found in Appendix I). These tables were utilised by the researcher to present the master themes found in the 'Findings' chapter, where the outcome of this analysis will be laid out in greater depth.

Figure 3: Superordinate themes and master themes

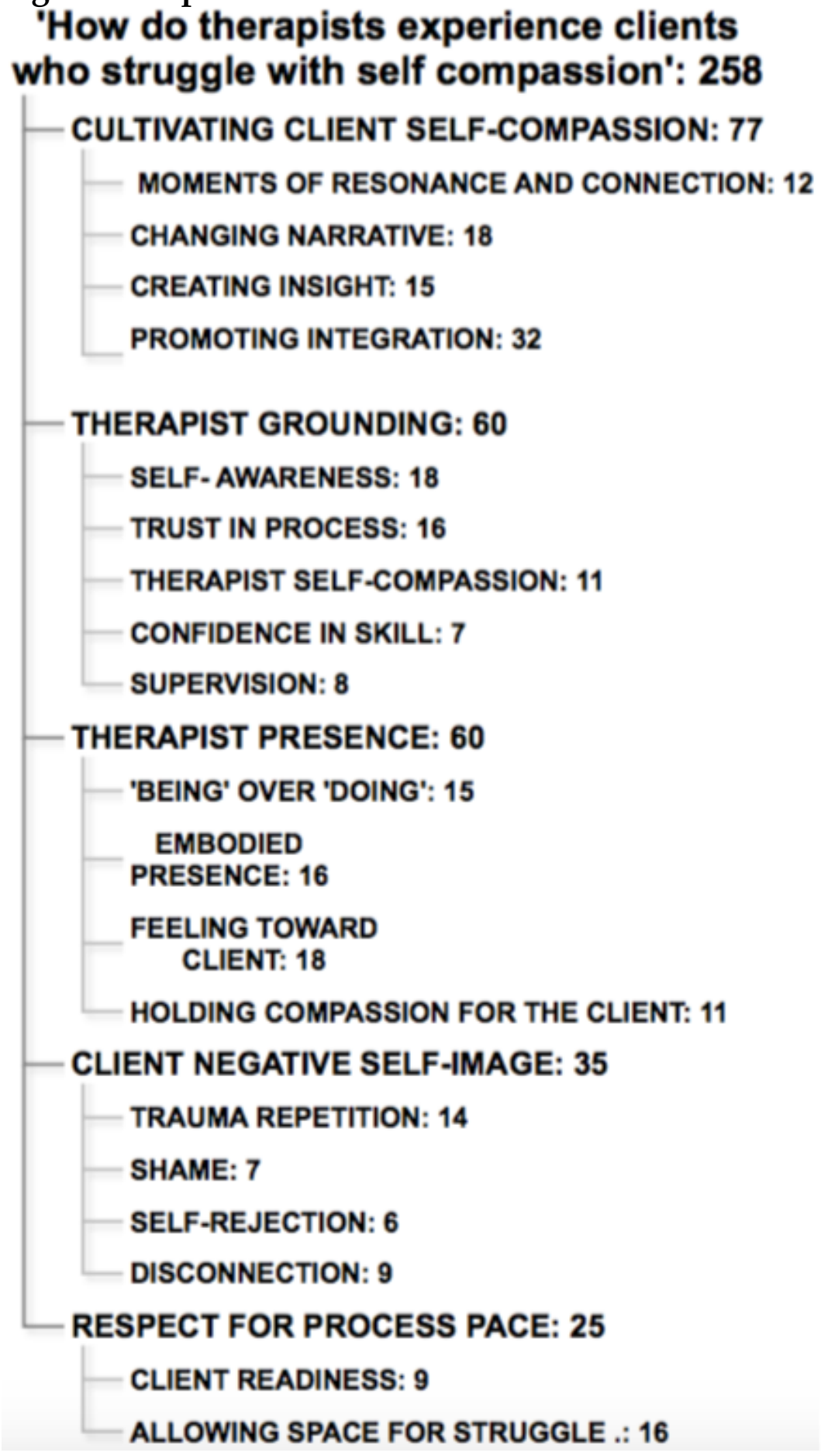


Figure 4: Table with transcript examples of themes

Master Theme: Respecting Process Pace			
Superordinate themes	Transcript A	Transcript B	Transcript C
Client readiness	P10H2 so they're getting to deep stuff really quickly they've both come wanting and ready	P10H4...even when you might gently direct them in that way they're not available to hear they're not ready to hear...they're just not	P2H5 i sense they're in touch with that quality in themselves and that then indicates that actually theres the
Allowing space for struggle	P27H1 he said he wasn't ready, i don't think im doing anything different	P6H10 hold that balance of being able to validate and offer a different perspective whilst also allowing them to be in the place that they're in	P34H7 the getting of the pain really fully and then theres the arising of that desire to help and then in that arising of the desire to !17

Findings

Now each master theme will be explored with its superordinate categories. From here each participant and their corresponding transcript will be referred to as '**A**', '**B**', and '**C**', with examples given from the transcripts which can be found in Appendix G to support each interpretation.

Therapist grounding

'it reinforces for me that the core conditions are sufficient, they're necessary and it's because they're there, that I think that this opening up happens' (TAP10H1)

The master theme of 'therapist grounding' emerged from superordinate themes that relate to the elements that lay in the *background* of the therapist's experience. These elements enhance the therapist's sense of themselves, both as a therapist; such as

'supervision', and as a person; such as an awareness of their own 'self-compassion'.

Self-awareness

All of the therapists described how coming back to their own experience was an important part of the process. For **A**, knowing herself in relationship with her own self-compassion corresponded to how 'deep' the client would be able to go with her. **A** went on to say that 'clients are empathic' (TAP16H2) and 'will only go as deep as the counsellor is ready to go' (TAP18H1).

B was active with self-awareness as a process, openly questioning himself during the interview; 'does that say, as much about my own difficulty in sitting with someone' (TBP8H3), he continually sought to understand how he was experiencing his time with the clients who struggle, showing self-awareness was an ongoing and circular process.

C took this further to acknowledge self-awareness to be a key part of his therapeutic technique; 'if theres something not quite happening with the client i'll kind of always look at myself first' (TCP4H1). Thus self-awareness was commandeered to gather information during times of stuckness. Much of the dialogue refers to the here-and-now experience of **C** during the interview, such as 'i caught myself checking out my own body...' (TCP19H3). The researcher noted that C was self-checking at various points throughout the interview, with several long silences, which prompted the researcher to then be more mindful of herself. With **B** and **C** it was possible for the researcher to experience self-awareness working as a parallel process, as a way to stay grounded and gather information.

Self-compassion

Working with with this client group had a positive influence on the therapist's self- compassion, at least within their professional role. **C** stated that he was 'kinder on myself as a therapist' (TCP7H1).

Equally, **A** reflected, 'its helping me to be more compassionate towards myself in sessions' (TAP14H5).

B was more reflective of his overall journey towards self-compassion, retelling this journey, from previously seeking outside validation, to the discovery that 'turning towards self love and self compassion that was gonna be the big game changer' (TBP6H8). **B** implies that it was this part of his experience that he returns to when trying to help clients who struggle with self-compassion.

A and **C** also speak about the 'ongoing journey' (TCP36H6), suggesting that the journey towards self-compassion might not have a end, acknowledging it as an ongoing process that they continue to grapple with (TAP16H3). The researcher was moved when **C** revealed 'i'd say generally my clients get better at it than i do' (TCP36H2) which was followed by a profound moment of silence. Equally, **A** admitted 'I think its still a struggle, to be compassionate towards myself, definitely' (TAP30H1).

The therapists are grounded in their own experience with self-compassion by recognising this shared human experience as having the natural consequence of generating empathy; **A** describes her struggle as 'a helpful reminder for what its like for my clients' (TAP30H1). **C** describes 'an endless layer of compassion' for his clients, equating it with his own experiences of the struggle with self-compassion; 'cause its my own very struggle' (TCP36H1). Like **A, C** uses his experience as a generator of compassion for the other.

Talking about the struggle was an emotive subject; the researcher noticed that these moments of admission provoked feeling of compassion towards the participants. Having the ability to articulate their journeys towards self-compassion, and how their roles as therapists have influenced this, demonstrates how working with this client group has had an impact on their personal process in this area.

Supervision

B and **C** spoke of supervision as being an essential tool for ensuring

they are working in a balanced way. **B** describes the process; 'it recalibrates me...' (TBP18H1), giving him the confidence that he is 'honouring my client by how I'm practicing' (TBP18H5). **C** describes how his supervisor helped him to clarify his role and his boundaries, when he realised by his actions that he had 'stepped out of my role as as a therapist and i'd turned myself into a helper' (TCP11H2).

While **B** and **C** described being challenged by their supervisor to stay on track, in contrast **A** described the more supportive element of supervision, saying of her relationship with her supervisor; 'that level of trust that i know he wont judge me, no matter what I've done or think I've done' (TAP23H7). **A** characterised the parallel process of self-compassion in the supervisory relationship' 'he doubts himself therefore its ok for me to still doubt myself' (TAP23H2) , and 'he explicitly models the compassion' (TAP23H7) saying that her supervisor shows compassion for her and for her clients (TAP23H6), showing how self-compassion is reinforced and filtered down from the supervisory relationship into the client-therapist relationship.

Trust in process

A felt grounded by the theory of her modality; 'it reinforces for me that the core conditions are sufficient...' (TAP10H1), and often referred back to this when if she began to feel lost with a client (TAP14H4).

Trust in the process developed from having experience of the process working; when experiencing feelings of fear when client is in a self-destructive and distressed state, **C** states 'i've kind of done it long enough now...somehow we've always connected' (TCP31H1). Thus, trust in the process helped the therapist to 'relax' into the process (TCP32H2).

There is an element of hope and optimism, which is based on a sense of faith in the process; for example when **B** speaks about a client who hadn't made progress in therapy, he ponders 'maybe i am just that stepping stone...one hopes that... they might derive

something positive from the experience even if it hasn't necessarily given them what the hoped for' (TBP10H6). The optimistic trust of the process is present in **C**'s assumption 'that we're self-healing' (TCP2H4) when describing the buddhist concept of 'Bodhichitta' (TCP2H3).

B says 'fear is good because it always keeps me in check' (P19H2); for **B**, negative emotions such as self-doubt are reframed into a positive part of the process. When working with clients struggling with self-compassion it appears that having trust in the theory, and believing that the work is beneficial for the client beyond what might be positivistically measured, is valuable, especially when negative emotions arise and the therapist is feeling lost, fearful, or stuck with the client.

Confidence in skill

During the interviews, the researcher noted a felt sense that the therapists all had a quiet confidence when talking about their work with clients. **A**'s level of confidence was alluded to in the form of 'courage' when describing how she would now make different therapeutic decisions, believing she was 'less courageous when I was less experienced' (TAP14H1), inferring that she now had the courage to challenge clients more.

A also noted abstractly that as a therapist 'develops as a counsellor then they're ok to go deeper' (TAP18H2). **A** brings this concept back to herself when describing her experience of assessing many clients within a domestic abuse service; she would often be the first person that a client has disclosed to (TAP14H3). This experience had helped A to realise 'the way I am is enough' (TAP14H3), entailing that there was something about her, that allowed the clients to go to deeper; 'how can they trust me so quickly it must be something to do with the way I am so thats given me the confidence' (TAP14H4).

C's reflects on mistakes he made as a developing therapist when describing struggles with clients from early in his career. When the researcher asked what he might have done differently from these

experiences, **C** notes how he 'reframed the idea weakness into a calling it a learning edge' (TCP7H2).

The therapists are able to reflect, compassionately, upon their time-line of development as they grew more experienced, witnessing their progression, from which this confidence in their skill emerges.

2. Therapist presence

'...both of us become very present to that moment the invitation is to be with their own sense of now' (TBP16H8)

The master theme of 'therapist presence' elucidates the more subtle, ethereal qualities that the therapist holds while in the room with the client who struggles with self-compassion. These are the implicit, non-verbal, and perhaps unconscious; feeling, sense, and emotional experiences of the therapist.

'Being' over 'Doing'

There was a quality of presence in the therapists and their work with clients in the nature of simply *being* together in the room, as opposed to *doing* something explicit. **A** expressed opposition to the idea of having to 'do' something, saying 'it doesn't have to be big clever stuff, doings' (TAP23H5). **C** combines the notion of 'being' with *presence* explicit as he describes a technique for when he notices the client experiencing 'discomfort' in which he asks the client to place a hand over the area of sensation and allows them to 'be' with themselves for up to ten minutes. During this process, **C** describes his role as 'just trying to be with them so whether thats holding them or holding the space...' (TCP30H3).

B echoes the quality of presence, noting how both himself and the client become 'present to that moment the invitation is to be with their own sense of now' (TBP16H8) when a bodily shift is felt for the client towards self-compassion. It could be that 'doing' repeats the pattern of distraction from pain, whilst 'being' demonstrates a 'willingness to be with it' (TCP26H2).

A and **C** suggest that being over doing as allowing more space for the client; **A** says 'the best sessions are the ones when i don't say anything or say hardly anything' (TAP24H1). When a client is stuck, **C** makes a habit of questioning 'am I going to respond this in a way that could actually restrict than open up the space...' (TCP34H9). This over-'doing' which arises in different forms, such as talking too much or moving into a helper role, may subtly demonstrate a lack of willingness in the therapist to be with the client's suffering, which the client senses.

Holding compassion for the client

A discusses how she believes compassion is felt in the relationship, claiming that clients are 'empathic' and pick up when she is 'also struggling with self-compassion', noting that this happens 'even though nothing is said' (TAP16H1/H2) . The emphasis on how holding compassion is a non-verbal process is echoed by **C** when he claims; 'my guess is about fifty percent of the time i don't word it at all' (TCP20H2). **C** elaborates on his internal process when the client is struggling; 'what i'm saying to myself is lets just try and make this space as compassionate and as warm as gentle as it can be' (TCP19H2). Thus for **A** and **C**, holding compassion in mind is important for it to be transferred and felt by the client.

B describes how he will 'have the compassion for my client when they can't have it for themselves' (TBP3H4) while **A** also agrees that some clients 'can't hold on to compassion for themselves' and suggests the role of the therapist is to 'model it towards ourselves' (TAP22H2). Both **A** and **B** are suggesting that when clients are at the stage of not being able to directly receive compassion, or hold onto it, the therapist can hold it on their behalf.

However, **C** notes that there can be pitfall to holding compassion for the client, warning that carrying too strong desire to 'help' can be detrimental. **C** recounts a time when he realised he was overstepping his role by becoming 'helper' (TCP11H2), which arose by his 'getting of the pain really fully' (TCP34H7). **B** also acknowledges this helping desire 'at times it can sort of draw me in

and make me want to fix it' (TBP6H9). This was noticed by the researcher in the feeling of a sad longing that arose sometimes when speaking to all the participants, but can be illustrated by a poignant moment especially with **B** when they revealed 'one of my dearest wishes would be at times if they could only see the gold that they are' (TBP6H2). It seems there is a fine line between holding compassion for the client and holding it too strongly, as left unchecked it might get cause the therapist to overstep boundaries and reduce the clients space.

Feelings towards client

The researcher felt that there was a sense of pride from **A** when she was talking about her clients who struggle with self-compassion. A described how her clients were putting effort into the work, emanating admiration and respect; 'she is so open to the work...both of these clients...its just incredible these two' (TAP8H9/H10). A similarly positive feeling was experienced during the interview with **B**, with more explicit feeling language used towards his clients; 'I feel really erm yeah have a huge amount of positive regard for them' (TBP2H5). **B** describes having an emotional response when his clients experience more self-compassion 'I often well up' (TBP16,H5), and he described feeling 'hugely privileged to bare witness' (TBP16H2). **A** had a similar story, recounting a moment when she had been visibly emotionally touched with the client, 'I had tears in my eyes' (TAP24H4). **A** felt it was important for the client to see that she was alongside and experiencing the emotions that the client was experiencing in the retelling of their painful moments as well as the positive ones.

Negative emotions towards the client were also experienced by therapists. For **B**; 'there are times when you feel just really sad i really really sad that someone doesn't see what you see in them' (TBP6H1) and describes feeling an 'element of powerlessness' (TBP10H5). **B** (TBP9H3) and **C** both described feelings of frustration when working with clients; 'with this client constantly i found it frustrating' (TCP4H2).

C talks about fear in the room, as he describes a 'surface of fear' and 'sea of compassion underneath that' (TCP19H1). Fear is mentioned later; 'i think it will always be scary i think if i found it anything less than scary i'd probably be in the wrong job' (TCP30H10). Similar to the theme of 'holding compassion for the client,' emotions other than compassion are held a by the therapist. Sometimes these are positive feelings such as pride, and compassion, other times sadness, frustration, and fear.

Embodied presence

The role of the therapist's awareness of their own body, and how this awareness is used in the sessions arose for all the therapists. When asked by the researcher what it feels like 'come back to being' , **A** gives an in depth response detailing her bodily-centred process, describing the sensation as 'it feels like I've got both feet solidly on the ground...i feel myself open up' (TAP17H1). This was essential for **A** to come back to her own sense of being whenever she began to become 'screwed up' or 'tense' with a client or judge herself during sessions.

B also had an embodied presence, often using language relating to his sensations. **B** referred to 'knowing where somebody is in their body' (TBP14H1) and described progressing with a client who had previously felt disconnected from her needs; 'we'd landed it felt like we'd dropped into something deeper that she'd almost become more embodied' (TBP13H9) as she became more compassionate towards those needs. For **B** 'a strong element of the work is about people being embodied in their own sense of self' (TBP13H10). **B** described this element in his practice in the way he facilitates the client to move towards understanding what how self-compassion feels in their body; he helps the client to 'grasp that sense of feeling of a knowing self...the invitation is to feel it in their body and then it and then to spread it through every part of their being so that they really embody it' (TBP14H6).

C uses awareness of his body as a way to gather information on what the client might be experiencing; 'i can just feel quite a strong

activation in the body that tells me that theres likelihood is theres a very strong activation in their body' (TCP35H2).

C felt that the body was essential for the client to fully 'get' self-compassion, 'it has to be done in the body...thats a kind of a metaphor for the heart' TCP22H2). The researcher noted the **C** practiced the mind-body connection actively during the interview, taking time to answer questions by often 'checking in' with his own body.

3. Cultivating Client Self-Compassion

'now she's thinking, I wouldn't be who I am today if that hadn't happened to me' (TAP8H12)

The therapists explore the different ways they facilitate the cultivation of self-compassion through the therapy process. This theme explores how the therapists experience the client's changing relationship with the self during this cultivation, and what the moments of realisation are like when more self-compassion begins to emerge for the client.

Promoting integration

All the therapists used language such as 'parts', inferring the clients have several different and potentially opposing aspects that they work with. **A** demonstrated the use of a Russian doll, an analogy which she had used with several clients, taking the doll apart, displaying the different dolls or 'parts' inside, before putting it back together for the researcher. **A** described how 'without those bits inside you see your empty theres nothing...but they're all they all have to be there to be part of you' (TAP8H6). **A** describes the client who, after an suffering abuse, worked hard in the sessions to begin to accept that part of their life; 'what happened to me is a part of me its who I its part of who I am now' (TAP8H11). **A** expresses a reverence for this clients work towards self-compassion in accepting this part.; 'that awfulness..., how can she love that, and she really wants to I think be able to love all of herself, even the bits

she doesn't like' (TAP8H14), **B** also speaks about integration throughout the interview, believing its a key part of his role to encourage integration; 'my work which is all about connecting oneself to one self' (TBP8H5). B sums this up; 'seeing the value that that someone brings into the world when they can I suppose integrate all the bad and good stuff'.

C terms integration as 'reclaiming parts of ourselves' (TCP21H7). **B** and **C** also talk about 'turning towards' (TCP28H1) as opposed to rejecting the self, especially the parts in pain or suffering, which is in essence, the very definition of compassion.

C alludes that how he promotes integration in his practice is by encouraging the 'witness' of the client, making a distinction between the 'part who's witnessing and the part who's experiencing'(TCP16H2). He encourages the client to 'remain both the person...who's having that experience ...but also be aware that they're also the person who's witnessing this who stand back and observing it' (TCP16H1) as a a way to turn towards and integrate painful experiences.

Creating insight and Changing narrative

These two themes have been placed together, although they concern different phenomena, because they occur in close succession, with the moment of insight often leading to a change in the client's narrative. The creation of insight is when the therapists spoke about their experiences of the distinct *moment* when the client gains a new insight about themselves. As a result of these moments of insight, the opportunity for a different narrative emerges which is more self-compassionate.

A describes work with a clients who, despite giving narratives of distressing events, they would still 'beat themselves up' for their responses and lack compassion. **A** notices this process to the client, and describes the response; 'they seem surprised that I notice' (TAP5H3). **A** talks about a client who was also training to be a therapist; 'she said i learnt what empathy is from you' (TAP24H3)

and goes into greater depth of the moment of insight; ‘she saw my face that was when she realised that what had happened to her was actually something huge’ (TAP24H4).There is something in the moment of realisation, of ‘surprise’, mentioned again (TAP7H4) that becomes visible for **A** in the client’s expression that shows a moment of insight has occurred.

B retells a moment when working with a client; ‘it just was such revelation to her’ (TBP13H3), describing the moment of revelation as ‘what felt really poignant for me and i think for her was the re recognition that that doom and gloom was actually a friend’ (TBP13H4); this is when the moment of revelation becomes a change in the clients narrative, with this previously rejected part of ‘doom and gloom’ her becoming accepted and integrated. **B** focuses on his role in offering the client a different narrative, describing how he will play a ‘devils advocate’ in order to ‘reframe' the experience of the client (TBP5H6). **B** claims he draws upon the ‘inherently curious’ (TBP15H1) nature of the inner child to help with this process; ‘we get curious, and through curiosity....ooh oh that happened’ (TBP22H9). For **B** this changing of narrative takes place by ‘giving them...an understanding of what its what it was probably like for them as a child’ (TBP12H7) and from the example above, the client then came to recognise how ‘vulnerable’ and ‘untooled she was to deal with that situation’ (TBP13H12). This then became a ‘real understanding and a real compassion’(TBP13H6) for the client.

B presents an analogy of how he views the work of insight and narrative; ‘we’re panning for gold’ (TBP6H3). The researcher felt this was a powerful analogy of the process; developing a more self-compassion view entails seeking out new meaning which will be more valuable for the client amongst many less useful interpretations.

Moments of resonance and connection

The therapists described feeling emotional connection with their clients which can form a peak moment of relational depth, when

there is insight, deep connection, or resonance with the client. **A** recounted this as a 'look on peoples faces' (TAP8H7) during times when a client finds insight, describing these as 'incredibly powerful' (TAP25H1) experiences. There is an enthusiasm that **A** has for her work when the client begins to embrace self- compassion, as she exclaims 'yes this is what its all about!'(TAP25H3).

B also spoke about these felt shift moments as an 'incredibly moving and energising experience in the room' (TBP14H7), which had a 'hugely gratifying...and very emotional' (TBP16H1) quality. Although these moments of deep connection and emotion might be a form of gratification for the therapists, providing a incentive to do this kind of therapy work, **B** explains that the client also benefits when the therapist is deeply moved; 'an important element of of being moved... and letting someone see that you are moved by their process' (TBP16H6). **A** notes a similar moment when a client sees how they impacted her when she was moved to tears by their process, the client 'realised that she'd been really seen' (TAP25H2) in a place that they hadn't previously connected to.

C also details a 'powerful form' of 'compassion in action' describing times when he is sitting with a client 'just being with themselves' in silence (TCP23H1). The researcher experienced a sense of veneration of **C** towards their clients in this process. **C** also describes 'a sort of softening that goes on in the body' (TCP30H1) when they witness the client turning towards self-compassion while **B** further describes these experiences as a becoming 'very present to that moment' (TBP16H8). It seems to be a pleasant experience for the therapist, a softening, or becoming more present, when they witness the client being self-compassionate.

However whilst **A** and **B** speak about the lighter side of fully resonating with clients, **C** recalls the difficulty of being pulled out of shape by feeling a close connection with the clients negative experiences; 'one gets the pain, so kind of fully' (TCP34H6). Thus these moments of resonance can be both in the positive or negative, but in both cases feel like they are powerful.

4. Client negative self-image

'his hatred of the dark side of him, his fear that there was a bit of him that was like his Dad' (TAP8H5)

This was one of two smaller master themes which began to emerge, however fewer codes fell into these themes, so this as well as the 'client negative self-image' master theme will be covered in less detail compared to previous themes.

Shame and self-rejection

The therapists describe aspects that arise consistently for their clients who struggle with self-compassion, which arise from shame being 'in the field' (TCP15H2). **C** refers to shame from the Buddhist perspective as a 'near-enemy of compassion' (TCP15H2), that is, shame is often considered the opposite of self-compassion or at least a big hinderance to it. **A** commented on a client, speaking about his childhood admiration of his violent father; 'What he has identified is the shame' (TAP10H6), The response of **A**'s client above can be seen as a 'push away' (TCP21H1), or rejection of part of the self; 'his hatred of the dark side of him, his fear that there was a bit of him that was like his Dad'(TAP8H5). **B** similarly describes a client who feels ashamed of their needs (TBP6H14) who rejects this part of herself; 'very low self esteem... a very limited sense of self...super critical and harsh on herself' (TBP5H1).

Disconnection

The shame leads to a rejection of part of the clients self, which is noticed by the therapists as a disconnection. **B** describes the disconnection between the 'need' and 'desire' of the client 'for their life to be better' but they 'struggle with the idea of how that can really be' and the client is 'not available to hear' (TBP10H4). **A** touched on this idea of the client disconnecting from their needs, recalling an experience when the client said they were tired in the session, she decided to challenge him about this, reasoning that had she let it go, she would have been then 'giving him permission not

to meet his own needs' (TAP13H1). **A** noticed the process of disconnection that was happening underneath the clients reluctance; 'its you saying some part of you saying don't do this we're getting too close'(TAP13H1). These examples illustrate the ambivalence that sometimes drives clients who struggle with self-compassion. Alongside the desire to do the work and to change, **A** and **B** recognised the part of their client that was not available, or that is afraid of them getting too close, and this polarity is felt as a sense of disconnection by the therapist, with **A** using her role to bring this into awareness for the client.

Disconnection also has a more physical dimension as in working with this client group, as **C** talks about disconnection from the body-mind paradigm, describing his experiences 'where clients are so completely in their minds they cant access their bodies' (TCP22H1) and how difficult the working towards self-compassion can be with clients who struggle with embodiment 'it gets really tricky when clients just absolutely cut off from feeling anything' (TCP22H3).

Trauma repetition

C explains the manifestation of repetition as a way to 'protect against those feelings' which become 'trapped trauma' (TCP17H1). Trauma shapes future relationships for the client, including the relationship with the therapist, which reinforces the struggle with self- compassion. **A** gave an example of a client who was 'continually reinforcing or repeating the pattern of, i get abused, because I'm not worthy' (TAP21H3) and explains the importance of her maintaining boundaries when a client kept pushing them because the client 'was so desperate for us to repeat the patterns of her abuse' (TAP20H1). **A** explains her own role in this repetition; 'we've got to help them to move out of that circle because in that circle the patterns are repeated over and over again' (TAP21H2).

B describes a client not allowing herself to have needs. By not having needs met when younger, they 'resent this child having needs' (TBP6H13) in the present. Hence, the therapists experienced

this phenomena, albeit in quite different ways, that reflect the individual and unique natures of each clients trauma.

5.. Respecting process pace

'hold that balance of being able to validate and offer a different perspective whilst also allowing them to be in the place that they're in' (TBP6H10)

Allowing space for struggle

Therapists attempted to hold an neutral position quality of acceptance as to where the clients were in their journey, by allowing space for the struggle with self-compassion. **B** talks about holding a 'balance' between being able to 'offer a different perspective' whist also 'allowing them to be in the place their in' (TBP6H10).

C notes that the 'desire to help' can result in a 'shrinking of the clients space' (TCP34H7), and uses a metaphor of moving from his 'front foot' to 'sitting back' to allow space when he notes that he might be pushing the client (TCP34H9). There is a sense that the struggle is as important as finding resolution, and the therapists are aiming to honour that, by letting the client come to self-compassion at their own pace.

Client readiness

When recognising a lack of progress with some clients, therapists compared some clients as being more or less ready than others. **A** talks about two clients who she attributed their getting to 'deep stuff really quickly' to them both having come 'wanting and ready' (TAP10H2). **B** speaks about the converse when he describes clients who have the 'need and the desire' for 'their life to get better' but the client is 'not available' and 'not ready' to hear (TB10H4).

Part of the therapists expression of self-compassion towards themselves is allowing that much of what happens in the room isn't down to them or their skills as a therapist. Sometimes they may work hard with a client and they don't connect, the client doesn't

get what they came for. This ties in with having a trust in the process, that sometimes the therapist is a 'stepping stone' (TBP10H6). Allowing that successful outcomes in therapy may be more to do with the client being ready or unready for change takes a weight off the therapists when things don't progress.

Discussion

In this chapter the researcher will discuss the implications of the findings of the study, beginning by reflecting on the how the findings relate to the extant literature on self- compassion identified in the 'theory' chapter. The research will be evaluated; firstly, by examining issues that arose for the researcher specific to the method used in this study, secondly, with regards to general methodological issues of IPA, and lastly, by considering the status of these finding and their contribution to theory. The researcher will give recommendation for further research, and give a personal reflection on their experience of conducting this research.

Contextualising findings in the extant literature

Findings from this study that converge with findings from other literature, emerged in the master theme of 'therapist grounding'; the background elements that the therapists relied upon when working with clients who struggle with self-compassion. The concern around 'compassion fatigue' and its links with work-related stress (Sinclair et al., 2017) has led to this becoming a well-researched phenomena. Research in the field of compassion and therapist self-care (Patsiopoulos and Buchanan, 2011), and other-focused concern (Boellinghaus et al. 2014) has been affirmed by the present study in demonstrating the importance for therapists having a relationship with their supervisor, which is not only challenging, but supportive, non-judgmental, and compassionate, so that self-compassion in the therapist is strengthened and filtered down from the supervisory relationship into the client-therapist relationship. This supports the findings of Vivino et al. (2009) that

therapists experienced compassion from mentors and teachers as well as friends or their own therapists, which they felt allowed them to be more compassionate towards their clients.

Boellingaus et al. (2014) suggests that given significant rates of psychological distress in practicing psychological therapists, there is a need to cultivate self-care and compassion during therapy training. However the findings of this study suggest that self-compassion is an ongoing process for the therapists and one that would benefit from being consistently revisited, in addition to being implemented in trainings.

The superordinate themes of 'self-awareness' and 'self-compassion' showed that the therapists awareness of their own suffering and compassion helped them to resonate with the the client's experience. Kohut (1977) described this as 'vicarious introspection'. This idea is supported by Boellingaus et al. (2014) who showed that self-compassion helps to support more other-focused concern.

This may be especially important in working with clients who struggle with self- compassion, as part of the 'therapists presence' entails 'holding compassion for the client' whilst the client is unable to hold it for themselves. Lawrence and Lee (2014) found that a common experience amongst clients as they first began focusing on self-compassion was in fact a paradoxical increase in fear and self-criticism before they were able to gain the benefits of increased self-compassion. One of the therapists in the present study acknowledged this element of fear, which has not been recognised in previous studies (Lawrence and Lee, 2014). The therapist being able to hold and model compassion for the client in the presence of fear, as the client is first turning towards self-compassion, and acknowledging the courage this takes for both the client and the therapist, is worth bringing to light.

Vivino et al. (2009) found that therapists felt compassion for their clients when they could identify with the clients suffering. However, the present study shows that this needs to be carefully balanced, as the therapists recognised their desire to become

'helpers', which sometimes got in the way of the process, when they had over-identified with the clients pain. Vivano et al. note that therapists-in-training often struggle to allow clients to experience pain, or challenge clients to change. The therapists in this study acknowledged these as issues they had overcome as they had become more experienced; this is expressed in the findings as the theme of 'allowing space for struggle' as well as 'confidence in skill' with one of the therapists relating the courage they now felt to challenge their client when they previously wouldn't have. While these are areas that seem to come with experience, they could be used to think about an emphasis for trainee therapists; helping them to understand more fully that the struggle is a valuable part of the process.

The findings of this study of 'client readiness' also reflected Vivino et al. (2009)'s findings on factors that facilitated or hindered therapist feelings of compassion towards a client. Vivino et al. found client involvement in the therapy process to be beneficial towards therapists readily feeling compassion, whilst client defensiveness or lack of involvement was problematic. The researcher proposes the theme of 'respecting process pace' to be beneficial in understanding these feelings, the therapist can hold onto the idea 'client readiness' as being an important factor to help the therapist understand and accept both positive and negative outcomes of therapy as sometimes being independent of their skill and beyond their control.

There was one concept of this study that emerged from the therapists experiences that has been only briefly touched on by other studies (Lawrence and Lee, 2014; Vivano et al. 2009) that the researcher proposes could be emphasised for any future conceptualisation of self- compassion. That is, that the nature of compassion and self-compassion has an embodied quality, and represents a feeling or emotion. There was an emphasis during the therapist's stories on non-verbal relating of compassion between themselves and the client, and the role of the body in understanding self-compassion.

Lawrence and Lee (2014) found that this was echoed in client experiences with CFT, that despite the client being able to logically understanding compassion, it wasn't until self- compassion was *felt* that 'switch on' moments occurred, that the client could have positive affective responses to self-compassion.

These 'switch on' moments were found in the present study, to be powerful experiences that were felt by the therapists as 'moments of resonance and connection'. These experiences were felt as affirming of the process, and motivational for the therapist.
From this, the researcher has come to agree with Vivano et al.'s (2009) summation that compassion is a distinct from empathy, when they describe compassion to be 'broader and deeper than empathy in that it allows a deeper engagement'. The researcher suggests, from the experience of interviewing the therapists in the study, that in addition to being deeper and allowing deeper engagement, an essential quality of compassion is that it is most fully experienced and engaged with in an embodied, feeling, way. This supports what many contemporary therapeutic approaches to compassion, such as CFT and MSC, are working towards; the inclusion of mindfulness based interventions which privilege the body more than perhaps other more narrative and cognitive based models. It also has implications for how future research might be conducted, so that it takes into account the embodied dimension of self-compassion.

Evaluation of the study

One of the biggest issues the researcher experienced was understanding how to move from a descriptive analysis of the data to an interpretative one.
Pringle et al. (2011) cites how Smith et al. (2009) encourages researchers to 'go beyond' the apparent content and narrative of participants. This interpretative element is what, Smith et al. (2009) claims, moves it beyond descriptive phenomenological methods such as Giorgi's (2009) method. However, IPA also requires the findings to be firmly anchored in direct quotes from participants

accounts (Smith et al. 2009). The researcher found that giving enough interpretation, whilst staying close to the data was challenging to balance. On one hand, holding too closely to the data made the themes too broad and didn't take into account the influence of the researcher on the data. On the other, there are questions as to whether IPA can accurately capture the experiences and meanings of experiences rather than opinions of it (Touffer, 2017). By moving away from the data the researcher may start to give opinions based more on their own experiences and world-view than the 'lived experience' of the participants.

The accusation that IPA is mostly descriptive and not sufficiently interpretative is a common critique (Larkin et al. 2006, Brocki and Wearden, 2006). However, as Tuffour (2017) points out, a large quantity of publications that outline the methodological and philosophical underpinnings of IPA has emerged which provide clarification. The researcher agrees that Smith et al's (2009) steps are inherently interpretative; it isn't possible for the findings to be presented in a format of a few thousand words selected from transcripts containing over 25,000, without some interpretation of the researcher occurring in the process of choosing what parts of the participants accounts to use and how to group them into themes. As Pringle et al. (2011) notes 'it is arguable whether it is possible to describe something without adding an interpretation at the same time'.

IPA is deceptive in its apparent simplicity. For the novice researcher, IPA may initially look like a suitable method, requiring fewer participants compared with grounded theory, which tends to use larger sample numbers to substantiate theory (Barbour 2007), and requiring less time intensive immersion than Moustskas's (1990) heuristic method, which requires an undefined amount of time for stages such immersion and incubation. IPA is appealing for a small scale study with limited time and resources. However, Pringle et al. (2011) argues that to fully grasp capturing the balance of the interpretative element, one must have a good grasp on the philosophy before undertaking IPA. The researcher submits that

IPA, for the interpretation to be carried out as intended, is likely beyond the scope of a novice researcher, or is a method for those with a deep interest in the underlying philosophy.

Smith *et al.* (2009) advises researchers to find a sample that is 'fairly homogenous'. One question that arose for the researcher was whether themes emerged due to the phenomena being explored, or whether other similarities between the participants were more influential when convergence occurred in the data. The most notable commonality of the participants was that their frameworks for practice were primarily humanistic, as was the modality of the researcher. This may have had some benefits for the study; the researcher used similar terminology and language as the participants. A central criticism of IPA is it's unsatisfactory recognition of the integral role of language (Tuffour, 2017). Further, IPA is said to work best under the prerequisite assumption that both the participants and researchers have the necessary eloquence to communicate the nuances of experiences (Ibid). In the field of therapy, one could argue that these nuances are well taken into account as part of the daily practice of therapists, and that they would, hopefully, have these skills, making it a non-issue, and thus IPA quite suitable for research in the psychotherapy field.

However the participants and researcher sharing a specialist language may have been problematic; some themes could have derived from the application of the shared modality, instead of the participants experiences with clients. For example **C**, discussed a theoretical take on self-compassion as a subject, but was reluctant to talk about specific client case studies. **A** mentioned clients that she felt the work was going *well* with, so there was less of a sense of struggle, which was the aim of focus on for the question. It could be that the participants were not adequately directed during the interview towards their own experience and away from theory. However, IPA favours an open and less directive approach to interview technique (Smith and osborn, 2008).

Additionally, the researcher had a previous professional relationship with all of the participants, having attended training with two and been in a supervision group with the other. This may have had both useful and deleterious effects. Rapport was built easily in the interview, and the therapists were like to be more open about their experiences. However having some previously shared learning experiences, in addition to belonging to the same modality, the knowledge acquired from the interviews may have been circular. There is the danger that the researcher was uncovering knowledge that was already known, rather than expanding the upon the understanding of the phenomena at question.

This is made more problematic as IPA is trying to give an ideographic account of each participant, and yet the themes that emerged seem more generalisable, or perhaps more useful, to those who practice from a humanistic stance.

It is difficult to balance Smith et al's (2009) intention of suggesting a small homogeneous sample which 'represent a perspective, rather than a population' with the concept of the ideographic inquiry. A contradiction arises if the study is trying to be ideographic, broad generalisations between participants may not be feasible. This can make it difficult to establish which variables are important (Pringle et al., 2011). The researcher experienced this difficulty, as the final two themes didn't fully emerge. There is ambiguity as to the number of participants that would be useful in such as study. Smith et al (2009) recommend three participants for the novice researcher, and due to the small scale nature of the research with time and person resource limitations the researcher this number was chosen. The dilemma became that while more participants may have helped the themes fully emerge, fewer numbers allows for a richer depth of analysis that might be inhibited with a larger sample (Pringle et al, 2011).

A further issue that arose regards the inconsistency between the researchers understanding of lived experience, and the IPA method outlined by Smith and Osborn (2008) reliance on interpreting text

data. Finlay and Ballinger (2006) suggest that IPA focuses on the individuals 'cognitive, linguistic, affective and physical being;, yet by using a method of transcription, therefore removing the researcher from the verbal cues of a tape recording, and equally, the visual cues of body language, diminished the researchers understanding of the affective and physical dimensions of the participants experiences. It was difficult for the researcher to recall what had felt like important cues in the room when analysing the data without visual or auditory prompts. This is a flaw of a research design that relies on the interpretation of communication when a large part of communication is non-verbal (Mehrabian, 1972). This is compounded if it is believed, as the researcher does, that a large part of the phenomena of compassion and self-compassion is also non-verbal. While Smith et al. (2009) described the approach of IPA as a stepped method, they also acknowledges that these are only guidelines and are open to adaptation. Acknowledging this flexibility was useful for the researcher in the ability to use mind-mapping software, in order to group codes, suiting their learning style better than traditional methods. However, the flexibility permitted within IPA could be utilised further. Future explorations of the phenomena of self-compassion could include using an interview method where notes are made during the interview, which may have helped the researcher recall more the feeling in the room; or using a video recording of the participants to refer to while analysing the text to give visual information and keep the experience 'alive' during the analysis.

Taking this further, it is questionable whether portraying the findings in a text format can sufficiently express a phenomena such as self-compassion when, as discovered in this study, an important dimension of self-compassion lay in it being an embodied, feeling experience as much as a cognitive one. As Tuffour (2017) acknowledges 'IPA's concern with cognition exposes it to criticism, because some aspects of phenomenology are not compatible with cognition'. In addition, the participant's and researcher's modality also places emphasis on the role of the body in therapy, reinforcing

the idea that cognition is a small part of understanding lived experience. Thus, restricting findings to writing on a page is too limiting to fully represent the depth of lived experience. Other research methods such as 'mindful enquiry' (Bentz and Shapiro, 1998) might be more suitable for a more mind-body sensitive enquiry into self-compassion, whilst master themes could also be better expressed via other creative conduits, such as pictures, music, poetry or other forms, which a more a heuristic exploration would allow (Moustakas, 1990).

Status of the findings

Qualitative studies such as IPA run countercultural to the traditional medical paradigm used in much contemporary healthcare research, which holds a positivistic view of truth and favours quantitative studies like Randomised Control Trial's, the aim of which is to take generalised knowledge to apply to the individual. Referring back to the dilemma of ideography versus generalisability, we must question what the aim of the qualitative study is; if we assume that qualitative studies aim for the converse of quantitative studies, and try to build from the individual to the general, things become problematic. This is a common misconception, but IPA aims to do something else. One way to describe the aims of IPA is by using Stephens (1982) distinction between horizontal generalisability and vertical generalisability; horizontal generalisability concerns findings that are applicable across multiple settings, while vertical generalisability is concerned with building interpretative theory (Cassidy et al. 2011). Thus findings from IPA should be considered in terms of their ability to supplement understanding and increase insight (Cassidy, et al. 2011). Smith *et al.* (2009) suggest that researchers in IPA think in terms of 'theoretical transferability rather than empirical generalisability'. Cadwell (2008) proposes the idea of 'theoretical dialogue', that findings can influence and contribute by opening dialogue. Green and Britten (1998) suggest that the value of IPA is that the findings are attuned to issues that could be usefully explored in practice. Perhaps, like the undertaking of therapy itself,

one has to explore the world of IPA and other idiographic methodologies to understand their value; as such, the final part of this discussion will reflect what the researcher feels to have been personally learnt by conducting this research.

This might be one way to measure the value that this kind of qualitative study has in the current climate of research practices, though it comes across as a little vague, and like the studies themselves, down to the individual. Furthermore, while value may be determined by some of the above ideas, the rigour or quality of a study may still be questionable. Greenwood (2010) discusses the idea of influence, using Freud's case studies as an example of how idiographic research can be highly influential. But the problem arises then that a piece of qualitative research could be highly influential, while the researcher could be at best biased, at worst dishonest, the method inconsistent and the findings misleading, just as Freud cases have been critiqued (Crews, 1998). The negative impact of false positive findings shouldn't be underestimated; once results become accepted theory, many resources of time and money can be wasted in their pursuit, whilst it takes longer to disprove a theory than to establish it (Loannidis, 2005)

Smith *et al.* (2009) advocated external audit as a way to enhance rigour; the nature of this study as being part of an academic assessment process may have influenced this studies rigour. Yardley (2000) proposes a more structured assessment of quality within qualitative studies regarding four principles; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Bringing Yardley's (2000) principles into context with the current study, Shinebourne (2011) suggests that sensitivity to context is inherent in the choice of IPA, with its idiographic principles and the researcher recruiting participants from a particular context. Smith et al. (2009) contends that sensitivity is present throughout all the stages of IPA, from careful gathering of data, to grounding the interpretations of participants' accounts in verbatim extracts, to

contextualising the report in extant literature. Commitment and rigour has been established by a depth of analysis of the data that requires considerable time and immersion in the data. Transparency is shown through the elucidation of the step-by-step process to towards finding the data, whilst the raw transcript data is available in the appendices should the reader choose to refer to them. The researcher has struggled with coherence; finding it challenging to fully reduce the superordinate themes into coherent master themes. Further, while the methodology of IPA fits with the researchers stance on the knowledge and truth, the emphasis on the use of verbal communication and language does not, missing the physical and embodied truths of experience. In terms of impact and importance, the present study is likely to have limited impact on others; it is unlikely to be published, however the researcher felt the research overall a worthwhile undertaking for their professional development, and the therapists who took part unanimously expressed a positive experience from having participated.

However, this study is the first IPA study, to the researchers knowledge, to explore experience from the point of view of the therapist in working with clients who struggle with self-compassion. The findings supports many findings of the Vivino et al. (2009) study and provides an alternative perspective to the Lawrence and Lee (2014) study. In addition, the area of research of self-compassion overall is a relatively new, but rapidly growing area in the field of therapy, and has a promising outlook for pragmatically contributing to how therapists practice (Kirby et al, 2017).

Further research

This research has shed light on several areas of interest for future research, especially in reflecting on some of the issues that arose as part of using the IPA method to explore therapists experiences of clients who struggle with self-compassion.

The current study could be replicated, but the method altered to take into account some of the difficulties experienced by the

researcher. Firstly, more participants could be invited to take part; whilst using IPA a maximum of three more would be recommended to maintain the richness and depth of the analysis. In addition, the participants could be selected to represent alternative modalities, and would ideally not have had a previous relationship with the researcher.

More than one method of data collection, such as diaries or group discussions in addition to interviews, could be used to provide triangulation 'within method' as suggested by Casey and Murphy (2009).

Using video recordings of the participants instead of audio recordings, and referring back to these during analysis may provide an extra layer of insight and interpretation, keeping the data more 'alive' rather than relying on recall. These changes and additions to the current research might enhance findings, improve the completeness of the data and create higher quality research.

Alternative methodologies which might be more suitable to the study of self- compassion, which allow an alternative expression of findings that could convey the more embodied and non-verbal qualities of the phenomena might be Moustaka's (1990) heuristic enquiry, or a mindful enquiry (Bentz and Shapiro, 1998)

The current study brought out superordinate themes of 'holding compassion for the client' and 'feelings toward the client'. Considering the valid concern of the healthcare community about compassion fatigue (Sinclair et al. 2017), this may be a useful line of enquiry to continue. Whilst this study found that the therapists felt there is some value in holding compassion for the client, it would be interesting to gain an understanding of therapist's experiences when they are unable to hold compassion for the client.

Personal reflections

I have changed from the third person expression to the first person in order to concisely convey my personal reflections on how

conducting this study has contributed to my own practice. With impact and importance being a measure of the quality of research proposed by Yardley (2000), I felt it important to reflect on my experience in conducting this study

Firstly, I have learnt something of the process of conducting small scale research using IPA, and its place and importance within the therapy world. It is hoped that this will help me to be more discerning and critical in my understanding of research literature that I read in the future, as well as laying a foundation for any future research I undertake.

My experience of this research has prompted me to evaluate not only my own relationship with self-compassion, but has given me a greater enthusiasm for its potential to be part of a solution in what is a ubiquitous and endemic issue in Western culture. Outside of the realm of recently developed therapies that have been specifically designed around promoting compassion, self-compassion is brought into mainstream theoretical frameworks far less than concepts like empathy, self-acceptance or self-esteem, and I believe this needs updating to account for the current research.

The most notable change I have made to my practice as a therapist, is to draw attention to self-compassion by talking about it with other healthcare professionals. It has been my experience, during the interviews with the therapists in this study, and in the conversations since, that inviting self-compassion into awareness by the act of speaking about it, can be a powerful avenue to ignite and deepen my relationship with self- compassion. Given the often emotionally challenging nature of the therapy profession, perhaps this is something that many therapists could use a little more of.

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