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Practitioner Report

An Exploration of People's Experiences of Compassion-focused Therapy for Trauma, Using Interpretative Phenomenological Analysis

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Self-compassion enhances psychological well-being, and compassion-focused therapy aims to alleviate psychological distress by fostering its development. The experience of becoming self-compassionate for people with complex mental health difficulties has not been analysed in the literature, despite clinical observations that this process is difficult. This study explored the process of becoming self-compassionate for people with posttraumatic stress disorder, using interpretative phenomenological analysis.
Semi-structured interviews were conducted with seven participants. Five superordinate themes emerged from the data including: (1) the battle to give up the inner critic: who am I if I am not self-critical?; (2) an aversive and alien experience: how it feels to develop self-compassion; (3) the emotional experience of therapy; (4) self-compassion as a positive emotional experience; and (5) a more positive outlook in the present and for the future. Self-criticism formed an important part of the participants' self-identity, and they experienced an initially aversive emotional response to self-compassion, describing it as a completely new experience and one to be feared. Despite this, they were able to persist with therapy and subsequently experience positive emotional responses to self-compassion. They reported the therapeutic relationship as an important factor making this possible. Participants reflected on several reasons for the aversive nature of developing self-compassion, which are discussed. A process model of the journey from self-criticism to self-compassion is proposed. It is suggested that the obstacles frequently experienced when developing self-compassion can be overcome, instilling hope for both therapists and clients.

Key Practitioner Message:

- The process of developing compassion for the self can be frightening for people who have a tendency to be self-critical and have few experiences of compassion from others.
- Despite this initially aversive response, participants in this study were able to develop self-compassion and experience its benefits, such as increased hopefulness for the future.
- Therapists are encouraged to persist with compassion-focused therapy when met with resistance from clients, since overcoming this can be a key part of the therapeutic process.

Keywords: Compassion-focused therapy, Self-criticism, Shame, Self-compassion

INTRODUCTION

There is increasing evidence that people can be trained in compassion awareness and focusing (e.g., through imagery practice) and that this has a range of beneficial effects on mental state and attitudes to others (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Hutcherson, Seppala, & Gross, 2008) as well as on various physiological parameters of well-being (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008). Compassion can be experienced from others, towards others and for oneself. However, self-compassion (i.e., compassion for oneself) has been found to be particularly beneficial in reducing psychological distress and improving well-being (Gilbert, 2007; Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004; Neff, Kirkpatrick, & Rude, 2007).

In contrast to self-compassion, which is primarily based in affiliative systems, self-criticism is linked to the threat affect system and tends to be associated with aversive emotional states (2009a, 2009b, Gilbert, 2005, 2010). It is a major vulnerability factor for a range of psychopathologies including eating disorders, substance abuse, mood

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and anxiety disorders (e.g., Gilbert & Irons, 2005; Whelton & Greenberg, 2005; Zuroff, Santor, & Mongrain, 2005) as well as for the maintenance of posttraumatic stress disorder (PTSD, Lee, Scragg, & Turner, 2001; Harmen & Lee, 2009).

Self-criticism and self-compassion are therefore associated with different mental health outcomes, and given that self-criticism has been conceptualized as a lack of basic affiliative processes, it follows that people who are highly self-critical could be trained to become more self-compassionate. Indeed, this is the primary focus of Compassion-focused therapy (CFT), which should therefore be particularly suitable for this population, including those with PTSD.

Compassion-focused Therapy

Compassion-focused therapy (CFT) is based on an integrated, biopsychosocial model of psychotherapy (2009a, 2009b, Gilbert, 2000, 2007, 2010), which contextualises the human mind in its environment and draws heavily on the role of evolution in this process. CFT 'refers to the underpinning theory and process of applying a compassion model to psychotherapy' (Gilbert, 2009a, 2009b, p. 199). It is a transdiagnostic approach to working with the shame and self-criticism that is present in many mental health problems such as depression, addiction, psychosis, PTSD and social anxiety. It was developed, in part, from the observation that people who are highly self-critical find it difficult to generate feelings of contentment, safeness or warmth in their relationships with others and themselves (Gilbert, 2009a, 2009b). Moreover, highly self-critical and shame-focused individuals typically do less well in standard Cognitive behavioural therapy (CBT, Rector, Bagby, Segal, Joffe, & Levitt, 2000) and frequently state that they understand the logic of CBT but do not experience a congruent emotional response to their alternative, more helpful thoughts (Stott, 2007).

Within the CFT model, the ability to access positive affiliative emotions is considered to play a vital role in regulating negative, or threat-based, emotions (Gilbert, 2005). People who are less able to generate positive affiliative emotions (such as those who have early experiences of neglect or trauma, whose care giving and attachment relationships may be highly threat-focused) are therefore more vulnerable to psychological difficulties. CFT views psychopathology within the context of an unbalanced affect regulation system and symptoms of psychopathology are understood to be emerging strategies to manage and cope with threat-based emotions.

Three primary affect systems are identified in the CFT model, on the basis of research into the neurophysiology of emotion (Depue & Morrone-Strupinsky, 2005). The *threat-protection system* rapidly evokes negative emotional responses including anger and anxiety and is involved in detecting threat and self-protection. Two positive affect systems are also identified; the *incentive and resource-seeking system*, which results in excitement and achievement-related emotions and the *soothing and contentment system*, which is associated with safeness and calming positive emotions. This latter system is linked to affection and kindness from others as well as from the self and is considered to be vital in providing a sense of well-being (Gilbert, 2010).

The primary objective of CFT, therefore, is the development and strengthening of affiliative affect. As such, it differs from traditional psychotherapeutic approaches that seek to reduce negative emotional experiencing and do not explicitly focus on increasing positive affective responses (Gilbert, 2010). This positive affect system is considered to play a fundamental role in regulating the threat system, reducing distress and enhancing psychological well-being (e.g., Longe et al., 2010).

The Difficult Nature of Becoming Compassionate to the Self

It has been suggested that for highly self-critical people, the generation of self-reassuring or compassionate feelings can be unfamiliar and frightening (Gilbert, 2009a, 2009b; Gilbert & Procter, 2006, 2010). Self-critical people have been found to respond to compassionate images with threat responses, as measured physiologically by their heart rate variability (Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008) and neurophysiologically through fMRI (Longe et al., 2010).

Gilbert and Procter (2006), in the first evaluation of group CFT, noted that many participants 'had a real fear of becoming self-compassionate' (Gilbert & Procter, 2006, p. 370). Gilbert and Procter (2006) sought reflections on how people had experienced the group, which included finding it a moving and deeply helpful experience. They concluded that it is 'clear that many patients have various fears of compassion, see it as a weakness or have very little to guide them at first' (Gilbert & Procter, 2006, p. 373).

Gilbert (2010) proposed several preliminary explanations for the difficulty that highly self-critical people report in becoming self-compassionate. One such explanation relates to attachment theory, in that kindness from the therapist reactivates the client's attachment system and in doing so reactivates aversive emotional memories of, for example, trauma or neglect (Bowlby, 1973, 1980). Gilbert (2010) also proposed that compassion from others and self-compassion can trigger feelings of grief resulting from a need for affection and care from significant others but an absence of this in the past. Further hypotheses relate to metacognitive beliefs such as being non-deserving of compassion or perceiving it as a weakness (Gilbert, 2010). These proposed explanations for the fear of self-compassion are the focus of

current quantitative research (Gilbert, McEwan, Matos, & Rivis, 2011; Gilbert, McEwan, Chotai, & Gibbons,). Gilbert et al. (2011) reflected that these fears present a major barrier to recovery, particularly for people who experience high levels of shame and self-criticism. It is therefore vital that they are better understood.

In a study utilizing interpretative phenomenological analysis (IPA), Pauley and McPherson (2010) explored the meaning of compassion for people with anxiety and depression and reported that participants thought that compassion for themselves would be difficult, with one participant stating that 'I don't think I'm really ever going to be able to do that' (Pauley & McPherson, 2010, p. 137). This qualitative evidence suggests that self-compassion is a difficult concept for people with psychological difficulties to comprehend and can evoke feelings of hopelessness.

Gilbert et al. (2011) developed three self-report measures of metacognitive beliefs about fears of compassion; fear of compassion from others, for others and for the self. Fear of compassion for the self was significantly correlated with fear of compassion from others, and both of these variables were found to be linked to self-coldness, self-criticism and depression. Gilbert et al. (2011) concluded that 'self-criticism is not just about negative attitudes to oneself but it also contains within it a fear-based orientation to affiliation' (Gilbert, McEwan, Matos, & Rivis, 2011, p. 13). Given the known benefits of compassion in promoting psychological well-being, it is important that any resistance to it in psychotherapy is addressed as part of the therapeutic process. Gilbert et al. (2011) suggested that enabling clients to overcome their fears and develop self-compassion is an important way in which psychotherapy can be advanced.

Present Study

Clinical experience indicates that there are many blocks and obstacles to the process of shifting from self-criticism to self-compassion (Gilbert, 2010). In many disorders, these include triggering metacognitive beliefs such as not being deserving and the initiation of a grief process linked to awareness of feelings of disconnection (Gilbert, 2010). With the exception of one study (Pauley & McPherson, 2010), data on the difficulties of shifting from self-critical states to a self-compassionate stance are based on anecdotal clinical narratives (e.g., Gilbert & Procter, 2006).

As mentioned previously, CFT is a transdiagnostic approach to working with the shame and self-criticism that is present in many mental health problems such as depression, addiction, psychosis, PTSD and social anxiety. The difficulties experienced by people with a diagnosis of PTSD are known to be characterized by increased self-criticism and feelings of shame (Harmen & Lee, 2009; Lee et al., 2001). Since highly self-critical people are also hypothesized to have difficulty developing self-compassion (Longe et al., 2010; Rockliff et al., 2008), this study included people with a diagnosis of PTSD, to advance understanding of their experience of this process.

The study aims to produce an in-depth understanding of the experience of completing a course of compassion-focused therapy and of the process of developing self-compassion. Due to the limited current understanding of this process, a qualitative research design is used, in which the subjective experience of the participant is the primary focus. The primary research questions are firstly, what are people's experiences of CFT for trauma? Secondly, what are people's experiences of the process of becoming more compassionate to themselves? In addition, the secondary research question is how can people's experiences of CFT help inform its implementation?

METHODS AND PROCEDURE

Participants were five women and two men who had completed a course of CFT for trauma. They were aged between 30 and 54 years and all met Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Text Revision (DSM-IV TR, APA, 2000) criteria for PTSD. All participants had a history of traumatic experiences that varied in nature from repeated traumatic experiences in childhood to a discrete traumatic event in adulthood. Ethical approval did not permit the author to have access to participants' care records and therefore further information regarding their traumatic experiences is not available.

Four participants had completed CFT in a group format, and three had completed individual CFT. CFT was delivered by clinical psychologists, who had completed CFT training consistent with the Compassionate Mind Foundation guidelines and were supervised by the founding member of this foundation and a board member who is a recognized expert in the model. A qualitative research design was used, and semi-structured interviews were conducted to collect data. The study was approved by Oxford B Research Ethics Committee.

People who had completed two CFT groups for PTSD in different regions of South East England were asked if they would be willing to take part in the study by the clinical psychologist facilitating the group. People who had completed individual CFT with one of the group facilitators were also invited to take part in the study. With their consent, participants were then contacted by the author and the interview was arranged. Prior to the start of the interview, they gave consent to take part in the study and for their interview to be recorded. Participants also consented to anonymized quotations from their interview transcripts being used in publications resulting from this study.

The interview explored people's experiences of CFT. The questions were designed to be open-ended and general to

encourage participants to provide as much information as possible. The interview schedule was designed with several areas of interest in mind to ensure that it covered a range of aspects of the therapeutic experience. The areas of interest included helpful and difficult aspects of CFT, a focus on feelings throughout therapy rather than specific therapeutic techniques, barriers experienced during therapy and changes that participants had experienced as a result of therapy. The interviews were digitally recorded and transcribed verbatim. Interviews were carried out by the author over a 9-month period and ranged in length from 45 to 90 minutes.

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis is concerned with how people understand their experiences and is data-driven rather than theory-driven. As such, it takes a bottom-up, inductive approach. It aims to explore the meanings that participants attach to their experiences and therefore does not test hypotheses. Participants are considered experts with regards to their own experiences, and IPA affords them to tell their own stories, in their own words (Smith, Flowers, & Larkin, 2010). The aim of IPA is to negotiate a shared understanding through conversation and intersubjective meaning-making with the participant, with the primary focus being the person's subjective experience. IPA has recently been the subject of criticism and debate as to whether it represents good scientific practice (Giorgi, 2010; 2011). Such claims, however, have been disputed on the basis of differing views as to what constitutes scientific evidence and how this should be measured (see Giorgi, 2010; Smith, 2010; Giorgi, 2011 for further discussion). IPA is increasingly recognized as a useful tool in providing valuable contributions to healthcare research (Pringle, Drummond, McLafferty, & Hendry, 2011; Smith, 2010), and as such, was thought to be an appropriate method for use within the present study.

Interviews were initially read through several times to enhance familiarity with the data. Initial ideas about the interviews and any interpretations were noted separately. A table was created including three columns (as recommended in Smith et al., 2010): the middle column contained the original transcript and the right column included exploratory comments. This was the first stage of the analysis and included descriptive, linguistic and conceptual comments on the data (see Smith et al., 2010 for further information). The left column was then completed, which included emergent themes from the transcript. A table such as this was completed for each interview. Emergent themes were then grouped into clusters of themes representing potential higher order themes. Emergent themes were then transferred onto a separate table, with corresponding indicative quotations and line numbers, for each interview. Potential higher order themes across all interviews were then compared with and grouped into superordinate themes, which comprised a final table.

Reflexivity and Credibility Checks

From an IPA perspective, the researcher's interpretation of a participant's experience is second-order and consists of a mutual understanding of an experience. The influence of the researcher is therefore recognized as vitally important. The researcher must be aware of, and reflect on, any expectations they may have regarding their research. The author was interviewed by a trainee clinical psychologist about the research process, which brought her presuppositions to the surface to be reflected upon. Throughout the research process, the author also kept a reflective journal of her experiences of each interview and of the process of analysis.

A key component of IPA is its emphasis on subjective interpretation, or meaning-making. The emergent themes and superordinate themes were independently checked by two of the researchers involved in the study. A peer IPA group was formed with four trainee clinical psychologists who were also using IPA for their research. This group met on average every 4 weeks, and notes from these meetings were kept in the author's reflective journal. Examples of data from the study, as well as suggested themes, were presented to the group, and a discussion was held as to whether the themes were firmly grounded in the data. This helped to ensure the credibility of the analytic process.

RESULTS

Five superordinate themes emerged from the analysis. The first theme concerned participants' experience of the battle to give up the inner critic and the resulting loss of self-identity. The second related to the aversive experience of becoming self-compassionate. The third explored the emotional experience of therapy. The fourth examined participants' changed outlook on life, and the final theme addressed self-compassion as an unexpected positive emotional experience. With the exception of the fourth theme, each superordinate theme had a number of related subordinate themes. The superordinate themes, the corresponding subordinate themes and the indicative quotations can be seen in Table 1.

Superordinate Theme 1: The Battle to Give Up the Inner Critic: Who Am I if I Am Not Self-Critical?

The first superordinate theme comprised two subordinate themes: 'fear of loss of self-identity' (theme 1.1) and

Table 1. Subordinate themes, superordinate themes and indicative quotations resulting from phenomenological analysis

Superordinate themes	Subordinate themes	Indicative quotations
1: the battle to give up the inner critic: who am I if I am not self-critical?	1.1: fear of loss of self-identity	'am I going to like the person that I've become? because I've been like this, with these memories and these thoughts and this for so long' (Participant 4*)
		'You have to push yourself, you have to. And then if you don't push yourself well you're just a bad person. You must be a high achiever because if you are not you are nothing. To start off with there was a vacuum and it was well that vacuum shows that I am nothing. I am worthless' (Participant 2)
	1.2: the relationship between self-compassion and self-criticism	'I felt a bit stupid to start with. You feel a little bit stupid talking to yourself but you kind of, that's the crucial point when you have to push yourself through that phase and then force yourself to do it' (Participant 5)
		'it isn't easy just to feel it [self-compassion] and get it and sometimes I get tired of it. I just think I'm bloody useless and I don't want to feel better. I don't want to think nice things. I don't want to feel good. And sometimes it is hard to do that but most times I can make myself feel that way' (Participant 7)
2: an aversive and alien experience: how it feels to develop self-compassion	2.1: self-compassion is alien and a frightening experience	'Dread. Erm, it's as if, I don't know, it's as if I was frightened of it [self-compassion]. I was frightened of how I was going to feel. How I was going to react. Because I was never used to doing things to help myself' (Participant 7)
		'but it's [developing self-compassion] hard because you erm, it's like being an atheist and someone trying to convert you' (Participant 6)
	2.2: I don't deserve self-compassion	'It's really difficult to start off with. Erm. It doesn't feel right to be kind to yourself. That was the hardest thing. I really sort of railed and struggled against that, because basically I felt that my illness was all my fault' (Participant 2)
		'I didn't want to be kind to myself. Because I still felt I didn't deserve to be happy or to have nice thoughts or to be kind to myself. I thought that by [being compassionate], there were things that would make me smile and I felt, well, I know it sounds silly, as if I wasn't allowed to smile' (Participant 7)
	2.3: the desire to reject self-compassion and CFT: it feels hopeless	'There's no way that I'm going to think what you're telling me I am gonna think (laugh). There is no way at the end of 6 months that I am gonna think like this at all. I thought I might as well go home now' (Participant 4)
		'I think I just felt sceptical and the reason for that was it had been going on for so long without feeling any great improvement. You kind of begin to doubt whether you are ever going to feel any kind of improvement. Erm which is where the resistance comes from' (Participant 5)
3: the emotional experience of therapy	3.1: the importance of the therapeutic relationship	'One of the strongest things was the actual therapists themselves. Erm they were so kind. Erm the kindness was amazing. Erm not only as doctors but as human beings. Their

(Continues)

Table 1. (Continued)

Superordinate themes	Subordinate themes	Indicative quotations
		generosity was, I'd never come across that level of kindness before and, and their empathy erm at the same time they were very challenging and they made us work hard' (Participant 1)
		'You need that kind of person steering you and guiding you through the process and actually just, just keep saying to you that it is okay to feel like this. It is okay to want to cry. It is okay to be nice to yourself. It is a good thing to be good to yourself' (Participant 7)
	3.2: feeling versus thinking compassion—realizing it's not my fault	'In the beginning I didn't believe it. I would say I'm trying to be compassionate to myself but I didn't actually see that…I'd think to myself oh, you know, well, that's fine and I'm happy and on the surface everything's okay. But I never felt it. But as it went on, now, I can feel it. You know, I can feel it in my body than, rather than just in my mind' (Participant 7)
		'we just did a lot of work on blame and how it made us feel and how it wasn't our fault and things and I just had a "switch on" moment I suppose. To think well hang on a minute none of what happened to me was actually my fault' (Participant 4)
	3.3: I am not alone in my struggles	'You think you are the only one and then you realize that you are not alone. There are other people who feel the same and you are not alone. It's just unfortunate that you have been through these experiences' (Participant 6)
		'It can make you feel less desperate. That there are other people that feel like you and you are not the only person who went through that experience. If you are really struggling it could be quite hard to see. Or it could be good to know of other people that have been through it and are doing better in life than you are. So it's quite, I think when you get to know people better, you get to know that actually you all have the same issues, the same anxieties' (Participant 3).
4: self-compassion as a positive emotional experience	N/A	'it was like getting a drink of water in the desert. Erm. Once I had kind of given up the addictions of blaming myself it was like this whole guilt trip had gone' (Participant 2)
		'I had a reaction that I could feel. No question about it there was a definite wow, that sort of feeling that you get shivers all the way down your back. It's like wow! Erm really quite something. You know a real sort of wow' (Participant 5)
5: a more positive outlook in the present and for the future	5.1: enjoying life rather than just living it	'I'm very generous with myself now and you know I wouldn't have gone anywhere as well. I had this thing about not, not, not being compassionate. Not taking myself off to the theatre and I *love* the theatre' (Participant 1).
		'I look forward to every day. I get a real sense of happiness and a real sense of achievement. It's a different kind of achievement to what I used to have. Just actually looking back at the end of the day and thinking actually I've done all

(Continues)

Table 1. (Continued)

Superordinate themes	Subordinate themes	Indicative quotations
		those things and I've enjoyed them gives me a far greater sense of achievement and purpose than there used to be' (Participant 2)
	5.2: a new sense of hopefulness for the future	'My whole outlook is different. I feel like I've got a future now, which I didn't feel, well I've never felt like that really. No, so I feel like I've got a future now, which I didn't feel like 6 months ago' (Participant 4)
		'It is still very, very difficult but I can see actually now I've got a future. I need to look towards my future and I deserve to have my future' (Participant 7)

*To ensure anonymity, participants were given numbers rather than fictional names since the study included just two male participants.

'the relationship between self-compassion and self-criticism' (1.2).

When describing their experience of being introduced to the concept of self-compassion and the CFT model, participants often reflected on their concern about losing a part of their self-identity. Hostile and derogatory self-criticism formed an important part of participants' self-identity, and losing this part of themselves was an uncomfortable prospect, described as 'bewildering' by Participant 4. Participant 2 reflected on her previous threat-based belief that one must strive and achieve to avoid self-critical thoughts that she is a bad person. This highlights that participants understood self-criticism to be important in enabling them to achieve and protecting them from a very negative self-identity. It also suggests that their experience of being asked to give up this previous way of coping evoked a void in which they began to question their self-identity.

When describing being introduced to the concept of self-compassion and what this felt like, participants talked about their experience of increased self-critical thoughts. Participants' experiences of increased self-criticism prevented them from becoming self-compassionate. This occurred both when contemplating self-compassion at the start of therapy (referred to by Participant 5, see Table 1) and after the completion of therapy (indicated by Participant 7). It seemed that self-criticism was an important way in which participants coped with negative emotional experiences and that they were therefore reluctant to relinquish this familiar coping strategy.

Superordinate Theme 2: An Aversive and Alien Experience: How It Feels to Develop Self-Compassion

The second superordinate theme had three subordinate themes: 'self-compassion is alien and a frightening experience' (2.1), 'I don't deserve self-compassion' (2.2) and 'the desire to reject self-compassion and CFT: it feels hopeless' (2.3).

All participants experienced a negative emotional response to the concept of developing self-compassion. A number of participants described this process as alien in nature and something that they had never experienced before. Self-compassion was therefore a very difficult concept to understand and evoked a powerful emotional response. Throughout the transcripts, participants described strong aversive responses to self-compassion such as it feeling frightening, overwhelming, terrifying and dreaded.

In describing their experience of developing self-compassion, participants reflected on their understanding of why this was so difficult. Several participants understood self-compassion to be something that they did not deserve. They therefore resisted becoming self-compassionate at the start of therapy and a number of participants commented on the experience of self-compassion as not feeling 'right', suggesting that this was not their usual way of relating to themselves.

Participants expressed a desire to disengage in the early stages of therapy. They frequently identified a sense of hopelessness at the start of therapy, in that they thought they would never be able to become self-compassionate. From their accounts of this experience, it seems that becoming self-compassionate felt like an impossible task, and one that they wanted to avoid.

Superordinate Theme 3: The Emotional Experience of Therapy

The third superordinate theme included three subordinate themes: 'the importance of the therapeutic relationship' (3.1), 'feeling versus thinking compassion—realizing it's not my fault' (3.2) and 'I'm not alone in my struggles' (3.3).

Acceptance, non-judgement, feeling valued and understood and feeling believed in were characteristics of the

therapeutic relationship that participants described as helpful and important. Of particular importance to participants was their perception of the therapists as human beings, rather than just professionals, who genuinely cared for them rather than providing them with the tools to feel better.

The importance of emotional experiencing was not only evident in relation to participants' relationship with the therapists, but also with regard to their relationship with themselves, which is the focus of the second subordinate theme. Participants described the process of shifting from believing that they were to blame for their previous traumatic experiences, to the realization that they were not responsible for such experiences. An interesting characteristic of the participants' experiences of this process was that they spoke of the difference between *thinking* that they were not to blame and *feeling* that they were not to blame. They identified the therapeutic relationship as an important means through which this became possible, in that the therapists' belief in them enabled them to shift their beliefs about themselves. The experience of feeling safe in the mind of another was therefore of fundamental importance.

All group members reflected on the realization that they were not alone in their struggles, in that they had similar experiences to other people. Experiencing a sense of common humanity and shared understanding was important to them. Realizing that other people in the group had similar difficulties enabled participants to begin to accept that these were understandable reactions to their experiences. This appeared to be an important aspect of the therapeutic experience and enabled them to begin to shift from a position of self-blame to self-compassion.

Throughout the process of conducting IPA, it is important that the researcher notices ways in which data suggest differing accounts of a person's experience (divergence) as well as similarities (or convergence) within identified themes. In contrast to participants who received group therapy, those that had undertaken individual therapy did not reflect on gaining a sense of shared humanity, but all emphasized the value of the therapeutic relationship and contributed to subordinate theme 3.1. The emotional experience of gaining a sense of shared understanding therefore differed between group and individual recipients of CFT. Although they did not witness others' difficulties, it was important to individual members that they felt understood by the therapist. Interestingly, one participant who received individual therapy identified an increased sense of isolation at the start of therapy and the potential value of receiving support from others who had experienced similar difficulties.

Superordinate Theme 4: Self-Compassion as a Positive Emotional Experience

The fourth superordinate theme was concerned with the unexpected positive emotional experience of self-compassion. Despite initially experiencing self-compassion as aversive and unachievable, participants also reflected on the positive experience of self-compassion. This appeared to be surprising to them and different to their expectations of what self-compassion might feel like. Participants described this experience as operating on a number of levels, including a feeling-based (or experiential) experience and a cognitive experience. It is noteworthy that although frequently referring to their positive emotional reaction to self-compassion, participants seemed to have more difficulty articulating what this experience was like and labelling their emotional response to self-compassion than they did describing their previous negative emotional reaction to the idea of self-compassion. The sense of surprise that participants expressed suggests that this was an unexpected and novel outcome and a feeling that they had not previously experienced.

Superordinate Theme 5: A More Positive Outlook in the Present and for the Future

The fifth superordinate theme had two related subordinate themes: 'enjoying life rather than just living it' (5.1) and 'a new sense of hopefulness for the future' (5.2).

Participants expressed a shift in their understanding of what mattered to them in the way they live their lives and described a shift in their understanding of what constitutes achievement during the course of therapy. Many participants described gaining a sense of enjoyment from life rather than just living or always striving to achieve life goals. They described a new form of achievement in doing things that they enjoyed or from simple things in life, which reflects a more compassionate relationship with themselves. They had begun to allow themselves enjoyment from life, which they had neglected to do previously.

Participants' changed outlook on life was also exemplified by a new sense of hopefulness for the future. Whilst realistic about the ongoing struggle that they face with their difficulties, many participants spoke of their more optimistic view of the future, in comparison to a very bleak outlook previously. They had developed a new belief that they deserved to be happy, which they had not held previously. This also reflects a more compassionate relationship with themselves. This sense of hopefulness is in contrast to their sense of hopelessness both prior to therapy and when they were introduced to the concept of self-compassion.

DISCUSSION

The Journey from Self-Criticism to Self-Compassion

The superordinate themes that emerged from the IPA analysis reflect the journey (including a series of stages) upon which participants embarked throughout therapy.

A suggested model of this process is shown in Figure 1. Initially, participants spoke of their reluctance in ceasing to be self-critical and their fears of losing an important part of their self-identity (superordinate theme 1). Related to this, they experienced a highly aversive emotional response to the prospect of developing self-compassion, which was extremely frightening for them and to be resisted against (superordinate theme 2). Participants emphasized the emotional experience of therapy, including gaining a sense of common humanity and the power of the therapeutic relationship (superordinate theme 3), as important mechanisms in enabling them to make the transition from rejecting to accepting self-compassion. This represented an important shift in participants' relationships with themselves.

Believing in and *feeling* compassion for themselves enabled participants to accept self-compassion, which was vital in enabling participants to experience positive affective responses to it (superordinate theme 4) and have a more compassionate relationship with themselves. They described self-compassion as having a tempering effect on self-criticism. The positive affect resulting from self-compassion, reduced self-criticism and improved relationship with themselves led to participants making huge changes in the way they live their lives and their sense of hopefulness for the future (superordinate theme 5).

Participants therefore experienced an emotional journey through CFT, which resulted in a dramatic shift from hopelessness to hopefulness, as illustrated in Figure 1. The proposed model might be useful in informing clinical practice and can be used as a guidepost for therapists working with CFT. Further research is needed to test its clinical utility; however, this model maps onto a process model of therapy developed from clinical practice (Lee, 2009), indicating ecological validity.

The Role of Self-Criticism

In participants' accounts of their experiences of being introduced to CFT and self-compassion, they frequently reported an increase in self-criticism (a threat response, see superordinate theme 1). Participants' experience of becoming self-compassionate was aversive (superordinate

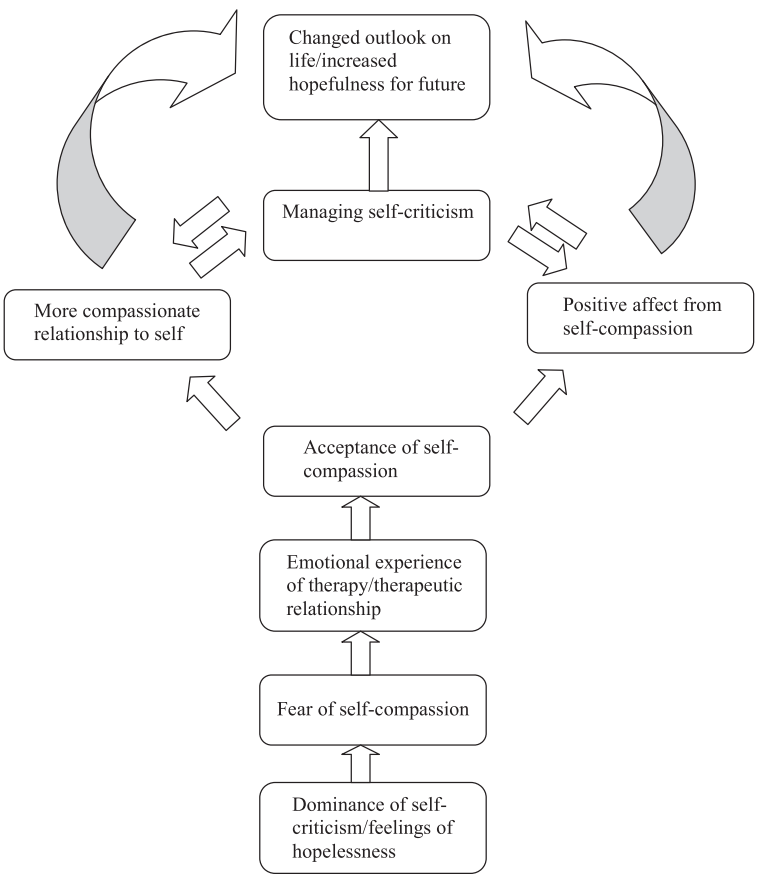

Figure 1. The journey from self-criticism to self-compassion

theme 2) and it therefore appeared that their threat system was being activated, triggering a self-critical response resisting against compassion. This could be understood by considering self-criticism as a representation of the internalized relationship that participants have with themselves. As observed by Bowlby (1973), activation of the attachment system through interrelationships or intrarelationships accesses all the emotional memories associated with original care giving experiences. Thus, in these cases, rather than the attachment system triggering a self-soothing style of internal dialogue and resulting emotional state, it triggers a self-attacking style of self-talk reflecting the conditioning of their attachment system. Participants had previously utilized self-criticism to cope with their difficulties and preserve their self-esteem and self-identity. The experience of the loss of this was therefore extremely anxiety provoking for them.

The resistance reported to letting go of self-criticism is clinically an important issue. In CFT, previous coping strategies such as self-criticism are viewed as understandable ways in which people have learned to keep themselves safe in the difficult situations in which they find themselves. Emphasis is placed on people's attempts to protect themselves but also on the unintended negative consequences in which these safety strategies inherently result, for example feelings of internal shame arising from self-criticism. From the participants' understanding of their experiences in this study, it seems that despite the work carried out concerning this issue in CFT, they continued to have great difficulty accepting that self-criticism was not helpful to them. This is an important consideration for the implementation of CFT, and participants' experiences of this process evidenced in this paper could be used to validate and normalize these difficulties for future recipients of CFT.

The Experience of Developing Self-Compassion

Participants described the process of becoming self-compassionate as terrifying, frightening, scary and dreaded, like learning a foreign language and like learning the alphabet again (superordinate theme 2). This is consistent with previously reported clinical observations (Gilbert, 2010), informal reflections sought from people who have completed a CFT group (Gilbert & Procter, 2006) and predictions of this experience by people with anxiety and depression (Pauley & McPherson, 2010). The aversive experience of becoming self-compassionate is also consistent with neurophysiological findings that self-compassion triggers activation of the amygdala (the threat response system in the brain) in highly self-critical people (Longe et al., 2010). A number of participants understood the difficulty of developing self-compassion as being because they thought it was something that they did not deserve. They frequently described self-compassion as 'not feeling right' and reflected that this led to feelings of hopelessness at the start of therapy as they did not think that self-compassion was possible. This is also consistent with the findings of Pauley and McPherson (2010).

The hopelessness experienced by participants at the start of therapy, as well as their aversive reaction to self-compassion led participants to wish to reject CFT and disengage from therapy. The participants in the present study overcame these difficulties and completed therapy, but there may be some for whom this process feels too overwhelming. Restoring a sense of hope is an important component of psychotherapy (Rogers, 1961), as is the normalization and validation of people's experiences. These findings reinforce the crucial importance for therapists engaging in CFT to devote time to their clients' fears of developing self-compassion. In essence, this will become an extensive focus in the therapeutic process, and it seems vital that it is not terminated prematurely so that it is of benefit to the client.

In contrast to their initial aversive emotional reaction to self-compassion, several participants reflected on progressively more positive feelings evoked by self-compassion (superordinate theme 4). This demonstrates that they experienced the process of becoming self-compassionate as an emotional journey, with Participant 2 describing their new ability to be self-compassionate as being like 'getting a drink of water in the desert', despite previously describing self-compassion as feeling like 'moving heaven and earth'. This former quotation indicates that self-compassion was experienced as something that was vitally important to well-being and something that had been much needed previously. The importance of compassion, including self-compassion, has been recognized in eastern philosophy for centuries but is only more recently recognized in Western psychological models. The positive emotional response to compassion reported by participants in this study suggests that this was life-changing for them and provides further evidence for the power of self-compassion in promoting recovery from psychological distress. Despite their initial fear response, participants were able to trust in the therapists and therapeutic methods, attempt to develop self-compassion and subsequently experience its benefits. This presents a strong argument for the use of CFT with people who have difficulty being self-compassionate and provides a sense of hope to clinicians who are met with a threat response and resistance from clients at the start of CFT. It also provides support for the assumption that the soothing and contentment system can be activated even for those who do not have many previous experiences of compassion from others or to themselves, but that this system can remain dormant due to a lack of these experiences.

Feeling One's Way Through Therapy

Participants reflected on the difference between being told that they were not to blame for their traumatic experiences and believing or *feeling* that they were not to blame. This highlights a distinction between the rational and emotional mind and is consistent with Gilbert's (2010) observation that clients engaging in CBT can often recognize that their thoughts are unhelpful or illogical but do not have a positive emotional response to alternative, more helpful thoughts (Stott, 2007). Participants in this study reflected that the emotional shift in their beliefs about their experiences was crucial, described as a 'switch on' moment by Participant 4. This is in contrast to thinking differently about their experiences, which participants described as being incongruent with their emotional response.

The importance of the emotional experiencing and the therapeutic relationship in psychotherapy is well documented in the literature and is receiving increasing recognition as being fundamental in contributing to therapeutic change (Greenberg, 2008). Participants in the present study identified both the therapeutic relationship and their relationship with other group members as important experiences enabling them to begin to develop self-compassion. Importantly, although not receiving therapy with others, all individual CFT participants highlighted the importance of the therapeutic relationship. Specific characteristics of the therapeutic relationship that were identified as important included feeling accepted, valued, understood and non-judged. This emotional connection is considered vitally important in the CFT model and appears to matter to the people engaging in it.

From Hopelessness to Hopefulness

Participants reflected on changes in the way they live their lives both in the present and their outlook on the future. A number of participants said that they had begun to do things for the sake of pleasure rather than the focus being on achieving something and that this was a new experience. They also had a more positive outlook on the future than previously and looked forward to living rather than having a sense of dread. This shift from hopelessness to hopefulness for the future was identified as an important transition by the majority of participants as a result of therapy. Although this paper is not concerned with establishing the effectiveness of CFT, the changes identified by participants are an important indication of the gains they made in therapy, described by a number of participants as life-changing.

The importance of engaging in activities for the sake of both pleasure and achievement has long been recognized in psychotherapy for depression (particularly CBT) and is not a new concept. For instance, the focus of CBT interventions for depression is very much on targeting the incentive and resource-seeking affect regulation system by promoting activities that provide a sense of achievement, resource building, mastery and pleasure. However, for this system to provide continued access to positive emotional states, it requires constant reactivation to regulate the threat system, since it is short-lived by nature. If a person is unable to achieve or has unrelenting standards in their personal goals, they will be left vulnerable to feeling threat-based emotions as they may no longer be able to meet their self-expectations through the incentive and resource-seeking system. CFT states, therefore, that both positive affect regulation systems must be activated in people's lives, so that they may experience a positive emotional response to simply *being* as well as *doing*. It is of interest that participants in this study experienced a barrier to carrying out these activities previously, as they did not feel that they deserved such positive experiences. Therefore, an important part of their experience of CFT was not only in developing self-compassion and self-soothing but by accessing that state, they felt more deserving and accepting of other positive affective states. As such, they were then able to accept and allow themselves to enjoy and find pleasure in their lives.

CONCLUSION

Participants in this study without exception experienced an aversive and threatening emotional response to self-compassion and therefore, unsurprisingly found the process of becoming self-compassionate extremely difficult. They understood there to be a number of challenges in developing a more compassionate relationship with themselves including thinking that they did not deserve it, experiencing an increase in self-criticism when considering and attempting to apply self-compassion and fearing compassion because it resulted in feelings of vulnerability. They described the therapeutic relationship and the experience of feeling understood as being vital processes that enabled them to shift their beliefs about being deserving of self-compassion. Despite initial aversive responses to self-compassion, participants also experienced increasingly positive affective responses to self-compassion and described a changed outlook on life including an increased sense of hopefulness for the future. Participants' accounts of their experiences of CFT in this paper provide hope for treating clinicians and future recipients of CFT, that despite initial challenges, this therapeutic approach can enable people to experience the benefits known to result from a more compassionate relationship with the self.

This research demonstrates that therapists and clients must not give up because they find compassion too difficult. Overcoming the fear of compassion is the elixir of recovery from psychological distress and it is part of

normal human functioning; a vital skill in managing one's inner world, relationships and psychological well-being.

LIMITATIONS

As with the majority of IPA studies, the small sample size in the present study and the greater proportion of female participants limits the generalizability of the findings. Although CFT was developed to be transdiagnostic, the inclusion of only participants with a diagnosis of PTSD places caution upon interpretations drawn from the conclusions presented. The experience of receiving CFT may well be different for other diagnostic groups, and this warrants further research. Furthermore, the IPA analysis included participants with a range of traumatic experiences (from discrete events to repeated trauma) and it may be that the experience of developing self-compassion differs depending on the nature of these experiences.

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