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The experience and meaning of compassion and self-compassion for individuals with depression or anxiety

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Objectives. The objective of this study was to explore the meaning and experiences of compassion and self-compassion for individuals with depression and anxiety.

Design. An interpretative phenomenological analysis (IPA) epistemology and methodology were adopted as the study was focused on understanding the meaning and experiences of participants towards self-compassion from existing theory.

Methods. Ten participants were selected based on a *Diagnostic and statistical manual of mental disorders*, 4th ed. – text revision diagnosis of depression or an anxiety disorder. Individuals were excluded from this study if they had additional diagnoses which impacted significantly on their disorder or on ethical grounds if participation was seen as psychologically distressing.

Participants completed a semi-structured interview with questions were based on existing self-compassion research. Interviews lasted an hour and were analysed using IPA methodology.

Results. Participants' reflections suggested that they saw compassion having two central qualities: kindness and action. Participants reported that they thought having compassion for themselves felt meaningful in relation to their experiences and useful in helping with their depression or anxiety. However, participants reflected that they felt being self-compassionate would be difficult either because the concept itself felt challenging to enact or their experience of psychological disorder had negatively impacted on their ability to be self-compassionate.

Conclusions. Participants' positive perceptions of self-compassion offer encouragement to clinicians as it appears people can connect with the concept meaningfully as well as seeing it as being useful. Clinicians focusing on self-compassion may gain greater efficacy when they incorporate both aspects within interventions. Findings about the difficulties associated with self-compassion provide valuable information as to why people find it difficult to adopt which can be used in the development of future clinical interventions.

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The increasing incidence of depression and anxiety is one of the key drivers in the development of innovative and increasingly efficacious therapeutic interventions for these disorders (Beck, 2005; Bland, 1997). As part of this therapeutic development, the incorporation of eastern, predominately Buddhist, psychological constructs into western clinical interventions has received increasing attention (Baer, 2003). Several therapeutic approaches including mindfulness based cognitive therapy, acceptance and commitment therapy, and compassion-focussed therapy (CFT) have incorporated eastern principles and practices into interventions and reported a range of positive outcomes (Baer, 2003; Gilbert, 2005; Hayes, Strosahl, & Wilson, 1999; Kenny & Williams, 2007).

Compassion

One of the key principles emphasized within many schools of Buddhism is learning to be compassionate which is posited to help individuals develop their ability to recognize and motivate themselves towards meaningful change. Compassion within Buddhism is seen as a way of helping individuals to train their minds, which can lead to a general improvement in well-being and ultimate enlightenment. The compassionate stance that individuals gradually learn to adopt towards themselves and others enables them to cope with challenging emotions with a greater degree of understanding, self-directed care, and support which further enables even the most difficult change. There has been an increasing focus on compassion from a range of psychological perspectives of which this paper will focus on the social psychological and clinical/evolutionary approaches. Each of these approaches has focused on different aspects of compassion and reported positive outcomes from their research suggesting that the ability to be compassionate towards self offers significant benefits for individuals (Gilbert, 2009; Neff, Rude, & Kirkpatrick, 2007).

Social psychological perspective

In an effort to develop a greater understanding of compassion from a western perspective, Neff (2003a,b) conceptualized and defined the construct of self-compassion which has led to a focus on understanding individuals' abilities to adopt a self-compassionate stance and the impact of self-compassion on well-being (Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). In defining self-compassion, Neff (2003a, 2004) posited that there are three constructs which underpin self-compassion: mindfulness, being able to take a kind psychological stance towards self, and having a sense of a common humanity.

Research into self-compassion based on Neff's (2003b) conceptualization has focused on defining the construct's nature and relationship with other psychological constructs as well as exploring whether being self-compassionate leads to a healthier relationship with self. Findings from this research have consistently demonstrated that it is negatively correlated with measures of depression, anxiety, self-criticism, and rumination and has a positive relationship with psychological traits like happiness and optimism which suggests that its impact on an individual can be far reaching (Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). Two studies found that self-compassionate individuals are kinder and more accepting of themselves in negative situations as well as being able to keep these situations in perspective when compared to individuals with lower levels of self-compassion (Leary, Tate, Adams, & Allen, 2007; Neff, Kirkpatrick, & Rude, 2007). These findings, amongst

others, have led Leary *et al.* (2007) to tentatively suggest that self-compassion may act as a psychological buffer from the impact of negative life-events by helping individuals to more accurately evaluate themselves and their life experiences.

The findings from self-compassion studies offer important insights into the construct from a social psychological perspective but need to be treated with caution as they have been largely correlational which limits an understanding of the direction of relationships between self-compassion and other constructs (Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). Existing research has also been exclusively conducted on non-clinical populations which limit the conclusions that can be draw in terms of the impact and nature of self-compassion in populations with psychological disorder (Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). Most importantly, these findings offer little understanding of individuals' experiences of self-compassion and the meaning they might ascribe to these experiences, particularly when experiencing psychological disorder.

An evolutionary perspective of compassion

In contrast to Neff's (2003a) perspective, Gilbert's (2005) social mentalities theory explains the development of compassion through an evolutionary model which posits that life experience shapes individuals' brains in terms of the enhancement of a number of processing systems and biopsychological structures. In terms of affect regulation, Gilbert (2009) suggests that there are three key systems: a system for responding to threat, an incentive/excitement system, and a soothing/calming system. The system of soothing/calming is developed in an individual through a secure attachment to a significant other (often a parent) who adopts a compassionate stance towards the individual so that their distress is repeatedly and appropriately calmed and soothed. As a result, the individual gradually internalizes compassion for themselves which fosters the development of self-soothing behaviour, empathy, a healthy tolerance for distress, and a motivation to care for themselves and ultimately others (Gilbert, 2005, 2009). In stark contrast, an individual who has either not experienced compassion or experienced excessive negativity from significant caregivers when the soothing/calming system is developing in childhood and adolescence will often develop significant levels of self-criticism, shame, and guilt as an adult as a direct result of these experiences.

Gilbert and Irons (2005) suggest that the utility of being able to develop a self-compassionate stance for individuals who have high levels of self-criticism and shame in association with their psychological disorder is that decreasing these levels of negativity also positively impacts on their disorder. This positive impact is due to the development of positive internal processing systems which individuals then draw on to promote self-compassion which results in a corresponding reduction in the use of more critical and hostile internal processing systems (Gilbert, 2009; Gilbert & Irons, 2005).

Clinical interventions based on Gilbert's (2005) work have gradually evolved into compassionate-focussed therapy (CFT) which centres on helping individuals who have had limited experiences of compassion from which to develop their own self-compassionate stance to do so within a therapeutic setting (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006; Gilbert & Procter, 2006). Current CFT interventions endeavour to engage and develop the individual's soothing/compassionate system through exercises like compassionate letter writing and the development of self-compassionate

imagery that the individual can draw on when they are being self-critical (Gilbert & Irons, 2005; Gilbert & Procter, 2006). The picture in terms of the efficacy of these and other compassion-focused interventions is only beginning to develop as a result of the relative infancy of CFT but existing studies suggest that it is a promising intervention with clinical utility, particularly with individuals who have proved resistant to more traditional therapeutic approaches (Gilbert & Procter, 2006). Ongoing research into the application of CFT continues to develop new interventions and it appears that it may offer individuals a new and innovative way of developing a self-compassionate stance in a therapeutic setting although these interventions are largely at a preliminary stage (Gilbert & Procter, 2006; Gilbert *et al.*, 2006). Within this research, an increased understanding of the individual experiences of compassion would offer a valuable insight into how individuals relate to the concept which could help in the shaping of new clinical interventions.

Current study

This study was designed to explore the experiences and meaning of compassion and self-compassion with individuals diagnosed with either depression or anxiety. In addition, this study was focused on trying to understand individuals' experiences of trying to develop and maintain a self-compassionate stance whilst experiencing depression or anxiety.

Method

Design

An interpretative phenomenological analysis (IPA) epistemology and methodology were used in this study. An IPA approach was seen as the most appropriate as the research was focused on exploring the experiences and meaning of self-compassion for participants within existing theory. Broad research questions such as those posed in this research are commonly encountered in IPA research as it promotes the understanding of individuals' experiences with phenomena rather than making specific predictions about what will be encountered (Chapman & Smith, 2002).

IPA focuses on individual participants in context and explores their relationship to and understanding of the phenomena in question (Chapman & Smith, 2002; Willig, 2001). The researcher is interested in how the research participant understands and makes sense of their experiences in terms of their relatedness to and engagement with these phenomena (Smith & Osborn, 2003). In addition, IPA acknowledges that the understanding and analysis of an individual's experience is always an interpretive process as it relies on the beliefs and experiences of the researcher which influence the manner in which the study is conducted (Willig, 2001). By acknowledging the impact of the researcher's beliefs, it is possible for IPA research to focus on drawing out new information with regards to existing theoretical positions from the focus on the experiences of the individual participants (Smith & Osborn, 2003).

Participants

Participants were recruited from the researcher's clinical caseload. Prospective participants were given information about the nature of the study before being asked

to participate. A purposive sampling process consistent with an IPA approach was used to select participants (Chapman & Smith, 2002). The primary inclusion criterion for participants was that they had a *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. – text revision (DSM-IV-TR) diagnosis of either a depressive or anxiety disorder (American Psychiatric Association, 2000; Willig, 2001). This criterion was set so that the study could focus on a population relevant to existing self-compassion research (Gilbert *et al.*, 2006; Leary *et al.*, 2007). To ensure that conclusions drawn from this study were only based on the experiences of individuals with anxiety or depression, individuals were excluded if they had another diagnosis that would significantly impact on their experiences, for example, schizophrenia or substance misuse. The other exclusion criterion was based on feedback from an Ethics Committee, with individuals being assessed in terms of their level of psychological distress and excluded if it was deemed that they were too distressed to complete the study or if completing the study was assumed to be likely to cause distress.

Data collection

The core components of a semi-structured interview were developed by drawing on existing compassion and self-compassion literature. These components were then refined into specific questions and piloted with service users and colleagues. Feedback helped to shape the final interview (see Appendix) in terms of the relevance and wording of questions and the capacity of the questions to draw out the experiences of individuals. The interview used the areas outlined in Neff's (2003a) definition of self-compassion as a way of providing a structure for the interview.

Results

Study sample

Research participants' ages ranged from 20 to 61 with a mean of 40 and a standard deviation of 12.5. All participants were from a White British background. There were nine women and one man. Six participants had a primary diagnosis of a major depressive disorder and four had a diagnosis of a specific phobia. Three participants with depression also had a diagnosis of generalized anxiety disorder.

Analysis

Themes were developed using an iterative process consistent with an IPA methodology. This process started with an initial familiarization with the data conducted by reading each transcript and then a more detailed analysis of each transcript followed which resulted in themes being modified and revised after each transcript. An initial summary of these themes was then refined with reference to individual transcripts as new perspectives developed.

Two processes were used to enhance the reliability of the analysis. The first relied on gaining feedback from participants on a summary of their interview and how accurate they felt this was. The second drew on feedback on the themes developed through the analysis from an independent reviewer and the researcher's supervisor. Following feedback, further refinements of themes were conducted until a structure with three superordinate themes with related subordinate themes was finalized. These themes are as follows:

(1) Compassion is a kind and active process
Subordinate themes:
Compassion is about being kind towards people.
Compassion requires action.

(2) Self-compassion is meaningful and useful
Subordinate themes:
Self-compassion feels meaningful for me.
Self-compassion might help me with my depression/anxiety.

(3) Being self-compassionate is difficult
Subordinate themes:
I'm not sure I can be self-compassionate.
Negative impact of depression/anxiety on my ability to be self-compassionate.

These themes will be explored in the remainder of this paper.

Compassion is a kind and active process

When asked for their definition of compassion, a majority of participants drew on their experiences of being compassionate towards others and offered examples of when they had been compassionate.

Compassion is about being kind towards people

Compassion was largely experienced by participants as being a process in which kindness or being kind was a key component. Participants frequently paired the concept of being kind with other aspects of compassion but universally reflected that for them kindness was central. Participants did not define what they meant by kindness, which creates a difficulty in fully understanding exactly what they meant when they used that word:

> S7: 'Compassion, I think, is, um, when somebody shows sort of kindness and understanding.'

> S9: 'Compassion, um, oh, its kindness to other people.'

> S4: 'Well, I understand it to mean being caring and kind, um, to someone else, supporting them in difficult circumstances, whatever.'

Compassion requires action

Participants were clear that they saw compassion as an active process which developed from the kind approach taken towards people. The form of action was reflected as extending from listening through to both practical and emotional support:

> S1: 'The ability to, to stop and listen to them and, you know, be an ear for them to talk, maybe offer a little bit of advice, if you felt they wanted it, but, I think, more importantly, just be there for them.'

> S10: '. . . compassion's more like a verb, in my view. I don't know, actually implies doing something, I would say.'

Self-compassion is meaningful and useful

None of the participants reflected on any experiences of being self-compassionate in their reflections on compassion. When prompted by the researcher to consider the concept of self-compassion, all participants initially responded in terms of the meaningfulness of the construct for them and reflected on the possibilities that being self-compassion could hold for them:

> S3: '. . . I never, I never actually ever thought of self-compassion before. So, it has made me think about it and, and think about being a bit kinder to myself. Um, I think I'm quite compassionate towards other people anyway. Um, and perhaps not enough towards myself. . . '

Self-compassion feels meaningful for me

Participants reflected that self-compassion closely mirrored what they had felt was either missing or diminished as a consequence of their experience of psychological disorder and this ranged from a sense of being kinder towards themselves through to a sense that they need to be able to forgive themselves for what they had previously seen as failings in their lives:

> Interviewer: 'What do you think the point of self-compassion would be?'
>
> S4: 'The point would be to give you inner peace; it would be [pause] the finality of it. You can let go of whatever it is that's there.'
>
> S5: 'If I didn't learn to forgive myself, if I didn't, if I don't start to let go then all that hard work, all those years have been for nothing. Um, I've made mistakes, and I've kinda got to accept that I've made mistakes and move on from it.'

Self-compassion might help me with my depression/anxiety

In addition to the sense of meaning associated with self-compassion, many participants reflected that the construct felt as if it would be useful in a practical manner with their psychological disorder. As the interview schedule had been based around Neff's (2003b) description of self-compassion, the sense of usefulness was described in both a general sense and with relation to the three subconstructs within that description, namely, kindness to self, mindfulness, and a sense of common humanity. A majority of participants viewed the concept of kindness towards self as being useful in terms of being able to learn to forgive their mistakes and to accept themselves for the person they were. In doing so, participants saw kindness towards self as a way of being happier in their lives in general:

> S9: 'And to allow yourself the fact that you're human, you know, maybe you don't get it right. When you make a mistake or you've made a bit of a, you know, "cods up" you can just say, "Well, you know, you're human, you're not perfect, you don't get it right every time, do ya?"'
>
> S1: 'Well, when its, when it's solved, whatever it is, I feel much happier. Much more able to live with such a stupid thing. [Laughs] There's no need to get upset about it, it's all, you know, fine.'

A majority of participants talked about the quality of being mindful as being able to be more objective so that they could see situations from different perspectives rather than just the negative ones they tended to find themselves in when depressed or anxious. It is interesting that being objective was the main way participants expressed their experience of mindfulness as it is more formally defined as primarily being a skill of

observing and accepting one's thoughts rather than taking a stance towards them such as objectivity might imply (Kenny & Williams, 2007). These differences in definition suggest that individuals without an experience of mindfulness may well not entirely understand the actual meaning of the concept and therefore require a degree of psychoeducation to help them to better understand it:

> S7: 'I think . . . . you are just somehow able to be more objective and look at things more objectively and look at things in a more balanced fashion.'

A number of participants who reflected that having a sense of common humanity felt useful based this opinion on their actual experience of knowing other people who had had either depression or anxiety. In particular, several participants reflected that knowing that other people had recovered from their experience of psychological disorder meant that they felt it was possible for them to do so. It seems that knowing that others have experienced psychological disorder helped participants to feel less isolated and inadequate:

> S3: 'Well, because it means that if other people have done it, then I can do it as well. And if other people have gone through experiencing the same feelings that I'm experiencing and got through it then, then yes, it can be done.'

Being self-compassionate is difficult

Despite the positive responses to the concept of self-compassion from many participants, there was also a perception from them that having or developing self-compassion was difficult and that this difficulty related to the concept of self-compassion or came from their experiences of depression and/or anxiety.

I'm not sure I can be self-compassionate

All participants reflected that they felt there would be difficulties in trying to adopt a self-compassionate stance. On a general level, these issues were about the perceived difficultly in adopting the philosophy of the construct particularly when they had no or limited prior experience of it. Most participants also reported that they thought that there would be unique difficulties in engaging with each subconstruct of self-compassion as defined by Neff (2003a):

> Interviewer: 'Do you think it's possible to have compassion for ourselves?'
>
> S2: 'Um, I think its possible but I don't think it's something I feel.'
>
> S4: 'Um, I think I'm my own worst critic so I can sit and understand things in other people but I wouldn't necessarily accept them in myself.'

Many participants reflected that they believed that learning to be kinder towards themselves would be difficult because they believed that their existing negative attitudes towards themselves were so long-standing that they would, in all likelihood, resist all attempts to change them. For these participants, the difficulty with being kinder to themselves was as much about the challenge of developing a new approach to themselves as it was to reduce the negative influence of existing thought patterns:

> S3: 'I wish I could be kinder to myself because I think, talking about that self-compassion and everything, I'm sure I know people that are very kind to themselves and they're good to themselves and look after themselves and make time for that and, and I think they're better,

much better off for it. But I, um, don't think I'm really ever going to be able to do that, that's how I feel.'

Many participants reflected that although they understood the general concept of being mindful, they believed that developing the psychological skills associated with this concept would be extremely difficult. Participants' reflections suggested that they did not believe that they had the psychological wherewithal to be mindful although this belief had developed without any of them having had any experience of mindfulness. As mentioned previously, aspects of these perceived difficulties might relate to understanding the concept of mindfulness rather than the ability to be mindful itself:

S5: '. . . any thought process is running at anxiety things so you can't then talk to yourself or be compassionate towards yourself or whatever to get yourself out of it.'

S9: 'But with myself, I don't think I'm very good at being objective. I think I'm, I can get quite um, what's the word, um, I can get quite focused on one thing and find it difficult to, to look at it in an objective round way.'

Participants reflected that the long-term negative impact of psychological disorder on their thoughts and feelings rather than the active experience of either depression or anxiety was the major impediment to them developing a sense of shared humanity. The deeply personal way that many participants had experienced their disorder meant that they found it difficult to see that they had indeed shared experiences with other people in a way that could be of utility for them, often because of the isolation associated with the disorder:

S8: 'You can't [pause] you just feel like on your own and just feel nobody else um, could feel like that or has felt like that.'

S2: 'Because it feels so personal that there's no way in the world that anyone else could go through that.'

Negative impact of depression/anxiety on my ability to be self-compassionate

All participants reported that when they were experiencing depression and/or anxiety it impacted significantly on their ability to be self-compassionate and that this difficulty applied equally to the overall concept and to the underlying constructs proposed by Neff (2003b):

S9: 'I think when I'm depressed, I just really, really just don't like myself, so, there's no way that I'm going to feel compassion for myself, really.'

S3: '. . . I think being anxious stops you thinking straight, in a funny sort of way. It stops you thinking logically because you're so focused on what is making you anxious or what it is you've got to do or what situation you're in.'

All participants reported that their ability to be kind and forgiving towards themselves was not only diminished when depressed or anxious but was replaced with increasing levels of self-criticalness and an unforgiving nature with varying levels of frustration and anger towards self:

S1: 'Yeah, because, again, I get, I get frustrated because I am anxious because it all seems, you know, because even the anxiety is exhausting so I get frustrated being in that situation but at the same time you can't really control it that much. So I get angry with myself, again.'

S10: 'When I feel depressed it's almost impossible to be forgiving towards myself, um, because when I feel depressed I think that's, it's my fault that I feel depressed and then, and so that makes me feel even worse.'

A majority of participants reported that when they were depressed or anxious, rather than being mindful, their attention tended to be focused almost entirely on negative experiences. In tandem with this negativity, most participants reflected that they had lost their ability to be mindful and therefore they tended to make negative interpretations:

> S5: '. . . I find its harder to be calm sometimes and think about it objectively, with me, while I'm, since I've had the anxiety. I tend to, things will tend to get out of proportion, I think, or seem bigger than they are now than they perhaps would have done before.'

> S10: 'Um, it makes me feel worse. I see the worst possible sort of outcome and I see that things are worse than they really are [pause] and you can't see how they're going to get better.'

When feeling depressed or anxious, most participants reported that they felt increasingly isolated, often to the point of feeling disconnected. These feelings tended to develop from initially stopping caring about themselves before radiating outwards to incorporate others until the individual experienced a sense of being alone:

> S8: 'No, it just feels like nobody else could ever, ever go through what you feel. As bad as that, you know, because it is horrible, it's just, really, I suppose, you don't really care at the time, you don't care what other people think.'

Discussion

Compassion is a kind and active process

The consistent reflection by participants that, for them, kindness was a key constituent of compassion suggests that although they are often conceptualized in the psychological literature as distinct constructs this might not necessarily be how they are experienced by individuals. Neff (2003a) has proposed that kindness to self is a key constituent of self-compassion and it may well be the case that kindness underpins aspects of compassion more generally. If further research was to replicate these findings then it would seem important for clinical interventions to not just reflect theoretical constructs but also the experiences of individuals in their everyday lives. It may also be the case that the two constructs appear to overlap because of the nuances of language and that the difficulty with separating them may not be useful on a pragmatic level when working with individuals experiencing psychological disorder. Indeed, as this study did not ask participants to define what kindness meant for them, it might well be the case that there is confusion about what the two concepts mean and how indeed they should be defined.

Participants' reflections that compassion is best expressed through action suggest that regardless of how compassion is defined, people commonly experience it through either their own or other people's compassionate actions. In a sense, this finding suggests that people may well regard the expression of compassionate sentiments as being less than the whole of what compassion is intrinsically about. The ability of clinical interventions to reflect the active nature of compassion, as seen by individuals, may be important in terms of people being able to experience giving or receiving compassion rather than it existing on only a theoretical level within a therapeutic setting.

Self-compassion is meaningful and useful

An important finding of this study is that although participants reflected at length on the concept of compassion, they did not mention self-compassion until prompted to do so. This finding suggests that individuals with psychological disorder either have not ever had a sense of self-compassion or that this has been lost at some point during their experience of either depression or anxiety.

When participants were introduced to the concept of self-compassion, a majority were readily able to see it both as having meaning for them and also some utility in terms of helping them with their experiences of psychological disorder. The willingness of participants to initially engage with and then thoroughly consider the concept suggests that it not only has face validity but also a depth which individuals are able to discover largely for themselves with only limited prompting, in this case from the researcher during the interview. As such, the experience of participants in this study reflects findings from Gilbert's (2005), Neff, Kirkpatrick, and Rude, (2007), and Neff, Rude, and Kirkpatrick, (2007) research which indicates that individuals can engage with self-compassion both as a theoretical construct and a lived experience.

Participants' perceptions that self-compassion could be a useful construct for them in terms of trying to overcome anxiety and depression suggests that not only do the various compassionate-based interventions have their respective clinical evidence for efficacy but that individuals will be able to engage with the concept of being self-compassion on a pragmatic level, even without knowledge of what specific interventions entail. The willingness of participants to see self-compassion as having utility suggests that if other difficulties can be overcome, most individuals will be able to connect with clinical interventions designed to develop self-compassion as they will see and understand the purpose of self-compassion in terms of it helping them with their depression and anxiety.

Being self-compassionate is difficult

The difficulties with either developing or being self-compassionate reported by participants in this study reflect broad findings from the CFT literature (Gilbert *et al.*, 2006). What is most interesting is that participants clearly delineated between the practical difficulties of developing and then maintaining a self-compassionate stance and the negative impact that their experience of psychological disorder had had on their self-compassion. Both of these participant identified difficulties offer very different challenges for clinicians in terms of developing and implementing compassion-focused interventions and suggest that it is important that they are considered independently as well as in tandem. It appears from what participants have reflected in this study that when both types of difficulties have been appropriately addressed an individual is most likely to be able to develop a self-compassionate stance.

The practical difficulties participants saw in being able to adopt a self-compassionate stance suggest that one of the central challenges for clinical interventions lies in helping individuals to see that they do indeed hold the potential to be self-compassionate. For some participants, even the consideration of self-compassion seemed a daunting prospect because of a generally negative self-concept whereas for others it related to considerations about being able to adopt particular characteristics or skills associated with self-compassion. For clinicians, this information suggests that there are two distinct challenges even within this area of difficulties: firstly to help individuals to see that they have the capacity for self-compassion and secondly to help them with the actual

development of self-compassion skills. These challenges are ones that have already been considered within CFT and these findings suggest that further developments in these areas will be welcomed by those who struggle with being self-compassionate.

Reflections by participants that their experience of depression or anxiety had impacted on their ability to be self-compassionate reinforces the findings of previous self-compassion research (Gilbert, 2009). For some participants, the impact of the disorder was such that it made it harder for them to engage in a self-compassionate manner whereas for others, the impact of the disorder made being self-compassionate impossible. An interesting related finding was that many participants reported that it was not just that they found it difficult to be self-compassionate but also that they experienced the exact opposite of self-compassion when depressed or anxious. This finding suggests that the challenge for clinicians is not just in helping someone to learn to be self-compassionate from a neutral starting-point but that many individuals will be starting from an extremely negative standpoint which will, in all likelihood, lead to a more involved and lengthier intervention (Gilbert & Irons, 2005). These reflections reinforce the findings of previous compassion research but the reflections of participants adds an additional depth to the developing understanding of the negative relationship between psychological disorder and self-compassion (Gilbert *et al.*, 2006). Furthermore, these findings reinforce the rationale behind many of the interventions associated with CFT in that they initially help people to overcome a fear or rejection of self-compassion before developing the construct for themselves (Gilbert, 2009).

Limitations

Three important limitations of the current research relate to the study's sample. Firstly, the comparatively small sample size of this study, a factor in most IPA studies, and the exclusively White British and 90% female sample mean that the ability to generalize from these findings is restricted. The second limitation of this study is that participants in the research had been diagnosed with only one of three psychological disorders. Whether the meaning of self-compassion for individuals would vary based on their experiences of other disorders is unclear but provides a point of caution in the conclusions drawn from this study in terms of a wider population. The study's third limitation was the use of clients from the researcher's clinical caseload as research participants. Clients were invited to be participants because of practical limitations for the researcher in terms of accessing alternative populations. The existing relationship of the participants with the researcher will almost certainly have impacted on their responses during the interview. However, the nature of this impact is difficult to gauge but is an important consideration in terms of participant responses. All of these limitations could be addressed in future research which could seek to broaden this study's findings with different populations.

Conclusions

Findings from this study clearly indicate that participants saw compassion as an important concept which incorporated a sense of kindness as well as action. Participants also reported that they could see both the benefits and challenges of being self-compassionate. Self-compassion appealed as a concept that was meaningful to participants' experiences and also as something they could apply which could usefully

help with either depression or anxiety. At the same time, the challenges identified with being self-compassionate, either because of perceptions of the concept itself or as a result of psychological disorder, were reminders that this concept is one with which individuals can find it difficult to connect. These challenges are ones for clinicians to consider both when working with self-compassion and also in the design and refinement of self-compassionate interventions. Self-compassion is a compelling concept which draws individuals to it but also challenges them in ways which often require the compassionate support of others so that they can ultimately be self-compassionate themselves.

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Appendix

Compassion interview schedule

Preamble: 'I am hoping that we can cover a range of topics and ideas today. Please remember that there are no right or wrong answers and that I am looking for your ideas on the various topics that we cover. It is your experiences and thoughts that I am most interested in. I will probably ask you all at different times to explain to me in more detail or in a different way what you have said because I am interested in what you have to say and want to understand it better.'

Initial focus: Establish what is understood by compassion/self-compassion

- Could you tell me what you understand compassion to mean and give me an example of an experience you have had in your life of someone being compassionate. (Focus on the various aspects that the individual suggests in their definitions and go into these in more detail).
- Are there times when you find it easier or harder to be compassionate towards other people?
- How does feeling (depressed/anxious) effect your ability to be compassionate towards others?
- Do you think it is possible to have compassion for ourselves?
- What would be the point of being able to be compassionate towards ourselves?
- Are there times when it would be difficult to be compassionate towards ourselves?

Focus on kindness towards self

- How do you tend to react with yourself when you make mistakes, get things wrong, or don't succeed in the way you would have liked to?
- Can you think of any positives to being able to forgive/be kind towards yourself when you make mistakes or don't live up to your own or other people's expectations?
- What do you think would help people to learn how to be more forgiving and understanding towards themselves?
- How does feeling (depressed/anxious) effect your ability to be kind towards yourself as compared to when you are feeling more positive and/or relaxed?

Focus on mindfulness

- How easy or hard do you find it to separate yourself from your thoughts and feelings and to be able to be as objective as you need to be in a situation? (I can give an example to make what I am saying clearer).
- Do you find when you are feeling (depressed/anxious) that it is more difficult to separate yourself from your thoughts and feelings and to be as objective as you would like to be?
- What sorts of things can happen to you if you are not able to separate your thoughts and feelings as they occur from who you are?

Focus on common humanity

- Do you feel as if you share similar experiences to other people? In other words, do you think that the sorts of experiences you have are, in general, experiences that happen to other people?
- Is it helpful when you are experiencing something upsetting or challenging to think that you are not the only person who has experience this? (Why/why not?).
- How does your sense that you are having similar experiences to other people change when you are feeling (depressed/anxious)?

Focus on depression/anxiety

- When you are feeling (depressed/anxious), what change/s does this have in terms of how you feel and think about yourself?
- When you think about how you feel about yourself now and how you were feeling about yourself when you were last well, what would you say the major differences are?
- Do you think that any of what we have talked about today would have an effect on your (depression/anxiety). (If so, which aspects would and how would they?).

Focus on other constructs

- We have talked about a number of different topics and ideas today that have all linked together in different ways. Are there any other ideas or experiences that we have not thought about that you think would connect to our discussion?
- Do you have any other thoughts about anything that we have discussed today or any comments to make about the discussion itself?