A Whole New World:

Journey Towards Self-compassion

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Glossary

APA: American Psychological Association
BPD: Borderline Personality Disorder
BPS: British Psychological Society
CAT: Cognitive Analytic Therapy
CBT: Cognitive Behavioural Therapy
CBT-BN: Cognitive Behavioural Therapy for Bulimia Nervosa
CBT-E: Enhanced Cognitive Behavioural Therapy
CFT: Compassion Focused Therapy
CFT-E: Compassion Focused Therapy for Eating Disorders
DBT: Dialectical Behaviour Therapy
EDE-Q: Eating Disorder Examination Questionnaire
FDA: Food and Drug Administration
GT: Grounded Theory
IPA: Interpretative Phenomenological Analysis
IPT: Interpersonal Psychotherapy
MBCT: Mindfulness Based Cognitive Therapy
NICE: National Institute for Health and Care Excellence
NP: Narrative Psychology
RCTs: Randomised Controlled Trials
SGAs: Second-Generation Antipsychotics
SSCM: Specialist Supportive Clinical Management
SSRIs: Selective Serotonin Reuptake Inhibitors

A Whole New World: Journey Towards Self-Compassion.

How do individuals who struggle with eating difficulties experience self-compassion after taking part in an eight-week compassionate mind group?

Abstract

Objective
This research explored the experience of self-compassion in women with eating difficulties who completed an eight-week compassionate mind training group.

Background
Research that examines self-compassion has mainly focused on the general population and the methods utilised mainly involve quantitative methodologies, such as questionnaires or surveys. Therefore, it appeared important to conduct this research by exploring participants' lived experiences.

Methods
To collect data, semi-structured interviews were conducted with seven women between the ages of 25 and 51 years old. All participants were fluent in English and they had participated in the therapy group one to three years prior to taking part in this research.

Results
During the analysis stage four superordinate themes were developed: "A Whole New World – Journey towards discovering and describing self-compassion", "It's a Long Way To The Top – Journey towards finding self-compassion", "Journey For Life – Journey towards integrating self-compassion in life" and "A Trouble Shared Is a Trouble Halved – The experience of being in therapy group". Each of these themes encompasses three sub-themes. The analysis of the data represents my understanding and interpretation of the participants' lived experiences.

Conclusion
These themes were further discussed in relation to the literature and attempts were made to explore how compassionate mind therapy could be introduced in the treatment of eating disorders. The findings of this study provide some insight for Counselling Psychologists and other mental health practitioners that work with individuals suffering with eating disorders.

Introduction to the Portfolio

This portfolio commences with empirical research that explores the lived experience of self-compassion in women suffering with eating difficulties. It then goes on to present a client study that summarises my clinical work using Compassion Focused Therapy with a male client who self-referred to the service where I worked. Lastly, with the hope to disseminate the findings from my research, the portfolio ends with a publishable paper that will be submitted to the journal *Eating Disorders*.

This portfolio represents my journey towards becoming a Counselling Psychologist and, as a result of my research, towards developing my self-compassion. This research has been a journey filled with many emotions that range from excitement to terror. I believe that these reflect how I feel at this point in my life when I am about to finish my training and embark on "a whole new world".

When I first started this Doctorate, two things particularly fascinated me: people's stories and the topic of eating disorders. During my time at university I felt attracted to different topics and have tried to work with different populations, however nothing ever caught my interest as much as researching and working with people with eating disorders. In addition, throughout my life I always found myself attracted to Buddhism and Eastern philosophy as well as towards therapies that tried to explicitly connect mind and body. For my Master's dissertation, I looked at the effectiveness of mindfulness in the treatment of binge eating using a quantitative approach; therefore when I started my Doctorate, I had no doubts regarding the topic I wanted to research. However, this time I turned towards a method that would allow me to get closer to my participants' experiences.

Furthermore, as part of my training to become a Counselling Psychologist, I specifically looked for placements that would allow me to work with individuals who struggled with eating disorders. This led me to a private hospital that treats adolescents struggling with their eating and, in particular, with anorexia nervosa. This placement has been incredibly helpful in allowing me to further develop my theoretical knowledge and clinical experience of eating disorders. Additionally, during my time at the hospital I have had the opportunity to co-facilitate a Cognitive Behavioural Therapy (CBT) group and a Mindfulness group. These experiences allowed me to understand and experience first hand the importance of finding effective treatments for eating disorders.

This portfolio is permeated by two themes, my interest in the topic of eating disorders and my development as a Counselling Psychologist. In my journey towards becoming a Counselling Psychologist, I had to learn to integrate two different roles: that of researcher and of reflexive practitioner. In my placements, I learnt to work using evidence-based approaches, to integrate different models and techniques as well as to reflect on my work and myself. This thesis has helped me to further integrate these aspects and feel more at ease in my role of scientific practitioner. Furthermore, this research has allowed me to start my own journey towards developing self-compassion and to become more accepting of myself. I am very grateful to my participants for sharing their journeys with me and am also extremely appreciative of all my clients, who over the years have opened up and shared their vulnerabilities and fears with me.

I believe that eating disorders are an extremely important topic to address and research as they affect a large number of individuals and can present with devastating consequences. Furthermore, the treatments currently employed do not often enable full recovery, especially for anorexia nervosa, and many clients relapse. I am extremely glad that the literature on eating disorders and their treatments is continuing to expand and that different researchers are constantly looking to develop new treatments for this population. I am also grateful to have been given the opportunity to complete this research and hope to have positively contributed to the existing literature.

I plan to continue working with and researching eating disorders, as I believe that clinical practice should always go along with scientific research. I also strive to continue developing my self-compassion, to being curious and to keep developing as scientific practitioner. This portfolio marks an important milestone for me and, in particular, for my future career. It has been a long and difficult journey, however it was also full of excitement and has confirmed my passion for working within the field of eating disorders.

"*The most terrifying thing is to accept oneself completely*" (Jung, 1957)

Sections of The Portfolio

Section A: Research Study

This section comprises my Doctoral Research, which is entitled "A Whole New World: Journey Towards Self-Compassion. *How do individuals who struggle with eating difficulties experience self-compassion after taking part in an eight-week compassionate mind group?*".

This research explored the experience of self-compassion in women with eating difficulties who completed an eight-week compassionate mind training group. Seven semi-structured interviews were conducted with women between the ages of 25 and 51 years old, who self-identified as having eating difficulties. The data collected was analysed using interpretative phenomenological analysis and four super-ordinate themes were developed and presented. Each of these themes encompassed three sub-themes. The analysis of the data represented my understanding and interpretation of the participants' lived experiences. These themes were further discussed in relation to the literature and attempts were made to explore how compassionate mind therapy could be introduced in the treatment of eating disorders. Lastly, implications and recommendations for Counselling Psychologists were suggested.

Section B: Client Study

This section describes my clinical work with a client who had self-referred to therapy to deal with the consequences of having been physically and emotionally attacked. The client study represents a summary of the key stages of therapy over ten sessions. Furthermore, it describes the approach I used to work with client, which consisted of integrating Cognitive Behavioural Therapy (CBT) and Compassion Focused Therapy (CFT). This work illustrates the practice of Compassion Focused Therapy in the context of therapy and aims to demonstrate its efficacy in developing the soothing system when working with clients that present with high levels of shame and self-criticism.

I decided to present my sessions with this client because I believe they were a successful piece of work that demonstrated my capacity in working with and integrating different approaches to suit the client's needs. At the same time, however, I found this work quite challenging. In particular, I found working in a short-term setting very difficult, however this helped me become aware of my expectations when working in such a context. Furthermore, these sessions helped

me improve my skills, while reflecting on the helpfulness of both CBT and CFT when working short-term with severe cases. Lastly, our work allowed me to combine my research interest (self-compassion) with my therapeutic practice.

Although this client did not present with an eating disorder, I decided to include our work in my portfolio as I wanted to demonstrate the effectiveness of introducing self-compassion as well as CFT's techniques regardless of the presenting problem.

Section C: Publishable Paper

This section presents a paper, which summarises the four super-ordinate themes found during the analysis: "*A Whole New World*", "*It's a Long Way To The Top*", "*Journey For Life*" and "*A Trouble Shared Is a Trouble Halved*". I aim to publish this paper in the peer-reviewed journal *Eating Disorders*, therefore it has been formatted according to the journal's guidelines.

I chose this journal because it focuses specifically on the prevention and treatment of eating disorders. In addition, in its aims and scope the journal specifies that it "takes a fundamentally practical, humanistic, compassionate view of clients and their presenting problems" (*Eating Disorders*). The aim of this article is to present the experience of self-compassion amongst women with eating difficulties with the hope to provide insight for Counselling Psychologists and other professionals who work with this population. The publication of this paper in this journal would mean that the findings could be read by practitioners who work in different fields and share an interest in the subject of eating disorders.

Summary

This portfolio depicts both empirical and clinical data of self-compassion in an attempt to explore the concept in depth. The aim of this portfolio is to present the reader with theories of self-compassion and eating difficulties, an interpretative phenomenological analysis of self-compassion in women suffering with eating difficulties and lastly, a client study of self-compassion in a male client. My interest in working with people with eating disorders is at the core of this portfolio together with my journey towards becoming a Counselling Psychologist. Therefore, within the portfolio runs the theme of the importance of developing efficient treatments for eating disorders and how self-compassion might play an important role in helping this population. I hope the reader will gain a comprehensive understanding of self-compassion and its possible use in the treatment of eating disorders.

SECTION A: DOCTORAL RESEARCH

A Whole New World: Journey Towards Self-Compassion.

How do individuals who struggle with eating difficulties experience self-compassion after taking part in an eight-week compassionate mind group?

Giulia Di Clemente

Supervised by Dr Courtney Raspin

CHAPTER 1: Introduction

1.1 Introduction

The principal focus of this chapter is to explore the treatments available for eating disorders, with particular attention paid to Compassion Focused Therapy (CFT) and the construct of self-compassion. The chapter begins with an overview of the treatments available for eating disorders as recommended by NICE (2004) since the majority of clinicians follows its guidelines; particular attention will be given to Cognitive Behavioural Therapy (CBT) and its enhanced version (CBT-E) as they are currently the best researched and they achieve the best results, particularly for bulimia nervosa and binge eating disorder. The chapter will then continue with brief summaries of how Interpersonal Psychotherapy (IPT), Cognitive Analytic Therapy (CAT) and Dialectical Behaviour Therapy (DBT) work, as evidence for their effectiveness in the treatment of eating disorders is growing and they have also been recommended by NICE. The NICE guidelines also recommend family therapy and pharmacotherapy for the treatment of eating disorders, however these will only be briefly described as family therapy is recommended for the treatment of younger patients and this study only included adults, and pharmacotherapy has received limited support and is usually not the first choice of treatment (Bruna & Fogteloo, 2003).

The main focus will be on understanding how CFT and the construct of self-compassion work, followed by an exploration of how they can be effective in the treatment of eating disorders. Particular attention will be given to the way in which CFT understands and describes the brain structure as some people with eating disorders present with neurocognitive deficits and brain abnormalities (Treasure, 2012); furthermore, the chapter will explore in depth the three affect-regulation systems (Gilbert, 2010) as individuals struggling with eating disorders often present with emotional processing deficits (e.g. Brewer et al., 2015; Bydlowski et al., 2005), and it will also describe the skills of compassion and self-compassion and how they are taught. Although a specific version of Compassion Focused Therapy has been developed for eating disorders (CFT-E, Goss & Allan, 2010) it will not be explored as the compassionate mind group in which participants took part was not based on this model. Since the study explored the experience of self-compassion in women who have completed an eight-week compassionate mind group, the chapter will also present a summary of the benefits of group therapy. Lastly, the chapter will end with a brief summary of the literature review and the rationale for this research.

1.2 Treatments for Eating Disorders

During the past years our understanding of the etiology of eating disorders has considerably improved with treatment approaches following suit (McGilley, 2006). Nevertheless, even though we are now more aware of risk factors, almost half of eating disorders patients present with a chronic or unremitting illness (Steiner & Lock, 1998). Supporting this finding, a review conducted by Steinhausen in 2002 of treatment outcomes for anorexia nervosa reported that of those that survive the early stages, 20% remain chronically ill and 63% experience relapse. Similarly, Wilson and colleagues (2007) found that amongst individuals with bulimia nervosa or binge eating disorder receiving treatment, only half find the treatment effective. The National Institute for Clinical Excellence (NICE, 2004) developed a set of guidelines to advise clinicians on the treatment of eating disorders.

These guidelines are developed by a multidisciplinary team and are based on the best available evidence. In 2011 NICE reviewed its guidelines, but concluded that the studies conducted in the seven years between the publication of the guidelines and the review, no new evidence had been found. For this reason, they decided not to update the original guidelines (NICE, 2011a; 2011b). The standard treatment for eating disorders revolves around a team approach, which includes the patient, their family as well as medical and mental health professionals (e.g. dieticians and psychiatrists; Kreipe et al., 1995; Weltzin et al., 2014). In a review of the current treatments, Pike and colleagues (2015) concluded that anorexia nervosa is particularly challenging to treat, however there are promising results for children and adolescents. For bulimia nervosa, the review found CBT to be the best treatment, achieving full remission of bingeing and purging behaviours in 20-50% of cases, however they also highlight Interpersonal Psychotherapy (IPT) as a viable alternative. Lastly, for binge eating disorder, psychological, behavioural and pharmacological treatments achieve significant reductions in binge eating. CBT-E has received good support for its effectiveness with transdiagnostic patients (e.g. Fairburn et al., 2009). For younger patients, the NICE guidelines recommend family or systemic therapy. For adult patients and for individual therapy, the NICE guidelines recommend CBT for all individuals suffering with an eating disorder since, to date, CBT is the best researched and most effective treatment available. For individuals struggling specifically with anorexia nervosa, the guidelines also suggest the use of Cognitive Analytic Therapy (CAT) and IPT. Dialectical Behaviour Therapy (DBT) is suggested for complex cases and, specifically, for those complicated by self-harm. Pharmacological interventions present with limited evidence for their effectiveness in the treatment of anorexia nervosa, however the NICE guidelines suggest that for bulimia nervosa and binge eating disorder they

can be used as an alternative or additional first step. I will now briefly describe and present evidence for all these treatments.

1.2.1 Cognitive Behavioural Therapy (CBT) and Enhanced Cognitive Behavioural Therapy (CBT-E)

Cognitive behavioural therapy (CBT) is the most researched approach as a treatment for eating disorders. Cognitive behavioural therapy sees cognitions, emotions and behaviours as interlinked; a change to one of these factors will cause changes to the other two as well. In addition, this approach recognises the important role that behaviours have in preserving and changing our cognitions and emotions. The aim of CBT is to help clients recognise the cognitions that underline problematic behaviours and emotions, and to help that client re-evaluate these cognitions. Cognitive behavioural therapy has been used as a treatment for eating disorders since the 1980s. Garner and Bemis (1982) suggested a CBT approach for the treatment of anorexia and Fairburn (1981) developed a CBT treatment for bulimia. In the past years, different researchers and clinicians have looked at the use of CBT as a treatment for binge eating disorder and obesity (e.g. Agras et al., 1997; Waller & Kennerley, 2003). In 2009, Fairburn and colleagues developed Enhanced CBT (CBT-E), which is a transdiagnostic personalised treatment approach that provides a more focused approach compared to CBT, and is based on the assumption that there are common cognitive mechanisms that underlie all eating disorders. As a matter of fact, CBT-E focuses on the processes that maintain eating disorder behaviours, such as emotions and cognitions, regardless of diagnosis.

According to the guidelines from NICE (2004) and the American Psychological Association (APA, 2006), the evidence for the treatment of anorexia nervosa in adults is weak. As a matter of fact, the highest level of evidence for adult treatment in the NICE guidelines is grade C. Currently, the clinical consensus indicates that CBT, IPT, CAT, and focal psychodynamic therapy are equally beneficial (APA, 2006; NICE, 2004). However, new studies suggest that CBT-E could be a useful treatment for adults diagnosed with anorexia nervosa. Fairburn and colleagues (2013) showed that significant weight gains and reductions in eating disorder pathology were achieved in two-thirds of adult patients (out of a total of 99 patients); these changes were maintained at follow-up as well. Another study by Dalle Grave and colleagues (2013) also found promising results for using CBT-E as a treatment for adolescents diagnosed with anorexia nervosa. Danielsen and colleagues (2016) suggest that the scarcity of research on treatments for anorexia nervosa could be due to different factors, such as its low prevalence, the severity

of medical complications, the high drop-out rate, and the extended treatment duration needed to successfully treat this diagnosis. For bulimia nervosa, CBT's efficacy is well established (e.g. Brown & Keel, 2012; Chen et al., 2003), with CBT-BN currently being the leading treatment (NICE, 2004). In general, the evidence for the efficacy of CBT with bulimia nervosa is very strong; findings suggest that CBT achieves symptoms remission in 40-50% of cases, with symptoms reductions in 60-70% of individuals (e.g. Pike et al., 2015; Vitousek, 1996; Wilson, 1999). In addition, in controlled trials CBT has been shown to be superior to the majority of therapies available and some clients even benefit from the use of self-help manuals (e.g. Cooper, Coker, & Fleming, 1996). However, the main criticisms of CBT-BN are that only 50% of individuals achieve full and lasting recovery and attrition rates are high (e.g. Vanderlinden, 2008). Recently, though, studies exploring the effectiveness of CBT-E for the treatment of bulimia nervosa have shown promising results, with 53-66% of individuals making significant improvements and maintaining them at follow-up (Fairburn et al., 2009; Byrne, Furslan, Allen & Watson, 2011). Furthermore, Watson and colleagues (2012) found that individuals report improved quality of life after receiving CBT-E, and a qualitative study by Onslow and colleagues (2016) reported that individuals experienced CBT-E as helpful and the changes achieved during treatment were still present at the two-year follow-up. With regards to binge eating disorder, APA (2006) and NICE (2004) guidelines support the use of CBT and selective serotonin reuptake inhibitors (SSRIs). A review conducted by Brownley and colleagues (2016) found strong support for the use of CBT, lisdexamfetamine, and SGAs in the treatment of binge eating disorder. Other studies also found good support for the use of CBT-E (e.g. Fairburn, 2008; Treasure et al., 2010; Wilson et al., 2010) and IPT (e.g. Grilo et al., 2012; Hay, 2013; Kass, 2013) for the treatment of binge eating disorder.

In conclusion, CBT and CBT-E have received strong empirical support for their effectiveness in the treatment of bulimia nervosa and binge eating disorder in adults; however, studies supporting their use with anorexia nervosa in adults and adolescents are more inconsistent (e.g. Zipfel et al., 2015). Furthermore, CBT seems to be as effective as other approaches for individuals who also have a history of trauma, high levels of dissociation or co-morbid personality disorder (e.g. Peterson et al., 2016; Sansone & Fine, 1992; Waller, 1997). Moreover, although CBT remains one of the most effective treatments available, researchers still need to understand why attrition rates still remain quite high, and explore how to avoid drop-outs given that factors such as lowest reported weight, tendency to avoid affect and time spent waiting for treatment have been shown to be significant predictors (e.g. Carter et al., 2012; Onslow et al., 2016; Waller & Kennerley, 2003).

1.2.2 Family Therapy

In the last decades, among the treatments available for eating disorders, family therapy has become quite an important one, in particular when working with anorexia nervosa (e.g. Eisler, le Grange, & Asen, 2003), and its effectiveness has been reviewed extensively (Jewell et al., 2016). Family therapy for anorexia nervosa is, in fact, the recommended treatment for adolescents in the APA (2006) and NICE (2004) guidelines, and is the only well-established treatment for this population (Lock, 2015). The studies looking at family therapy for adolescents with anorexia nervosa are extremely consistent, showing that adolescents respond well to this treatment without the need of an inpatient admission (e.g. Agras et al., 2010; Eisler et al., 2000; Lock et al., 2016). By the end of treatment, more than half of the clients reach healthy weight, and at follow-up 60-90% are fully recovered and only 10-15% remain ill (e.g. Couturier et al., 2013; Lock, 2015). Furthermore, Lock and colleagues (2010) found that adolescents that received family therapy had significantly fewer hospital admission compared to adolescents that received individual therapy. A similar result was also found by Agras and colleagues (2014), who reported that adolescents receiving family therapy gained weight more quickly and used less hospital days than adolescents receiving systemic family therapy. However, when comparing different types of family therapy, results are still preliminary as the number of comparative studies conducted is still small and they also include small sample sizes (e.g. Eisler et al., 2000; le Grange et al., 1992).

Data on the effectiveness of family therapy with adults with anorexia nervosa is still quite limited and the one that is available usually looks at chronically ill clients for whom it is generally quite difficult, regardless of the treatment approach, to achieve positive results (Eisler et al., 2003). Similarly to the latter, the research for family therapy and bulimia nervosa is also quite limited (Jewell et al., 2016). However, family therapy has been found to be superior to CBT in a recent randomized clinical trial (Le Grange et al., 2015). Furthermore, previous studies have shown family therapy for bulimia nervosa to achieve comparable results to CBT (Schmidt et al., 2007) and superior results than supportive therapy (Le Grange et al., 2007).

In conclusion, as different researchers have demonstrated family therapy has become firmly established as the treatment for adolescents with anorexia and bulimia nervosa (e.g. Le Grange et al., 2015). However, while there is evidence of its efficacy from RCTs, to date results have not yet been replicated independently of model developers (Jewell et al., 2016). Furthermore, other treatments for adolescent anorexia nervosa (e.g. CBT) have not yet been directly compared with family therapy and it is possible they could be equally effective (Jewell et al., 2016).

1.2.3 Pharmacotherapy

The medications most frequently used in the treatment of eating disorders are antidepressant as it is thought that eating disorders might be caused by same chemical imbalance that causes depression (Jackson et al., 2010). However, Bruna and Fogteloo (2003) mention that pharmacotherapy is usually not the first choice of treatment for eating disorders as the physical health of clients as well as their unhelpful cognitions and the eating disorders maintaining factors need to be addressed as quickly as possible. In addition, more research supporting the effectiveness of drugs in the treatment of eating disorders is needed as medication trials are highly variable (Jackson et al., 2010). The literature on the use of pharmacology for the treatment of anorexia nervosa is very limited and managing patients using medication alone does not seem appropriate given the medical complication associated with it and the high mortality rate. To date, no study has shown pharmacology alone to be an effective treatment for anorexia nervosa, since individuals are often non-compliant with it due to fear of gaining weight (e.g. McKnight & Park, 2010). For bulimia nervosa, studies suggest that the use of fluoxetine has a good risk-to-benefits ratio, while for binge eating disorder the drugs with good risk-to-benefits ratio are citalopram and sertraline. To date, only one medication has been FDA approved for the treatment of eating disorders, and that it fluoxetine for the treatment of bulimia nervosa; however, binging and purging only respond to higher doses (Jackson et al., 2010). Furthermore, these studies also suggest that pharmacotherapy is effective in suppressing binge eating in only 20% of cases (Treasure, 2012). For binge eating disorder, there is some evidence that SSRIs, tricyclic antidepressants, and sibutramine may be effective; however, most of the trials conducted have been short-term (Jackson et al., 2010). As previously mentioned, CBT appears to be effective in the treatment of binge eating disorder, but it does not help with weight loss. Limited evidence suggests that combining CBT and medication can improve both symptomatology and weight loss (Reas & Grilo, 2008).

In conclusion, the evidence for the use of medication as sole treatment for eating disorders is still limited and there are still gaps in the literature that need to be addressed, particularly with regards to methodologies implied as there is a tendency for lack of rigor in the designs and analysis (e.g. Flament et al., 2012; Jackson et al., 2010). However, there is preliminary evidence for the effectiveness of combining medication with CBT and other effective therapies (e.g. Roohi & Hashemian, 2016).

1.2.4 Interpersonal Psychotherapy (IPT)

Interpersonal psychotherapy (IPT) was developed as a structured, short-term, outpatient psychological treatment for major depression (Klerman et al., 1984; Markowitz et al., 1998; Weissman et al., 2000), and over the years, numerous randomized controlled trials have shown its effectiveness (Cuijper et al., 2011). Since IPT appeared to be effective for the treatment of depression, different researchers and clinicians started to use it for other mental health problems, including eating disorders (Fairburn et al., 1991; Weissman et al., 2000; Wilson et al., 2010). IPT posits that an important component of well-being and psychological adjustment is interpersonal function. In addition, IPT is based on research that has linked changes in the social environment to the beginning and to the maintenance of depression (Weissman, Markowitz, & Klerman, 2007). When IPT is applied to eating disorders, it assumes that the development of this disorder happens in a social and interpersonal context. Furthermore, the maintenance of the eating disorder and the response to treatment are thought to be affected by the interpersonal relationships between the individual and significant others (Murphy et al., 2012; Wilfley et al., 2003). For this reason, IPT for eating disorders aims at addressing interpersonal difficulties, thus removing and modifying the processes in which the eating difficulties developed and are maintained.

The evidence supporting the idea that eating disorders are influenced by interpersonal factors is quite strong, for example many individuals with anorexia and bulimia nervosa report that the onset of their difficulties was preceded by stressors linked to relationships with family members or friends (e.g. Schmidt et al., 1997). With bulimia nervosa and binge eating disorder, a history of negative interpersonal factors, such as negative comments about shape, is very common (e.g. Fairburn et al., 1997; 1998). In the literature on the treatment for eating disorders, IPT has been used as an active comparison group in different studies (Cuijpers et al., 2016). In the NICE (2004) guidelines for the treatment of eating disorders, IPT is the leading empirically supported alternative to CBT for bulimia nervosa, and is one of the recommended treatments for binge eating disorder.

The evidence for the use of IPT as a treatment for anorexia nervosa is still in its early stages, however different trials are being carried out to evaluate its effectiveness (e.g. McIntosh et al., 2000, 2005). In 2011 Carter and colleagues conducted a randomized controlled trial looking at the long-term efficacy of CBT, IPT and specialist supportive clinical management (SSCM). The results showed that about 50% of individuals had a good outcome at follow-up and there were no significant differences amongst the three treatments. In addition, results suggested

that, compared to participants in the SSCM group, participants in the IPT group had the best global outcome at follow-up. Participants in the CBT group seemed to have a more steady recovery, however, the improvements at follow-up for CBT were not as common as those for IPT. Although this study presented with different limitations, it is still a positive result for interpersonal psychotherapy. For the treatment of bulimia nervosa, two main randomized controlled trials have been conducted. The first was conducted by Fairburn and colleagues (1991), and they compared IPT with CBT; results showed that CBT was significantly more effective at reducing key behavioural features of bulimia nervosa, however this difference disappeared over the eight-month follow-up. Therefore, although IPT was slower acting, it appeared as effective as CBT in the longer term (Murphy et al., 2012). This result was also replicated by Agras and colleagues (2000) in a much larger study; again, CBT was found to be superior to IPT at the end of treatment, but the two treatments were equivalent at follow-up. For the treatment of binge eating disorder, two main studies have looked at the effectiveness of IPT. In the first study, Wilfley and colleagues (2002) compared group CBT and group IPT and found no significant difference between the two approaches at the end of treatment and at follow-up. In the second study, Wilson and colleagues (2010) compared individual IPT, with guided CBT self-help and behavioural weight loss treatment. At the end of treatment, there was no difference between the three groups, but at the two-year follow-up IPT and guided CBT self-help were significantly more effective than behavioural weight loss treatment in eliminating binge eating. More recently, Fairburn and colleagues (2015) compared CBT-E and IPT in a transdiagnostic sample and observed that CBT-E was more effective at the end of treatment; this difference was still significant at follow-up, however participants in the IPT group had shown significant additional improvements.

In conclusion, when being compared to other treatments, IPT showed successful long-term outcomes for bulimia nervosa and binge eating disorder (Wilfley et al., 2003). Studies looking at bulimia nervosa present similar outcomes between CBT and IPT for binge eating at both short-term and long-term (Fairburn et al., 1993; 1995). Agras and colleagues (2000) supported this finding by reporting that, although patients receiving CBT had good outcomes in the short-term, the outcome measures at follow-up were similar between CBT and IPT. For binge eating disorder, group IPT proved to be an effective treatment when compared with group CBT, with 62% of patients reporting no binge eating after one year (Wilfley et al., 2002). Lastly, the study by Carter and colleagues (2011) looking at the efficacy of IPT as a treatment for anorexia nervosa reported positive preliminary results. However, given the severity of this illness, it is likely that interpersonal psychotherapy will not be enough on its own (Wilfley et al., 2003).

1.2.5 Cognitive Analytic Therapy (CAT)

Cognitive Analytic Therapy (CAT) was developed by Ryle in the 1980s. CAT was influenced by the analytic and the cognitive models (Ryle, 1990) with the idea of rendering psychoanalytic therapy deliverable in a time-limited and structured way. The cognitive components of CAT were influenced by the works of Lazarus, Bandura and Kelly. Lazarus (1999) argued that cognitions, emotions and motivation are interdependent and that integration is necessary for well-being. Coping is therefore an important part of emotion and depends on both thoughts and motivation. By saying this, Lazarus implied that there are different paths for better emotional coping (Tanner & Connan, 2003). Bandura (1986) suggested that self-efficacy is the main cause of coping behaviour and studies have found support for this hypothesis (e.g. Mineka & Thomas, 1999). An important focus of CAT is to increase self-efficacy and agency; therefore Kelly's (1963) construct theory is particularly relevant for this approach. The psychoanalytic aspect of CAT derived from different object relations theories. The aim of CAT is to increase self-efficacy and self-reflection, while promoting change. To do this, CAT is divided in three main parts: reformulation of the problematic patterns, recognition of these patterns and revision of the patterns.

Treasure and Ward (1997) provided a rationale for the use of CAT as a treatment for eating disorders and suggest that the collaborative style of CAT might help engage ambivalent clients and might also help to weaken power struggles. Individuals with anorexia nervosa often experience interpersonal and emotional difficulties and CAT's emphasis on unhelpful relationship patterns and affect processing might be valuable (Tanner & Connan, 2003). Furthermore, individuals diagnosed with anorexia nervosa perform inadequately on theory of mind tasks (Tchanturia et al., 2001) and the use of the CAT map to enable the growth of theory of mind might be particularly helpful (Tanner & Connan, 2003). In addition, CAT uses an integrationist style that allows the therapist to use other techniques to address engagement and collusions (e.g. CBT to promote behavioural change; Tanner & Connan, 2003). Lastly, Tanner and Connan (2003) suggest that the rationale for using CAT as a treatment for anorexia nervosa can also be applied to bulimia nervosa. In particular, they point out that individuals with bulimia nervosa often present with co-morbid difficulties and CAT allows for these issues to be addressed at the same time as the eating disorder (Tanner & Connan, 2003). Furthermore, CAT can be used with adolescents and adults, and its flexibility allows for it to be used in individual, group and family therapy.

The literature on the effectiveness of CAT as a treatment for eating disorders is quite scarce. Tanner and Connan (2003) report that there are only two treatment studies available. The first was a pilot study comparing CAT with educational behaviour therapy (EBT) in the treatment of anorexia nervosa (Treasure et al., 1995). The authors stated that individuals in the CAT group reported greater subjective improvement at follow-up and they also showed better outcomes on the Morgan and Russell scale. Nevertheless, the differences between the two groups were not statistically significant. The second study compared CAT with family therapy, psychodynamic therapy and supportive therapy in a larger sample (Dare et al., 2001). The authors reported that CAT, family therapy and psychodynamic therapy performed better than supportive therapy, however there was no significant difference between the three. In conclusion, more research is needed on the effectiveness of CAT for the treatment of eating disorders.

1.2.6 Dialectical Behaviour Therapy (DBT)

During the last fifteen years, a number of new treatments and extensions from previous CBT treatments have started to emerge. These treatments have been termed third wave, and have been described by Hayes (2004) as:

> "*Grounded in an empirical, principle-focused approach, the third wave of behavioral and cognitive therapy is particularly sensitive to the context and functions of psychological phenomena, not just their form, and thus tends to emphasize contextual and experiential change strategies in addition to more direct and didactive ones. These treatments tend to seek the construction of broad, flexible, and effective repertoires over an eliminative approach to narrowly defined problems, and to emphasize the relevance of the issues they examine for clinicians as well as clients. The third wave reformulates and synthesizes previous generations of behavioral and cognitive therapy and carries them forward into questions, issues, and domains previously addressed primarily by other traditions, in hope of improving both understanding and outcomes*." (p. 658; italics in original).

These third-wave therapies present with common features, such as a focus on mindfulness, and acceptance (e.g. Hayes, 2004; Öst, 2008); one of these therapies is Dialectical Behaviour Therapy (DBT). DBT is a cognitive behavioural treatment that was originally developed to help individuals who were chronically suicidal and diagnosed with borderline personality disorders (BPD). When developing DBT, Linehan (1993) integrated acceptance procedures with standard cognitive behavioural procedures, and mindfulness is taught as a core set of skills, which is similar to what happens in Compassion Focused Therapy (CFT; Gilbert, 2010).

DBT is a treatment that received good support for the treatment of women with BPD, self-harm and substance abuse (Linehan et al., 1991; 1999). When eating disorders present with co-morbid personality disorder, treatment efficacy is often poor (Dennis & Samsone, 1997). For this reason, DBT could be effective in treating individuals with eating disorders and co-morbid BPD.

DBT (Linehan, 1993a; 1993b) is based on 'Biosocial Theory", which sees BPD as developing from "a probable biological tendency towards emotionality that is shaped by an invalidating environment" (Palmer & Birchall, 2003, p.271). DBT is usually an outpatient treatment, however it has been modified for inpatient and day-patient use (Bohus et al., 2000). It is a long-term approach and the treatment is usually divided in four parts. Three of those directly involve the patient and they are: weekly individual therapy sessions, group sessions and telephone contact between sessions. The last part consists in meetings amongst professionals where they discuss the patient. One of the strengths of DBT is the supportive framework available for both patients and professionals (Palmer & Birchall, 2003).

The literature supporting the effectiveness of DBT as a treatment for eating disorders is still limited. The main work has been conducted by a group at Stanford, where they look at skills training as a treatment for binge eating disorder (Welch & Tech, 1999; Telch, Agras, & Linehan, 2000); however, they have mainly looked at therapies informed by DBT, which are much shorter than the full version. Safer, Telch and Agras (2001a; 2001b) conducted a trial for outpatient DBT for women diagnosed with bulimia nervosa and the treatment was found to be superior to a waiting list. The results of this study suggest that short-term treatment centred on emotion regulation could be useful for treating bulimia nervosa, however they do not completely support the hypothesis that full DBT could be effective in treating eating disorders (Palmer & Birchall, 2003). Other studies were mainly descriptive and uncontrolled. For example, Marcus, McCabe and Levine (1999) described using a DBT treatment for individuals with eating disorders and co-morbid BPD. The authors report that all participants remained in therapy and showed progresses even at the 18-months follow-up. However, there was no comparison group and many participants were lacking pre-treatment measures. A recent meta-analysis conducted by Lenz and colleagues (2014) on the effectiveness of DBT for treating eating disorders reported that DBT may be efficacious for decreasing disordered episodes, however the authors describe these results as preliminary due to the small number of studies conducted and included. In conclusion, the effectiveness of full DBT for eating disorders still needs to be assessed (Palmer & Birchall, 2003).

1.2.7 The Story So Far

Eating disorders are a very serious pathology, however the findings reported above suggest that the efficacy of existing cognitive behavioural treatments is not satisfactory and there is room for improvement (Brownley et al., 2007; Bulik et al., 2007; Shapiro et al., 2007). As previously mentioned, anorexia nervosa has the highest mortality rate of all psychiatric illnesses (Birmingham et al., 2005), but the efficacy of existing treatments is low (Carter et al., 2011; Zipfel et al., 2014). Amongst adolescents family therapy is considered an effective treatment, however its effectiveness can only be defined as moderate since many adolescents continue to present eating disorders symptoms even after completion of the treatment (APA Presidential Task Force on Evidence-Based Practice, 2006). Currently, the clinical consensus, although weak, indicates that CBT, IPT, CAT, and focal psychodynamic therapy are equally beneficial (APA, 2006; NICE, 2004). However, new studies suggest that CBT-E could be a useful treatment for adults diagnosed with anorexia nervosa. Possible reasons behind these poor figures include individuals' resistance to begin treatment (Serpell et al., 1999; Vitousek, Watson, & Wilson, 1998), poor treatment adherence and acceptance (Halmi et al., 2005) and high drop-out rates (51-73% of individuals with an eating disorder drop out of treatment; Halmi et al., 2005; Fassino, Piero, Tomba, & Abbate-Daga, 2009; Kahn & Pike, 2001; Mahon, 2000, Surgenore, Maguire, & Beaumont, 2004). With regards to bulimia nervosa and binge eating disorder treatments appear to be more effective, however they are still not satisfactory (Kass, Kolko, & Wilfley, 2013). CBT and CBT-E (Fairburn et al., 2009) seem to produce the best outcomes for these illnesses (Byrne et al., 2011; Hay et al., 2009; Shapiro et al., 2007; Wonderlich et al., 2014). However, a recent comprehensive study showed that by the end of the CBT-E treatment, only 38.6% of patients with bulimia nervosa met criteria for remission and, after sixty weeks, 45.6% met the same criteria (Byrne et al., 2011).

These findings seem to suggest that there is room for improvement and that new treatments might be needed (Brennan, Emmerling, & Whelton, 2015; Fairburn et al., 2009), since many standard treatments are still not effective for at least half of the patients (Wilson et al., 2007). One of the criticisms that has been put forward towards current treatments is that they fail to make explicit the link between emotions and cognitions (Corstorphine, 2006). One approach that has recently been put forward to address this gap is Compassion Focused Therapy (CFT; Gilbert, 2010). One of the main goals of CFT is the development of compassion. This can be divided into three aspects: developing compassion for ourselves (self-compassion), developing compassion for others and being open to receiving compassion from others. Amongst the components of compassion, self-compassion has been found to be especially helpful for decreasing psychological

distress and improving well-being (Gilbert, 2007; Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004; Neff, Kirkpatrick, & Rude, 2007; Sirois, Kitner, & Hirsch, 2015). For this reason, the development of self-compassion could be an effective intervention for helping individuals suffering with eating disorders.

1.3 Self-Compassion

Self-compassion is a construct that sees suffering and failure as human, and is based on the belief that everyone is worthy of compassion (Neff, 2003a). In one of her early publications, Neff (2003a) eloquently described self-compassion as:

"*Self-compassion involves being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness*" (p.87)

Self-compassion therefore involves self-kindness rather than self-criticism in the face of pain and failures; in addition, individuals see their worth as unconditional even after failure (Leary et al., 2007). Self-compassion can therefore be thought of as including three main elements: self-kindness, common humanity and mindfulness. Self-kindness refers to treating oneself non-judgementally, common humanity refers to seeing pain as part of the human experience and not a result of one's failures or inadequacies and mindfulness refers to being present in the moment without over-identifying with or avoiding negative thoughts and feelings (Neff, 2003a). Over-identification and avoidance are associated with the search of self-esteem (Karanika & Hogg, 2015); over-identification involves rumination of one's failures and, in the long term, avoidance intensifies the negative thoughts and feelings (Neff & Vonk, 2009). Neff's definition of self-compassion draws from social psychology theories and from Buddhism; in CFT, Gilbert incorporates this definition and its theory but he also adds an evolutionary aspect arguing that the development of self-compassion is based on attachment theory and develops from infancy (Gilbert, 2000a; 2000b; 2005; 2010a; Gilbert & Irons, 2005). Therefore, cultivating compassion for oneself can encourage individuals to grow, while promoting well-being (Neff, 2003a); in fact, there is a growing amount of research linking self-compassion with different aspects of well-being (e.g. Barnard & Curry, 2011; Lawrence & Lee, 2014). Furthermore, self-compassion has received strong evidence for being an adaptive emotion regulator and coping strategy (e.g. Sirois, Kitner, & Hirsch, 2015).

The way in which self-compassion fosters well-being is by helping individuals feel cared for, connected and calm during difficult times (Gilbert, 2005). In particular,

self-compassion helps individuals to change their unhelpful cognitions and behaviours, while protecting against failure through effective coping mechanisms (Neff, 2003a; Neff, Hsieh, & Dejitterat, 2005). Research conducted on self-compassion suggests that higher levels of self-compassion are linked with decreased negative emotions, anxiety and depression, and increased positive emotions and happiness (Arimitsu & Hofmann, 2015; Neff, Kirkpatrick, & Rude, 2007; Lawrence & Lee, 2014). Furthermore, self-compassion positively correlates with life satisfaction (e.g. Neely et al., 2009; Seligowski, Miron, & Orcutt, 2014), and this finding was replicated across different cultures (Neff, Pisitsungkagarn, & Hsieh, 2008; Yang, 2016). Individuals with higher levels of self-compassion have been found to cope better with failure and have lower levels of rumination (Leary et al., 2007; Neff et al., 2005; Lawrence & Lee, 2014; Raes, 2010). Although these findings are mainly correlational and do not imply causation, they do suggest that the ability to experience self-compassion is correlated with well-being (Van Dam et al., 2011). Furthermore, self-compassion has been found to be effective in the treatment of different diagnoses, including eating disorders (e.g. Kelly & Tasca, 2016; Krieger, Berger & grosse Holtforth, 2016; Pauley & McPherson, 2010).

Self-Compassion and Eating Disorders

Different researchers have started to explore the link between self-compassion and eating disorders, while trying to understand if helping individuals develop self-compassion could be helpful in the treatment of eating disorders. Braun, Park and Gorin (2016) conducted a literature review on self-compassion, body image and eating disorders and reported positive findings that support the use of self-compassion in the treatment of eating disorders. In fact, they reported that self-compassion appears to negatively correlate with body and eating disorder-related outcomes in both clinical and non-clinical populations. However, all of the twenty-eight studies they included in their review used quantitative methodologies. Braun and colleagues (2016) also add that individuals diagnosed with eating disorders report higher levels of fear of self-compassion and lower levels of self-compassion. For example, a study conducted by Kelly, Vimalakanthan and Carter (2014) argued that fear of self-compassion was the strongest forecaster of eating pathology and reported that individuals who displayed bigger gains in self-compassion at the beginning of treatment had the most significant decrease in eating pathology at the end of treatment, which lasted 12 weeks. Tylka and colleagues (2015) looked at the effects of self-compassion in a large community sample and found that self-compassion was associated with lower eating difficulties and internalisation of the 'thin-ideal'. Although causation cannot be inferred from these studies as they mainly utilised correlational methods, they do provide positive preliminary findings,

which support the effectiveness of self-compassion in the treatment of eating disorders. Furthermore, researchers have also looked at evidence supporting the hypothesis that self-compassion can also act as a protective factor against eating disorders.

In their review, Braun and colleagues (2016) also looked at evidence supporting the hypothesis that self-compassion can prevent the occurrence of a risk factor. According to the tripartite influence model, media, peer, and familial interactions are seen as risk factors that are essential in fostering the internalization of society appearance norms, which corresponds with body dissatisfaction and eating pathology (Keery, van den Berg, & Thompson, 2004). Among the different studies looked at in the review, self-compassion was linked with lower media and interpersonal thinness pressures, thin-ideal internalisation, comparison of appearance, body checking, body shaming, body dissatisfaction and drive for thinness (Braun et al., 2016). Therefore, although preliminary, these findings suggest that higher self-compassion might bypass risk factors that are known to nurture eating disorders (Braun et al., 2016). Tylka and Kroon Van Diest (2015) had suggested four ways in which self-compassion could act as a protective factor against eating pathology, and the literature review by Braun and colleagues (2016) provided substantial support for this hypothesis.

The suggested way in which self-compassion might protect against eating disorders are the following (Tylka & Kroon Van Diest, 2015):

1. *Self-compassion directly decreases eating disorders symptoms*.

In the literature review conducted by Braun and colleagues (2016) different studies found a strong correlation between self-compassion and lower eating disorder symptoms. In addition, greater improvements were observed when self-compassion increased during treatment. For example, Albertson and colleagues (2014) reported that individuals participating in a 3-week self-compassion group significantly improved their levels of self-compassion, body appreciation, body dissatisfaction and body shame. In addition, all the improvements were maintained at the three-months follow-up. Another study by Mosewich and colleagues (2011) reported that self-compassion correlated negatively with body checking, body shame and objectified body consciousness; however, it did not predict mandatory exercise. In accordance with the literature, results for anorexia nervosa were less robust than for bulimia nervosa and binge eating disorder.

2. *Self-compassion protects against risk factors*.

Lower levels of self-compassion were found to correlate with adverse body image variables and appeared to mediate the relationship between risk factors and eating disorder symptoms. Furthermore, higher levels of self-compassion correlated with other protective factors, such as body appreciation, which may block the initial occurrence of risk factors. For example, a cross-sectional study with undergraduate female students reported that self-compassion negatively predicted body checking and body shame, but not beliefs about appearance control. Furthermore, self-compassion moderated the relationship between restrictive and critical eating messages given by caregivers and body checking/shame (Daye et al., 2014).

3. Self-compassion interacts with a risk factor to stop its effects.

Different types of studies (e.g. longitudinal and cross-sectional) reported that self-compassion interacts with risk factors and prevents them from causing negative outcomes. Amongst clinical samples, lower levels of self-compassion and higher levels of fear of self-compassion were linked with poorer treatment outcomes. Ferreira and colleagues (2014), for example, conducted a cross-sectional experiment with eating disorder outpatients and found that the positive subscale of self-compassion predicted eating pathology. In addition, self-compassion mediated the positive influence that shame memories have on eating pathology.

4. Self-compassion interrupts the chain through which risk factors operate.

Only one study examined moderated mediations and reported stronger mediational links between risk factors and individuals with low levels of self-compassion; Liss and Erchull (2015) conducted a cross-sectional study with female undergraduate students and stated that women with lower self-compassion reported higher body checking, body shame, negative eating attitudes and depression. In addition, among women with low self-compassion mediational paths between body checking and body shame and from body checking to negative eating attitudes were significantly stronger than for women with higher self-compassion. However, more research is needed in this area (Braun et al., 2016).

In conclusion, although preliminary, these findings suggest that higher self-compassion might bypass risk factors that are known to nurture eating disorders (Braun et al., 2016). Furthermore, there is growing support for the hypothesis that self-compassion might be an important factor in the treatment of eating disorders. One way in which self-compassion could be introduced in the treatment of eating disorders is through Compassion Focused Therapy.

1.4 Compassion Focused Therapy (CFT)

Compassion Focused Therapy (CFT) was developed by Gilbert to specifically address the concepts of shame, self-criticism, and hostility towards the self (Gilbert, 2000, 2009, 2010). In particular, Gilbert noticed that individuals presenting with high levels of shame and self-criticism found it difficult to engage with therapy as, even though the theory made sense to them, they often struggled to translate this into change (Gilbert & Irons, 2005). The main hypothesis put forward to explain why these individuals did not feel different revolves around their difficulty in generating positive and compassionate feelings towards themselves; therefore CFT was developed to help them cultivate self-compassion and positive emotions (Gilbert, 2010).

Compassion Focused Therapy is an integrated and multi-modal approach rooted in evolutionary psychology, neuroscience and social psychology, however it also borrows many teachings from Buddhism and is closely linked to the psychology and neuropsychology of caring (Gilbert, 2010). According to CFT, individuals start to develop compassion in early childhood and the mechanism through which individuals develop compassion is based on Fogel, Melson and Mistry's (1986) model of nurturance. According to this model, nurturing needs to be enacted by carers and involves *awareness* of the need to be nurturing, *motivation* to nurture, *expression* of nurturing feelings, *understanding* what is needed to nurture and an ability to match nurturing with the *feedback* from others (Gilbert, 2010). Gilbert (2000a) then argued that these aspects of nurturing can be directed either towards the self or towards others. Compassion, therefore is linked to early affectionate experiences and attachment security (Gillath, Shaver, & Mikulincer, 2005). As a matter of fact, the aim of CFT is to teach compassion, which involves developing compassion for the self and for others, as well as being open to receiving compassion from others. The reason behind this is that feeling cared for, and accepted is necessary for our psychological maturation and well-being (Cozolino, 2007; Siegel, 2001, 2007). The positive effects of compassion have often been reported; different studies, in fact, have demonstrated that helping individuals develop compassion for themselves and for other can improve different mental health issues (e.g. Hoffmann, Grossman, & Hinton, 2011), including eating disorders (e.g. Allan & Goss, 2011). For example, CFT has been shown to decrease both depression and anxiety in individuals presenting to community mental health teams (Judge, Cleghorn, McEwan, & Gilbert, 2012), in individuals with long-term mental health difficulties (Gilbert & Procter, 2006) as well as in individuals in high security psychiatric settings (Laithwaite et al., 2009). Overall, there is growing literature demonstrating the effectiveness of helping individuals

develop positive and compassionate emotions towards themselves to improve mental health (e.g. Ashworth, Gracey, & Gilbert, 2011; Goss & Allen, 2014). In addition, there is increasing evidence showing that compassion can be taught and this has beneficial effects on a range of aspects, such as attitudes toward other people (e.g. Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Hutcherson, Seppala, & Gross, 2008).

Compassion Focused Therapy aims to teach compassion by helping individuals develop a range of skills, such as non-judgment and empathy; furthermore, since CFT is rooted in evolutionary psychology, it helps individuals develop self-compassion by highlighting and explaining that our brains evolved in a way that can become problematic by being triggered into mental health problems, therefore not everything is "our fault" (this is referred to as 'tricky brain'; Gilbert, 2014). Additionally, CFT explains that due to our brain structure, we developed three affect regulation systems that allow us to organise our brain, and these can become unbalanced over time (Gilbert, 2014). Since both of these concepts are important for understanding how self-compassion might be implemented in the treatment of eating disorders, I will spend some time exploring them further.

1.4.1 'Tricky' Brain

Compassion Focused Therapy uses the concept of 'tricky brain' to explain the fact that our brains are incredibly complex and can do great things, however they are not well-designed and this can cause different problems (Gilbert, 2014). One main problem is that, over the years, humans evolved complex cognitive capacities and an objective sense of self, but our brains still have old emotions and motives (such as surviving). Moreover, with our new capacities we are able to stimulate or distort these emotions and motives, which can stimulate threat emotions and maintain activated physiological responses that give rise to mental and physical health problems (Gilbert, 2014; Sapolsky, 1994). For example, by ruminating on what could have happen or will happen, we can maintain ourselves in an anxious state. Another issue arising from having a 'tricky brain' is that, although we have compassion motivation systems, we also have harm intending systems that can cause us to use our intelligence to damaging effects. Nevertheless, our intelligence can also be used to override these harm systems to help others and towards compassionate goals (Loewenstein & Small, 2007). Lastly, our capacity to create an objective sense of self can give rise to problems of narcissism, but also of shame, self-criticism and self-harm (Gilbert, 2014). These last three, in particular, have been linked to different mental health problems as they continuously stimulate the threat system (Gilbert, 2009). From this, it emerges that the human

brain has the capacity of generating complex and unhelpful loops between motives, emotions and cognitions (Gilbert, 2014). However, CFT highlights that this is not our fault and that our brains evolved like this, which can have a de-shaming effect on individuals (Gilbert, 2014). Furthermore, CFT helps individuals to work with the 'tricky brain' by helping them become mindful of what goes on in their minds without getting caught in the loops; this can be particularly important when working with individuals diagnosed with eating difficulties as many present with neurocognitive deficits (e.g. Kanakam & Treasure, 2013).

Many of the neurocognitive deficits observed in individuals suffering with eating disorders are found in the executive function area (Kanakam & Treasure, 2013; van Elburg & Treasure, 2013). Executive function is an umbrella term that includes a group of neuropsychological processes that manage goal-directed behaviours (Miyake et al., 2000). Different studies have provided evidence that deficits include difficulties in shifting behaviours and thoughts (Roberts, Tchanturia, & Treasure, 2010; Tchanturia et al., 2011; Wu et al., 2014), difficulties in concentrating on the bigger picture and in incorporating smaller pieces to form a bigger picture (Lopez et al., 2009), and difficulties in ignoring irrelevant information while attending to new information (Duchesne et al., 2010). These issues have been found across diagnoses and the level of harm is similar amongst anorexia and bulimia nervosa diagnoses (Lang et al., 2014). Furthermore, previous research has shown that individuals with binge eating present with poor inhibition control (Rosval et al., 2006; Wu et al., 2013). Therefore, Compassion Focused Therapy can be helpful for individuals diagnosed with an eating disorder as it can help them develop compassion and become more aware of the ways in which their brains work without getting caught in the unhelpful loops. Nevertheless, because of the way in which our brains evolved, we also have motivational systems that allow us to avoid threats and seek resources. By drawing from Depue and Morrone-Strupinsky's (2005) work, Gilbert (2010) described three systems: the threat and protection system, the drive system and the soothing system.

1.4.2 The Three Affect Regulation Systems

In the context of Compassion Focused Therapy, compassion is conceptualised from an evolutionary perspective, which focuses on the evolution of the affiliative system (Leaviss & Uttley, 2015). Research on the neurophysiology of emotions identified three main emotion regulation systems (Depue & Morrone-Strupinsky, 2005): the threat and protection system, the drive, resource-seeking and excitement system and the soothing system. The aim of CFT is that of re-establishing a balance amongst the three systems in order to help individuals who

find it difficult to access the soothing system when responding to threats (Gilbert, 2010).

The Threat and Protection System

The threat and protection system is fundamental in quickly detecting and responding to threat (LeDoux, 1998). When this system becomes activated our attention becomes biased and focuses only on the threat, and emotions such as anger and anxiety arise and ripple through the body to alert us of the threat. It is these emotions that give rise to "fight, flight or freeze" behaviours (Leaviss & Uttley, 2015). Although the emotions that arise when this system is active can be painful and difficult, this system evolved as a protection system (Gilbert, 2010). As a matter of fact, our brains prioritise dealing with threats than pleasurable things (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001). The threat system is linked to particular brain systems, such as the amygdala and the hypothalamic-pituitary-adrenal (HPA) axis; therefore, when in threat mode, our attention, thinking, behaving and emotions are all focused on the threat and the only goal in our mind is that of safety (Gilbert, 2010). However, the smooth operation of this system can be difficult for different reasons, for example many of its responses conflict with each other (i.e. fight and flight) or accentuate feelings of threat (e.g. avoidance) (Gilbert, 2009). Furthermore, individuals who present with psychological difficulties and had to cope with traumatic life experiences, can become sensitive to threat and develop different safety strategies for coping with it (Goss & Allan, 2010). For example, Goss and Allan (2010) hypothesised that eating disordered behaviours are used to manage threat by avoiding a dreaded event or by disrupting a painful emotional experience. The aim of Compassion Focused Therapy is therefore to help individuals see their responses as evolutionary as well as understand their symptoms and difficulties in terms of safety strategy (Gilbert, 2009).

The Drive, Resource-Seeking and Excitement System

The drive system is linked to seeking and acquiring and has a motivational function. When this happens our attention becomes focused on rewards and resources and positive emotions such as excitement and vitality arise. Therefore, the function of this system is to give positive emotions that guide, motivate and encourage us to look for resources that are needed to survive and prosper (Depue & Morrone-Strupinsky, 2005). When this system is balanced with the other two systems, it can guide us towards achieving important life goals (Gilbert, 2010). However, when there are blocks to our goals that are perceived as threats, the threat system becomes activated and the result is that we either stop pursuing our goal or we overcome the block (Klinger, 1977; Gilbert, 2010). When individuals disengage from a goal, they can experience their mood dropping; the greater the

implications of giving up are, the lower the mood gets (Gilbert, 2010). The goal of Compassion Focused Therapy is to explore the function that these goals hold and what happens if the goal becomes unattainable. Goss and Allan (2010), for example, suggest that eating disordered behaviours have a functional role in attempting to regulate threat through the drive system, with pride in behaviours being an important aspect of threat regulation. For this reason, these two systems become interlinked and, when safety strategies are successful, people are likely to experience positive emotions; however, when individuals fear they will lose their ways of managing threats, they enter a state of perpetual threat that has detrimental effects on their physical and mental health. Lastly, when the drive system and the threat system become interlinked, it prevents the development of soothing regulation strategies (Goss & Allan, 2010).

The Soothing System

Gilbert (2010) eloquently described this system as:

"*This system enables us to bring a certain soothing, quiescence and peacefulness to the self, which helps to restore our balance*" (p. 48)

The soothing system produces emotions such as peacefulness, well-being and contentment. Contentment, in particular, refers to a form of happiness in which a person is satisfied with the way things are and feels safe. This system therefore gives rise to positive emotions that are quite different from those of excitement and striving elicited by the drive system. What complicates the functioning of this system, is that it is also linked to affection and kindness (Gilbert, 2010). For example, when a baby is distressed, the love of a carer can have a calming and soothing effect. Coan and colleagues (2006), in fact, showed that the destructive effects of negative events can be alleviated by social bonding and soothing behaviours. Actually, the soothing system is of vital importance in compassion training as it is fundamental for our sense of well-being. From this, it is possible to notice how the soothing system evolved with attachment and affiliation (Depue & Morrone-Strupinsky, 2005) and its function is that of managing distress and promoting bonding.

According to CFT, individuals start to develop the soothing system and compassion in early childhood and the mechanism through which individuals develop them is based on Fogel, Melson and Mistry's (1986) model of nurturance. According to this model, nurturing needs to be enacted by carers and involves *awareness* of the need to be nurturing, *motivation* to nurture, *expression* of nurturing feelings, *understanding* what is needed to nurture and an ability to match

nurturing with the *feedback* from others (Gilbert, 2010). Gilbert (2000a) then argued that these aspects of nurturing can be directed either towards the self or towards others. For this reason, the sensitivity and responsiveness of the caregiver are thought to be critical with regards to how a child learns to regulate emotions (O'Shaughnessy & Dallos, 2009). However, these factors are not the only ones responsible for the outcome attachment between the carer and the child (Sharp & Fonagy, 2008). One factor that has been looked at in particular is mentalization (Premack & Woodruff, 1978), which refers to the ability to infer or think about the mental states of other people or the self (Liotti & Gilbert, 2011; Sharp & Fonagy, 2008). From this, the child develops internal working models of the mother and other carers that will become a prototype for future relationships and for guiding emotions (Bretherton & Munholland, 1999). One of these relationships is that with the self. If, for example, the child experiences the caregiver as rejecting or unreliable, s/he is more likely to develop strategies to cope with the distress without having to go to the caregiver (Bretherton & Munholland, 1999). These strategies, however, tend to decrease or deactivate the function of the attachment system, which can result in the child having difficulties accessing their emotions or ruminating on their distress (Mikulincer & Shaver, 2005). Compassion, therefore is linked to early affectionate experiences and attachment security (Gillath, Shaver, & Mikulincer, 2005) and difficulties to access the soothing system could be due to its under-stimulation in infancy or to environmental or biological causes (Belsky & Beaver, 2011; Gilbert, 2014).

When individuals struggle to access the soothing system, they find it hard to feel reassured or calmed when they create alternative thoughts or employ helpful behaviours (Gilbert, 2009). In addition, Mikulincer, Gillath and Shaver (2002) found that threat can prime access to memories that are used for coping and, if individuals self-soothing abilities have been under-stimulated and under-developed, individuals can find it difficult to self-soothe and might experience higher levels of shame and self-criticism.

1.4.3 Shame and Self-Criticism

Different researchers have highlighted the important link between self-criticism and different mental health difficulties (e.g. Whelton & Greenberg, 2005), including eating disorders. In addition, it can weaken the success of traditional approaches such as CBT (Rector et al., 2000). It has been hypothesised that for individuals with high levels of self-criticism, compassion and soothing emotions might be unfamiliar and frightening (Gilbert, 2009a, 2009b; Gilbert & Procter, 2006). As a matter of fact, studies measuring physiological responses and using fMRIs showed that these individuals respond to compassionate images with responses usually

associated with threats (e.g. higher heart rate; Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008; Longe et al., 2010). In one of their studies Gilbert and Procter (2006) noted 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*" (p.373)

Gilbert and colleagues (2004) acknowledged two forms of self-criticism: one concentrates on mistakes and the sense of inadequacy, the other aims at hurting the self and at experiencing self-hate. In the same article, the authors also added that self-criticism has two functions: one that promotes improvement and one that promotes self-persecution. With regards to individuals suffering with eating disorders, research has found that they tend to criticise themselves to elicit self-persecution, while presenting with lower levels of self-compassion (Barrow, 2007). Fennig and colleagues (2008) showed that self-criticism on its own is a strong predictor of eating disorders symptoms and in a qualitative study, Tierney and Fox (2010) found that individuals with anorexia can be very harsh towards themselves. Regardless of diagnosis, in fact, individuals struggling with an eating disorder are likely to be very self-critical and present with high levels of hostility towards themselves (Goss, 2007; Williams et al., 1993, 1994). The relationship between self-criticism and eating disorder symptoms can be mediated by shame (Kelly & Carter, 2013). Shame, in fact, is a very potent and multidimensional feeling (Kim, Thibodeau, & Jorgensen, 2011).

Compassion Focused Therapy sees shame as both internal and external. Internal shame sees the person's attention focused inwards and coping mechanisms focus on regulating internal emotions. External shame sees the attention focused outwards and coping mechanisms focus on social interactions (Allan, Gilbert, & Goss, 1994; Gilbert, 1998, 2002, 2007). Shame can be influenced by different emotions, behaviours and specific biological aspects such as elevated levels of cortisol (Dickerson & Kemeny, 2004). Shame often revolves around social comparison with different emphases, for example other individuals' bodies or emotions (Gilbert, 2002; Power & Dalgleish, 1997). A review conducted by Ali and colleagues (2016) found that individuals struggling with eating difficulties often report feelings of shame.

Different studies have found that individuals with eating disorders present with significantly higher levels of shame compared to other clinical groups (e.g. Cook, 1994; Goss & Allan, 2009; Masheb, Grilo, & Brondolo, 1999). The studies also found that the focus of shame was also different in eating disorders populations,

being more associated to eating and eating disordered behaviours (Frank, 1991; Sanftner & Crowther, 1998). Furthermore, different authors found that women who have an eating disorder or are recovering from it present with high state and trait shame, even when depression was controlled for (Gee & Troop, 2003; Troop, Allan, Serpell, & Treasure, 2008).

Gilbert (2007) suggested that high levels of self-criticism and shame continually stimulate the 'threat system', which results in detrimental effects for positive emotions. These results are quite important for the field of counselling psychology as they demonstrate that individuals with certain characteristics, such as high self-criticism and high levels of shame, can experience compassion as unsafe and threatening (Gilbert, 2007; Gilbert & Irons, 2005; Gilbert, McEwan, Matos & Rivis, 2011; Lawrence & Lee, 2014). However, fear of compassion can be much easier to tackle in therapy by using techniques such as gradual exposure and desensitization (e.g. Abramowitz, Deacon, & Whiteside, 2012).

In a randomised controlled trial conducted by Jazaieri and colleagues (2013), results showed that fear of compassion decreased after individuals were trained in developing compassion. These results suggest that compassion can be both taught and learnt through training, and that fear of compassion can be decreased (Gilbert et al., 2011; Gilbert et al., 2014; Leaviss & Uttley, 2015). In addition, from a biological perspective, practicing compassion has been shown to reduce immune responses linked to stress (Pace et al., 2009), and, in general, compassion reduces depression and promotes effective coping strategies (Neff & Vonk, 2009). Furthermore, a review of the literature suggested that 'loving kindness meditation' and 'compassion-based meditation' correlate with an increase in positive emotions and a decrease in negative emotions, in addition, these meditations may increase the activation of brain areas that are responsible for empathy and processing of emotions; 'compassion-based meditation' has also been found to reduce distress and immune responses caused by stress (Hoffmann et al., 2011).

Given that feelings of shame and self-criticism might derive from an under-developed soothing system, a key part of the therapy is to help individuals understand that many of the cognitive biases and emotions they experience are built-in and have been caused by biological and environmental processes (Leaviss & Uttley, 2015). Furthermore, if one imagines shame and self-criticism as being on a spectrum, at the opposite side one can see compassion (both for self and others (Goss & Allan, 2014). Therefore, the aim of CFT is to help individuals respond to self-criticism with compassion and kindness, with the final goal of increasing well-being and re-establishing a balance between the three affect regulation systems.

1.4.4 Compassion

The word compassion derives from the Latin *compati*, which means to suffer with. Although the concept of compassion has only been recently introduced in Western science, Buddhist approaches have been talking about this concept for more than 2000 years (Irons, 2014). In the Buddhist philosophy, compassion is seen as a key factor in promoting happiness and wellbeing by liberating our minds from the influence of negative emotions such as fear, and anger (Goleman, 2003). Most definitions of compassion recognise that it is rooted in caring motives, and that it requires a range of skills to be enacted, such as empathy, distress tolerance, and courage (e.g. Dalai Lama, 1995; Gilbert, 2015). One of the most adopted definitions of compassion defines it as:

"*a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it*" (underlining was added to original; Gilbert, 2015, p. 242)

This definition suggests that there are two psychologies (Gilbert, 2015) involved: the intention of noticing and engaging with the suffering, and the intention to acquire the skills needed to alleviate and prevent suffering. When compassion is used in therapy, all these different components are put together and have the potential to be taught and trained (Gilbert, 2010). Compassion can also be thought of as being part of prosocial behaviour, which has been one of the main drivers of human evolution and intelligence (Carter, 2014, Gilbert, 2015).

Over the years, researchers have looked at the psychological mediators for caring behaviour, such as compassion. There is now a large literature that suggests oxytocin is associated with a number of prosocial behaviours that underline mammalian and human sociality and caring (e.g. Carter, 2014; MacDonald, 2013). However, oxytocin can also be associated with more negative responses, such as maternal aggression towards potential threats to their babies (De Dreu, Greer, Van Kleef, Shalvi, & Handgraaf, 2011). Although the physiological mechanisms behind caring behaviours can be traced back to primates and beyond, there are certain aspects of human compassion that have only recently evolved (Gilbert, 2015). One major development in the evolution of humans was cognitive mechanisms that allow us to understand our minds and social contexts in completely new ways; these include skills such as empathy, theory of mind and mentalizing (Suddendorf & Whitten, 2001). Therefore, what turns caring into compassion in humans is the ability to bring these skills to the motivation for caring, and for us to understand other people's minds (Gilbert, 2015). From these studies, it is possible to notice how the nature of compassion is quite complex, and how it is linked to early

attachment experiences (Gilbert et al., 2011). Furthermore, in CFT compassion is understood in terms of specific attributes (Gilbert, 2009).

The attributes of compassion include care for well-being, sensitivity, sympathy, distress tolerance, empathy, and non-judgement (Gilbert, 2009). Care for well-being requires individuals to connect the motivation to be caring with the purpose of alleviating distress and aiding the development of the target receiving caring. Sensitivity refers to the individual sensitivity towards distress and needs, while sympathy implicates being moved by the feelings of distress. Compassion also involves being able to stay with and tolerate difficult feelings, rather than avoid or deny them. Empathy involves being able to understand the functions and origins of other people's inner world. Self-empathy refers to the ability of standing back from and understanding our own thoughts and feelings. Lastly, non-judgement means experiencing the moment as it is, without criticising or shaming (Gilbert, 2009). The aim of CFT is therefore to help individuals who present with an under-developed or blocked soothing system to cultivate compassion by having the therapist demonstrate the attributes of compassion (Gilbert, 2009). As a result, compassion stimulates the soothing system and, in turn, the latter returns to doing its natural job of regulating threat and distress (Irons, 2014). The positive benefits of developing and practicing compassion have often been demonstrated in the literature.

Different studies have found that, when individuals practice exercises based on compassion, important changes occur in several neuro-biological and neuro-physiological mechanisms (Irons, 2014). For example, different authors reported that when individuals self-reported increased levels of compassion, they also showed improved immunological responses (Lutz et al., 2008; Pace et al., 2009), as well as reduced levels of negative emotions and mental health symptoms, and increased levels of positive emotions, well-being and happiness (Neff & Germer, 2013). Furthermore, compassion has been found to be helpful in a variety of diagnoses, such as depression, and eating disorders (e.g. Gale et al., 2014; Gilbert & Procter, 2006).

In brief, compassion is rooted in caring motivational systems, and social mentalities that "have become open to cultivation and regulation through high-level cognitive processes, complex social and cultural practices, and self-identity issues" (Gilbert, 2015, p. 250). Furthermore, research conducted on compassion has shown that it can have beneficial effects on our minds and bodies, and on social relationships (e.g. Neff & Vonk, 2009; Pace et al., 2009). In addition, research looking at the use

of compassion in the treatment of eating disorders has also found preliminary positive results.

Compassion and Eating Disorders

Compassion Focused Therapy was initially used to help individuals with eating disorders by adding specific aspects of the therapy to the NICE recommended treatment (i.e. CBT; NICE, 2005) in a group format (Goss & Allan, 2010). The idea behind it was to improve the effectiveness of already existing treatments by adding interventions that would arouse and nurture the soothing system. Preliminary evidence for the effectiveness of CFT as an addendum to CBT was promising; Gale and colleagues (2014) reported significant improvements on an extensive range of eating disorders symptoms during the treatment. Individuals that seemed to benefit the most from the program were those that had been diagnosed with bulimia nervosa, with three-quarters recovering by the end of treatment. In the same study, the authors reported that amongst individuals diagnosed with anorexia nervosa 33% recovered or improved and 26% could be classified in the 'functional' range of the EDE-Q. The authors conclude that for a population where there is limited evidence for the effectiveness of any treatment, these could be thought of as promising results. Furthermore, a study by Holtom-Viesel, Allan and Goss (2014) looked at the impact of CFT components on self-compassion, self-criticism and shame. The CFT aspect was introduced after a psychoeducational component and a CBT component had been completed. The study observed that it was only after CFT was introduced that self-compassion increased, shame and self-criticism decreased, and levels of symptomatology started to reduce. Although these are preliminary studies, their results are still promising. In addition, a number of studies found that individuals with high self-criticism might show, at least initially, negative responses to compassion (e.g. Gilbert et al., 2011; Longe et al., 2010; Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008).

In conclusion, compassion has been shown to have beneficial effects on our minds and bodies, and this can be helpful for the treatment of different diagnoses, including eating disorders. In addition, research has found compassion to be linked to early attachment experiences; therefore cultivating compassion in individuals that present with under-developed or blocked soothing systems, can help restore a balance amongst the three affect regulation systems and stimulate the soothing system to regulate threat and distress by producing feelings of contentment and well-being. These studies, and previews reviews conducted on compassion (e.g. Hoffmann et al., 2011), suggest that it is possible to teach elements of compassion and self-compassion.

1.5 The Skills of Compassion and Self-Compassion

There are different ways in which the skills of compassion and self-compassion can be developed; in 2004, Gilbert created a therapy intervention called *Compassionate Mind Training* in which individuals that are often self-attacking are helped to cultivate the skills of self-compassion. As a matter of fact, Gilbert (2009, p.199) described it as such:

"*Compassion focused therapy refers to the underpinning theory and process of applying a compassion model to psychotherapy. Compassionate mind training refers to specific activities designed to develop compassionate attributes and skills, particularly those that influence affect regulation*"

The idea behind compassionate mind training is that some individuals did not have the opportunity to develop their abilities to understand the source of their distress, be gentle and soothing in the context of disappointments and setbacks; this causes them to be highly threat focused and sensitive (Gilbert & Procter, 2006). Therefore, clients are helped to develop a more compassionate relationship with themselves by having the therapist demonstrate the skills and attributes of compassion (Gilbert, 2009). The skills of compassion help individuals create their own feelings and images of warmth and kindness (Gilbert & Irons, 2004), and this is done through a variety of activities.

The activities through which individuals are taught the skills of compassion and self-compassion include compassionate attention, compassionate reasoning, compassionate behaviour, compassionate imagery, compassionate feeling, and compassionate sensation (Gilbert, 2009). Compassionate attention requires individuals to focus their attention towards memories, qualities or things that are associated with warmth, support and kindness. In individuals struggling with certain difficulties, such as individuals struggling with eating disorders, the threat system is often focused on problems and difficulties; therefore, practicing compassionate attention, can help these individuals refocus their attention and liberate it from the hold of the threat system. Compassionate reasoning involves paying attention to how individuals think about others and, in particular, themselves. Through this skill, individuals are helped to create alternative thoughts that are kind, supportive and helpful. Compassionate behaviour focuses on alleviating distress and promoting development and growth; however, this does not mean avoiding painful emotions or tasks. Furthermore, through this skill, individuals are taught to focus on their efforts rather than on their results. Compassionate imagery uses different exercises to help individuals generate compassionate feelings for themselves.

Through these exercises, clients are helped create and imagine their ideal of compassion while, at the same time, being encouraged to practice becoming 'the compassionate self' (Gilbert, 2009, p. 205). The skill of compassionate feeling involves experiencing self-compassion as well as compassion from and for others. The ways in which compassionate feelings can be generated are numerous and they include the therapeutic relationship and the other skills of compassion. Lastly, compassionate sensation involves noticing bodily sensations and feelings that arise while practicing self-compassion and compassion for others.

In conclusion, compassionate mind training aims to help individuals create feelings of warmth, kindness and support within themselves by facilitating the development and cultivation of these skills (Gilbert, 2009). In a recent study, Gale (2012) investigated the outcome of a compassionate mind training programme with individuals with eating disorders and concluded that the programme led to improvements on different aspects of eating difficulties, shame and self-criticism; suggesting that helping people become more self-compassionate can have a positive impact on their eating psychopathology. Furthermore, different researchers have demonstrated that it is possible to teach these skills (e.g. Gilbert & Procter, 2006; Hoffmann et al., 2011), and this can be done in both individual and group therapy.

1.6 Group Therapy

The therapeutic benefits of group therapy are, in fact, well known and many studies attest to this (e.g. Burlingame, MacKenzie & Strauss, 2004; McRoberts, Burlingame & Hoag, 1998; Smith, Glass & Miller, 1980; Tillitski, 1990). As a matter of fact, in their book about group psychotherapy, Yalom and Leszcz (2005) explain that:

> "*a persuasive body of outcome research has demonstrated unequivocally that group therapy is a highly effective form of psychotherapy that is at least equal to individual psychotherapy in its power to provide meaningful benefit*" (p.1)

In the field of eating disorders, there is a growing interest for the use of group therapy in the treatment of eating disorders as it is more cost-effective than individual therapy, but still offers the same opportunities of growth (Pisetsky et al., 2015). Although no comparative study found group therapy to be superior to individual therapy, an increasing amount of papers demonstrate the effectiveness of group therapy for the treatment of eating disorders (Garcia, Martinez, Leon & Polo, 2016; Hendren, Atkins, Sumner, & Barber, 1987; Moreno, Fuhriman, &

Hileman, 1995). More recently, in a quantitative study, Pisetsky and colleagues (2015) found that individuals who engaged in the therapy group early on also showed improved eating outcomes after twelve months. Wanlass and colleagues (2006) suggest that individuals with eating disorders present with common characteristics that can be better addressed in group therapy. Some of these characteristics are isolation, low self-esteem, difficulties in recognising feelings and difficulties in communicating with others (Hendren, Atkins, Sumner, & Barber, 1987). One effective aspect of group therapy is that it offers a safe environment where individuals can disclose and talk about their eating disorders, which are usually kept as a secret and are often entrenched in feelings of shame, guilt and self-hatred (Riess & Rutan, 1992). Another factor that plays a role in group therapy is hope. Wanlass and colleagues (2006) suggest that when members of the group are able to help others, they in turn feel more confident in their ability to recover. However, the most helpful aspects of group therapy for eating disorders appear to be cohesion, insight and development of social skills (Moreno, 1994). In fact, as Barth (1994, p.69) eloquently put it:

"The group process can be seen as a kind of group 'swimming lesson' in which group members work together with the therapist to develop the necessary skills and muscles to be able to negotiate the waves of their own feelings without using their eating behaviour as a life raft"

This last point in particular, seems to be applicable to CFT and compassionate mind training as individuals are taught the skills of self-compassion by having the therapist demonstrate these skills in a way that is perceived as de-shaming, safe, and compassionate (Gilbert, 2009) and this can also be done in a group setting. Furthermore, compassionate mind training invites people to develop their own images of warmth by recalling how one felt when being compassionate towards others (Gilbert & Procter, 2006); this can be easily practiced in a group setting, particularly if the group includes individuals struggling with similar difficulties. For individuals suffering from eating disorders this could be an important experience, as they often feel isolated and alone with their symptoms (Barth, 1994), as well as ashamed of their struggles (Wanlass et al., 2006). Furthermore, Wanlass and colleagues (2006) also suggest that a group setting where others present with similar struggles might give individuals the confidence to share their vulnerabilities as they can expect understanding and support from others. As a matter of fact, CFT focuses on developing emotional experiences while decreasing shame, and when these experiences are shared in a group setting they can become particularly powerful (Bates, 2005; Gilbert, 2010). In addition, the first evidence of the effectiveness of compassionate mind training came from group therapy (Gilbert &

Procter, 2006). Recent studies are showing that group-based CFT can be effective for different individuals, including those struggling with eating disorders (e.g. Gale et al., 2014).

In conclusions, although Compassion Focused Therapy is often delivered in an individual setting, additional studies show that it can be delivered in a group setting (Judge, Cleghorn, McEwan & Gilbert, 2012). However, more research is needed to explore the effectiveness of group CFT with individuals struggling with eating disorders, as well as research exploring participants' views in order to inform practice and improve treatments available (Sparrow & Tchanturia, 2016).

1.7 Overview of Compassionate Mind Group

The groups in which my participants took part were based on compassionate mind training in that the aim was that of teaching compassion, and they lasted eight weeks. In the beginning, participants were told about confidentiality and were introduced to the concept of compassion. They were given the definition of compassion and the theory behind it, such as an explanation of the 'tricky brain' and of the three systems. To help them with their practice, participants were introduced to mindfulness and were given homeworks to do during the week. Every session after the first started with a review of the previous week and of the homeworks. Furthermore, videos with explanations of the theory or meditations were included in every session. During the following weeks, participants were introduced to the skills of compassion and were given exercises to develop and practice these skills. In the eight weeks, participants were taught grounding meditations that often focused on the soothing system, practiced imagery and experiential meditations that helped them to understand and feel what the qualities of compassion were. Some of the compassion meditations they used in the group and practiced at home are very well known, for example they practiced creating a safe space or imagining a compassionate friend. During the course of the group they were also given exercises that would help them become aware of their inner critic and that would give them ways of responding to it (e.g. the soften, soothe and allow exercise). Lastly, they concluded the group with the development of a compassionate formulation and by writing their compassionate life story.

1.8 Brief Summary Of The Literature Review And Introduction To The Study

Looking at the literature on the treatments available for eating disorders and, in particular, at how compassion and self-compassion could impact treatment outcomes, one can see how complicated the picture is. Eating disorders are extremely widespread and are the most lethal amongst psychological disorders (Brennan, Emmerling, & Whelton, 2015). In the past years, eating disorders have received increasing attention, which led to significant improvements in our understanding of eating disorders as well as significant advances in the development of prevention and treatment interventions (Pennesi & Wade, 2015). Nevertheless, there are still big gaps with regards to delivering effective interventions.

A review of treatments available for eating disorders reported that for anorexia nervosa 20% remain ill and 63% relapse (Steinhausen, 2002). The best treatment currently available for anorexia nervosa is CBT and the evidence for its effectiveness is weak (NICE, 2004). Similarly, treatments for bulimia nervosa and binge eating disorder appear to be effective for only half of the patients (Wilson et al., 2007). One of the reasons put forward to explain these results is the high rate of drop-outs (Fassino et al., 2009); as a matter of fact, Treasure (2012) suggests that the most difficult aspect of treating eating disorders is engaging the client. Gilbert (2010) suggests that some individuals might find it difficult to engage with the therapy because, even though the theory makes sense to them, they do not feel any differently. He also adds that these individuals might present with higher levels of shame and self-criticism, which prevents them from being able to create warm and soothing feelings towards themselves.

Individuals with eating disorders can feel a great level of shame, which is usually extremely harsh and deeply internalized (e.g. Gilbert & Goss, 2002). One of the most painful sources of shame is self-criticism (Whelton & Greenberg, 2005). Compassion Focused Therapy (CFT) was specifically developed to help individuals with high levels of shame and self-criticism to develop more compassionate inner voices (Leaviss & Uttley, 2015). There is a growing amount of studies supporting the introduction of CFT in the treatment of eating disorders, with different researchers reporting positive outcomes (e.g. Goss & Allan, 2014). One particular aspect of compassion that has been shown to be particularly effective in counteracting self-criticism is self-compassion (e.g. Neff, 2003). Self-compassion has also received strong evidence support for its effectiveness in helping individuals with eating disorders (e.g. Braun et al., 2016). Pennesi and Wade (2015) suggest that a major limitation of current theories used to inform treatments

is the failure to emphasize variables such as biogenetic factors and developmental factors. CFT is rooted in evolutionary psychology, neuroscience and social psychology approaches; therefore interventions based on this approach would be able to integrate the developmental and neurobiological aspects of eating disorders. However, research that examines self-compassion has mainly focused on the general population and the methods utilised mainly involved quantitative methodologies, such as questionnaires or surveys. The National Institute of Clinical Excellence (NICE, 2004) suggests that patient experience is a key element of therapy development; therefore, it appeared important to conduct this research by exploring participants' lived experiences. Furthermore, Pennesi and Wade (2015) suggest that a way of improving current treatments would be to invest in "dismantling studies that can identify which elements of interventions are actually required to produce meaningful changes" (p. 186) and by specifically exploring the concept of self-compassion I hope to do just that.

A further aim of this study was to provide Counselling Psychologists with further knowledge on how individuals struggling with eating disorders experience the development of self-compassion after taking part in a compassionate mind therapy group. I hope that the findings from this study and the suggestions made throughout the thesis can help professionals understand this phenomenon better as well as provide clinicians with more tools to help this particular client population.

For these reasons, I will conduct a qualitative study, which explores the experience of self-compassion in women with eating difficulties who completed an eight-week compassionate mind therapy group.

CHAPTER 2: Methodology

2.1 Introduction

This chapter aims to provide an explanation of the way in which I have attempted to answer the research question: How do individuals who struggle with eating difficulties experience self-compassion following an eight-week Compassionate Mind therapy group?

Firstly, I will present the research aims and objectives. Then, I will broadly explain my rationale for adopting a qualitative approach and, in particular, for adopting Interpretative Phenomenological Analysis. While doing so, I will also outline my ontological and epistemological assumptions. Lastly, I will finish by describing in detail the procedures adopted for this research, including the steps that have been taken to ensure that it is a valid, high quality and ethical piece of work.

2.2 Research Aims and Objectives

The aim of this research was to explore the experience of developing self-compassion in women with eating difficulties. An interview schedule to explore this experience was developed and used with each individual.

2.3 Rationale for Adopting a Qualitative Approach

2.3.1 Consideration and Rejection of Quantitative Methodology

At the beginning of my doctoral training I believed that quantitative methods were the best way to achieve accurate observations because, like Yardley and Bishop (2008) suggest, I believed I could control the environment by eliminating confounding variables and I could use measures that would not be influenced by subjective impressions. However, throughout my Doctorate in Counselling Psychology, I too became a 'reconstructed positivist' (Willig, 2013) in that I started to question my positivist beliefs and veered towards a post-positivist/critical realist position.

Positivism suggests that it is possible to produce objective knowledge by describing what is 'out there' and getting it right (Willig, 2013). Kirk and Miller (1986) also added that positivism assumes that the external world itself determines the right view that can be taken of it, regardless of the process or the circumstance in which it is viewed. However, I reject this idea as I realised that research on human beings does not only need to be grounded in empirical evidence, but it also requires a degree of imagination and interpretation (Fishman, 1999). In fact, I

agree with Hansen (2004) in saying that reality does not exist as a singular entity; instead each individual creates reality through his or her different way of experiencing and understanding the world. Therefore, human perception can be considered to be dependant on the observer (Chalmers, 1999).

In addition to these critiques, positivism has also been criticised for failing to take into account the roles history, society and culture have played in the formation of knowledge (Willig, 2013). As a matter of fact, as Willig (2013) eloquently suggests, positivism works with existing theories and encourages the formation of communities of scientists that test their own and each other's theories; a result of this would be that newcomers could find it very difficult to contribute to the generation of knowledge.

The positivist paradigm has so far dominated research in the field of 'Self-Compassion' and 'Eating Disorder'. This means that scales looking at symptom recovery have often been preferred and previous researchers have not always sought patients' views of their experiences. Furthermore, researches that have been qualitative in nature have mainly explored clinician's views and experiences. However, according to the British Psychological Society (2014) the aim of Counselling Psychology is "the exploration, clarification, and understanding of clients' world-views, underlying assumption, and emotional difficulties" (p. 16) and this research aims to do this by adopting a qualitative approach.

2.3.2 Acceptance of Qualitative Methodology

Yardley (2000) suggests that qualitative methodologies present with different desirable characteristics that might not be present in quantitative methodologies. For example, qualitative methodologies focus on exploring in depth different aspects of the topics being studied, while quantitative methodologies often concentrate on a limited number of variables at one specific time. In addition, quantitative methodologies use these variables to observe the way in which they relate to each other in large groups. Qualitative studies, on the other hand, tend to focus on particular experiences of the individuals taking part in the research. In addition, qualitative methodologies have also become interested in culture and language, which has led to an in-depth examination of "philosophical and socio-cultural foundations of concepts and procedures which have sometimes been employed in quantitative research with little explicit discussion of their origin, function and connotations" (Yardley, 2000, p.215).

As discussed in the literature review, most of the research conducted on compassion and eating disorders has largely been dominated by the quantitative

paradigm; therefore, it seems necessary to conduct research looking at participants' experiences and to learn from this. Since the study aims to advance understanding of how individuals attempt to make sense of self-compassion, the approach that seemed best suited for this purpose was a qualitative approach and, in particular, Interpretative Phenomenological Analysis (IPA; the rationale for choosing this approach will be explained in more detail later in the chapter). The choice of methodology was also influence by my training as a Counselling Psychologist. In my training I place subjective experience at the core of my clinical work, therefore it seems more appropriate to employ a research paradigm that is closer to my views. Yardley (2000) also suggests that qualitative methodologies can be compared to traditional clinical practice as, similarly to therapy where the main aspect is the therapeutic relationship, in qualitative research the interaction between the researcher and the participants is of key importance.

2.3.3 Compatibility of Qualitative Research and Counselling Psychology

In the past, qualitative research methods served as a cornerstone to help counselling advance its theory and practice (Ponterotto, Kuriakose & Granovskaya, 2008). Humanistic and psychodynamic approaches, in fact, were originally based on qualitative research. For example, Roger's person-centred approach was developed through the analysis of case studies and noticing that the therapeutic relationship was central to therapy (Ponterotto et al., 2008).

Throughout the years, counselling psychologists have had to 'fight' with other professions (e.g. psychiatry) in order to demonstrate their legitimacy. To do so, many have used research to demonstrate their effectiveness. Quantitative research was particularly favoured as it allowed researchers/counselling psychologists to produce knowledge that would convince other people that their statements were "true" (McLeod, 2001). Recently, however, there has been an increase in the use of qualitative methodologies among counselling psychologists. One of the reasons as to why qualitative research has become increasingly popular with counselling psychologists is offered by McLeod (2011, p.1):

"*Qualitative inquiry holds the promise of discovery, of generating new insight into old problems, and producing nuanced accounts that do justice to the experience of all those participating in the research*"

Therefore, qualitative research has the capacity to add new knowledge to that produced by quantitative studies while making sure that participants' voices are heard and their accounts are explored in depth. McLeod (2011) then goes on to add that qualitative research represents a form of narrative knowing that is based

in everyday experience; therefore, it has the potential to make a significant contribution to the evidence-base for Counselling Psychology. Similarly, Ponterotto (2005) argued that the inclusion of qualitative approaches would help the field of Counselling Psychology to advance in terms of both professional knowledge and social impact.

Another reason why counselling psychologists can be drawn towards qualitative research is because it highlights the emotive and cognitive aspects of participants' experiences. Furthermore, qualitative research is a social and creative process that usually involves a close interactive contact with participants. All these characteristics are of importance to counselling psychologists (Ponterotto et al., 2008). Qualitative research imitates clinical practice and can produce relevant findings for therapists. Hill (2005) suggested that this is the case because findings from qualitative studies can be generalised to the therapy context and can be implemented in the therapy work. Qualitative research also imitates clinical practice by encouraging the active involvement of the participant and by focusing on understanding the subjective experience of the participant. Consequently they both imply a "bottom-up" approach (Silverstein, Auerbach & Levant, 2006). A "bottom-up" approach refers to when the researcher moves from specific to more general observations; when using a qualitative approach, in fact, the researcher starts by observing and detecting patterns in a specific context, then she begins to formulate hypotheses based on these observations and lastly, she develops theories that can be generalised to a wider population. This way, the theory is directly influenced by the client (Willig, 2013). In addition, engaging with the subjective world of participants might help me to answer my research question in a way that brings together my chosen methodology (i.e. qualitative research and IPA), my research question and my professional role (i.e. counselling psychologist).

For the reasons outlined above, a qualitative method and, more specifically, IPA seemed a suitable method for this research.

2.3.4 Ontological and Epistemological Standpoint

This study aims to produce Critical Realist knowledge. For this research, I will consider critical realism as an ontology and an epistemology.

Critical realists believe that a reality exists, however this reality cannot be properly detected as our ways of studying it are flawed (Guba & Lincoln, 1994). According to Dobson (2002), the critical realist sees reality as a result of social conditioning, therefore reality cannot be understood without considering the social aspects involved in the process of deriving knowledge. However, a critical realist does not

see reality as a product of just this process. Critical realism contends that our beliefs and expectations have an impact on the way in which we perceive facts, and in particular facts of the social realm (Bunge, 1993). Critical realism approaches knowledge generation differently compared to the more direct realism version. In fact, critical realism is based on the assumption that although the data can inform us about what is going on in the real world, it does not do so in a self-evident and unmediated way (Willig, 2012). A critical realist, therefore, does not assume that the data directly reflects reality but acknowledges that the data needs to be interpreted. Therefore, critical realism acknowledges that subjectivity is essential in the production of knowledge (Madill, Jordan, & Shirley, 2000). In order to interpret the data, a critical realist goes beyond and draws on knowledge, theories and evidence from outside the research being conducted. To do this, it is not necessary for the participants to be aware of the underlying mechanisms that guide their overt behaviours and experiences (Willig, 2012).

In preparation for this research I spent a long time considering my assumptions regarding knowledge. As Willig (2012) suggests, it was useful to think of my position on the spectrum that sees realism at one end and relativism at the other. An extreme realist approach was rejected because it is not possible for participants to accurately describe actions and events. This is due to the fact that, although those actions and events happened in reality, participants have access only to their subjective experience of reality. Realism, in fact, takes data at face value and sees them as a description of events that actually took place in the real world (Willig, 2012). In addition, realism proposes that it is possible for the researcher to accurately reflect what is going on in the world or inside the mind of the participants (Willig, 2012). However, it is not possible for me/the researcher to produce accurate knowledge without interpreting the data and, therefore, imposing my own knowledge and beliefs.

On the other hand, an extreme relativist approach was also rejected because participants' accounts, although mediated by culture, language and politics, still provide access for the researcher to their experiences of an actual reality and not a reality purely constructed by language (Pilgrim & Rogers, 1997). Burkitt (2003) convincingly argues that perception does not need to be personal or linguistic, but it can involve our 'intercorporeal ties' towards each other and the world. For example, it can be argued that when we are born, we do not yet possess language, however we still have embodied experiences (e.g. hunger). Therefore, experience can exist before and without language. Burkitt (2003), in fact, goes further to suggest that language does not form a separate reality, and that it is possible that

we transform the world in language, culture and history, rather than construct it (Burkitt, 2003).

In conclusion, a critical realist position was adopted because critical realism allows the researcher to comprehend the historical, institutional context within which psychology and our participants operate (Parker, 1999). Healy and Perry (2000) argue that within a critical realist framework both qualitative and quantitative methodologies can be used to research the underlying mechanisms that cause actions and events. In addition, critical realism allows the researcher to present findings in a tentative way by keeping in mind that interpretations represent possibilities rather than certainties (Willig, 2012). The analysis will therefore be considered to be a tentative account of me making sense of the participants making sense of reality, thus the result will be the production of Critical Realist knowledge.

2.4 Method: Interpretative Phenomenological Analysis (IPA)

2.4.1 Theoretical Underpinnings of Interpretative Phenomenological Analysis

The interview transcripts will be analysed using Interpretative Phenomenological Analysis (IPA).

Interpretative Phenomenological Analysis is concerned with each individual's perspective of the world as they see it and experience it (Kvale, 1996b), as well as being concerned with how individuals are making sense of the world they're living in (Smith & Osborn, 2007). These two points show how IPA is rooted in both phenomenology and hermeneutics.

Phenomenology describes a philosophical approach to the study of experience and a range of research methods. Although different phenomenologists have different interests, phenomenology itself can be said to concentrate on thinking about what the experience of being human is like (Smith, Flowers & Larkin, 2009). Phenomenology is particularly helpful for psychologists as it provides us with many ideas about how to study and understand lived experience.

The leading figures in phenomenological philosophy have been Husserl, Heidegger, Merleau-Ponty and Sartre. Husserl's work points to the importance of focusing on the experience itself and how it's being perceived. For Husserl, examination of the human experience is key. However, in order to be able to access the experiential content of consciousness (which he called 'thing'), we need to eliminate all the obstacles that could get in the way (Smith et al., 2009). Husserl

also highlighted the importance of being reflexive, by turning our gaze inwards towards our perception of 'things', while examining human experience. This last point, in particular, has become central to IPA. IPA researchers, in fact, place the process of reflection at the centre of their attention. Husserl's work was further developed by Heidegger, Merleau-Ponty and Sartre.

Husserl work can be thought of as being primarily concerned with psychological processes such as perception, awareness and consciousness. Heidegger, on the other hand, is more concerned with existence itself and with the practical activities and relationships that we are part of and we use to make sense of the world (Smith et al., 2009). Heidegger focused on the 'worldliness' of our existence (Smith et al., 2009), which he called *Dasein* (the state of being-in-the-world). This meant he saw the world as ready to be used by individuals, with objects ready to be exploited by individuals. IPA took from Heidegger the concept that human beings can be thought of as 'thrown into' a world of objects, relationships and language (Smith et al., 2009). A further concept that was also adapted from Heidegger is the idea that our being present in the world is always temporal and in relation to something, therefore understanding how individuals make sense of things is of vital importance. While Heidegger concentrated on the 'worldliness' of our existence, Merleau-Ponty focused on the 'embodied' nature of our relationship with the world.

Merleau-Ponty suggested that humans see themselves as different from everything else in the world, which is due to our sense of self being holistic and engaged in looking at the world rather than being incorporated by it (Smith et al., 2009). As Merleau-Ponty eloquently describes it:

> "The body no longer conceived as an object in the world, but as our means of communication with it" (1962, p106)

For IPA it is vital to consider that the body shapes our knowledge of the world because, even if we observe and experience empathy for another person, we can never share their experience completely as the latter belongs to their own 'embodied' position in the world (Smith et al., 2009).

While Husserl, Heidegger and Merleau-Ponty offered important and interesting concepts, Sartre also offered a clear indication of what a phenomenological analysis of the human condition entails. In his work, Sartre highlights the importance of the process of becoming ourselves, which is also beautifully described by Kierkegaard:

"An existing individual is constantly in the process of becoming" (1974, 79)

The concept that focuses on what we will become also links to one of the main ideas expressed by Sartre, 'nothingness'. For Sartre, importance should not only be placed on the things that are present but also on those that are absent. From this, he extended Heidegger's concept of 'worldliness' by adding that we are able to consider our experiences as dependent on the presence or the absence of our relationships with other people. IPA can learn from Sartre's analysis of people occupied with projects in the world and "the embodied, interpersonal, affective and moral nature of those encounters" (Smith et al., 2009, p.21).

IPA is also influenced by hermeneutics, which began with the interpretation of biblical texts but subsequently expanded to a wider range of texts (Eatough & Smith, 2008). Our understanding of an object/event is always mediated by an already existing knowledge. IPA does not attempt to find the essence of experience as Husserl suggested, but it tries to capture particular experiences as experienced by particular people (Smith et al., 2009). When understanding other people's experiences, one can see oneself as having an impact on the analysis or not. While I am trying to be a reflexive researcher and hoping to limit my impact on the data as much as possible, I also recognise myself as a person. Being a person means that my previous knowledge and beliefs will come into play when analysing the transcripts. The 'fore-conception', as Heidegger (1962) termed it, can become an obstacle to interpretation. However, while the existence of fore-conceptions comes before our meeting with new things, our understanding might work the other way around (i.e. from the thing to the fore-conception; Smith et al., 2009).

Heidegger questioned the possibility of any knowledge without an interpretative stance, and hermeneutic phenomenology added that the interpretative analyst is able to propose a perspective on the text that the author is not. IPA, in fact, sees research as a dynamic process in which the researcher holds an active role (Smith & Osborn, 2007). Interpretative phenomenology does not try to put the researcher's assumptions and beliefs aside, but it works with them. The whole process of interpretative phenomenology is made by an interaction between the data and the researcher (Willig, 2013) in which the researcher's assumptions and beliefs are needed to make sense of other people's worlds through a process of interpretation (Smith & Osborn, 2007). Moreover, IPA researchers can add 'value' to the text by analysing it, adding connections with other data and using psychological theory to inform the interpretation. The hermeneutic circle clarifies this concept; in order to understand any given part, we look at the whole and to understand the whole, we look at the parts. The process of analysis in IPA is, in

fact, iterative; the researcher does not follow a linear path, but moves back and forth between different ways of thinking about the data (Smith et al., 2009).

2.4.2 Methodological Considerations

Prior to choosing Interpretative Phenomenological Analysis (IPA) to answer the research question, other qualitative approaches had been considered. These were Grounded Theory (GT) and Narrative Psychology (NP). Below, I will briefly compare these approaches to IPA before outlining my rationale for adopting Interpretative Phenomenological Analysis for the analysis of the data collected through the semi-structured interviews.

2.4.3 Interpretative Phenomenological Analysis Versus Grounded Theory

Grounded Theory originated in the field of sociology and postulates that meaning is negotiated and understood through interactions with other people (Blumer, 1986; Dey, 1999; Starks & Brown Trinidad, 2007). Grounded Theory involves the identification and integration of categories developed from data, which results in the development of a theory that provides an explanation for the phenomenon being studied (Willig, 2013). Different researchers have highlighted the many similarities between IPA and Grounded Theory, such as they way in which they collect and analyse data (Brocki & Wearden, 2006). Nevertheless, there are different ways in which IPA and Grounded Theory differ.

First of all, as Willig (2013) eloquently argues, Interpretative Phenomenological Analysis differs from Grounded Theory in its theoretical grounding. Grounded Theory, in fact, was developed to allow new theories to emerge from data, therefore working with induction. However, this approach has also been criticised for not paying sufficient attention to the role of the researcher (Willig, 2013). Instead, IPA sees research as a dynamic process in which the researcher holds an active role (Smith & Osborn, 2007). Interpretative phenomenology does not try to put the researcher's assumptions and beliefs aside, but it works with them. The whole process of interpretative phenomenology is made by an interaction between the data and the researcher (Willig, 2013) in which the researcher's assumptions and beliefs are needed to make sense of other people's worlds through a process of interpretation (Smith & Osborn, 2007). Furthermore, IPA is particularly suited to explore and understand participants' experiences, while Grounded Theory was developed to explain social processes (Willig, 2001). Another difference between these two approaches can be found in their samples. IPA sampling, for example, is usually purposive, homogenous and small in order to provide the reader with contextualisation and to allow the researcher to illuminate a particular research

question while interpreting data in depth (Brocki & Wearden, 2006; Smith & Osborn, 2003). Grounded Theory, on the other hand, utilises theoretical sampling; this means that the researches keeps recruiting participants and collecting data until no new themes emerge (i.e. until saturation is reached; Brocki & Wearden, 2006). Lastly, these two approaches differ in their end product. While IPA is often reported as a story to allow the reader to understand and feel what it is like to have that experience (e.g. self-compassion); grounded theory aims to produce a theory that explains the phenomenon being studied (Starks & Brown Trinidad, 2007).

In conclusion, IPA seemed to suit the research question better than Grounded Theory. As a matter of fact, the aim of this study was not to generate a theory but to explore the lived experience of individuals struggling with eating difficulties and, in particular, to understand how they experienced self-compassion.

2.4.4 Interpretative Phenomenological Analysis Versus Narrative Psychology

Another approach that was considered for this study was Narrative Psychology. Narrative Psychology is interested in the ways in which individuals organise and bring order to their experiences (Willig, 2013). To do this, Narrative Psychology looks at the way in which people compose their experiences into stories (Willig, 2013). There are many similarities between Interpretative Phenomenological Analysis and Narrative Psychology. For example, both approaches are based on post-modern/post-structuralistic schools of thoughts, which highlight the role played by language in social interactions (Griffin & May, 2012). Furthermore, IPA and Narrative Psychology are both interpretative and see meaning as co-constructed by the participants and the researcher (Griffin & May, 2012); hence, they both see the researcher as having an active role (Willig, 2013). However, there are also some key differences between these two methods.

First of all, IPA originates from phenomenology and seeks to understand what it is like for an individual to experience a particular phenomenon. Narrative Psychology, on the other hand, draws from different theories and, researchers adopting this approach, can use different varieties of analysis depending on their beliefs regarding the formation of ‘narratives’ and the way in which they function (Willig, 2013). Furthermore, Narrative Psychology sees meaning as being flexible in that individuals can always develop new stories to describe it; for this reason, there is a debate amongst researchers using Narrative Psychology regarding the extent to which it is possible to get as close as possible to participants’ experiences (Griffin & May, 2012). IPA, on the contrary, aims to come as closed as possible to individuals’ lived experiences and is a more specified approach. For example, the phases of data collection and analysis are clearly differentiated, while this is not the

case for Narrative Psychology (Willig, 2013). Lastly, Narrative Psychology is interested in the social context in which these stories generate and in the way in which the latter are shaped by the context (Griffin & May, 2012; Willig, 2013); while Interpretative Phenomenological Analysis is concerned with each individual's perspective of the world as they see it and experience it (Kvale, 1996b), as well as being concerned with how individuals are making sense of the world they're living in (Smith & Osborn, 2007).

Since the aim of this study was to try and get as close as possible to participants' experiences while trying to understand how they were making sense of these experiences, Interpretative Phenomenological Analysis seemed the appropriate choice.

2.4.5 Rationale for Adopting Interpretative Phenomenological Analysis

Early experimental psychology defined itself as the science of experience, and was interested in distinguishing the relationship between the inner world and the external world (Ashworth, 2003). However, Spinelli (1989) argued that psychology has lost its original purpose by overlooking the study of experience. This problem was also highlighted in the literature review conducted for this research.

In addition, IPA can be considered to be epistemologically flexible compared to other qualitative methodologies, and this can be desirable in psychological research (Larkin, Watts & Clifton, 2006). IPA is becoming increasingly established as a method in Counselling Psychology and, in particular, when the researcher is trying to explore an area of interest, rather than testing a hypothesis (Smith & Osborn, 2007). In their latest book Smith and colleagues (2009) provide examples of IPA research that they have conducted in four areas: 'health and illness', 'sex and sexuality', 'psychological distress' and 'life transitions and identity'. The current study could be placed in at least two of these topic areas, 'health and illness' and 'psychological distress'. Furthermore, in 2011 Smith conducted a review of IPA publications and identified eating disorders as the 12th topic most frequently researched. In the review, Smith (2011) found ten papers that used IPA to explore an aspect of eating disorders. More recently, Gale (2012) conducted a literature review and identified nineteen articles about eating disorders that utilised IPA as a methodology. Since then, other articles have also been published (e.g. Fox & Diab, 2015; Hannon, Eunson & Munro, 2017). These papers explored different areas of eating disorders, such as specific aspects of the illness and treatments, which suggests that IPA can be a suitable method for research involving people with eating disorders. I therefore interpret this as a confirmation of the suitability of this method for this study. Lastly, the aim of this study was to explore the lived

experiences of self-compassion among individuals struggling with eating difficulties and learn from them without making any claims regarding possible causes for their thoughts, feelings or perceptions. Since for IPA there is nothing more important than understanding individual subjective experience (Eatough & Smith, 2008), it seemed appropriate to choose this methodology for the analysis of the interview transcripts.

2.5 Methodological Procedures

Seven one-to-one semi-structured interviews were conducted with women struggling with eating difficulties, who completed an eight-week compassionate mind therapy group. Interviews were conducted by myself, and lasted between 40 and 80 minutes. I also transcribed the recordings of the interviews and analysed them in accordance with IPA methodology.

2.5.1 Quality

In order to make sure this research was valid and of high quality, I followed Yardley's (2000) suggestions. Yardley (2000), in fact, recognised that while the criteria for judging the quality and validity of a quantitative piece of research are well established, there is no specific way that has been instituted for qualitative methodologies. For this reason, she suggests four essential qualities that a good qualitative research should have: sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. According to these, I made sure that I was aware of the relevant literature as well as of the philosophical background of the chosen approach. I also gave myself enough time to engage with the topic, while making sure that I was developing the appropriate skills needed for this research. At the same time, I tried to acquire an adequate sample for my study so that I could ensure my data collection and analysis were rigorous. I also made sure that the methodology chosen for this study was coherent with my research question and that I presented and disclosed all the relevant aspects of this research. Lastly, I believe that my research will be valuable for the field of Counselling Psychology as eating difficulties are affecting a large percentage of the population, but evidence for efficacy of treatments shows there is still room for improvement.

2.5.2 Sample Size

IPA is usually conducted on small sample sizes, since the aim is to examine in detail the perceptions and understandings of the group being studied rather than make general claims (Smith & Osborn, 2007). As a matter of fact, qualitative research often prioritises depth of understanding over breadth of coverage,

therefore the knowledge it produces has a tendency to be localised and context specific (Willig, 2012). Therefore, it could be argued that Interpretative Phenomenological Analysis is an idiographic approach rather than a nomothetic one.

In their discussion on sample size, Smith et al., (2009) state that there is no right answer regarding how many participants one should have. However, they notice that small sample sizes might be more appropriate since one of the aims of IPA is to produce a detailed account of individual experiences. In addition, they suggest that the researcher might become overwhelmed by the amount of data generated if too many participants are interviewed. For these reasons, they suggest a sample size between three and eight participants. In light of the richness of data produced by seven interviews, a decision was made not to recruit more participants.

2.5.3 Sampling Strategy

IPA is concerned with understanding participants' lived experiences, therefore during the analysis the researcher is concerned with trying to understand how a specific phenomenon is being subjectively understood by individuals in a specific context (Smith et al., 2009). For this reason, a small homogenous sample is necessary to understand the phenomenon under consideration. Purposive sampling was used in order to achieve a homogenous sample.

2.5.4 Inclusion Criteria

Participants needed to be at least 18 years of age, and needed to have completed an eight-week compassionate mind therapy group. In addition, participants needed to present with eating difficulties, however a formal diagnosis was not required given the qualitative nature of the study.

2.5.5 Recruitment Strategy

Once ethical approval was granted by City University, the recruitment process started. Participants were recruited in a private clinic for eating disorders in London using flyers (Appendix A) that described the object of the research. One of the psychologists who had run the eight-week compassionate mind groups identified potential participants. The reasoning behind this was to ensure the study would remain ethical and safe for participants, as the clinician knew the histories and stories of these individuals. The same psychologist emailed the flyers to potential participants. It was hoped that this would increase participants' confidence in the study as well as reduce possible anxiety regarding being contacted by someone they did not know.

In the flyer, potential participants were invited to contact me, my research supervisor, or the Psychologist via email if they had any questions or were interested in participating in the research. Interestingly, while the study was open to both genders, only females responded to the flyer. Individuals who were interested in participating were e-mailed a copy of the Participant Information Sheet (Appendix B). The Information Sheet was written to provide participants with as much information as possible about the research, including its aim and what it would entail. Those who wished to proceed with the interview were given the opportunity to ask any further questions, and if they were still interested in taking part, they were e-mailed a Consent Form (Appendix C). We then collaboratively scheduled an appointment that was suitable for the participant and myself. All the interviews took place at City University.

2.5.6 Introducing the Participants

Every participant was assigned a pseudonym to protect her identity. The participants' pseudonyms were chosen by picking the first name that appeared for the first seven alphabetical letters depending on the interview order (e.g., first woman to be interviewed, first letter of the alphabet: A – Ava).

The seven participants had completed the group between 1 and 3 years prior to participating in my research and they were all part of different groups; however the content of the groups and the facilitators were always the same. The group is designed to help participants explore the themes of mindfulness and compassion with the view of guiding them towards becoming non-judgemental towards their minds and bodies as well as to become more self-compassionate. In particular, the group is centred on the teaching of the skills of compassion. All participants, apart from one (Elizabeth), had been in a group solely for individuals struggling with eating difficulties. Elizabeth had taken part in a group where individuals with different diagnoses were included.

The demographic information collected from participants included their age, ethnicity, marital status and employment status. I did not ask for participants' diagnoses or their weight as I did not feel that this information would make their experience any more or less valid. Although a formal diagnosis was not required to take part in this study, all participants used specific terminology to describe their eating difficulties (e.g. Bulimia Nervosa) and often provided a self-diagnosis. Therefore, to keep myself close to participants' accounts and to help the reader better understand what these women were struggling with, I will also continue to use formal terminology to describe their presentation throughout this chapter. All

participants had received individual therapy sessions either prior or in conjunction with the group.

Below I will briefly present each participant to help the reader put them into context:

Ava

Ava is a twenty-nine year old woman with White ethnic origins. Ava is currently in a relationship but she is not married. She is currently employed. Ava presented with Bulimia Nervosa.

Brittany

Brittany is a forty-four year old woman with mixed (Asian and White British) ethnic origins. Brittany is currently in a relationship but she is not married. She is currently employed. Brittany presented with Binge Eating Disorder.

Chloe

Chloe is a fifty-one year old woman with White ethnic origins. Chloe is currently in a relationship but she is not married. She is currently employed. Chloe presented with Binge Eating Disorder.

Danielle

Danielle is a forty-one year old woman with White ethnic origins. Danielle is currently in a relationship but she is not married. She is currently unable to work due to family issues. Danielle presented with Binge Eating Disorder.

Elizabeth

Elizabeth is a thirty-nine year old woman with White ethnic origins. Elizabeth is currently single. She is currently employed. Elizabeth presented with Binge Eating Disorder.

Faith

Faith is a twenty-five year old with White ethnic origins. Faith is currently married. She is currently studying, but is also self-employed. Faith presented with Anorexia Nervosa.

Grace

Grace is a forty-one year old woman with Asian ethnic origins. Grace is currently single. She is currently self-employed. Grace presented with Bulimia Nervosa.

Pseudonym	Age	Ethnic Origin	Marital Status	Employment Status	Presentation
Ava	*29*	*White*	*In a relationship*	*Employed*	*Bulimia Nervosa*
Brittany	*44*	*Mixed*	*In a relationship*	*Employed*	*Binge Eating Disorder*
Chloe	*51*	*White*	*In a relationship*	*Employed*	*Binge Eating Disorder*
Danielle	*41*	*White*	*In a relationship*	*Unemployed*	*Binge Eating Disorder*
Elizabeth	*39*	*White*	*Single*	*Employed*	*Binge Eating Disorder*
Faith	*25*	*White*	*Married*	*Student, Self-Employed*	*Anorexia Nervosa*
Grace	*41*	*Asian*	*Single*	*Self-employed*	*Bulimia Nervosa*

Table 2-1. Demographic Details of Participants

2.5.7 Interviews

In order to collect detailed data about a specific group, the researcher needs a flexible instrument. Consistently with the philosophical underpinnings of IPA, semi-structured interviews were used to gather data (Appendix D). Semi-structured interviews allow the researcher to modify questions depending on the participant's answers or to use prompts to elicit more information around interesting topics. Semi-structured interviews enable participants to offer rich accounts of their experience, while at the same time offering enough flexibility to the researcher to explore compelling topics that emerge during the interviews (Smith, Harré, & Van Langenhove, 1995). The advantages of using semi-structured interviews include facilitating rapport between researcher and participants, and greater flexibility that allow the research to go into novel areas and richer data.

Participants were asked the same eleven questions, however flexibility played a key role. Prompts varied depending on the answers provided by the participant, and if the participant presented other themes I explored them.

2.5.8 Development of The Interview Schedule

The interview schedule was developed following Smith's (1995) suggestions. Firstly, I thought about the main themes that I wanted to explore through my interviews: personal description of self-compassion, effect of self-compassion on participant's life, effect of self-compassion on eating difficulties and experience of being in a therapy group. Afterwards, I reflected on what would be the best way of addressing these themes by looking at how sensitive each topic was. By doing this, I could start the interview with less sensitive questions in order to give participants the time to warm up and become more comfortable. Nevertheless, I chose to put the one I considered the most sensitive topic (effect of self-compassion on eating difficulties) as the penultimate question instead of putting it as a last question. The reasoning behind this is that I wanted to conclude the interview with a less sensitive topic so that participants would have time to calm down and, possibly, leave the interview feeling relaxed or calm. While thinking of the interview schedule I also thought about prompts for every question, which could help me to further explore participants' lived experiences. Once an interview schedule was agreed with my supervisor, I used it as a guide in my seven interviews to help participants share their personal experiences.

2.5.9 Procedure

The following procedure was replicated for every interview:

After I had met the participant and answered any questions she might have about the study, I went through the Consent Form with her to ensure she understood everything. The participant and I signed two copies of the Consent Form, and we kept a copy each. Participants were also asked to sign a separate Consent to Audiotape Form (Appendix E). Each participant was then reminded that participation to the study was entirely voluntary and she could withdraw at any stage, whether by not completing the demographic questionnaire, choosing not to be interviewed or by exiting the interview at any point. It was also added that we could interrupt the interview at any time if she needed a break. After having obtained permission from the participant, the digital recorder was switched on and I repeated my aims for the interview, reminding the participant that I was looking for her personal experience and that my questions were just an aid I used to guide the interview.

Before the start of the interview, participants were asked to complete a Demographic Questionnaire (Appendix F). The interviews ranged from forty minutes to eighty minutes. The interviews were conducted at City University in

small rooms that had been previously booked in order to ensure privacy to each participant and reduce distractions. Only the participant and myself were present during the interview. At the end of every interview, participants were asked whether they had any comments regarding the interview and if there was anything else they wanted to add. I debriefed every participant by re-stating the aim of the research and thanking them for their participation. A copy of the Debrief Form (Appendix G) was given to each participant. Lastly, a Resource Pack (Appendix H) with a list of contacts they could approach if further support was needed was also handed to participants.

2.5.10 Recording, Transcription and Data Storage

The interviews were recorded on a digital recorder, care was taken during the interviews not to mention the participants' names in order to maintain anonymity. I transcribed every interview verbatim. Interview transcripts included all spoken words, pauses, false starts and other important aspects (e.g., loud exhaling) as suggested by Smith et al., (2009). Transcripts were encrypted and stored securely. Every participant was assigned a pseudonym to protect her identity.

The interviews' recordings and transcripts will be made available to the examiner if required, all electronic and written records will be destroyed in September 2018. Participants were informed they could withdraw their data until May 2016. This data was chosen as withdrawal of the data would not be possible after write up.

2.5.11 Textual Analysis

The existing literature on IPA does not describe a single method of analysing data, however various options have been suggested. Smith, Flowers and Larkin (2009) provide a very detailed and clear guide, which has influenced my analysis.

The core of IPA lies in its analytic focus, which is directed towards the participants' attempts at making sense of their experiences. As a result, Smith et al., (2009) suggest that IPA analysis is a process that continually moves from the particular lived experience to the shared, and from the description to the interpretation of the text. For this reason, Smith (2007) has described the analysis stage as an iterative and inductive cycle. The analysis was conducted using the six stages proposed by Smith et al., (2009); reading and re-reading, initial noting, developing emergent themes, searching for connections across emerging themes, moving to the next case and looking for patterns across cases. Below I will describe how I engaged with each of the six steps; examples relating to these stages can also be found in the appendix (Appendix I).

1. Reading and Re-reading

Interviews were recorded and then transcribed verbatim, including the researcher's questions, so that they could be analysed. The assumption in IPA is that the researcher is interested in understanding the participant's psychological world. The aim is therefore to understand the meanings that the participant has found for their situation, rather than counting how often a theme appears in the participant's account. The analysis started with reading the transcripts multiple times while listening to the interviews in order to familiarise myself with them. The importance of immersing oneself in the data is often highlighted in the IPA literature (e.g., Smith et al., 2009) and listening to the tapes while reading the transcripts helped me to remember the experience of the interview. This process was repeated for every interview before analysing them individually. As suggested by Willig (2001), I also recorded on the interview transcripts my thoughts and reactions in response to the text.

2. Initial Noting

The first encounter with the transcripts was undertaken with curiosity and an open mind. On the left-hand side of the transcript I annotated initial findings, which included what was interesting or significant arising from the transcript. As suggested by Smith et al., (2009) I made three different types of comments, which focused on three aspects of the text; descriptive, linguistic and conceptual.

My descriptive comments focused on describing the substance of what the participant had said. These comments were kept as close to the text as possible in order to minimise the influence of my knowledge and ideas.

My linguistic comments noted how the participant used language to explore their experience. These included noting how the participant spoke, for example the pace or volume of their tone as they answered a question. Among these comments I also included non-verbal communication, which helped me to better understand how the participant presented herself.

My conceptual comments helped me to engage with the text on a more interrogative and conceptual level (Smith et al., 2009). These comments were mainly constituted by questions that I would ask myself while reading the transcript. For this reason, they mainly drew on my personal and professional knowledge and this helped me to tentatively understand the lived experience of the participant.

3. Developing Emergent Themes

Once the previous stages were completed, I went back to the beginning of each transcript and looked for emerging themes. At this stage, my main aim was that of reducing the volume of detail of the notes whilst maintaining the complexity of the data (Smith et al., 2009). At this point, I was mainly using my initial notes rather than the transcript itself, focusing on chunks of the transcript while recalling what I had learnt during the previous steps. The transcript was therefore fragmented into different parts, with the hope that it would come back together as a "new whole" at the end of the analysis (Smith et al., 2009).

The emergent themes were an attempt to capture what was important in the various comments attached to a part of the transcript. Consequently, they did not just report participants' words and views as the previous comments, but they also included my interpretations (Smith et al., 2009).

4. Searching for Connections Across Emergent Themes

The themes emerged from the previous stage were ordered chronologically, that is in the order in which they occurred in the transcript. These themes were typed up and moved around to form clusters of related themes, which were then printed. I cut out each theme and used a large floor space to move them around (a picture of this process can be found under Appendix J). During this stage, some of the themes were discarded as they did not fit well with other themes or they lacked sufficient evidence in the transcript. This process helped me to find clusters of themes as well as superordinate concepts (Smith & Osborn, 2007).

The clusters of themes were given a label, which was intended to describe the essence of all sub-ordinate themes within it. A summary table (Appendix K) containing the cluster themes and the citations representing these themes in the text was constructed (Willig, 2001). Throughout the process, I discussed some of the clustered themes with my supervisor to check and validate my analysis process.

5. Moving to the Next Case

Given the idiographic nature of IPA, I engaged with each interview individually using the previous four steps. Once I had completed these steps for one transcript, I moved on to analysing the next interview. When doing so, I continuously

reminded myself that I was looking at a different individual's lived experience so to bracket ideas that emerged from previous transcripts.

I consciously decided not to use findings from the first transcript to look for themes in subsequent transcripts as this would have prevented my fresh engagement with new interviews, and themes from the earlier transcripts might have been given unjustified importance (Willig, 2001).

6. Looking for Patterns Across Cases

This final stage involved looking for patterns across cases. In order to do this, I looked at the cluster themes from the different transcripts in relation to each other to form super-ordinate themes (Willig, 2001). To complete this step I printed out summary tables, cut out individual rows of cluster themes and emergent themes, spread them out on a large floor space and considered how they related to each other.

A table was constructed that illustrated how emergent themes were grouped under super-ordinate themes; the table also included quotes and references of where these super-ordinate themes were expressed in the participants' transcripts (Appendix L). This process led to the re-labelling of themes. As suggested by Smith et al., (2009), the recurrence across cases was kept in mind when grouping and naming super-ordinate themes.

2.6 Ethics

Ethical approval at the proposal stage was granted by City University. Approval from further bodies was not required given the nature of the study.

The British Psychological Society has defined ethics as "the science of morals or rules of behaviour" (BPS, 2009, p.6). As a member of the British Psychological Society and a scientist practitioner, I highly value the ethical guidelines proposed by the British Psychology Society and made sure that I strictly adhered to them throughout this research. At every point in the research I considered the four general principles described by the British Psychological Society's Code of Ethics and Conduct; Respect, Competence, Responsibility and Integrity (BPS, 2009). One of the key objectives of this research was not doing harm to the participants and to the population they were a part of. In order to do so, I tried to consider every aspect of this research from the participant's perspective, while following the

guidelines outlined by the British Psychological Society in the 'Ethical principles for conducting research with human participants' (BPS, 2009) as outlined below.

Consent

The Information for Participants was written in plain English and clearly outlined the aims and procedures of the research project. The form also included possible risks to participants. I chose to disclose fully the rationale of the study because it would ensure the interview's ethical integrity as Brinkman and Kvale suggested (2008). Participants were asked to sign two copies of the Consent Form (Appendix C) prior to the research interview. The participants kept one of the copies and I kept the second, which was stored securely in order to preserve anonymity. Prior to the interview, participants were also asked to sign a Consent to Audiotape Form (Appendix E).

Deception

In the 'Information for Participants' and the 'Consent Form', I was open and honest about the aims of my research and what it would entail. I did not withhold any information that might have cause distress to participants.

Debriefing

During the debriefing stage participants were given the opportunity to add anything the interview might have missed, to clarify any aspect of the research that was not clear and to discuss how they felt about taking part in the study. Participants were also given a Resource Pack that included information regarding support services available to them. The Resource Pack was offered to every participant whether distressed had been picked up in the interview or not.

Withdrawal from Research

Participants were made aware and reminded at every stage of the research that their participation was voluntary and they had a right to withdraw from the study at any point (including during the interview). Participants were also reminded they could request the destruction of their questionnaires and of any tape recording until May 2016.

Confidentiality

Participants were assured of their right to anonymity and of the efforts taken to preserve their identity. To preserve confidentiality, Consent Forms were stored securely and separate from any transcript and questionnaire. Interview transcripts were stored anonymously. With participants' consent, extracts from the transcripts were included in the research findings section, all identifying details were omitted and every participant was given a pseudonym.

Protection of Participants

The risk of psychological distress was kept to a minimum, however if any participant experienced psychological distress I was prepared to contain their distress in a sensitive and empathetic manner. Furthermore, I had prepared a Resource Pack that included relevant sources of support.

Giving Advice

If I became concerned about any physical or psychological problems during the interviews, I was prepared to let the participant know. However, this did not occur with any participant in the study. As mentioned above, participants were offered a Debrief Form and a Resource Pack to provide them with further support should they need it.

2.7 Reflexivity

Reflexivity is a core principle of both qualitative research and Counselling Psychology. Reflexivity can be defined as the process in which I, the researcher, become aware and reflective of the way in which my position towards the research, the questions I ask (both to my participants and myself) and the methodology chosen impact on the psychological knowledge produced in the analysis (Langdridge, 2007).

For researchers, it is particularly important to become consciously aware of what they bring into the research. Langdridge (2007) also highlights that reflexivity becomes particularly important when the researcher is interested in exploring the lived experiences of vulnerable people and communities, and s/he is not someone who has experienced the issue themselves as was the case for this study. The risks of not being reflexive in this instance could lead to misrepresentation of the

participants and to construct psychological knowledge that reflects my own position as an 'outsider' (Langdridge, 2007).

As Willig (2013) points out, my own motivations and investments in the research, however, do not represent 'biases' that need to be eliminated from the research, but conditions that frame and influence both the research and its findings.

With this in mind, below I made explicit some of the assumptions that I have brought into the research with me. These features were 'discovered' and analysed during meetings with my research supervisor, meetings with university colleagues, lectures and individual reflections.

1. My position as an 'outsider'

With regards to the experience of the participants in this research, I consider myself as an 'outsider'. My weight has always been considered 'normal'/healthy and I have never experienced eating difficulties. I am certain, however, that my appearance as a slim young woman impacted on my participants when we met. For example, participants might have assumed that I too had eating difficulties. Alternatively, they might have assumed that I was just interested in 'studying' them as they do in laboratories with guinea pigs. If this was the case, power imbalance could have become an issue to be aware of. During the interviews, I therefore tried to be very mindful of any power imbalance arising. I hope that, even if I have not experienced eating difficulties myself, I was able to maintain an open and curious approach towards this research.

Not having experienced this experience first-hand does not mean that I approached this research without assumptions or expectations. Through personal therapy, experience with placements and from conducting this research, I have become increasingly aware of my similarities with individuals who struggle with eating difficulties. For example, I am aware of wanting to be a perfectionist with almost everything that I do (including this research). Perfectionism is often seen as a common trait among individuals struggling with Anorexia Nervosa. In addition, I recognise that I lack compassion towards myself and this is something that I have in common with individuals with eating disorders (e.g. Ferreira, Pinto-Gouveia & Duarte, 2013), therefore looking in more depth at compassion therapy could also be beneficial for myself. In addition, I have participated in an eight-week mindfulness based cognitive therapy (MBCT) group and have realised that mindfulness is a necessary component of compassion. This research would help me understand the similarities and differences between mindfulness and

compassion and compare my experience with the experience of this group. I believe that having these traits and experiences that might be similar to those experienced by my participants can make me a closer 'outsider' than the average 'outsider'. In addition, my personality and my previous experiences helped me to approach the interviews in a more empathic and understanding way.

2. Impact of the literature and previous clinical work

The introductory chapter shows that I am familiar with current literature regarding self-compassion and eating difficulties. One assumption from the current literature is that individuals struggling with eating difficulties can present with low levels of self-compassion and find the experience of developing it quite difficult. During my interviews and the analysis stage, I have tried to keep an open mind and not assume that my participants also had low levels of self-compassion or found it difficult to develop it. In addition, previous findings suggest that participants who live with eating difficulties are often stigmatised by society. For example, Roehrig and McLean (2010) showed that individuals struggling with eating difficulties are often seen as more fragile, more responsible for their eating difficulties and more likely to use their difficulties to gain attention. This research has motivated me to embrace the principle of beneficence, with the aim to produce scientific findings that can be helpful for the participants and the wider scientific community. I therefore became aware of my hope that this research would be able to give back to these participants some power of knowledge.

In addition, through my experience as a Trainee Counselling Psychologist in a private hospital for eating disorders, I became particularly interested in studying and reading about eating difficulties. During my work with clients, I became particularly aware of the difficulties some of them had in finding any kindness for themselves. Since I would like to continue working with this particular population (i.e. individuals struggling with eating difficulties) in my future career, I decided to explore the topic of self-compassion from the participants' point of view with a further aim of understanding how to work better with clients that are experiencing eating difficulties. During the interviews, I was very aware of this aim, and I tried to make sure that the questions I asked were, as much as possible, aimed at understanding the participants' experience.

Although I had previous experience in working with people with eating disorders, I had not received any CFT training and had not taken part in or observed the compassionate mind group that my participants took part in. I believe that this had different benefits, such as helping me to avoid too many preconceptions and also

allowing me to “bracket off” previous experiences or thoughts, which could have influenced the analysis and the outcome of this research. With the term “bracketing off” I refer to Husserl’s idea of transcending culture, context and assumptions to identify the essence of a subjective experience (Smith et al., 2009). Bracketing is a method that is often used to increase the rigour of a research (Tufford & Newman, 2012), therefore I believe that, not having experienced CFT training or the compassionate mind group myself, positively contributes to the rigour of this study.

2.7.1 Methodological and Procedural Reflexivity

During the pre-proposal phase, I met with my research supervisor to discuss my concerns regarding diagnosis. I was not sure whether I needed my participants to have a formal diagnosis or whether I could accept their self-diagnosis. Our conversation helped me to understand that for a qualitative study looking at lived experiences it was not necessary to have a formal diagnosis, as it was the experience of my participants that counted. As a matter of fact, I realised that what I was actually interested in were their symptoms and how these were affecting their lives and their self-compassion. Therefore, a formal label would not have made the participants’ experiences any more or less valid. However, by reflecting on this I realised that my past as a positivist was still having impacts on my way of conducting research and I needed to pay attention to this to avoid using an epistemology that clashed with my methodology.

In addition, after I had finished the interviews with my participants, I met again with my supervisor to discuss my struggle to transcribe and analyse the data. During our conversation, I realised that my perfectionism was slowly creeping in my research and was preventing me from moving forward. I realised that I had to challenge the expectations I had for myself, I was afraid of having committed mistakes and having followed the interview schedule too strictly. However, I realised that I needed to become more compassionate towards myself and this helped me to realise that until then I had been feeling anxious about filling the shoes of the researcher, which seemed too different from that of a Trainee Counselling Psychologist.

CHAPTER 3: Analysis

3.1 Introduction

In this chapter I will present the four super-ordinate themes and their sub-ordinate themes derived from analysing the seven interviews using interpretative phenomenology. I will explore each category in turn through the use of direct quotes[1], furthermore each section will end with a brief summary of the sub-ordinate theme. The presented themes represent my attempt to tell the story of women who suffer with eating difficulties and are trying to understand and develop self-compassion. I hope that my analysis has been able to capture the complexity and richness of my participants' lived experiences.

Through the analysis I have identified four super-ordinate themes:

1. A Whole New World – Journey towards discovering and describing self-compassion
2. It's A Long Way To The Top – Journey towards finding self-compassion
3. Journey For Life – Journey towards integrating self-compassion in their lives
4. A Trouble Shared Is A Trouble Halved – The experience of being in a therapy group

As can be seen from the table below, each super-ordinate theme has its own sub-ordinate themes, which will be presented and explored in more depth in the remainder of the chapter.

All the themes were expressed by the majority of participants, however this chapter will also explore participants' opinions that seem to differ from others.

Throughout the analysis process, I kept the research question at the forefront of my mind: **How do individuals who struggle with eating difficulties experience self-compassion after taking part in an eight-weeks compassionate mind group?**

[1] Direct quotes were taken from participants' interviews and are presented in italics. The participant's pseudonym and the line number follow each quote. Pauses in speech have been represented by the use of three dots, while clarifications or omissions are indicated by square brackets […].

Theme 1 A Whole New World	Theme 2 It's A Long Way To The Top	Theme 3 Journey For Life	Theme 4 A Trouble Shared Is A Trouble Halved
A Fundamental Change	*Easier Said Than Done*	*Impact On Life*	*Developing Trust*
Know Thyself	*A Painful Journey*	*Impact On Relationships*	*Fighting Together*
Letting Go Of The Fight	*Challenges Ahead:* *My Fear of Losing* *My Critical Voice*	*Impact On Eating*	*Do As I Do*

Table 3-1. Super-ordinate and Sub-ordinate Themes

3.2 Super-ordinate Theme 1: A Whole New World – Journey towards discovering and describing self-compassion

In this theme, participants described their journey towards discovering self-compassion and trying to come up with their own definition of it. Initially, all the participants spoke of self-compassion as a new concept that they had to learn about and that seemed completely different from anything else they knew (sub-theme 1: A Fundamental Change). The majority of participants noticed how self-compassion helped them to get to know every part of themselves including those 'negative' ones that they would shy away from or condemn (sub-theme 2: Know Thyself). After they had understood self-compassion and it had helped them to see every aspect of themselves, all participants mentioned how self-compassion could be seen as a new and different way of responding to their critical voice (sub-theme 3: Letting Go Of The Fight).

3.2.1 A Fundamental Change

When conducting the interviews, I noticed that all of the participants talked about self-compassion as something completely new, a concept that had been introduced to their lives by the group and that caused drastic changes. Ava, for example, described self-compassion as such:

"*I think, think it's quite a fundamental change in view point*"

(Ava: 64)

Here it seems that Ava is describing self-compassion as a concept that provided her with a new way of seeing things, such as thoughts and emotions. Furthermore,

she uses quite a strong word (i.e. fundamental) to describe how self-compassion affected her, perhaps wanting to highlight how big and important this change was for her. Elizabeth reiterated the point by adding:

"*I think it's something you have to work at, it's not something that's there*"
(Elizabeth: 105-106)

However, in this quote, Elizabeth adds that self-compassion was absent before the group and that it was something so different and big that she had to work hard at in order to incorporate it in her life. Actually, further on in the interview Elizabeth reflected that self-compassion is such a hard concept that she is not sure she fully knows what self-compassion feels or looks like:

"*I don't think I really achieved self-compassion, not fully*"
(Elizabeth: 247)

As is already visible from these two quotes, the majority of participants described self-compassion as something that had been absent from their lives and that, when introduced, provoked major changes. Furthermore, Elizabeth's last quote shows her doubts regarding whether she ever achieved self-compassion and, perhaps, also highlights her confusion regarding what self-compassion is. As a matter of fact, at times it seemed that self-compassion was so distant and different from everything they knew that they could not find the right words to describe it and would resort to the use of metaphors:

"*It's like the course and the whole way, that whole system of thinking [self-compassion], it's like being taken to a country that you didn't know was there, so you only thought there was Canada and England and all of a sudden you've gone to Ireland. You don't have to go to Canada, you can go here instead. You don't have to be, you know, good or bad, you can be other things and you can see…it's another island in my mind that I can go to and I didn't know that there was such a place*" (Brittany: 227-230)

Here, Brittany seems to compare her journey towards self-compassion as that taken by Columbus when looking for America. Self-compassion, in fact, seems to be so different from other concepts that Brittany did not even know it existed. In her tone, there seemed to be relief in knowing that there was a new place that she could go to whenever she needed, almost as if self-compassion represented her safe haven. Similarly, Danielle said:

"*It's like you are on a motorway going at a hundred miles an hour and it's so easy to keep your foot on the pedal and…in the practice I think they were talking about the tracks in the snow. These ways of thinking, behaving or being that are just so harmful really. It's just so easy to keep going in the old tracks, but making the new tracks…ehm…takes time*" (Danielle: 100-102)

With this sentence Danielle appears to be reflecting on how difficult it is to change habits and to try something new. She sees self-compassion as a way of slowing down as well as being a new road. In particular, Danielle seems to be talking about neuroplasticity. Neuroplasticity is a scientific term used to describe changes that occur in the brain in response to new experiences (Davidson & Lutz, 2008). Changes in the brain structure, such as decrease in size, grey and white matter as well as altered neural patterns (e.g. Titova, Hjorth, Schiöth, & Brooks, 2013) can be one of the consequences of suffering with an eating disorder. However, these changes can be reversed and one way of doing that is by practicing meditation, mindfulness and self-compassion. Different studies, in fact, have shown that these practices can contribute to the development of neurophysiological structures that reinforce cognitive flexibility, affective plasticity and emotion regulation (e.g. Goldin & Gross, 2010; Hölzel, Carmody, Vangel, et al., 2011; Shapiro, de Sousa & Jazaieri, 2016). However, change can be difficult and Danielle's hesitation towards the end of her quote, perhaps, also expresses a tinge of fear in trying something new after years of doing the same thing without even having to think about it.

From these quotes it appears that participants found self-compassion puzzling at first as it was something they had not experienced before. However, they did not seem to struggle with the concept per se, but with what it meant to include it into their lives. As a matter of fact, they all reflected on the time it took and the hard work they had to put in to start incorporating this idea into their usual way of thinking or behaving, as it was something completely different from what they were used to. Perhaps, self-compassion also felt a bit scary at first as it took them to places that they did not know existed and, maybe, showed them parts of themselves that they were not aware of or were trying to avoid.

3.2.2 Know Thyself

Participants described self-compassion as a tool that could help them become more accepting of their feelings as well as of themselves. For some, self-compassion was helping them sit with their difficult feelings without ignoring them or reacting to them:

"*I mean it's about mindfulness real- really, but with a message, so it's all the good things that are related to mindfulness and being quiet and being able to sit with yourself and to sit with…difficult feelings*" (Chloe: 50-51)

Chloe seems to be saying that self-compassion not only helped her to sit and observe her difficult feelings but it also gave her a new way of responding and talking to these feelings, a 'message'. In order to be able to sit with difficult feelings it seems that people first need to become aware of these feelings as well as of their role in relation to them. As Brittany says, self-compassion cannot be achieved without awareness:

"*It's a tenderness towards…it's a softness towards self…it's uhm…it, it involves an aware- I don't think you can do self-compassion without awareness. I think you have to have awareness first to know that you're doing something to yourself and to know that what you're doing…that you are an agent in what you're feeling" (Brittany: 50-52)*

Here, Brittany suggests that before individuals can incorporate self-compassion into their lives, they have to become aware of their agency in terms of behaviours and feelings. Recognising this, however, does not necessarily mean criticising oneself but it means realising that what one is doing (e.g. restricting or bingeing) might be an attempt to make oneself feel better:

"*I think it's really tricky with eating because I'm obviously doing it on one level to help myself. I wouldn't be doing it otherwise and there's that sort of sense of nurturing myself and looking after myself that comes with food*" (Elizabeth: 311-313)

The concept of self-compassion, in this instance, is helping Elizabeth see that her eating disorder is actually attempting to help her take care of and nurture herself; however, she is also able to see that what she is doing to help herself might not be beneficial in the long run:

"*Unfortunately, its an extreme response that then becomes very negative so it…ultimately, I'm not nurturing myself or looking after myself or being compassionate but on one level, that's what I think that I'm doing*" (Elizabeth: 313-315)

Perhaps, this discovery might help her see that her eating disorder is actually covering a deeper need or pain and, in time, she could replace her eating

difficulties with more helpful and coping mechanisms (such as self-compassion). In all these examples, self-compassion has been used as a tool to shed some light on what was happening and to uncover deeper meanings. In a way, the concept of self-compassion was used as a catalyst for discovering and exploring the self. As Faith eloquently put it:

"*In the long term it looks like… happiness, restfulness, it also looks like wisdom. Ehm…knowing yourself. Ehm…knowing your flaws, knowing your strengths, being ok with that*" (Faith: 33-34)

With this sentence, Faith gives the idea that self-compassion can guide individuals into self-exploration by, perhaps, giving them strength and tranquillity. Through self-compassion it becomes less scary to observe all our aspects, both positive and negatives, and the strength possibly comes from knowing that self-compassion will help you feel calm and accepting of your flaws. Self-compassion, therefore, helps individuals get to know every piece of themselves and, I think, it could be in this way that self-compassion provides individuals with wisdom. In addition, what seems to transpire from these quotes is the acceptance that comes from developing self-compassion, giving individuals a new way of responding to their critical voice.

3.2.3 Letting Go Of The Fight

Most individuals who struggle with an eating difficulty have to face many battles, including an exhausting internal one: the battle against their critical voice. The critical voice seems to be always present and, more importantly, always ready to judge and criticize every little step they take:

"*You're caught in that persecutory place, which is a horrible place. So yeah…but it feels a bit like defeat because the persecution is very 'fight' whereas the self-compassion is very 'accept'* " (Brittany: 106-107)

With this quote, Brittany elucidates what it feels like to constantly hear this critical voice and it seems that she had gotten so used to being 'prepared for battle' that when she learnt about self-compassion she felt like she was giving up and was, perhaps, succumbing to her critical voice. Perhaps her quote also shows that her critical voice was not ready to be defeated and made her feel guilty for accepting self-compassion as an alternative. Contrary to what the critical voice does, self-compassion appears to be giving them a sense of acceptance that allows them to feel ok about their flaws. Some of these 'flaws' could include mistakes and failures.

"*It [self-compassion] takes away the aspect of failing, the giving up*"
(Danielle: 166-167)

Through this sentence, it appears that Danielle is saying self-compassion allowed her to take a new route without making her feel like she was forfeiting or losing the battle. Grace was able to expand on this point in her own interview and added:

"*So there is that kind of element…of kinda compassionate self-correction as well ehm…in the sense of sometimes seeing that you made a mistake and kinda understanding why you've made that mistake, not being punitive towards yourself for it but then thinking what can I do differently, what could I do better next time…and still…without kinda shaming oneself as it were*"
(Grace: 65-69)

Grace is suggesting that self-compassion does not mean observing negative emotions and experiences and giving up or putting them in a corner of the mind; self-compassion means being able to observe these experiences and think about what could be done differently next time. However, contrary to what perhaps the critical voice would do, self-compassion does not judge or shame but it allows the person to observe their mistakes from a place of acceptance. Self-compassion, then, seems to take away the dreaded feelings that arise when we feel like we have failed and have let ourselves or other people down. In addition, self-compassion provided individuals with something new that they could use to replace the critical voice.

"*I think that…those negative thoughts were…were less, because you had something to replace it with as well?*" (Chloe: 269-270)

Through her pauses and her almost question, it seems like Chloe is still trying to understand how self-compassion has been helping her, perhaps she was also not sure of how she could describe her critical voice or was trying to find the more 'compassionate' way of describing it. Nevertheless, she suggests that self-compassion provided her with an alternative, meaning that self-compassion did not just provide her with arguments or tactics that she could use against her critical voice but it actually gave her a replacement for it. Self-compassion, in fact, allowed individuals to create a new voice, a compassionate voice that that could replace and soothe the critical voice.

"*I think I used to be very critical at myself but then also be angry at myself for being critical*" (Ava: 53-54)

And further on in her interview, Ava added:

"Not only is about trying not to feel those feelings, it's also about not being then angry at yourself for feeling those negative feelings. So it's just kinda accepting that that's the way you feel and that's ok"
(Ava: 55-56)

In these quotes, Ava shows what the battle against her critical voice looked like, it is not only about being judgmental or critical of oneself but it's also about becoming angry with oneself for being critical. In a way, this battle is a vicious cycle with no way out. However, it appears that the self-compassion created a 'way out' from this cycle, which then allowed Ava to observe how she was feeling and actually accept that there would be times in which she might be critical of herself and that was ok. Throughout these quotes, I feel that what my participants are also implicitly saying is that the voice that was created through the development of self-compassion was something completely new.

"*Mindfulness is like knowing the language and the self-compassion is like being in that country, and you are actually able to use the language*"
(Danielle: 256-257)

Danielle implies that self-compassion and the self-compassionate voice opened new doors and allowed her to have new experiences. In addition, Danielle felt that she was able to use this new tool she had learnt and developed, which helped her experience new things and, perhaps, completely immerse herself in them. In fact, knowing the language of the country one is travelling to, can allow that person to immerse herself in the landscape and the culture. However, since self-compassion is something new and a big change, the journey towards developing it was not an easy one.

3.3 Super-ordinate Theme 2: It's A Long Way To The Top – Journey towards finding self-compassion

Within this theme, participants described their journey towards findings and developing self-compassion. Since most participants had to learn to be compassionate towards themselves from scratch, the journey towards self-compassion was not an easy one. From day one, participants felt that their journey was full of obstacles as well as painful emotions. The first obstacle that many of the participants experienced was how to apply what they were learning in the group to

their everyday life (sub-theme 1: Easier Said Than Done). A further obstacle arose when participants were asked to face the difficult emotions that were rising up (sub-theme 2: A Painful Journey). Lastly, participants felt that their critical voice was one of the biggest obstacles they had to get through (sub-theme 3: Challenges Ahead – My Fear of Losing My Critical Voice).

3.3.1 Easier Said Than Done

Many of these women felt that the theory of self-compassion and being compassionate towards others were two of the easiest parts of developing compassion; however, this did not mean that it was not a struggle for them to even entertain the idea of being compassionate towards themselves.

"*Umm…you know, obviously the idea of being compassionate in theory and the idea of being compassionate to other people is always going to be more easy than being compassionate towards yourself*"
(Elizabeth: 175-177)

With this sentence, it appears that Elizabeth feels she is pointing out the obvious as, of course, she could feel compassion for other people but she found it difficult to have compassion for herself. However, I wonder whether beneath the appearance of this sentence she was actually saying that she was not worthy of compassion, whether other people were and this was why it was easy to think about giving compassion to other people. In addition, even when they did start to entertain the idea that giving compassion to themselves was not as otherworldly as they had thought, there was another obstacle waiting for them on their path: how could they put it into practice? What did being compassionate towards themselves look like?

"*It [compassion] would be one of those things that would be where…where do you start? So…I kind of knew, for probably ten or fifteen years that I had to just sit with myself. I had no idea what that meant! (laughs) I had no…you know, to sit with my feelings and to just sit there and be comfortable with them, how…how do you do it?*" (Chloe: 57-59)

Chloe shows that she knew the theory and was aware of what she needed to do, however she had no idea where to start. In addition, research indicates that some individuals suffering with eating disorders struggle with distress tolerance (e.g. Anestis et al., 2007; Corstorphine et al., 2007; Fairburn, Cooper, & Shafran, 2003; Juarascio et al., 2016). Therefore, sitting with feelings and actually being able to tolerate them is something that some individuals suffering with eating difficulties try

to avoid, so how could they start to do it now? Furthermore, in order to put something into practice one has to know how to do it and many participants felt that they never had a model to show them how being compassionate was done. Perhaps this made it hard for them to even imagine what self-compassion could look like or feel like.

"*But even the notion of compassion is a difficult one if you've never had a model of compassionate carer or compassionate, you know, if you don't know what the hell is it and you're trying to manufacture it on your own it's quite difficult*"
(Brittany: 270-271)

When looking at this sentence, I was particularly struck by the language Brittany used as she seemed almost annoyed at the idea of having to develop self-compassion on her own. In addition, she also seems to be expressing her anger and grief about not having had examples in her life to show her what self-compassion felt like. Perhaps, these negative emotions represent Brittany's critical voice that was 'getting angry' with her for lacking self-compassion. In fact, she does not know "what the hell compassion is" and mentions that the notion of it becomes difficult to understand as well as to imagine, since she did not have examples from her life that she could think of. Furthermore, since she did not have examples she could think of, she felt that she did not have self-compassion in herself and had to "manufacture it", to create it from scratch. Lastly, the majority of participants felt that even if they could grasp the concept and apply it to themselves, it was easy to go back to driving in their old tracks (i.e. it was easy to go back to their old coping mechanisms).

"*Maybe not beating oneself up as much probably came a bit more easily though I think when, when there's certain things that really press your buttons then I think it's actually quite difficult not to spin off…ehm…into ehm…some form of recrimination or over-compensation*" (Grace: 79-80)

With this quote, Grace seems to be talking about the difficulty she faced when trying to substitute her old reactions (e.g. recrimination) with self-compassion. In particular, Grace seems to suggest that employing self-compassion became particularly difficult when things or situations were particularly triggering ("*really press your* buttons").

From these quotes it appears that, however different self-compassion might be from their usual ways of thinking and behaving, the actual concept and theory behind it did not seem difficult to understand. Nevertheless, my participants felt that

putting it into practice was a different matter altogether. Firstly, it might be difficult to do so without a model, and then it might be hard to use in everyday life given that they had not yet developed the skills to be kind towards themselves, and that self-compassion was very different from the ways they had of relating to the self. In addition, old ways of responding to situations had now become habits and it might be difficult to employ self-compassion when situations are particularly triggering. The journey towards self-compassion can also be complicated by the difficult emotions that it evokes along the way.

3.3.2 A Painful Journey

The majority of my participants engaged in this journey because they hoped it would help them get better and feel better. Perhaps what they did not realise was that this journey would also uncover painful and difficult emotions.

Many participants were really surprised when they discovered that developing self-compassion also meant realising the depth of their distress. For some, their eating difficulties were a way of coping with difficulties, such as painful emotions or challenging situations, and the self-compassion helped them realise that this was what they were doing. However, this also meant that they had to look at everything that had been hiding and it was not easy.

"*If you've not…if that's been…if that compassion's been missing to- and…and there were times when you had to acknowledge where that had been missing? And that's…what makes makes it quite hard, that's what makes it a bit challenging really*" (Chloe: 110-112)

Here, Chloe seems to be re-living her pain and distress through her many pauses and hesitations. In her journey she found that acknowledging that she had been missing self-compassion was difficult, and along the way, perhaps she realised that being critical of herself had not been as useful as she once thought and this might have made her feel like she had failed. However, once the cover had been lifted it was difficult to not look at what was underneath.

"*I found it, what I didn't expect in this particular eating thing, not outside…I didn't expect, I expected relief and I didn't get relief…that's not what I got…and I was quite shocked that actually what I got was more pain and I didn't expect that*" (Brittany: 116-117)

Here, Brittany explains how realising that self-compassion had been missing from her life actually evoked difficult feelings. She also adds that she had not expected

such negative feelings to emerge during the group sessions and, when this happened, it "shocked" her. Further on in her interview, Brittany added that by noticing her lack of self-compassion, she also became aware that her critical voice and her familiar ways of responding to pain were actually hiding a lot of pain:

"*So, by being more aware I started to understand how much pain I was in and I hadn't really understood that before. And understanding that and seeing what I was doing and how my mind was working was very painful*"
(Brittany: 119-120)

In this quote, Brittany illustrates how difficult it was for her to realise how much pain she had been in; however, what seemed to be even harder was to understand that the ways in which she had been behaving and thinking, were a way of actually coping with this pain. Perhaps her distress was also increased by the "depth" of her pain and by the fact that "*once she had seen it, she could not just walk away*".

In addition to realising how much pain they were in, some participants were particularly surprised by the emotions that arose when they were trying to be self-compassionate. Often these emotions were quite negative and this shocked them more than realising they had been suffering and had lacked compassion. One participant was particularly surprised as she could not generate compassion for a younger version of herself in one of the exercises. The exercise she is referring to is comprised of two parts, in the first part participants are asked to imagine how they would feel if they found a young child by the side of the road and this child is alone and crying. In the second part of the exercise, participants imagine themselves in the same situation, however this time they realise the young child is a younger version of themselves. Since this participant had been working with children for a long time, she was not expecting to not be able to feel compassion for herself as a child:

"*I remember going around the room and saying how we felt about that child. And my feelings were of disgust. And I think I realised how deep the damage to me was in terms of my lack of self-compassion. And even without compassion, how uncompassionate I feel generally towards myself. And it broke my heart because I was a TA for ten years, I love children, I love all children, and of course, you just do don't you*" (Danielle: 217-219)

The picture Danielle portrays is quite painful, first she talks about her feeling of "disgust" for herself almost as if she cannot even bear to look at herself, and then she talks about her heart being broken by the realisation that "you just don't do

you". Danielle also seems to be saying that she had spent many years of her life being nice and compassionate towards other people but she had forgotten to do that for herself. When she had said this in the interview I remember thinking that my heart, together with hers, broke a little too at the idea that she could not feel compassion for herself as a young, vulnerable child.

While Danielle felt quite negative feelings towards herself, some participants could not feel anything at all. The absence of emotions scared them and possibly acted as a 'wake up call' in terms of their lack of compassion.

"*Because I am very kind of outward focused in terms of how happy, very outwards focused in terms of pleasing people or being sensitive to other people kind of distress or anger or whatever and, and I had a real issue with this, like this where you know you sit there and you just like feel compassionate towards, you know loving-kindness towards yourself and I just didn't feel anything, I just like sat there like "uhmmm" obviously with my eyes closed and just didn't feel anything authentic, didn't generate any kind of positive emotion like I wasn't feeling bad, I wasn't feeling anything*" (Grace: 169-174)

The image portrayed by Grace, which is a bit different from the one portrayed by Danielle, is perhaps one of confusion rather than pain. This confusion probably derived from the fact that she felt very in tune with other people's emotions, she could sense when they were angry or upset and perhaps she thought she would be able to do that with herself too. One of the possible reasons behind her absence of emotions could be that she had detached herself from both negative and positive emotions, which left her in a limbo where she was not feeling anything. As a matter of fact, Grace reflected that she did not feel bad about not feeling anything, and her quote seems to describe her difficulty in accessing emotions, which perhaps left her feeling numb.

Self-compassion can therefore become a positive coping mechanism when dealing with negative emotions and experiences, however it can also uncover and show the suffering behind our familiar ways of behaving and thinking. Furthermore, when different individuals are trying to develop self-compassion they might be surprised by the strong emotions that arise or by the difficulty to access emotions. From these quotes it also appears that different aspects of their eating disorders, such as their critical voice, were lurking in the background and were ready to hinder their journey at any time.

3.3.3 Challenges Ahead: My Fear of Losing My Critical Voice

All of my participants had taken part in the therapeutic group as they were suffering with an eating disorder and were looking for something that could help them. One of the main obstacles they encountered when developing self-compassion was their critical voice and their fear of losing that voice.

Many participants often spoke in their interviews, both explicitly and implicitly, about their critical voice. This voice seemed to be always present and appeared to be a way of driving their behaviours while also acting as a safety strategy to regulate threats. The voice, in fact, was often described as telling them how to behave and how to do things better; however, this appeared to be a defence against different threats such as negative emotions. Furthermore, developing self-compassion meant challenging directly the critical voice since self-compassion involves offering non-judgemental understanding and kindness to oneself. For some participants, it seems that this felt unsettling and scary:

"*But I don't think personally that I was ready to be fully compassionate or ready to fully embrace anything much with a full blown eating disorder and I think that you know, maybe this is different for different people, but you know, sometimes I couldn't even get out of bed, so... and I couldn't go to work and I couldn't maintain a normal life, so the idea of going to a compassionate group –it's a little bit too ambitious I think*" (Elizabeth: 193-197)

Here, Elizabeth seems to be talking about her fear of losing her critical voice. In fact, she does not believe she was ready to be fully compassionate and, at different points in her interview, mentioned that she is not sure whether the group was helpful for her and whether she was able to even develop self-compassion. Perhaps, when Elizabeth's critical voice was challenged in the group sessions, she perceived the situation as threatening, which as a result activated her 'threat system' (Gilbert, 2010) and prompted her to activate her safety strategy (i.e. her critical voice). As a result, it appears that this cycle prevented Elizabeth's engagement with the group and with self-compassion. This struggle with the critical voice and its maintenance cycle was also expressed by other participants:

"*I think the self-compassion and the eating stuff and probably most things, is the area of stuck…the area that's difficult is kindness to self because the times you need it the most are the times you're least kind to self*"
(Brittany: 102-103)

Brittany realises that the eating and everything it entails is the area of "stuck", the reason why she went onto this journey. However, in this quote, she is also portraying a picture of how the maintenance cycle of her critical voice worked. As a matter of fact, Brittany realises that the times in which she needed to be compassionate towards herself, were also the times when she struggled the most and her critical voice would become active. It is possible that during those times Brittany felt vulnerable as she was trying to modify a behaviour (i.e. her critical voice) that was actually trying to help her respond to threat. As a result, her 'threat system' would be triggered and her critical voice would be activated as a safety strategy to protect her. Since the critical voice was acting as a defence mechanism, it is also possible that the idea of losing this through the development of self-compassion felt scary at first, hence the feeling of "stuckness" that Brittany talks about. Other participants, including Grace, also expressed this struggle with the critical voice:

"*I think there's always a part of people when they're used to being quite self-critical, which says 'no, actually if you do it this way it would have been different and it would have been better' and…to a certain extent there's a tension with that and being self-compassionate*" (Grace: 114-116)

In this quote, Grace reiterates what Brittany had said in her interview but adds that her critical voice acted as a safety strategy by also telling her how to behave and how to do things better. This way, perhaps, Grace would be able to protect herself in future situations from negative or unpleasant feelings. Therefore, it is possible that the idea of losing this "protection" (i.e. the critical voice) felt unsettling for Grace too and caused tension in her. Similarly to Grace, Faith also spoke about her critical voice as a defence against negative feelings:

"*So, yeah. I was gaining weight, and because I didn't know how to control my eating, I felt guilty when I didn't eat. When I had a day where I was… I use the word 'bad', but that's not very self-compassionate, so…you know what I mean, I hadn't eaten, I'd restricted. I'd feel guilty and then I'd… I'd almost binge, to make up for it. To make me feel less guilty. So, that's the struggle I was going through. So there was a lot of negativity, a lot of lack of self-compassion going on there, at the same time*" (Faith: 97-101)

With this quote, it seems that Faith's 'threat system' and critical voice would become activated to protect her from her negative feelings and, in particular, from guilt. However, although the critical voice is acting as a defence mechanism, it does not appear to be pleasant; as a matter of fact, Faith describes the times in

which it became activated as being full of negativity. Nevertheless, from this quote it also transpires the struggle of letting go of this critical voice as, even though it was negative, it was also protecting Faith from threats. In addition, Faith noticed that her critical voice would also become activated whenever it was being challenged by the compassionate voice:

"*Ehm… It was harder for me to accept... It was harder for me accept that I wasn't all these horrible things, ehm […] when I was asked to think about what this voice would be telling you, holding you. Ehm, and I found it difficult to believe it. I mean I am just conjuring up this… this stuff to try and make me believe that I am better than I am, but… Ehm… you know, that's not entirely true. And actually, I am not doing so well. And I am fighting against it… Fight against this, this kind of voice that I know needed to come out*"

(Faith: 121, 125-129)

In this quote, Faith seems to also be talking about her fear of losing her critical voice as she talks about her struggle as a fight against the compassionate voice that was trying and "*needed*" to come out and be heard. From her words, it seems that Faith's critical voice had been acting throughout the years as a driving mechanism for her behaviours as well as a way of regulating the 'threat system'; therefore, whenever either one of these functions was challenged by the compassionate voice, her critical voice would become activated.

These quotes showed that the journey towards developing self-compassion was not an easy one. On the contrary, it was a long and difficult one, filled with obstacles such as the difficult emotions that arose, the strength of the critical voice, which seems to be driving the eating behaviours, and their fear of losing this critical voice. However, once some of the obstacles had been overcome, self-compassion started to become part of everyday life.

3.4 Super-ordinate Theme 3: Journey For Life – Journey towards integrating self-compassion in their lives

The majority of participants felt that self-compassion was a journey that they were still completing, however they could already notice the impact that it was having on their lives, as well as on their eating and their relationships.

3.4.1 Impact On Life

All participants, but one, felt that self-compassion had a great impact on their lives. The one who felt self-compassion had no effects also reflected that she was not sure she had been able to develop it fully:

"I struggle with figuring out whether I'm compassionate towards myself…Or not. So I struggle with the whole concept quite a lot…ehm and I'm so much thinking in my head and I'm sort of academic about it…*I don't really know if I have ever been self compassionate or I could ever be, or perhaps I am or not…I don't know it's a difficult one for me*" (Elizabeth: 514-517)

In this quote, Elizabeth seems to be venting her frustration with herself and, perhaps, with self-compassion in general; it seems that Elizabeth struggled to get to the core of the theory of self-compassion and, perhaps, this prevented her from developing self-compassion and from engaging with it. Furthermore, it is possible that Elizabeth did not notice the subtle changes that self-compassion might have brought about. As a matter of fact, other participants mentioned that the changes they had noticed had been different from the ones they had expected:

"*I had a vision of this course making me very Zen-like and, you know, Buddhist monk style, but that hasn't changed and I'm still like, I'm still quite high energy, I still quite like operating in my drive system kinda having a lot going on and pushing for things and that certainly hasn't changed […] so I'm not sure it's made a noticeable change from the outside but it certainly made me feel I guess calmer and less up and downs*" (Ava: 163-164, 169-170)

Here, Ava clearly shows that she had different expectations from the group and how she would come out from it; in particular, she seems to refer to the three affect-regulation systems ('Threat System', 'Drive System' and 'Soothing System'; Gilbert, 2010) and suggests that, as a result of the group, there is more balance among the systems. In fact, although Ava still likes to operate in her drive system, she appears to be able to accept and work with this side of herself. Nevertheless, although other people might not notice any visible changes, it seems that Ava does feel different from the inside and has noticed changes herself. Furthermore, other participants noticed that they had not realised the full impact compassion had on their lives until they spoke about it with me:

"*I do think that actually just talking about it has made me realise that it probably was more of a change than I really acknowledged. So I think it has been, I think it has been something longer term?*" (Chloe: 231-231)

During our interview, Chloe reflected that perhaps self-compassion had not been just a 'quick fix' but it had actually impacted her and her life more than she realised. Perhaps, the changes were subtle and were slowly incorporated into her daily life without her noticing too much. Later on in the interview, she gave multiple examples of how she used exercises from the group to help her calm down or soothe herself. Self-compassion, in fact, can be developed every day and can become a useful tool to carry on their journey through life.

"*Yeah, it's part of every aspect of my life, you know. It really is. I think about…you know, I think about it all the time. […] It's like remaining steady when you're in a really rocky boat. And what the…this has done for me is about being level, and not sort of, being capsized. It's just about sailing through life, ehm, without capsizing the boat*" (Faith: 166, 168-169)

Faith portrays a beautiful picture of how self-compassion has become part of her everyday life; for her, being self-compassionate means being able to remain steady even when facing problems and, perhaps, difficult emotions. Her metaphor about the boat seems to be referring to the three affect-regulation systems (Gilbert, 2010), with the boat representing a balance between them. Through her journey, Faith realised that by becoming caught in the 'Threat System' ("*you can't really focus on anything apart from staying* alive") she could not do anything, and it was only when she started to look at difficulties and accept them that she found a balance. Many participants, in fact, noticed that developing self-compassion changed the way in which they related to themselves and allowed them to become more accepting and open, instead of being judgemental and critical.

"*It [self-compassion] completely changed my life. It completely changed the world. Changed me. […] It transforms every single aspect of my life one hundred percent and it's paved my view of what is success and what isn't working so well. Like, giving up my job, which I did a year ago last January, is the most successful thing I ever did, you know. I was finally time to give one hundred percent of my time to my health. Whereas in the past it would have been giving up, because I wasn't persevering, self-compassion just turned it upside down. It was the right, healthy thing to do […] Everything comes from a different place. Ehm…like everything comes from a place of kindness, rather than a place of discipline, a harsh discipline and struggle*" (Danielle: 254, 257-260, 274-275)

Again, Danielle gives beautiful examples of how developing a compassionate voice has become part of everyday life and how it's helping her make decisions that are healthy without feeling that she is failing. It sounds like along her journey Danielle was able to find a more compassionate voice, one that turned her world upside down and that helped her to become part of a kinder world. In particular, her quote suggests that Danielle was able to develop her 'Soothing System' and this helped her become more accepting and kind towards herself and her suffering. Danielle was not the only participant that spoke about how developing a compassionate voice had facilitated the development of a less judgemental attitude towards herself:

"*I think the whole course had an impact on my life. […] I'm sure it has had an impact, like it…what I was trying to describe before and I probably didn't describe very well, I was always very conscious that I had a critical voice and I used to get angry with my critical voice because I knew it was being unreasonable whereas this taught me to respond differently to my critical voice to kinda soften it and be nice to it and that I think has taken away a lot of the internal kind of… angst inside me*" (Ava: 100, 105-108)

Here, Ava shows that her compassionate voice helped her to respond differently to her critical voice and, by doing this, she feels that she is less angry inside. This seems to be in direct contrast to Elizabeth's experience, where she struggled to develop a compassionate voice and, because of this, continued to experience internal anger:

"*Maybe I'm just a little bit angry about it because it's all very well to have an awareness in theory about what self compassion is, but unless you're really feeling it, ah, I don't think it...it can't really, it can't help you at all*"
(Elizabeth: 507-509)

As a matter of fact, both critical voices appear to have kept Ava and Elizabeth in a vicious cycle where they would always be critical of themselves and their suffering. However, by developing self-compassion and a compassionate voice, Ava was able to develop a more accepting stance towards all aspects of herself, including her critical voice. Furthermore, self-compassion helped Ava to develop her 'Soothing System', which enabled her to "bring a certain soothing, quiescence and peacefulness to the self, which *helped* to restore *her* balance" (italics added to original quote. Gilbert, 2010, p.48).

From these quotes it appears that the majority of participants felt that developing a compassionate voice had a positive impact on their lives, in particular it helped them feel more stable while becoming more accepting of themselves and of their suffering. In addition, it is possible that as a result of developing a compassionate voice that promoted a positive relationship with themselves, these women were then able to acknowledge without judging and accept their eating behaviours.

3.4.2 Impact On Eating

As the group was developed to help individuals struggling with eating disorders, most of my participants noticed the role that self-compassion played in their relationship with food and with eating behaviours. There was only one participant who did not notice any change in her eating but she mentioned that she was not experiencing eating difficulties at the time.

Similarly to the previous sub-theme, many participants noticed that the impact of self-compassion on their eating had not been what they had expected.

"*Ehm… so it's not in the sort of way that I thought self-compassion would help my bingeing, It's not that I suddenly go into breathing mode and I'm being kind and soft and all of this. I just kind of get there… I just have to depend on these daily inputs. All these little strategies*" (Danielle: 308-309)

Perhaps, before starting the group Danielle thought she would just stop having the urge to binge or that she could always stop herself by using breathing exercises. Nevertheless, she realised that the development of self-compassion helped her in a different way, which was to help her develop new skills that provided her with alternative ways of responding to distress. For example, during the interview she mentioned that she always carried a bag of almonds with her because this gave her something to eat whenever she became hungry and it also stopped her from going into the supermarket and buying 'unhealthy' food. This and other strategies that Danielle put in place seem to be a result of developing the skill of 'compassionate behaviour'; this skill involves promoting behaviours that alleviate distress and facilitate development and growth (Gilbert, 2009). Furthermore, when participants were encouraged to develop this skill through different exercises, they were also encouraged to focus on their efforts rather than on the results; this is also visible in Danielle's quote as she does not appear critical of herself for not being able to avoid or stop her urges, instead she seems appreciative of her efforts. In the long term, perhaps, this skill will help her to avoid acting on the urges as it happened for Ava:

"*When I did the mindfulness, since doing the course from about half-way through the course I had gaps of five, six weeks without bingeing and throwing up…ehm, so I've done it maybe in the last three months maybe three times and that's really really unusual for me. So that's the sort of positive impact it's had on the symptoms. I'm sure it's had a positive impact on my frame of mind as well, but that's also related to not having the symptoms. So it's had a really positive impact for me and I've had lots of different interventions and this has been definitely the most positive intervention that I've had in terms of the symptoms specifically*"
(Ava: 116-120)

Ava feels that developing self-compassion was the most successful intervention for her in terms of her symptoms and, later on in the interview, she explained how self-compassion helped her:

"*It helped me be more in touch with my feelings I think. Like…(pause) it helped me feel the urge to binge in a different way, feel it more clearly and feel that that's all it is and sit with it and it will go away. It allowed me to sit with that which I've never been able to do before*" (Ava: 135-137)

Through these two quotes Ava shows that the group helped her to develop two specific aspects of self-compassion: mindfulness and self-soothing. Mindfulness helped her to notice without judgment her emotions and to sit with her urge to binge without acting on it, which was something that she had not been able to do in the past. In addition, the self-soothing allowed her to treat herself with kindness and to feel calmer inside. Perhaps another aspect of self-compassion that also helped her during her journey was acceptance, as was the case for Grace:

"*I suppose what, sometimes the self-compassion helps me to do is realise that certain behaviours are always gonna be problematic and are quite deeply engrained so my default position is going to be towards those things but self-compassion sometimes helps you to stop escalating things like when you've done something, like if you've eaten too much and you think 'I shouldn't be eating too much, should I get rid of it or should I try to ove'- like overcompensate the next day or something, there's less of that going on, it's like 'ok fine let's just lie down and draw a line under it', you know, and then I suppose sometimes if I can, occasionally (laughs) work out what has been really bothering me and, and try and be with that then, then I don't necessarily go down the root of the eating*"
(Grace: 319-326)

Here, Grace feels that practicing acceptance towards all of her aspects, including those that could be problematic, such as her eating, helped her to stop situations from escalating like in the example she gives. In addition, it seems that developing the skill of 'compassionate reasoning' helped her to break the eating disorder pattern and allowed her to not see her 'slips' as complete failures. Perhaps, these skills allowed her first to reflect on the ways in which she thought about herself and her emotions, and then to accept her thoughts and emotions whenever they arose while soothing herself. In the long run, it is possible that the skills of acceptance and compassionate reasoning could become replacements for Grace's eating behaviours by helping her prevent urges.

"*Yeah, of course, yeah. You know, when I had a day where I restricted, or a day where I binged, because I restricted, I was able to say: 'Ok, it's all right. It's ok. Don't panic. Ehm…you know, it happens it's a part of recovery, everyone goes through this'* " (Faith: 188-189)

In this quote, Faith again highlights the importance of acceptance especially when recovering from an eating disorder. Setbacks are a normal and important part of recovery, however many people experience them as failures and give up their progress. However, acceptance helped Faith to develop a compassionate voice that could help her respond to her critical voice and her setbacks with softness. Through her quote, Faith also demonstrates that she was able to embrace the concept of 'common humanity', which advocates that pain and failures are part of our human nature and, by doing this, she was able to feel compassion for her pain, even if the latter did come from her 'unhelpful' eating patterns.

From these quotes it is possible to see that individuals felt that self-compassion had important beneficial effects on their relationship with food. In particular, different participants noticed that acceptance seemed to be the most important aspect when dealing with their eating behaviours as it allowed them to notice them without becoming judgmental. Those participants that didn't notice any effects also reported that they were not experiencing symptoms at the time. Eating disorders have a massive impact on relationships and, by changing their relationship with food, they also started to notice changes in their other relationships.

3.4.3 Impact On Relationships

When participants started to work on the relationship with themselves and on their relationship with food, they also started to notice effects on their relationships with other people. Through the development of self-compassion some participants

realised that they could not really care for other people when they did not have enough love for themselves.

"*You can only love other people when you love yourself*" (Faith: 78-79)

Here, Faith clearly states that love has to come from within, and that it is very important that you love yourself before loving anyone else. This was a feeling that was expressed by other participants as well, for example Danielle said:

"*I think you can't help but…if you are compassionate to others it has to flow through you. You have to experience that compassion in a sense*"
(Danielle: 337-338)

In this quote, Danielle reflects that perhaps the compassion she had felt for others in the past might be different and, perhaps, not as strong as the one she feels now as she believes that you have to experience that compassion for yourself first. In a way, what Danielle is also saying is that it is impossible to give to someone something that you do not know and do not feel. The development of self-compassion could have helped Danielle foster a new relationship with herself and feel a different form of compassion for other people. This could have helped her change the dynamics in her relationships, as it happened for Chloe:

"*It makes those relationships much healthier…because you can, you can comfort yourself, you can do…you know you can give. […] if you love yourself and you're not needing that external validation, then of course it makes your relationship better because you're coming into it as an, as an equal*"
(Chloe: 246-247, 278-279)

Here, Chloe notices that self-compassion helped her to enter her relationships as an equal since she could take care of herself and did not need to rely unnecessarily on others to make her feel better. In addition, Chloe adds that the relationships are healthier and it seems that the reason behind this is that she takes as much as she gives; in fact, being self-compassionate allowed her to love herself as well as others but also allowed her to soothe herself and others. This last point was also reported by other participants:

"*It [self-compassion] has a big impact on my relationships I think, uhm…to offer someone compassion when they are coming at themselves with hatred*"
(Brittany: 209-210)

For Brittany, the skills of compassion became useful not only for herself but also for others. As a matter of fact, she felt she was able to offer compassion to others when they needed it and, in particular, when they were stuck in a place of constant criticism of themselves. Perhaps, it was easier to give compassion to these people as they were in a similar situation as Brittany used to be in.
Although self-compassion allowed participants to care and soothe other people, it also allowed them to say no at times and to put themselves first when needed:

"*Definitely in terms of my relationships with others, so I think sometimes that's about setting boundaries so it might mean that the self-compassionate response is not always to bend over backwards*" (Grace: 296-298)

Here, Grace highlights the importance of setting boundaries in relationships and perhaps suggests that, by developing self-compassion, she did not need to "*bend over backwards*" to feel less guilty and less critical of herself. Furthermore, Grace realised that always being available to other people might not be the compassionate thing to do for her as she might not be feeling well herself and might need to take care of that first.

In conclusion, the development of self-compassion helped these women work on the relationships they had with themselves, which in turn affected the relationships they had with other people. Through the development of self-compassion, they were now able to offer compassion to other people that resembled the one they felt for themselves. In addition, self-compassion allowed them to set boundaries in their relationships with other people, which helped them to foster healthier relationships. Perhaps, what also helped them to work on these relationships was the group setting in which the therapy took place.

3.5 Super-ordinate Theme 4: A Trouble Shared Is A Trouble Halved – The experience of being in a therapy group

Group therapy has often been used in the treatment of eating disorders, and has become increasingly researched in the last decades. However, being in a room full of strangers is never easy, particularly when you are being asked to share your inner thoughts and feelings, as well as your vulnerabilities with these strangers. Nevertheless, group therapy also has its advantages, for example it can facilitate individuals to feel less lonely and isolated.

3.5.1 Developing Trust

The first issue many participants encountered when starting this journey was that of trust amongst group members.

"*But these people were obviously very vulnerable, including me, and with vulnerability comes a lack of trust*" (Faith: 227)

Here, Faith suggests that feeling vulnerable had an impact on the development of trust amongst group members. However, some researchers suggest that one actually needs to be vulnerable to build trust (e.g. Brown, 2012); Brown (2012), in fact, suggests that trust means choosing to make something that is important for oneself vulnerable to the actions of others. However, it seems that Faith is also referring to the way in which a person responds to her own vulnerability. Perhaps, Faith is suggesting that making her hurt vulnerable to her own actions also meant making it vulnerable to her own critical voice. If this were the case, vulnerability could have become an obstacle when building trust in the group as the critical voice might have made her feel that she needed to 'defend' against others. For other people, the critical voice seemed to also cause feelings of shame:

"*Yeah…because it's all out of shame, I mean there's still shame in a group that you all know you're there for a reason, you've all signed up for a group with the word eating in it (laughs) so it's a little less and that's good I think*"
(Brittany: 182-183)

As Brittany suggests in her quote, shame was one of the main feelings associated with her eating disorder. A review conducted by Ali and colleagues (2016) found that individuals struggling with eating difficulties often report feelings of shame, and Kelly and Tasca (2016) added that this feeling is often increased by the secretive and isolating nature of eating disorder. In addition, individuals struggling with eating difficulties often experience self-criticism and inner-hostility (Goss & Allan, 2009), which is also visible in these participants' quotes. Hence, to come out in a group setting must have been very scary and, possibly, embarrassing. However, some participants reflected that having someone in the group that they trusted helped them feel secure and less vulnerable. The majority of participants, in fact, knew at least one of the facilitators and felt that they could trust them.

"*If you're in a safe place, you can allow it [self-compassion] to…to have more benefit because you will…you'd accept it a bit more and allow...so…this…what I said before about how do you just sit with those difficult feelings…you can sit there if you're with other people...and…in a supportive group, with someone who you know...you know that I felt safe with [therapist] because I trusted her for over a long period of time, so it. ..it just- it felt very easy to.. to let go*"
(Chloe: 67-70)

In this quote, it seems that Chloe is suggesting that for the self-compassion to develop she needed to feel safe, perhaps she was already feeling 'threatened' by this new concept and, being in a group, probably made her feel even more 'threatened' and vulnerable. However, Chloe also noted that feeling safe with one of the facilitators allowed her to "let go", to be less defensive and to make her difficult feelings vulnerable to the actions of others as well as her own. Further on in her interview, Chloe also added that she needed to feel safe before she could start to trust other people and, in a group, this might take a bit of time before it happens.

"*It takes a while to get the trust in the group. And so it, you...you know, it takes a little, it takes a little bit of time, so that's a bit of an obstacle in itself*"
(Chloe: 118-119)

Although the development of trust appears to be an initial obstacle, all participants mentioned that it did develop after a while and this allowed them to share more of themselves.

"*In this group it kind of, it was a very gradual process by which people opened up more and more about the issues and the reasons why they were in the room*"
(Ava: 210-211)

Ava reiterates what Chloe had said regarding needing time to develop trust, and adds that the more individuals opened up, the less vulnerable they felt, which then lead to the development of trust. What Ava also seems to be saying is that trust actually involves being courageous and taking risks as well as feeling safe. Therefore, when planning a therapy group it might be worth thinking about its characteristics as well as the tools available to help individuals feel safe and to help them develop trust, including perhaps getting to know the facilitators beforehand.

3.5.2 Fighting Together

One of the aspects that might help build trust as well as one of the advantages of group therapy is the feeling that participants get of not being alone in their suffering.

"*But I think the group really helped, I think, working with other people really helped. And actually seeing that I was…kind of, not the only one. […] I wasn't alone in this*" (Faith: 62-63, 223)

Here, Faith shows how taking part in the group helped her feel less alone as other people shared experiences that were similar to what she was going through. The group helped her normalise her experience as well as her emotions. Together with Faith, other participants felt that the group normalised their experiences:

"*Yes and because they're so solitary those battles, they're so solitary. To be in a group and everyone in the group is struggling with eating and has been or ha- or will or is not on that continuum it…as with all groups it normalises, it makes you feel less like a freak*" (Brittany: 177-178)

Brittany adds very eloquently that having an eating disorder often isolates you and makes you feel like a "freak". Brittany felt that she was fighting her battle alone and perhaps, before the group, she had not realised that there were many other people fighting similar battles to hers. Being part of a group helped her feel more 'normal' and also helped her to find allies for her battle. The feeling of being perceived as different and, in turn, not being understood was also expressed by other participants, including Elizabeth:

"*Initially, at least, being in a group with total strangers and not really knowing what they were, because it wasn't all about eating disorders, there were people who had anxiety problems as well, but you didn't know who was who and what they were there for. And for me, I just saw a group of very ordinary, sane looking people and I felt like I was the only one with a severe issue*" (Elizabeth: 203-206)

Here Elizabeth makes an important point about group therapy, which is who to include in it. Elizabeth was the only one of my participants that had taken part in a group where individuals with different diagnoses were included. The other six participants were in groups solely for individuals struggling with eating difficulties. In her group, Elizabeth felt different from other people and, perhaps, this prevented her from developing trust and fully engaging with the process of the group. This

feeling of diversity was not just highlighted by Elizabeth, in fact Brittany mentioned in her interview that:

"*I was of the group not that there was a group but there was probably three of us who were bingers everyone else was sort of anorexic in that sort of realm it felt from what they were saying, and I really had no insight into that experience and to listen to their, it was very different kinds of battles going on on that side of the room than the side of the room that binged*" (Brittany: 164-166)

Here, Brittany adds to what Elizabeth had said in her interview and suggests that different diagnoses, even if they are all of eating disorders, can feel very distinctive from one another. As a matter of fact, Brittany clearly states that she felt different diagnoses were fighting very different battles and this made it difficult for her to fully understand other people's experiences and, perhaps, emotions. However, she would feel a strong connection with other individuals who were struggling with similar difficulties:

"*I mean, what was helpful with the one other woman that I can remember who binged is how sad I felt when she talked, I felt sad when everyone talked but it was like somebody from another country talking when the anorexics would talk. When the bingers talked, I thought "oh God this is so awful, I really know where you are and I hate that you're there and I wish you could see how lovely you are" you know, I just wanted to pick her up and put her on my lap and hug her like a little person and say "you're lovely", you know, so that was useful in that you could then take that and go can you do that for yourself*" (Brittany: 168-172)

In this second quote, Brittany adds how it was easier for her to notice and feel moved by other people's suffering if they were struggling with similar issues as hers. This experience was particularly helpful for the development of her self-compassion as she could turn what she had felt for others towards herself and be as moved as she had been for them. Although Brittany was obviously not 'repulsed' by individuals with other diagnoses, she felt closer to people with the same diagnosis and, perhaps, different and at times isolated from people with different diagnoses, which sounds similar to what Elizabeth was also saying in her comment. However, Brittany still felt that the group had been helpful for her and would have recommended other people to take part in it. Together with Brittany, the majority of participants felt that hearing other people's stories was equally important and normalising.

"*For everyone to be able to say that and to go...and to just, you know, to just be really authentic and just say this is exactly me, this is who I am, this is you know and everyone else to get it and accept it as well*" (Chloe: 257-258)

What Chloe seems to be saying is that one of the most important aspects of group therapy for her was the aspect of acceptance. This concept also links to one of the aims of CFT, which is that of developing compassion for others (Gilbert, 2009). Feeling accepted and understood by other members for who she was, helped Chloe experience what compassion and self-compassion look like and feel like. It is possible that having other people be kind and understanding towards her, her inadequacies and her negative aspects, also allowed her to start experiencing the same kindness and understanding towards herself. Perhaps, what also helped her was knowing that she was not the only one struggling with these issues:

"*It was just really liberating to hear other people talk about their experience and what they needed and just…and actually to know that it…it gave me this sense of…you know, all of the people that are just- you pass in the street every day have so much going on that you would never know in a million years (laughs) that- ah… you know, that really, can just barely you know contain their anxiety and are just about functioning and yet, you would never know*" (Chloe: 254-257)

As a matter of fact, Chloe seemed surprised to discover that there were many other people suffering even though this was not necessarily visible from the outside. This experience, once again, seems to have provided Chloe with a sense of 'normality' that could have helped her feel less lonely and isolated, as well as more likely to accept these aspects of herself in line with the element of 'common humanity' promoted by self-compassion.

From these quotes, it seems that going through the experience of hearing other people's stories and experiences can be quite liberating as it helped them feel less lonely and more 'normal'. In addition, other group members helped them develop their own self-compassion as they acted as intermediaries (they could try to feel compassion for other group members and then try to turn it around towards themselves) as well as models. As a matter of fact, one of the aims of CFT is to help individuals develop compassions for others as well as being able to receive compassion from others (Gilbert, 2009). However, other group members were not the only ones that acted as a model of compassion.

3.5.3 Do As I Do

One aspect that was often spoken about in these interviews was the need to have a model, someone that could walk with them on this difficult journey and that could share some wisdom along the way.

"*I just don't know if I ever would have found it [self-compassion], if I ever heard of…I didn't really know what the word compassion meant […] but even with that book I wouldn't have understood it as well as I do having been in a group with fellow sufferers and with highly skilled group leaders*"
(Danielle: 115, 125)

In this quote, Danielle speaks about the need to have someone help you discover and understand self-compassion. That someone could be either a "fellow sufferer" (i.e. another group member) or the leaders of the therapeutic group. Danielle probably summarises what other participants said during their interviews: although self-compassion can be easy to understand in theory, it is quite difficult to apply it in practice, especially if they were lacking it to start with. Hence, having leaders and other members show them what self-compassion looks like and feels like was extremely important.

"*I think you maybe have to be taught it [self-compassion] to, you could probably find out for yourself, but you- you probably have to be taught it to some degree because if you need it, you probably (laughs) don't have the right words!- or the ability to do or say the right things that are going to be most helpful*"
(Chloe: 47-49)

Here, Chloe adds that the reason why she felt she needed to be taught self-compassion was because she did not have it to start with and did not know where to start or what to say to herself. With this quote, Chloe is also talking about the mechanism through which individuals develop compassion in childhood, which is based on Fogel, Melson and Mistry's (1986) model of nurturance. According to this model, nurturing needs to be enacted by carers and involves *awareness* of the need to be nurturing, *motivation* to nurture, *expression* of nurturing feelings, *understanding* what is needed to nurture and an ability to match nurturing with the *feedback* from others (Gilbert, 2010). Gilbert (2000a) then argued that these aspects of nurturing can be directed either towards the self or towards others. Compassion, therefore is linked to early affectionate experiences and attachment security (Gillath, Shaver, & Mikulincer, 2005); hence, the role of group leaders is to help individuals experience nurturing and safeness, as well as to replace self-

criticism with self-kindness (Gilbert, 2007). As a matter of fact, Chloe felt that, without the teaching, she would not have been able to find the words or do the things that would be most helpful for her in times of need. Perhaps, one of the reasons why having a model is so important for them is because they were so used to talking to themselves in a critical way that they did not even know where to start when talking compassionately to themselves.

"*I think the people doing the group need to be the manifestation of compassion, they need to be the living embodiment, because the model is so important and so rare, there's very few places in the world that are allowing for what it is*"
(Brittany: 281-282)

Brittany felt that it was vital for the group leaders to be "the living embodiment of compassion" as she felt that compassion is not often found in the world and, perhaps, it was important for her to have a space where she knew she could give as well as receive compassion. In addition, I wonder if having leaders that were the "manifestation of compassion" helped her develop trust in them and the model itself. Furthermore, if the leaders were being compassionate towards her or other group members she could think about them and their words in times of need:

"*So that when you shut your eyes and you're doing your hatred and violence against yourself you can go "what would she [group leader] say?""*
(Brittany: 283)

Here, Brittany shows how she would think of the group leader whenever she found herself stuck in the vicious cycle of her critical voice and would think of what they would say. Perhaps, thinking about the group leader's words was especially helpful at the beginning when they were not sure about what words to use in order to talk compassionately to themselves. Therefore, when group leaders demonstrated the skills and attributes of self-compassion, the same skills and attributes were instilled in group members, who were then able to develop a more compassionate relationship with themselves.

In conclusion, the group experience proved to be a helpful tool in the development of self-compassion, even if at times presented its challenges. The quotes show how, initially, it had been difficult to develop trust amongst group members and this was mainly due to feeling vulnerable, ashamed and not responding with openness. However, once trust began to develop, group members felt they were not alone anymore and they found people that would understand and accept them. In addition, as with every therapy group, most members found the experience

normalising. Lastly, being in a group proved helpful as they could follow the example set by their models (leaders or other group members). Having a model that they trusted helped them to internalise them and bring them to mind in times of need.

3.7 Summary

This chapter described an interpretative phenomenological analysis of seven interviews conducted with women who had taken part in a compassionate mind therapy group while suffering with eating disorders. The analysis found four super-ordinate themes, which described the experience of finding and developing self-compassion.

Initially, participants felt that self-compassion was 'a whole new world', a concept that they have never heard of and were not sure how it would become part of their lives. Introducing this concept was a major change for them as it gave them a completely different way of relating to themselves and their suffering. Furthermore, self-compassion allowed them to really get to know themselves, all of their parts and all of their emotions. Especially this last part did not come easily to them and evoked difficult feelings, such as pain.

The journey towards the development of self-compassion was not an easy one and participants encountered different obstacles. First of all, they found that the theory of self-compassion made sense, but how could they apply it to their everyday life? It seemed that this was actually harder than they thought it would be and the majority of them found it difficult to break out of their usual ways of responding to triggers. Furthermore, when they did try to be compassionate towards themselves, they discovered how much pain they had been in. This realisation was quite shocking for some, especially when they came to realise how little compassion they had been giving themselves. On top of all these difficult experiences and emotions, they discovered that their critical voice was a big hurdle that they would need to overcome. Whenever they needed to be compassionate towards themselves, they felt that their critical voice would take the lead and actually judge them even more. Porges (2007) suggested that when people feel safe, they are more open and flexible when responding to the environment, which means that individuals are more able to self-soothe. However, it seems that for these participants their critical voice was actually their safety strategy. Therefore, when the group and its content (self-compassion) tried to challenge the critical voice, participants' threat systems would become activated and they would be prompted to self-protect (i.e. activate their critical voice). Lastly, since they had spent many

years lacking compassion, they found it particularly difficult to believe this new voice that was trying to soothe them. Nevertheless, although it was a difficult road, many were able to start developing self-compassion and were starting to integrate it into their lives.

Once self-compassion became part of them and their lives, they felt that it had ripple effects on different areas of their lives. The self-compassion was making them feel steadier as they were now aware of their feelings and were able to respond to them in a different way. Furthermore, the self-compassion helped participants modify their relationship with food by facilitating the development of a compassionate voice, alternative ways of responding to triggers and of specific skills, such as mindfulness, self-soothing, compassionate behaviour and compassionate reasoning. By changing the relationship they had with themselves and with food, they experienced changes in their relationships with other people. Through the development of self-compassion they were able to form healthier relationships in which they felt able to say no and set boundaries. Furthermore, they felt that they did not need other people to take care of them as much, as now they could do that for themselves. One factor that was particularly important and followed them throughout their journeys was the setting in which the therapy took place.

The group setting provided a safe space in which participants could share their vulnerabilities and their feelings. However, it was not always easy being in a group as, initially, they felt that they had been put in a room with strangers and they were not sure whether they could trust them. The two main emotions that were holding them back from opening up were shame and feeling of vulnerability. Once they were able to develop trust, the group became a space where they did not feel like “freaks” and where they could find people that would understand them and accept them. This experience in particular seems to reflect and demonstrate one of the aims of CFT, which is that of helping individuals develop compassion for others (Gilbert, 2009). Furthermore, other members and group leaders became models of compassion that they could look up to for inspiration. By the end of the group, participants had been able to internalize their group leaders and would bring them to mind in times of need. With time, they were able to develop their own compassionate voice with their own words.

CHAPTER 4: Discussion

4.1 Introduction

This study aimed to investigate how women who suffer with eating difficulties experience and make sense of self-compassion after taking part in a Compassionate Mind group that teaches the skills of self-compassion. From the literature review and rationale for this study, it became clear that there is little qualitative research on this topic; therefore this study has the capacity to create new knowledge. Interpretative phenomenological analysis was the method chosen to describe the lived experience of these women. Qualitative interviews were conducted with seven participants, and a detailed analysis of the interview transcripts yielded the following themes: Them 1: *A Whole New World*, Theme 2: *It's A Long Way To The Top*, Theme 3: *Journey For Life* and Theme 4: *A Problem Shared Is A Problem Halved*. These superordinate themes were identified through the use of Interpretative Phenomenological Analysis as the representation of the key experiences that participants went through when interpreting self-compassion.

In this chapter, I will review the findings of each superordinate theme and I will develop them further by linking the findings to the existing literature; since I had decided to focus my research question on the experience of self-compassion rather than on the experience of being in a compassionate mind group, I will discuss in more depth the first three superordinate themes and will briefly discuss the fourth theme emerged from the analysis stage. While making links between the findings of this study and previous literature, I will identify areas where new understandings or questions for future research emerged. Afterwards, I will evaluate the strengths and limitations of this research, with suggestions for future research. Lastly, I will discuss the possible usefulness of the research findings for Counselling Psychologists and will conclude by reflecting on the impact I had as the researcher on the study.

4.2 Discussion of Analysis In Context

4.2.1 Superordinate Theme 1: A Whole New World – Journey towards discovering and describing self-compassion

All participants mentioned that compassion, and self-compassion in particular, were completely new concepts for them. In fact many described them as a "whole new world" which caused "fundamental changes" in their ways of thinking, feeling and behaving. These quotes support previous findings, which show individuals

suffering with eating difficulties as having lower levels of self-compassion (e.g. Tylka et al., 2015; Taylor et al., 2015). A review of the literature on self-compassion and disordered eating conducted by Braun and colleagues (2016) showed that self-compassion negatively correlated with body-related (e.g. thin idealisation) and eating disorders-related outcomes (e.g. dietary restraint); the findings were replicated in both clinical and non-clinical populations. This was also found in this study as formal diagnoses were not required, however participants referred to themselves as having bulimia nervosa or binge eating disorder and had accessed treatment to treat their eating difficulties. When participants were told about self-compassion, they felt that theory behind it made sense and was easy to understand, however they struggled with applying it to their lives.

Many participants mentioned that they had no idea what self-compassion looked like or felt like and this was a major obstacle when trying to practice it. In addition, self-compassion was completely different from everything that they had known so far and, to some, seemed "counterintuitive" as they felt that by being self-compassionate they were letting go of everything that they had worked so hard for and worried that their standards would significantly decrease. The fear that self-compassion will undermine motivation is a findings that has been reported by different researchers (Clay, 2016; Neff, 2009). In reality, Neff (2003a) reported that self-compassion does not correlate with levels of performance that one adopts for the self and Sirois (2014) reported in his study that procrastination was significantly associated with lower levels of self-compassion. Prior research suggested that this fear was actually caused by a fear of failure that is common in individuals with high levels of self-criticism (Neff, 2003a). Prior to starting the group, in fact, many participants were caught in a vicious cycle in which they would constantly criticise themselves about things that they would consider failures (e.g. not being able to lose weight); however, they would then get angry about being critical, thus starting this never ending stream of self-criticism and shame. The idea that individuals suffering with eating difficulties present with high levels of self-criticism and shame is not new. In fact, different researchers reported that high levels of self-criticism are common amongst all eating disorders diagnoses (e.g. Duarte, Ferreira, & Pinto-Gouveia, 2016; Goss, 2007). Furthermore, the literature on this topic suggests that individuals diagnosed with an eating disorder tend to be self-critical with the intent of harming and persecuting themselves rather than with the intent to promote self-improvement (e.g. Barrow, 2007). This was also found in this study, for example Brittany had referred to her self-criticism as being "caught in a persecutory place, which is a horrible place" and other participants had expressed similar views by adding that the self-criticism had caused them to become afraid of failures as well as feeling more ashamed.

Gilbert and Procter (2006) suggested that when individuals experience high levels of shame and self-criticism, they perceive the world and themselves as hostile and threatening, which can feel overwhelming; in fact, they also add that during these episodes "*there is no safe place either inside or outside the self to help soothe or calm the self*" (Gilbert & Procter, 2006, p. 354). This was also expressed by participants, who felt that they were in a constant "fighting mode" until they learned about self-compassion, which allowed them to let go of the fight. The women in this study felt that self-compassion allowed them to become more accepting, which in turn decreased their levels of shame and their self-persecutory criticism. Furthermore, self-compassion allowed them to become less afraid of failures; in fact, as Danielle said in her interview, self-compassion took away the aspect of giving up. With this sentence, Danielle and other participants who had expressed similar views, meant that self-compassion gave her another option: taking care of herself and thinking of what would be the most helpful thing for her to do. This option allowed participants to feel that they were doing the right thing, hence they were not giving up or failing. The quotes reported above and throughout the study support the idea that self-compassion is based on acceptance of suffering and failures as part of our common humanity (Braun et al., 2016; Neff, 2003a). In addition, these findings support previous research, which demonstrated that self-compassion helps individuals to reduce self-criticism and to facilitate better regulation of internal experiences such as thoughts and emotions (Brennan et al., 2015; Neff & McGehee, 2010). As a matter of fact, there is strong evidence supporting self-compassion as an adaptive affect regulation and coping strategy (e.g. Braun et al., 2016; Sirois et al., 2015). It was this aspect of self-compassion that might have allowed these seven women to really get to know themselves, their strengths and their flaws. This also helped them to understand that they had a role in what was happening to them and they could change that. In their interviews, both Faith and Chloe mentioned that self-compassion allowed them to sit with their feelings as well as being ok with their flaws.

Previous research suggests that eating disorders help individuals to control difficult emotions such as anger, sadness and shame (e.g. Dolhanty & Greenberg, 2007). This study suggests that self-compassion gave individuals a tool that allowed them to observe and accept those difficult emotions. In addition, self-compassion allowed these individuals to feel ok about their flaws and their suffering. Thus supporting previous findings, which suggest that self-compassion acts as an adaptive emotion regulation mechanism and it helps transform negative emotions into positive ones (e.g. Neff & Dahm, 2015; Sirois, 2015). The way in which this is achieved is by activating neural circuitry that is concerned with positive emotions

(e.g. Klimecki et al., 2015). Although this study did not look at neural circuitry, participants' accounts suggest that self-compassion helped them to accept their emotions and see them in a positive light, therefore it can be hypothesised that their neural circuitries also became activated during the course of the group.

To summarise, participants reported that self-compassion was a novel concept for them and, initially, it seemed to go against everything they thought and believed in. The group allowed them to develop self-compassion, which helped them create a new voice for themselves: a compassionate voice. This new voice allowed them to be more accepting of their humanity, which includes their suffering, their emotions and all aspects of themselves. The self-compassion therefore substituted their self-criticism, which participants compared to "letting go of the fight", and this in turn led to a decrease of negative feelings such as shame. The development of self-compassion however was not easy and many participants reported encountering many obstacles along the way.

4.2.2 Superordinate Theme 2: It's A Long Way To The Top - Journey towards finding self-compassion

All participants spoke about different hurdles that they had to jump through while trying to develop compassion for themselves. During the analysis stage, I was able to identify three main obstacles that were often spoken about in the interviews: self-compassion was easier said than done, the negative emotions that arose and, lastly, their critical voice and the fear of losing it.

All seven women felt that self-compassion was a concept that could be easily understood theoretically, however when it came to practicing it they felt they did not know what to do or what to say; this supports previous findings by Gale (2012) and Lawrence and Lee (2014). Furthermore, this finding once again highlights the absence or low levels of self-compassion in individuals struggling with eating disorders. However, it also adds that it can be particularly difficult for these individuals to develop self-compassion as they might not have the right tools. This hypothesis was also proposed by Gilbert and Procter (2006), who conducted a Compassion Focused Therapy group with individuals that presented with high levels of self-criticism and shame and noted that many participants had seemed afraid of becoming self-compassionate. At the end of the group, Gilbert and Procter (2006) looked at participants' reflections on the group and reported that "*it is clear that many patients […] have very little to guide them at first*" (p.373). This particular sentence appears to be in line with what participants from this study were talking about in their interviews. One of the reasons why individuals felt that they had little to guide them could be due to the fact they had never experienced compassion

from others or for themselves. Some of my participants, in fact, added that they had not experienced compassion from a carer while they were growing up, hence they had no example to follow and this made it difficult to practice self-compassion as they did not know what it looked like or felt like. This concept was then expanded by Gilbert (2010), who suggested that compassion from others or self-compassion could evoke feelings of grief in individuals, as they would become aware of the absence of affection and care from significant others during their development. In addition to not knowing what self-compassion felt like or looked like, some participants found it difficult to stay with their feelings.

Chloe, for example, had mentioned in her interview that she did not know what it meant to sit with her feelings and feel comfortable with them. This was also reported by other participants and it supports previous findings, which show that women with eating disorders find it difficult to be aware of their emotions as well as to regulate and express them (e.g. Davies et al., 2011). In a recent study, Dapelo and colleagues (2016) demonstrated that individuals with eating disorders found it not only difficult to pose facial expressions, but also to imitate other people's facial expression. These findings suggest that certain emotions, such as anger, fear and sadness might feel unbearable to individuals struggling with an eating disorder and this could lead them to emotional avoidance. This avoidance might be caused by an underlying fear of emotions. Gilbert and colleagues (2011) were the first to suggest that self-criticism, which is highly present in individuals struggling with eating disorders, is not just about being negative towards the self, but it also involves fear of affiliation. In the same paper, the authors suggest that individuals with high levels of self-criticism are specifically afraid of positive emotions, such as those generated by the development of compassion. In this study, however, participants mentioned that one of the biggest obstacles they faced was the increase of negative emotions.

Many participants reflected that they attended the group sessions as a way of finding relief from their distress, however what they initially ended up with was more pain. The pain was linked to the realisation of how much suffering they had been in and how unkind they had been to themselves. In the interview transcripts it is possible to notice that participants used quite strong words to describe this feeling, with one participant mentioning that realising how uncompassionate she had been towards herself broke her heart (see quote from Danielle). This finding seems to add new information to the existing literature, in fact, it is possible that these seven women were afraid of self-compassion when they started the group as they did not know what it was and their self-criticism did not deem them worthy of self-compassion; however, what seemed to be most difficult for them was actually

becoming aware of their negative feelings. From the way participants describe this obstacle, it becomes possible to compare it to the 'depression stage' of grief as described by Kübler-Ross and Kessler (2005). The authors, in fact, describe this stage as a time when individuals begin to realise and feel the extent of their loss. In this study, it seems that participants were grieving the loss of self-compassion in their pasts and were becoming aware of the depth of their suffering. Perhaps, these findings suggest that individuals struggling with eating disorders and those presenting with high levels of self-criticism could find developing compassion (including self-compassion) difficult for two different reasons: one, they are afraid of positive affiliations, and two, they are shocked by the realisation of the absence of self-compassion and find it difficult to sit with the feelings that this evokes in them. In addition, for many participants the development of self-compassion was complicated by the fact that they were afraid of losing their critical voice.

The majority of participants said that the main reason for taking part in this therapy group was so it could help them find relief from their distress as well as modify their eating behaviours. However, they felt that one of the biggest obstacles they had to face when trying to develop self-compassion was their critical voice and, more specifically, their fear of losing this voice. Most women, in fact, felt that self-compassion was an essential component for dealing with their distress, however they also felt that most of the time it was not present and in its place there was the critical voice that was full of negativity. This supports previous research showing that the critical voice is often hostile and abusive (e.g. Noordenbos et al., 2014), as well as research which found that when individuals struggling with eating disorders try to modify their behaviours, they are often met with internal hostility brought on by their critical voice (e.g. Pugh, 2016; this was also found amongst individuals struggling with PTSD by Lawrence & Lee, 2014). Furthermore, the quotes seem to also support previous research by suggesting that the critical voice was acting as a safety strategy against threat and would therefore become activated when the 'threat system' was triggered.

As a result, participants also reported that their critical voice made it difficult for them to believe their new compassionate voice, which created a state of tension; for example, Faith described this situation as a fight between the critical voice and the compassionate voice. In this instance, as in the case of other participants, it appears that the critical voice was protecting and defending these women from a perceived threat (i.e. the compassionate voice). Therefore, this supports previous research, which suggests that the critical voice makes individuals feel entrapped and submissive (e.g. Williams & Reid, 2012); at the same time, it also provides further information with regards to the maintenance cycle of the critical voice (e.g.

Gilbert & Irons, 2005), as individuals struggling with eating difficulties find it difficult to access their soothing system (Goss & Allan, 2014), therefore when threats arise, their critical voice becomes activated to regulate the 'threat system'. When the critical voice is activated, individuals experience an increase in self-criticism that can also increase feelings of shame; together, they maintain a sense of current threat, which could explain why individuals feel trapped by it (see diagram below). In addition, Gilbert (2010) had suggested that individuals with high levels of self-criticism believe that they do not deserve to receive compassion; however, it is possible that, together with this feeling, individuals are also struggling with the fear of losing a mechanism that protects them from threats as they worry that doing so might make them more vulnerable. Different researchers have argued that paying attention to the critical voice during treatment is essential to help individuals (e.g. Davies, 2008; Dolhanty & Greenberg, 2009); this group was helping individuals respond differently to their critical voice by helping them create a new voice that was less hostile and more accepting; therefore, it can be hypothesised that, although the critical voice was an obstacle, by creating a compassionate voice these seven women were able to re-activate the 'soothing system', which created a balance between their three affect-regulation systems and promoted a feeling of "safeness" (Gilbert, 2010). Safeness was defined by Gilbert in 1993 as:

> "*a state of mind that enables individuals to be content and at peace with themselves and the world with relaxed attention and the ability to explore*"
> (in Gilbert, 2010, p.49)

To sum up, participants spoke about self-compassion as being something that is easier said than done; with this they meant that the theory made sense and it seemed quite easy, however when it came to practicing it they did not know where to start as they were not sure about what it looked like and felt like. One reason as to why this seemed so difficult was the lack of compassionate models in their lives, in addition it was also suggested that a further reason could be the fear of self-compassion that some individuals experience. This study, however, also suggested that participants seemed to be going through different stages of grief while developing self-compassion and this appeared to be a big obstacle for them. This finding was different from previous research and it might be worth to research it further as literature is still limited (e.g. Gilbert & Irons, 2005; Gilbert, 2010). Lastly, participants felt that their critical voice and their fear of losing this voice were also impeding the development of self-compassion as they prevented participants from developing the new compassionate voice by activating the 'threat system'. This finding supported previous studies as it proposes that the critical voice is not just an aspect of eating disorders but it is a strategy that individuals

develop to defend themselves from threats (e.g. Forrest & Hokanson, 1975; Gilbert, 2000b; Gilbert 2002; Gilbert, 2009; Gilbert & Irons, 2005; Gilbert & Procter, 2006). Therefore, the development of a compassionate voice can feel threatening as it directly challenges the critical voice and individuals might worry that by losing this defence they might become more vulnerable to threats. Although the road to its development was a difficult and long one, participants felt that self-compassion had beneficial and profound aspects in many aspects of their lives, including relationships and their eating.

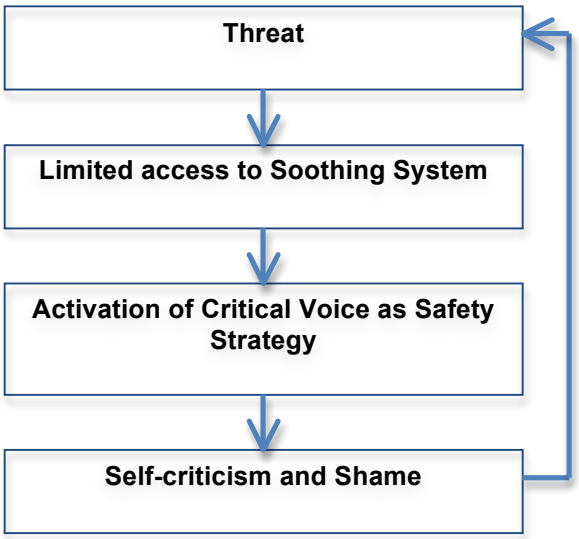

Figure 4-1. Maintenance Cycle of The Critical Voice

4.2.3 Superordinate Theme 3: Journey For Life – Journey towards integrating self-compassion in their lives

All participants but one mentioned that self-compassion had a huge impact in their lives, including their relationships with other people as well as with food. The only participant (Elizabeth) that did not think self-compassion had helped her improve any aspect of her life also mentioned that she did not think she was ready to embark on this journey and she did not feel she had been able to develop self-compassion. Kelly and colleagues (2014) had observed in their study that individuals who demonstrated fewer gains in self-compassion also showed fewer positive changes at the end of treatment, and Elizabeth's quotes from her interview seem to be supporting this finding. However, Elizabeth was the only one of my participants that had taken part in a group where individuals with different diagnoses were included. The other six participants were in groups solely for individuals struggling with eating difficulties. In her group, Elizabeth felt different from other people and, perhaps, this prevented her from developing trust and fully engaging with the process of the group. All the other participants, however, felt that

self-compassion had completely changed their lives and, although they might have entered the group to recover from an eating disorder, what they learnt had "ripple effects" in their lives.

Compassion and self-compassion are often taught as a range of skills, which involve creating feelings of warmth and kindness in a range of activities (Gilbert, 2009). One of these skills is that of "compassionate reasoning" where clients are taught to become aware of how they think about the world and themselves. In particular, clients are taught to pay attention to how they reason about their mood, their emotions and themselves. Individuals with high levels of shame and self-criticism often talk to and think about themselves in a cold, aggressive way to try and change the way in which they are feeling or behaving (e.g. Gilbert, 2009). Compassion Focused Therapy teaches these individuals to develop alternative ways of thinking that are kinder, supportive and helpful. In this research, participants often spoke about how they had acquired this skill by describing how critical they used to be of themselves and how this group had helped them develop a new way of thinking about themselves and of responding to their critical voice. Danielle, for example, had said that after the group "*everything comes from a different place. Everything comes from a place of kindness, rather than a place of discipline, a harsh discipline and struggle*". This quote clearly supports previous findings, which argued that individuals with high levels of self-criticism try to force themselves to change in a way that is unsupportive and discouraging (e.g. Barrow, 2007; Gilbert, 2009). Furthermore, this theme appears to support the finding from Gale and colleagues' study (2015) looking at personal practice amongst therapists, which showed that many participants adopted compassion as a '*way of life*' (p. 11) rather than as a technique. The same authors also argued that participants saw practice as a journey rather than a time-limited experience, however they also realised that practice was necessary to master the skills of compassion. With time, participants became able to use the exercises with more flexibility, but were also able to incorporate different aspects of compassion into their lives (Gale et al., 2015); this also seemed to be reflected in my participants' quotes. When looking at self-compassion in particular, it was the unconditional acceptance, in particular, that seemed to be the most important aspect for these seven women.

The word self-kindness refers to the propensity to be caring and understanding with oneself by offering warmth and unconditional acceptance. Neff (2003a, 2003b) proposes that self-kindness can counteract self-criticism. Many participants spoke about self-compassion as helping them accept themselves, their behaviours and their "failures". Acceptance seemed to be especially relevant with regards to their eating behaviours and cognitions. The majority of participants noticed that self-

compassion had a very positive impact on their eating, however they also noticed that the effect had been different from what they had expected. In their interviews they often spoke about how they thought self-compassion and the group would make them "Zen-like" and this would help them prevent binges for example. However, what they found was that self-compassion impacted their eating in different ways, for example by making sure that they would have small snacks during the day so that they would not get the urge to binge or by accepting that sometimes they would go through setbacks. One of the skills taught by Compassion Focused therapists is that of "compassionate behaviour" (Gilbert, 2009). Compassionate behaviour helps individuals to decrease distress and increase growth; this, however, does not mean that they will not engage in difficult or painful tasks/realities. Furthermore, Compassion Focused Therapy helps clients to focus on their efforts, rather than on their results; in this case, participants were able to accept setbacks with ease without being critical of themselves and this also helped them to "stop escalating things" (extract from Grace's interview). A further skill that also helped participants to accept their setbacks was that of "common humanity" (Neff, 2003a, 2003b). Common humanity is an aspect of self-compassion that recognises that everyone in this world is imperfect and everyone makes mistakes. Faith, for example, reflected that this definitely helped her when dealing with setbacks in her recovery and commented "*when I had a day where I restricted or a day where I binged because I restricted, I was able to say […] 'it happens, it's a part of recovery, everyone goes through this'*". However, it is possible that for six of my participants this aspect was easier to develop as they were in a group with people who were struggling with similar issues. As a matter of fact, Elizabeth's quotes suggest that by being in a group with different diagnosis she did not feel accepted or did not see her experience as being normalized by other group members; this resulted in her feeling different from and worst off than others. Perhaps future research could expand on this in order to make sure that every participant benefits from the group. Nevertheless, the six participants' interviews seem to provide further support to previous research, which examined the positive effects brought on by the development of compassion and self-compassion. For example, it seems that these seven women were able to develop more acceptance for themselves, their feelings, their behaviours and their failures, as well as increase brain plasticity which helped them become aware of their emotions and helped them to sit with them. Overall, these improvements seem to have helped these participants to develop and re-activate the soothing system, which allowed them feel reassured and calmed (e.g. Gilbert, 2009). This last point in particular appeared to be particularly important in the relationships that participants had with other people.

Many participants spoke about the positive impact that self-compassion and this group had on their relationships with others. This result took me a bit by surprise perhaps because the literature on this particular topic is quite limited and, also, I had not realised how intertwined compassion for the self and compassion for others were. Nevertheless, participants felt that self-compassion helped them in their relationships in three different ways: first, self-compassion allowed them to set boundaries in their relationships, second, self-compassion helped them feel equal in their relationships and third, participants felt that to feel compassion for others you had to experience it for yourself first. In the first instance, participants mentioned that self-compassion helped them to set boundaries in their relationships, which at times also meant saying no to the other person. This particular point offered a new finding, as I could not find any research conducted on this topic. In one Internet article on compassion, Ladner (no date) suggests that boundaries are actually an important aspect of developing compassion as they allow individuals to say no and this prevents them from feeling stressed or hurt. Compassion and self-compassion, in fact, advocate taking care of the self by trying to alleviate suffering and to heal oneself with kindness. When it comes to relationships then, being able to set boundaries actually means taking care of oneself as not setting them could mean exposing oneself to negative feelings. In her book The Gifts of Imperfection, Brown wrote:

> "*One of the greatest (and least discussed) barriers to compassion practice is the fear of setting boundaries and holding people accountable*" (Brown, 2010, p.16)

Brown then goes on to explain that, in her research, she realised that compassionate people were actually boundaried people. Her explanation for this is linked to acceptance; Brown feels that compassion is about accepting ourselves and other people. However, at times, being compassionate also means setting boundaries and holding people accountable for their actions (for example, if they are taking advantage of us). In my research, I also found that setting boundaries, apart from being linked to acceptance, also meant taking care of the self. By taking care of themselves, participants were also able to soothe themselves and this allowed them to create healthier, more equal relationships.

Many participants reflected on how self-compassion had helped them develop healthier relationships. One of the main reasons they gave for this was that they felt they were now entering their relationships as equals. Chloe, for example, added that she felt this was the case as she did not need as much external validation anymore. This supports prior research, which found that individuals with high levels of self-compassion are able to meet their own needs in terms of

kindness and self-comfort (Neff & Beretvas, 2012). Because individuals are able to meet their own needs, they are more likely to be able to find a balance between independence and connectedness, which has been shown to be an important factor in healthy relationships (Deci & Ryan, 2000). Another factor that can contribute to feeling equal in relationships is that:

"*Compassion is not extended to oneself because one is superior or more deserving than others, rather, it is done precisely because the individual recognises his or her interconnectedness and equality with others (Brown, 1999)*" (Neff, 2003, p.87)

This idea is in line with the principle of common humanity of self-compassion, which can facilitate feelings of being connected with others (Neff, Kirkpatrick, & Rude, 2007). The latter, together with acceptance, allows individuals to respond to suffering in a more compassionate way (e.g. Tirch, 2010). Brittany, for example, felt that self-compassion allowed her to offer other people compassion when they were "coming at themselves with hatred". However, many participants felt that in order to offer compassion to others, they needed to experience it for themselves first.

Participants' quotes from this study seem to suggest that they believed true compassion could only be felt after they had learned to develop self-compassion. In a study amongst nurses, Heffernan and colleagues (2010) suggest that developing self-compassion increases compassion for others as without self-compassion nurses might be ill-prepared to show compassion for others. This finding was also replicated in a study conducted by Beaumont and colleagues (2016) amongst student midwives, which showed that participants who reported higher levels of self-judgment were less compassionate towards both themselves and others. The authors also suggested that being self-compassionate in times of suffering allowed students to prepare for the demands of practice and study as well as develop compassion for others. Neff (2003) also suggested that individuals that approach their own experiences with compassion are more likely to have compassion for others as they do not need to engage in social comparisons in order to think of themselves as acceptable. Since research on this topic seems to be quite limited, it might be worth exploring it further to understand whether self-compassion is a prerequisite for compassion for others.

To recapitulate, all participants but one felt that self-compassion and the group had major positive impacts in their lives. First of all, they felt that self-compassion affected all aspects by allowing them to be more accepting and mindful (i.e. able to observe and sit with their emotions). However, they felt that self-compassion was

particularly helpful in two main areas: their eating and their relationships. With regards to their eating participants reflected that self-compassion had a different effect from the one they had imagined. For example, self-compassion allowed them to become more accepting of setbacks rather than prevent episodes of restricting or bingeing all together. In addition, self-compassion allowed them to take care of themselves by setting up strategies that would help them in their recovery (for example, snacking during the day). This last point was also helpful in their relationships. Participants reflected that self-compassion had allowed them to create healthier relationships where they could set boundaries and be able to say no. Participants also felt that developing self-compassion allowed them to feel more compassion for others. Perhaps a further aspect that impacted positively their relationships was conducting the therapy in a group setting.

4.2.4 Superordinate Theme 4: A Trouble Shared Is A Trouble Halved – The experience of being in a therapy group

All participants remained in the group for the whole duration (i.e. eight weeks), with one participant deciding to participate in the group two times as she felt she had benefitted so much from the first time that she wanted to do it again. Furthermore, every woman I interviewed reported that they would recommend the group to a friend struggling with eating disorders and some had already done so. However, participants felt that being in personal therapy alongside being in the group was probably the best combination as they could further discuss things that had arisen in the group during their individual session; this had also been suggested by Barth (1994) in her article on group therapy for eating disorders. When talking about the group participants three main processes emerged, the development of trust amongst members and the feeling of being less lonely, as well as of the advantage of having a model.

Many participants reported that it took a while for members to develop trust in the group and they reflected that this could be due to the fact they felt ashamed and vulnerable. Riess and Rutan (1992) argued that individuals struggling with eating disorders often keep the latter secret, which can elicit feelings of shame, guilt and self-hatred. The same authors also argued that group therapy could provide a safe space where participants can talk about their difficulties. This was also experienced by participants in this group and provided further support to previous research (Gale, 2012). Ava in fact noticed that with time people in her group began to open more about their feelings and started to talk about the reasons why they were taking part in the group. Ferencik (1992) proposed that interactions between group members can improve the dynamics of the group as well increase the therapeutic

effects of the group. The therapeutic benefits of group therapy are, in fact, well known and many studies attest to this (e.g. Burlingame, MacKenzie & Strauss, 2004; McRobert, Burlingame & Hoag, 1998; Smith, Glass & Miller, 1980; Tillitski, 1990). As a matter of fact, in their book about group psychotherapy, Yalom and Leszcz (2005) explain that:

"*a persuasive body of outcome research has demonstrated unequivocally that group therapy is a highly effective form of psychotherapy that is at least equal to individual psychotherapy in its power to provide meaningful benefit*" (p.1)

Similar findings were also found when looking at the effectiveness of group therapy for individuals struggling with eating disorders. For example, in a quantitative study, Pisetsky and colleagues (2015) found that individuals who engaged in the therapy group early on also showed improved eating outcomes after twelve months. In this study all participants but one, who actually found it difficult to engage with the group, reported that the group had very positive impacts on their lives and their eating. One variable that seemed to be particularly important in the development of trust and in increasing engagement was knowing that they were not alone, which is what Yalom and Leszcz (2005) termed "universality" and identified as one of the factors that promote therapeutic change. This might also be one of the reasons why Elizabeth struggled to engage with group and experience any benefits, as her group was constituted by people with different diagnoses and she felt left out and different from everyone else.

The majority of participants reported that their battles had been particularly lonely prior to the group and, at times they had felt like "freaks". However, once they started the group, they described feeling less alone and more normal. Franko and George (2006) reported that group therapy can be beneficial for women struggling with eating disorders as they often keep their difficulties secret and, because of this, can experience difficulties in their relationships which can result in isolation. In addition, group therapy can help individuals experience having their feelings put into words by another member or by the group leader. This experience has been called by Barth and Wurman (1986) the "me too syndrome", and it can be an extremely validating experience for individuals as it can make them feel accepted and less different. In addition, other group members can act as a mirror reflecting what one has been feeling or experiencing.

Brennan and colleagues (2015) found that this was actually the most important thing for their participants as it helped them to gain insight into their own feelings and behaviours regardless of diagnosis. In this study, however, some participants expressed the view that different diagnoses were "fighting different battles" and this

made it difficult for them to feel connected and to properly understand what the other person was going through. Barth (1994) however argued that this might not necessarily be a negative thing as participants can learn to accept and express their feelings even if they differ from those of other people. Baumann (2006, p.279) also suggested that group therapy "facilitates the process of separation-individuation in connection with others". Although I agree with both authors, in that including different diagnoses can help group members develop social skills as well as mirror more closely the outside world, in my work with individuals struggling with eating disorders I also noticed that different diagnoses do seem to present in a different way and to struggle with different difficulties, which can be difficult to address in the same therapy group. For example, individuals struggling with anorexia nervosa seem to struggle with the need to control their emotions as well as the environment surrounding them, while individuals struggling with bulimia nervosa seem to struggle with the feeling of being out of control. Nevertheless, regardless of difference, other group members and leaders can also act as mirrors in that they can show other people how to be more accepting and compassionate towards themselves and their emotions.

Different participants felt that in order to develop self-compassion, they needed someone to teach them about it and show them how it was done. Brittany, for example, felt that group leaders needed "to be the living embodiment of compassion" because this could help her think about what they would say when she was practicing self-compassion on her own. This seems particularly important as participants felt that they did not know what self-compassion was and did not know where to start when it came to practicing it. Gilbert (2009), in fact, argues that clients need to experience their relationship with the therapist/group leader as safe, compassionate and not shaming and from this "*the client will experience each of the attributes and skills of compassion in, and from, the therapist*" (p. 203). Furthermore, Gale and colleagues (2015) found that the practice of compassion and self-compassion can help therapists put themselves in the client's shoes, which seems to increase compassion and empathy for the client by allowing the therapist to appreciate the difficulties that can be experienced with the exercises. By having the group leader act as a mirror clients can learn the skills of compassion and direct them at themselves. Many participants reflected that initially they used the same words that their group leader had used and, in time, they learned to create their own words. This reflects the definition that Barth (1994) had given of group therapy in which she described the latter as a "group swimming lesson" in which everyone works together to develop the necessary skills.

In summary, participants felt that being in a group was actually helpful for both the development of self-compassion as well as with regards to their eating difficulties, which supports previous research. Participants felt that particularly helpful were the feelings of acceptance and less isolation that came with taking part in the group as well as the normalising experience. However, what they felt was particularly helpful in helping them develop self-compassion was having group leaders as well as other members that could show them what the skills looked like and felt like. In addition, having a model to follow helped them to develop their own compassionate voice.

4.3 Evaluation of the study

The aim of this study was to provide further knowledge on how individuals suffering with eating difficulties experience the concept of self-compassion after participating in a therapy group that teaches the skills of self-compassion. Previous literature on the subject has mainly been quantitative in nature and this study tried to address the gap in the literature by using a qualitative method; this way I could produce a study where participants could express their views on their lived experience. Furthermore, using a qualitative method could allow me to contribute knowledge and understanding on the phenomenon of self-compassion amongst individuals struggling with eating difficulties; as a Counselling Psychologist this was particularly important. In my opinion, the research has reached its aims, although with some limitations, which will be discussed in this session.

4.3.1 Quality Of The Study

Assessing quality in a qualitative research is not easy as there are no set rules that have been established. Nevertheless, Yardley (2000) proposed four characteristics that good qualitative studies should have, which have been kept in mind throughout this research and have been discussed in the methodology chapter. These four characteristics are: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. I will briefly discuss these characteristics in relation to my study as I believed following them throughout this research constitute a main strength of this study.

Sensitivity to context was initially ensured through the review of current and past literature on the phenomenon being studied, which allowed me to be familiar with the current theories around this topic. Furthermore, my placement in an inpatient unit for adolescents diagnosed with eating disorders provided me with an introduction to the clinical context of this study. Through personal reflection I tried

to be aware of possible relationship dynamics that could develop between the participants and myself and I also considered ethical issues in order to ensure the study was sensitive to the experiences of the participants and would not harm them in any way. Lastly, as Yardley (2000) suggested, I included different tools, such as philosophical and social psychology theories, to allow me to address the findings in a wider context.

Commitment and rigour have been ensured throughout this research. Firstly, I engaged with the topic in depth by reviewing the literature, and then I continued to engage with it during data collection and analysis. Furthermore, I tried to to ensure that commitment and rigour were maintained during the analysis stage by making sure that themes were as rooted as possible to the text; this process has been described in depth in both the methodology and analysis chapters. To increase the rigour during the analysis stage I made sure that I met with my supervisor regularly and we discussed my themes and the process I had gone through to find them. During these meetings my supervisor provided feedback on the labelling of themes and enquired about my analysis process. My supervisor is particularly interested in this topic and had ample awareness of the current literature, however she did not engage fully with the transcripts, which I believed was beneficial for me as she could provide alternative views. Lastly, my commitment to professional and ethical standards was present throughout the study and, in particular, throughout data collection in which I kept participants' well being at forefront of my mind.

Transparency and coherence are evident in different aspects of this research. The method chosen to conduct this research and analyse the data appeared to be the best fit with the current theory and research question; this was clearly illustrated in previous chapters and was an attempt on my part to show the coherence of this research. Transparency was ensured throughout the study by making sure I described all the processes involved in this research, including the analysis, and by being reflexive throughout. In fact, I have openly spoken about my thoughts and feelings about embarking on this journey and was explicit about my impact on this research. By doing so, I hoped the reader could see the analysis from my point of view.

The impact and importance of this study was a key aspect for me going into this research. Participants were incredibly generous and have given me their time as well as in-depth interviews, which provided rich data and information. I believe that eating disorders are a plague in our society, which needs to be addressed, and more research needs to be done to improve the outcomes of current treatments. I hope that the knowledge produced in this research will help improve the current

treatments available for this population and, for this reason, I will endeavour to publish my findings in different journals. The impact and clinical implications of this study will be discussed further on in this chapter.

4.3.2 Strengths and Limitations

The main strength of this study is its qualitative nature as it has resulted in the production of new knowledge on the topic of self-compassion amongst individuals struggling with eating difficulties. Furthermore, I believe that the sample size was a good fit for this study as it allowed me to immerse myself in the data without becoming overwhelmed, while at the same time allowing me to gather enough information about their experiences. Although applying a qualitative design and ensuring that the quality of the study are important strengths, this study also presented with some limitations.

The sample size of this study is in line with the recommendations (Smith, Flowers and Larkin, 2009) and it was believed that the seven interviews had yielded enough information. However, some people could argue that this is a limitation as there is no set number for qualitative studies and for some methodologies, such as grounded theory, a higher number of participants is required in order to achieve saturation. Nevertheless, having a small sample size allowed me to complete in-depth analyses of each interview, which ensured quality.

Smith and colleagues (2009) suggest that a homogenous sample should be used in qualitative research, particularly if using IPA to analyse the interviews. The sample for this study was homogenous in respect to shared experience of group therapy and eating difficulties, however participants were heterogeneous in different ways. Firstly, participants presented with different eating disorders self-diagnoses, however this study was interested in understanding the experience of self-compassion in individuals struggling with any eating difficulty, therefore the different diagnoses were not considered an issue. Furthermore, all participants interviewed had completed the therapy group in the same clinic and, although at different times, the group was always conducted by the same leaders. It could be possible that different groups offer different experiences and future research could explore this in more details. Lastly, this study included participants of different ages.

A further limitation to this study is the lack of generalizability due to its qualitative nature. However, as was previously noted, qualitative data is still scarce in this area and I believe that using semi-structured interviews to collect data and IPA to analyse it allowed me to immerse myself in the lived experiences of participants

and allowed me to produce rich data. Furthermore, the National Institute of Clinical Excellence (NICE, 2004) suggests that patient experience is a key element of therapy development and, since one of the aims of this research was to produce information that could enhance current treatments, a qualitative approach was deemed the best fit.

4.3.3 Future Research

From the information developed through this study and from its limitations it can be argued that future research could expand this thesis in different ways.

First, initially other individuals had been invited to take part in this study, but they had chosen not to participate. It might be that these individuals had different experiences and interviewing them could have yielded different results. Similarly, the study was initially open to both genders, however only females responded to the flyer. The majority of research in this area, particularly with regards to eating disorders, has been conducted with women since eating disorders are more prevalent with this group; however, new studies are trying to include males as well to reflect the increase of eating disorders diagnoses amongst them (e.g. Hudson et al., 2007; Lavander, De Young, & Anderson, 2010; Pennesi & Wade, 2015; Striegel-Moore et al., 2009; Striegel, Bedrosian, Wang, & Schwartz, 2012). It might be interesting to conduct a similar research to this one with male participants as this could yield different information. Furthermore, future studies could compare similarities and differences between men and women in order to ensure that interventions and theories reflect both points of view. Another biological factor that might yield different results is age. This study included participants of different ages and it could be interesting to expand this research and compare participants' experiences according to their age to see if there are any differences.

Secondly, although many modern clinicians tend to think of eating disorders transdiagnostically and as sharing core psychopathologies (e.g. Fairburn & Harrison, 2003), it might be interesting to research whether different diagnoses interpret self-compassion differently. Furthermore, from a clinical point of view, it might be interesting to research whether different groups (e.g. groups ran by different leaders, groups with content specific to eating disorders or groups including the same diagnosis) offer different experiences.

Lastly, although I believe that the qualitative nature of this study was its biggest strength, an important step for future research would be to include bigger sample sizes for qualitative studies as well as incorporate both quantitative and qualitative methodologies.

4.3.4 Clinical Implications

The findings of this study demonstrate the difficult journey that individuals struggling with eating disorders have to complete when trying to develop self-compassion. As described in the literature review chapter of this thesis, eating disorders are an important public health issue that affect all aspects of an individual's life and have detrimental consequences, including death in extreme circumstances. The treatments available for these diagnoses are improving and their effectiveness is definitely improving, however research still shows that many patients often relapse or never recover (particularly in the case of anorexia nervosa). For this reason it is important to continue to conduct research on this topic so that outcomes can be improved. Furthermore, the majority of research conducted has been quantitative in nature and, as NICE (2004) suggests, patients' views are a vital aspect of treatment development. This study has tried to address these issues by conducting a qualitative study that produced insight into the experience of women struggling with eating difficulties and the processes they undergo when trying to develop self-compassion after completing a therapy group that teaches the skills of compassion. From its findings, this research highlights different clinical implications. The aim of this section is therefore to provide Counselling Psychologists and other mental health workers with suggestions for practice when working with individuals struggling with eating disorders and, in particular, when trying to help them develop self-compassion.

1. Individuals with a diagnosis of eating disorder often present with high levels of self-criticism and shame (e.g. Goss & Allan, 2009; Duarte, Ferreira, & Pinto-Gouveia, 2016); the self-criticism they experience is often detrimental for them as, instead of promoting self-improvement, it becomes harmful and persecutory (e.g. Barrow, 2007). Helping people who struggle with eating difficulties to develop self-compassion as an aid to recovery can be extremely beneficial as it can help them develop adaptive emotional regulation strategies as well as effective coping mechanisms (e.g. Gilbert, 2005; Sirois, Kitner, & Hirsch, 2015).

2. Furthermore, Gilbert (2000, 2009, 2010) developed Compassion Focused Therapy as he had noticed that individuals presenting with high levels of self-criticism and shame were struggling to engage with other types of therapies, as they found it difficult to translate the theory into change. One of the most difficult aspects of managing eating disorders is that of engaging individuals when treating them (Treasure, 2012); therefore exploring and implementing treatments that could increase engagement seems particularly important.

3. If individuals struggling with eating disorders present with high levels of shame and self-criticism that could either be the cause or the result of their eating behaviours (e.g. Goss & Gilbert, 2002), perhaps one way of reducing these feelings is to help individuals develop self-compassion. Self-compassion as conceptualised by Neff (2003a, 2003b) involves three components: self-kindness, mindfulness and common humanity. By developing these three aspects, individuals can learn to become more accepting of themselves and their emotions as well as see their suffering as part of human nature and not something that makes them different or "weird".

4. Furthermore, individuals that present with eating difficulties often struggle with their emotions and can resort to their eating behaviours as a way of coping with them (e.g. Dolhanty & Greenberg, 2007). The development of self-compassion can help these individuals become aware of their emotions, both positive and negative, and allow them to observe and tolerate them. This would be beneficial in helping clients develop healthy coping mechanisms that would prevent them from engaging in disordered eating.

5. Setbacks are considered a normal part of recovery and, no matter how self-compassionate a person is, there could still be times in which facing emotions feels too difficult. When these setbacks happen, self-compassion can help individuals by allowing them to accept their failures and see these mistakes as part of our human nature. This could help individuals trying to recover from an eating disorder from experiencing a full relapse, as it would help them shift from self-criticism to self-acceptance. Goss (2011) suggested that when an individual is able to move away from self-criticism after eating, s/he will also be able to think about alternative ways of self-soothing and be more compassionate towards themselves.

6. The importance of the therapeutic relationship has often been discussed and, although it usually associated with the psychodynamic approach (e.g. Freud, 1912) and the person-centred approach (Rogers, 1957), all modalities highlight its importance. In this study, participants commented that one of the most important aspects in their development of self-compassion was having a therapist/group leader that could show them how it was done. One participant actually commented that the group leaders needed to be the "living embodiment" of compassion so that she could think of them and their words when trying to practice self-compassion at home. Therefore, compassion in the

therapist can help develop a good therapeutic relationship as well as provide and example for the client.

7. Furthermore, Gilbert (2009) argued that when the therapist uses the skills and expresses the attributes of compassion, the client experiences the relationship as affirming, safe and compassionate. In this way the client will experience the attributes and skills of compassion both in and from the therapist and, with time, will learn to apply those same attributes and skills to the self (Gilbert, 2009).

8. When clients feel safe in the therapeutic relationship, they are more likely to disclose their difficulties (e.g. Noyce & Simpson, 2016). This could be beneficial in two ways, first they would be able to see and feel the compassionate response of the therapist and, second, it could help disclose and face the difficult emotions that arise when trying to develop self-compassion. A good therapeutic relationship could therefore be beneficial for these clients, as the therapist could help them face and express different feelings, including grief, while also helping them develop acceptance and methods of self-soothing.

9. Goss and Allan (2014) argued that individuals struggling with eating difficulties do not often have access to the 'soothing system' as their behaviours and strategies become ways of regulating the threat system and this creates a vicious maintenance cycle. Consequently, by helping individuals create a compassionate voice it can be hypothesised that, although it might feel threatening at first to modify a safety strategy, it will also re-activate the 'soothing system', which then re-establishes a balance between their three affect-regulation systems. Therefore, creating a safe and compassionate environment in which clients can face their emotions and develop positive and healthy coping mechanisms is of vital importance.

10. Many participants reflected on how self-compassion had helped them develop healthier relationships. One of the main reasons they gave for this was that they felt they were now entering their relationships as equals. The equality they felt was due to their ability to self-soothe, as a matter of fact, individuals with high levels of self-compassion are able to meet their own needs in terms of kindness and self-comfort (Neff & Beretvas, 2012). Therefore helping individuals to become able to take care of themselves can be helpful in their relationships as they will be more likely to be able to find stability between independence and connectedness, which has been shown to be an important

factor in healthy relationships (Deci & Ryan, 2000). This change can result from developing a good therapeutic relationship with the therapist but also with other individuals in a group setting.

11. The therapy group can act as a family in which group leaders can be seen as parental figures and in which conflicts are not only re-lived but they are "relived *correctly*" (Yalom & Leszcz, 2005, p. 16; Gale, 2012). This could be particularly important for this population as they already struggle with both negative and positive emotions; this struggle can also turn into fear, which has been identified as a major obstacle for the development of self-compassion (e.g. Gilbert et al., 2011).

12. Lastly, in a group setting, clinicians need to pay attention to diagnoses included and make sure that participants do not feel left out or misunderstood, as was the case for Elizabeth. Furthermore, clinicians might consider developing/creating groups for specific eating disorders diagnoses, as in this study more than one participant suggested that "different diagnoses were fighting different battles" and this made it difficult for them to engage with what the other person was feeling.

The aim of this study was to provide Counselling Psychologists with further knowledge on how individuals struggling with eating disorders experience the development of self-compassion after taking part in a compassionate mind therapy group. All the suggestions that have been made in this chapter were thought for both individual and group therapy. I hope that the findings from this study and the suggestions made throughout the thesis can help professionals understand this phenomenon better as well as provide clinicians with more tools to help this particular client population.

4.4 Reflexivity

4.4.1 Methodological and Procedural Reflexivity

Throughout this research I tried to be aware of my own beliefs and how they could impact the analysis, in fact, I wrote them down on a notepad to limit their impact and make sure my research was not biased. However, being human, it is definitely possible that my views influenced the way in which I analysed and understood participants' experiences. Nevertheless, IPA sees research as a dynamic process in which the researcher holds an active role and the researcher's assumptions and beliefs are not put aside but worked with.

Utilising a qualitative approach has helped me to become more reflexive and it has confirmed my passion for working in the field of eating disorders. Furthermore, it has allowed me to combine my role as a Counselling Psychologist with that of a researcher. When conducting the interviews and analysing them, I utilised an approach that is similar to the one I use in my practice with my clients, which is me trying to understand their lived experiences and trying to add value by adding connections with other data and using psychological theory to inform interpretations. This research has inspired me to revisit the role of research not only in the wider context of my profession but also within my own practice. In fact, I realised how valuable it can be in terms of contributing new knowledge.

Reflecting on the methodology I chose, I acknowledge that different approaches could have yielded different results and, perhaps, the use of grounded theory could have allowed me to develop a theory around this topic. However, IPA was used because I believed it would be the best tool to help answer my research question as well as to generate the type of knowledge I had hoped to produce. The knowledge I hoped to produce was critical realist and the analysis was an account of me making sense of the participants making sense of reality.

Willig (2001) proposes three major challenges to IPA, which will be described and linked to the current study below. Firstly, Willig highlights the assumption of IPA researchers with regards to the representational validity of language, which is that the latter actually allows individuals to conceptualise and describe their lived experience. When this is considered from the researcher's point of view, it also means that language allows the researcher to capture participants' experiences. One obstacle that I encountered during this research was that of conducting it in a second language. At times, I worried that I would not understand the words that participants were using or would interpret incorrectly their accounts. However, I had put in place different strategies that could help me along the way such as asking my supervisor to look at my transcripts and see if sentences made sense and if I had misspelled anything. In addition, I also conducted my literature review in English, which allowed me to think and reflect on the topic in this language, and I believed this allowed me to get closer to participants' experiences.

The second challenge that Willig (2001) poses to IPA is whether participants can suitably report the richness of their experiences and communicate it to the researcher. Willig argues that individuals that are not used to expressing their emotions and thoughts might not be able to communicate the texture of their experience. The participants in this study ranged in educational level, however all

participants had received individual therapy before and this allowed them to feel comfortable when talking about their feelings, thoughts and behaviours. This became apparent to me during the analysis of the transcripts as I was often surprised by the depth and emotional content of the descriptions my participants provided.

The last challenge that Willig (2001) proposes regards the difference between description and explanation. Willig highlights that phenomenology can help researchers to understand how we experience reality, however it does not try to understand why. Furthermore, Willig argues that to go from sharing experiences with participants into understanding them, we need to understand the conditions that give rise to that experience; this however is not something that phenomenology claims to address. With regards to this study, I believe that gathering new information on a topic can be extremely valuable and interpretation can allow us to expand it. Furthermore, by using conceptual and theoretical frameworks to further the analysis, I hoped I was able to move beyond merely describing and I was able to start understanding the why by considering the clinical implications.

Lastly, this was the first time I was using IPA to conduct research and before starting I had my share of doubts regarding how I would find this experience. I was surprised to see that the analysis was actually an extremely enjoyable and natural experience for me. I believe that this was also caused by the fit between my epistemological standpoint and my chosen method. As I had never done this before, I made sure I used guidelines to help me throughout the process however I was also able to incorporate my preferences; for example, I chose to make connections between themes by spreading out on the floor the pieces of paper that included my line by line coding. Initially I was quite scared that I would create themes that did not reflect participants' experiences, however I found that constantly going back to the interviews allowed me to stay true to their accounts. Lastly, I chose to use creative titles for my themes as throughout the interviews participants often made use of metaphors and I believe that using metaphors or ways of saying myself would help me stay close to participants' lived experiences.

4.4.2 Personal Reflexivity

I am extremely grateful to have been able to conduct this research and to have been given the opportunity to understand what it means to be a woman struggling with an eating disorder and trying to develop self-compassion. Since the beginning of my training in psychology, I have always been interested in people's stories and (as clichéd as this sounds) in trying to help them. I am so glad to have found

participants who were willing to openly share their experiences with me even if this meant sharing their vulnerabilities and difficulties with me, a stranger. I hope that with this research I was able to give something back to them. Engaging with these women has had profound impacts on myself as an individual and as a Counselling Psychologist.

Firstly, this research has helped me to understand my lack of self-compassion at times and how this could be detrimental in terms of my work and, in general, in terms of my happiness. Having these brave women share their experiences with me has inspired me to embark on my personal journey towards self-compassion. While conducting this research I have started to practice self-compassion in my own time and have also started to look for a personal therapist with whom I can continue this journey.

I am aware that these similarities and reflections could have affected my analysis and interpretation of the data, however I am also aware that for certain aspects I had a position of outsider. For example, I have never suffered with an eating disorder, however my appearance as a slim woman could have affected the dynamics with participants in different ways. Some participants, for example, may have thought that I was conducting this research as I too had suffered with an eating disorder in the past. However, I also wonder what effect it would have had if my body shape had been different. In conclusion, rather than thinking of these effects as positive or negative, I prefer to think of them as part of the process and important for the findings.

Lastly, this research has been a journey filled with many emotions that range from excitement to terror. I believe that this reflects how I feel at this point in my life when I am about to finish my training and embark on “a whole new world”. The future elicits different feelings in me, however the main one seems to be fear as I am not sure where I am going with my life or what is going to happen. Nevertheless, as my participants did when trying to develop self-compassion, I too will try to walk this journey by getting over its hurdles.

4.5 Conclusion

Eating disorders are particularly common and are associated with many health problems and poorer social functioning. Many people who suffer from an eating disorder do actively seek help, however the treatments that are currently being employed to treat eating disorders seem to be helpful only for some individuals, with the remaining dropping out of therapy, relapsing or not reaching full recovery (Surgenor, Macguire, & Beaumont, 2004). A significant body of research found that individuals with eating disorders present emotional processing deficits; therefore treatments that focus on affect regulation could be efficient in helping this population. CFT derived from an evolutionary and neuroscientific model of affect regulation. During recovery, patients are helped to develop compassionate ways to manage their eating disorder and their self-criticism. Research that examines self-compassion has mainly focused on the general population and the methods utilised mainly involved quantitative methodologies, such as questionnaires or surveys. Therefore, it appeared important to conduct this research by exploring participants' lived experiences. For this reason, this study aimed to address this gap in the literature by exploring participants' experiences with regards to developing self-compassion after taking part in compassionate mind therapy group.

During the analysis stage four main categories were developed: *A Whole New World*, *It's A Long Way To The Top*, *Journey For Life* and *A Problem Shared Is A Problem Halved*. These themes provided an understanding of how some women develop self-compassion. The study confirmed previous research which showed that individuals struggling with eating difficulties present with little or no self-compassion. Many studies suggested that a main obstacle in the development of self-compassion is fear of compassion and of positive emotions, however this study found that the main obstacle was constituted by the negative emotions that arose. This process was likened to that of grieving as participants described having to come to terms with the absence of self-compassion in their lives. Furthermore, this study proposed that the critical voice is used as a safety strategy against threats and participants might initially be afraid of losing this mechanism for fear of becoming more vulnerable. Once participants were able to move past the obstacles, they found that self-compassion had different positive impacts including on their relationship with food and with other people. At the end of the group, all women mentioned that they would definitely recommend the group to other people; however, they would also suggest having individual therapy in conjunction with the group. These findings highlight the need to explore self-compassion as a treatment for eating disorders further. The study proposed different ways in which future research could expand the knowledge created with this research.

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Appendices

List of Appendices

Appendix A – Recruitment Poster

Did you take part in a therapy group that teaches the skills of self-compassion?

Do you suffer with eating difficulties?

Would you be willing to help me understand what your experience was like?

My name is Giulia Di Clemente and I am a trainee counselling psychologist. I am carrying out doctoral research to understand the experience of 'self-compassion' in those who take part in a compassion group that teaches the skills of self-compassion. The focus of the research will therefore be on the treatment you have received and not on the eating difficulties you might have experienced or are still experiencing.

If you decide to take part, you will be given an information sheet explaining everything the research involves. Information about your experience will be gathered through an interview with me. Confidentiality will be guaranteed at all times.

For more information about this study, or to take part, please contact:

Giulia Di Clemente at [redacted]

Or

Dr Courtney Raspin, who is supervising this project, at [redacted]

Thank you for your time

Giulia

This study has been reviewed by, and received ethics clearance through City University London Research Ethics Committee, [PSYCH (P/L) 14/15 184].

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

Appendix B – Participant Information Sheet

PARTICIPANT INFORMATION SHEET

My name is Giulia Di Clemente, and as part of my training qualification as a Counselling Psychologist, I am carrying out research to understand how people who struggle with eating difficulties experience self-compassion after having participated in a compassion focused therapeutic group.

Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The study aims to explore the experience of 'self-compassion' in those who take part in a compassion group that teaches the skills of self-compassion in order to identify how best to meet the psychological needs of this population. It is hoped that the results will help to improve the psychological treatment currently offered for eating difficulties.

Why have I been invited?
You have been invited to take part in this study because you took part in a therapeutic group that teaches the skills of self-compassion and I would like to hear your views on this experience and, in particular, how you experienced self-compassion.

Do I have to take part?
Participation is entirely voluntary, you can choose not to participate in part or all of the project, and you can withdraw at any stage of the project without being penalized or disadvantaged in any way. If you choose to participate in the study you will be asked to sign a consent form.

What will happen if I take part?
If you choose to take part, you will be asked to sign a Consent Form indicating that your participation is voluntary. You will then be asked a few questions about your experience of self-compassion after taking part in the therapeutic group. The interview will take approximately an hour and will occur at a time and place that is convenient for you.

Do I have to answer all the questions if I don't want to?
No, it is up to you whether you wish to answer the questions.

Do the questions relate to my difficulties?
No, the questions relate only to the treatment you received for those problems.

What are the possible disadvantages and risks of taking part?
It is not believed that any risk will arise due to your taking part in this project. Nevertheless, given the nature of the interview, if any psychological distress is caused you can stop the interview at any time and withdraw from the study if you wish to do so. Additionally, the researcher has put together a list of associations that you can contact to receive further information or help.

What are the possible benefits of taking part?
It is hoped that this project will be able to provide you with indirect benefits. As a matter of fact, your participation in this study will contribute to current knowledge regarding Compassion Therapy being used to help individuals experiencing and Eating Disorder. Furthermore, your participation might be able to benefit future clients.

What will happen when the research study stops?
The interview will be taped and will only be heard by the researcher and, if requested, by the examiner. Data collected by the researcher will not be available to anyone else, the tapes

will be kept securely locked and destroyed once the research process is complete. The date for this is planned to be no later than September 2016.

Will my taking part in the study be kept confidential?
Neither your name nor any personal details will appear in the final report. All identifying information will be anonymised.

What will happen to the results of the research study?
This project will be available to future students through City University Library. The researcher might choose to publish parts or all of the report in psychological journals. In both cases your anonymity will be preserved and any identifying details will be changed.

What will happen if I don't want to carry on with the study?
You can withdraw at any stage of the project up until the end of May 2016 without being penalized or disadvantaged in any way.

What if I have more questions about the study?
There will be time for you to ask further questions before you sign the Consent Form and at the end of the interview.

Can I receive a summary of the results of the report?
Yes, just tell the interviewer if you would like to receive a copy.

What if there is a problem?
If you have any problems, concerns or questions about this study, you can contact Dr Courtney Raspin at [redacted]. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: *How do individuals who struggle with eating difficulties experience self-compassion following an eight-week Compassioned Focused therapy group?*

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study is being carried out according to the ethical principles and procedures of the British Psychological Society. it has been reviewed by the Ethics Committee of City University.

Further information and contact details
For further information you can contact myself at [redacted] or Dr Courtney Raspin, who is supervising this project, at [redacted].

Thank you for taking the time to read this information sheet.

Appendix C – Consent Form

CONSENT FORM

Title of Study: *How do individuals who struggle with eating difficulties experience self-compassion following an eight-week Compassioned Focused therapy group?*

Ethics approval code: PSYCH (P/L) 14/15 184

This form contains important information. Please read it carefully.

If there is anything that is not clear to you, please ask for clarification.

If you agree to proceed with the interview, please sign this form as indicated.

I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.

I understand that the purpose of the study is to explore the experience of 'self-compassion' in those who take part in a compassion group that teaches the skills of self-compassion.

I understand that my participation in the study will involve being interviewed by Giulia Di Clemente, a Trainee Counselling Psychologist in the Department of Psychology, City University, London.

I understand that the research will be conducted according to the Code of Conduct and Ethical Principles of the British Psychological Society.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project up until the end of May 2016 without being penalized or disadvantaged in any way.

I understand that the interview will be audiotaped and then transcribed word by word.

I understand that if I want to have a break during the interview, I can get up and leave the room.

I agree for direct quotes from my interviews to be used in the final write-up with the understanding that anonymity will be preserved at all times and that I can withdraw my permission at any time.

I understand that if I want, I can ask for the tape recording to be destroyed.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.

I understand that if any part of the interview is published in written form in psychological journals my name will be changed together with any details that might identify me.

I understand that the tape will be securely stored during their use, and destroyed once the research has been completed by the end of 2016.

I understand that this project is not expected to involve any risks of harm any greater than those in daily life, and that all possible safeguards will be taken to minimise any potential risks.

I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.

PLEASE NOTE: After you have completed the interview, there will be time for you to add any further information, and to talk about the process of the interview together with the researcher.

You will also receive a list of organisations that offer information and support to people dealing with Eating Disorder.
This research is supervised by Dr. Courtney Raspin at City University, Northampton Square, London, EC1V 0HB.

e-mail: [redacted]

I agree to take part in the above study.

_____	_____	
Name of Participant	Signature	Date
_____	_____	
Name of Researcher	Signature	Date

If you would like to receive a summary of the results of the report, please state the best way to send it to you:

_____

_____

_____

_____

Date:

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix D – Interview Schedule

INTERVIEW SCHEDULE

I am conducting this interview because I am interested in your views and feelings about the compassionate mind group you participated in for your difficulties. I want to emphasize that there are no right or wrong answers, just your opinions. Please note there is no obligation to answer these questions.

It would be helpful if we could start with some background information, such as your age and your ethnic origin. This information will not be used to identify you in any way, but it will help me and future readers to understand my research in a specific context.

1) How did you make the choice to participate in a compassionate mind group?

2) How long were you in this compassionate mind group?

3) If a friend asked you to describe self-compassion, how might you do it?
Prompt: What does self-compassion look like?
Prompt: What does self-compassion entail?

4) Were there elements of self-compassion that you found easier?
Prompt: Were certain aspects easier to accept?
Prompt: Were certain aspects easier to understand?

5) Did you encounter any obstacles when learning about self-compassion?
Prompt: Were there certain aspects that were harder to accept or understand?

6) Has self-compassion had any impact on your life?
Prompt: Has self-compassion become part of any aspects of your life?
Prompt: Did the group affect any aspect of your eating?

7) Can you talk a bit about yourself before and after participating in the compassion therapy group?
Prompt: Did your self-compassion change from the beginning of the group?
Prompt: Did the group help you change in any way?
Prompt: Did the group affect certain aspects of your life?

8) Would you recommend someone you know to attend the group if they had eating difficulties?

9) If you had the power, what element of the group would you remove?

10) Similarly, what elements might you add?

Appendix E – Consent to Audiotape

CITY UNIVERSITY LONDON

CONSENT TO AUDIOTAPE

This agreement is written to clarify the confidentiality conditions of the use of audiotapes by Giulia Di Clemente for the purposes of psychological research.

The participant gives Giulia Di Clemente permission to tape the research interview providing that:

- The permission may be withdrawn at any time
- The tapes are used solely for analysis by Giulia Di Clemente
- The tapes will be stored securely and destroyed once the research has ended

This agreement is subject to the Code of Conduct and Ethical Principles of the British Psychological Society.

I have read and understood the above conditions and agree to proceed with the interview.

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

Appendix F – Demographic Questionnaire

DEMOGRAPHIC QUESTIONNAIRE

Before we start the interview, it would be helpful if we could start with some background information, such as your age and your ethnic origins.

This information will not be used to identify you in any way, but it will help me and future readers to understand my research in a specific context. Please note that neither your name nor any personal details will appear in the final report. All identifying information will be anonymised.

Please note there is no obligation to answer these questions.

1) How old are you?

……

2) How would you describe your ethnic origin?
- ☐ White
- ☐ Black Caribbean
- ☐ Black African
- ☐ Asian
- ☐ Mixed Please specify: ……
- ☐ Other Please specify: ……

3) What is your current marital status?
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Partnered but not married
- ☐ Single

4) What is your current employment status?
- ☐ Employed Please specify: ……
- ☐ Self-employed Please specify: ……
- ☐ Homemaker
- ☐ Out of work and looking for work
- ☐ Out of work but not currently looking for work
- ☐ Student
- ☐ Unable to work

Appendix G – Debrief Information

DEBRIEF INFORMATION

Thank you for taking part in this study!
Now that it's finished we'd like to explain the rationale behind the work.

Through this study I am looking to get in depth knowledge in the experience of 'self-compassion' in those who take part in a compassion group that teaches the skills of self-compassion.
In addition, I am hoping to gain enough information to be able to improve current psychological treatments offered to individuals who experience an eating disorder.

We hope you found the study interesting.
Is there anything that you would like to add to your comments during the interview?

Was there anything that you found particularly helpful about the interview?

Was there anything that you found particularly unhelpful about the interview?

If you have any other questions please do not hesitate to contact us at the following:
Giulia Di Clemente, Trainee Counselling Psychologist:
[redacted]

Dr. Courtney Raspin, Research Supervisor:
[redacted]

Ethics approval code: *PSYCH (P/L) 14/15 184*

Appendix H – Resource Pack

RESOURCE PACK

Thank you for participating in this study.

If the interview has raised anything that you wish to discuss or you want more information about, the following addresses and contact details might be of interest.

West Hill House – Highgate Consulting Rooms

Tel:	020 7482 4212
E-mail:	info@westhill-house.biz
Address:	West Hill House, 6 Swain's Lane, London N6 6QS, UK

Beat (Beating Eating Disorders)

Tel:	0845 634 1414 (Helpline. Monday – Friday 1.30pm – 4.30pm)
E-mail:	help@b-eat.co.uk
Address:	Head office, Wensum House, 103 Prince of Wales Road, Norwich, Norfolk, NR1 1DW, UK

National Centre for Eating Disorders

Tel:	0845 838 2040
Address:	54 New Road, Esher, Surrey, KT10 9NU, UK

Eating Disorders Support

Tel:	01494 793 223 (Helpline. Any time & any day)
E-mail:	support@eatingdisorderssupport.co.uk
Address:	Sun House, 32 Church Street, Chesham, Buckinghamshire, HP5 1HU, UK

Mind Infoline

Tel:	0300 123 3393 (Monday – Friday 9am – 6pm)
E-mail:	info@mind.org.uk
Website:	www.mind.org.uk

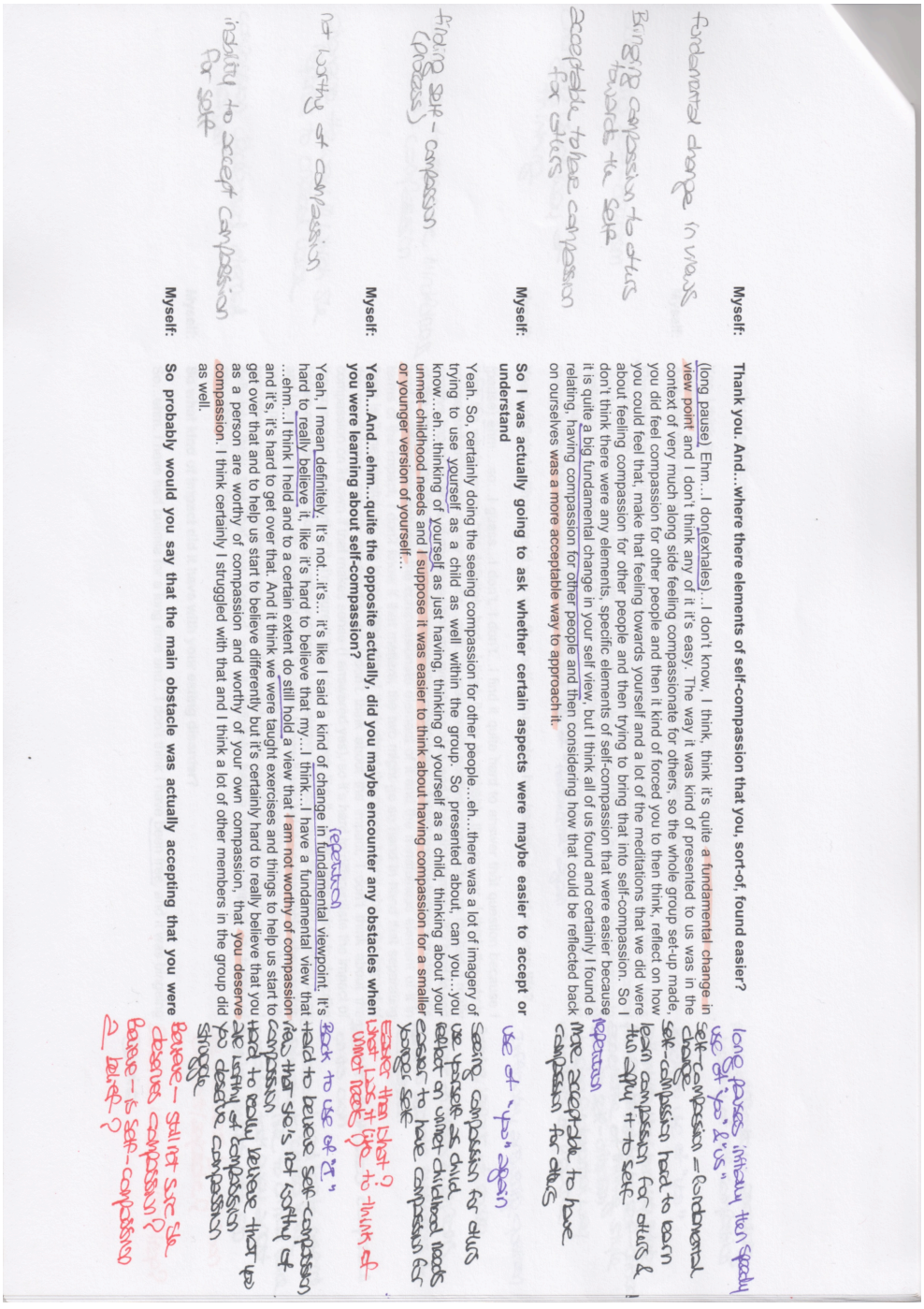
Anorexia and Bulimia Care (ABC)

Tel:	0300 011 1213 (Helpline)
E-mail:	mail@anorexiabulimiacare.org.uk
Address:	Saville Court,10-11 Saville Place, Clifton, Bristol, BS8 4EJ, UK

Elefriends (Supportive online community)

Website:	www.elefriends.org.uk

Appendix I – Examples of Coding Stages



Myself: **Thank you. And...where there elements of self-compassion that you, sort-of, found easier?**

(long pause) Ehm...I don(exhales)...I don't know. I think think it's quite a fundamental change in view point and I don't think any of it it's easy. The way it was kind of presented to us was in the context of very much along side feeling compassionate for others, so the whole group set-up made you did feel compassion for other people and then it kind of forced you to then think, reflect on how you could feel that, make that feeling towards yourself and a lot of the meditations that we did were about feeling compassion for other people and then trying to bring that into self-compassion. So I don't think there were any elements, specific elements of self-compassion that were easier because it is quite a big fundamental change in your self view, but I think all of us found and certainly I found e relating, having compassion for other people and then considering how that could be reflected back on ourselves was a more acceptable way to approach it.

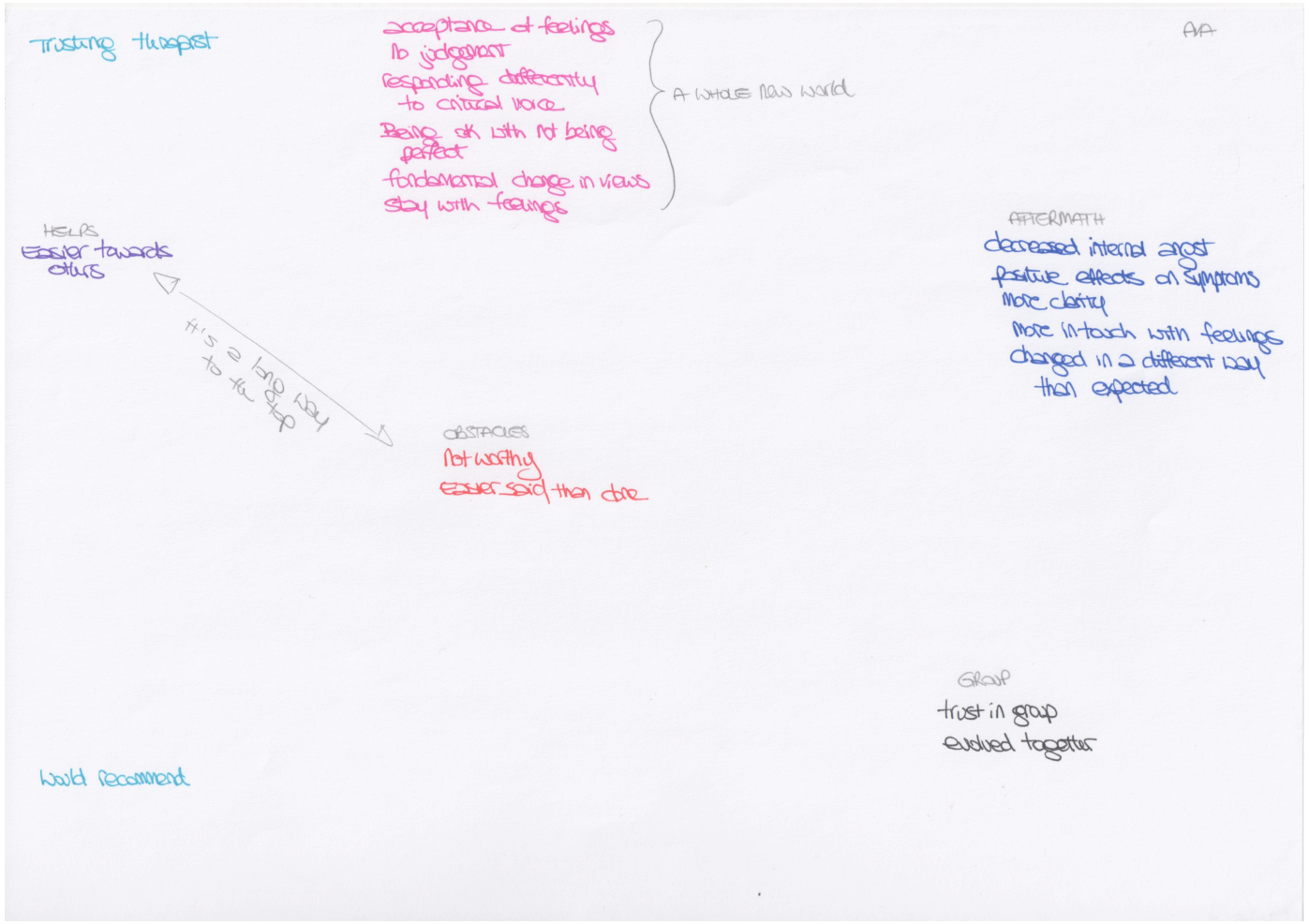
Myself: **So I was actually going to ask whether certain aspects were maybe easier to accept or understand**

Yeah. So, certainly doing the seeing compassion for other people...eh...there was a lot of imagery of trying to use yourself as a child as well within the group. So presented about, can you...you know...eh...thinking of yourself as just having, thinking of yourself as a child, thinking about your unmet childhood needs and I suppose it was easier to think about having compassion for a smaller or younger version of yourself...

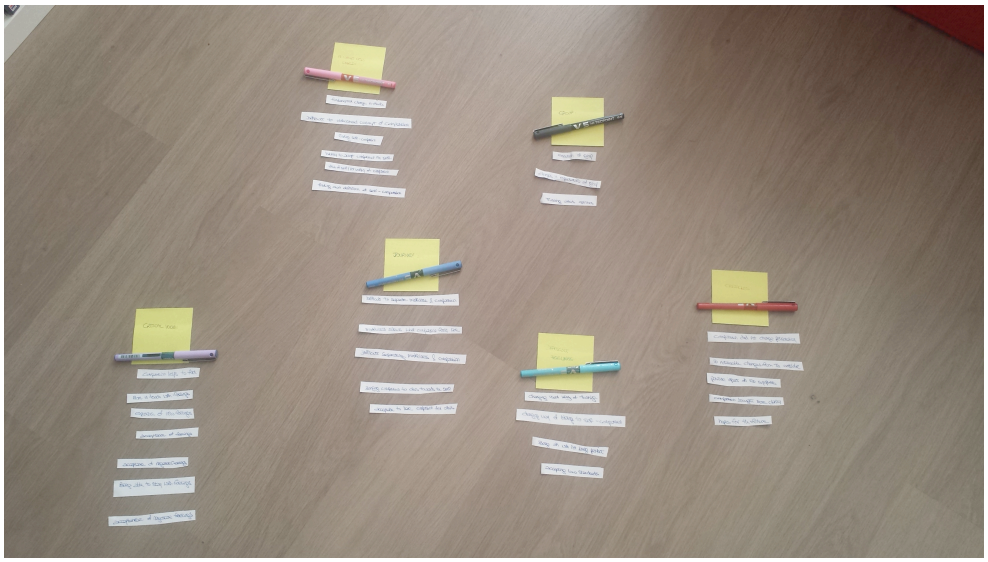
Myself: **Yeah...And...ehm...quite the opposite actually, did you maybe encounter any obstacles when you were learning about self-compassion?**

Yeah, I mean definitely. It's not...it's... it's like I said a kind of change in fundamental viewpoint. It's hard to really believe it, like it's hard to believe that my...I think...I have a fundamental view that I am not worthy of compassion (as that she's not worthy of ...ehm...I think I held and to a certain extent do still hold a view that and it's, it's hard to get over that. And it think we were taught exercises and things to help us start to get over that and to help us start to believe differently but it's certainly hard to really believe that you as a person are worthy of compassion and worthy of your own compassion, that you deserve compassion. I think certainly I struggled with that and I think a lot of other members in the group did as well.

Myself: **So probably would you say that the main obstacle was actually accepting that you were**


Trusting therapist
acceptance of feelings
No judgment
responding differently to critical voice
Being ok with not being perfect
fundamental change in views
stay with feelings
A whole new world
AA
HELPS
Easier towards others
it's a long way to the top
OBSTACLES
Not worthy
Easier said than done
AFTERMATH
decreased internal angst
positive effects on symptoms
more clarity
more in-touch with feelings
changed in a different way than expected
GROUP
trust in group
evolved together
Would Recommend

Appendix J – Searching for Connections Across Emergent Themes



Appendix K – Sample of Summary Table of Cluster Themes

Themes	Quotes
A fundamental change	*"I think it's something you have to work hard at, it's not something that's there" – Elizabeth* *"I think, think it's quite a fundamental change in view point" – Ava* *"It's like the course and the whole way, that whole system of thinking, it's like being taken to a country that you didn't know was there, so you only thought there was Canada and England, and all of the sudden you've gone to Ireland, You don't have to go to Canada, you can go here instead. You don't have to be, you know, good or bad, you can be other things and you can see…it's another island in my mind that I can go to and I didn't know that there was such a place." – Brittany* *"It's like you are on a motorway going at a hundred miles an hour and it's so easy to keep your foot on the pedal and…in the practice I think they were talking about the tracks in the snow. These ways of thinking, behaving or being that are just so harmful really. It's just so easy to keep going in the old tracks, but making the new tracks…ehm…takes time" – Danielle*
A painful journey	*"I found it, what I didn't expect in this particular eating thing, not outside…I didn't expect, I expected relief and I didn't get relief…that's not what I got…and I was quite shocked that actually what I got was more pain and I didn't expect that. […] So, by being more aware I started to understand how much pain I was in and I hadn't really understood that before. And understanding that and seeing what I was doing and how my mind was working was very painful" – Brittany* *"I remember going around the room and saying how we felt about that child, and my feelings were of disgust. And I think I realised how deep the damage to me was in terms of my lack of self-compassion. And even without compassion, how uncompassionate I feel generally towards myself. And it broke my heart because I was a TA for ten years, I love children, I love all children and, of course, you just don't do you." – Danielle*

Appendix L – Sample of Table of Super-ordinate and Sub-ordinate Themes

Superordinate Theme	Sub-ordinate Themes	Quotes
A whole new world	Letting go of fight	*"You're caught in that persecutory place, which is a horrible place. So yeah…but it feels a bit like defeat because the persecution is very fight whereas the self-compassion is very accept" – Brittany* *"So there is that kind of element…of kinda compassionate self correction as well ehm…in the sense of sometimes seeing that you made a mistake and kinda understanding why you've made that mistake not being punitive towards yourself for it but then thinking what can I do differently, what could I do better next time…and still…without kinda shaming oneself as it were" – Grace* *"It [self-compassion] takes away the aspect of failing, the giving up" – Danielle* *"Mindfulness is like knowing the language and the self-compassion is like being in that country, and you are actually able to use the language" - Danielle*

SECTION C: PUBLISHABLE PAPER

How do individuals who struggle with eating difficulties experience self-compassion after taking part in an eight-week compassionate mind group?

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How do individuals who struggle with eating difficulties experience self-compassion after taking part in a compassionate mind group?

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Abstract

This research explored the experience of self-compassion in women who completed an eight-week compassionate mind group while suffering with eating difficulties through interpretative phenomenological analysis.

Semi-structured interviews were conducted with seven women between the ages of 25 and 51. All participants had participated in the group one to three years prior to taking part in this research.

During the analysis four superordinate themes were developed, each of these themes encompasses three sub-themes. These were further discussed in relation to the literature and attempts were made to explore how compassionate mind therapy could be introduced to existing treatments of eating disorders.

Introduction

According to the National Eating Disorders Organisation, twenty million women and ten million men in the United States has suffered from an eating disorder at some point in their life (Wade, Keski-Rahkonen, & Hudson, 2011). Similar incidence rates are also found in Europe; according to B-eat (2015), more than 725,000 people in Great Britain are affected by an eating disorder. Therefore, conducting research on this topic seems extremely valuable.

Eating disorders symptoms are often not only intransigent and ego-syntonic, but the majority of individuals also suffer from co-morbid issues that complicate treatment and hamper recovery (Hudson, Hiripi, Pope, & Kessler, 2007). Many professionals prefer to use manualised treatments that have been shown to be effective in randomized controlled trials; however, an increasing number of outcome studies reveal that these treatments rarely lead to full recovery (Cloak & Powers, 2010). A review of treatment outcomes, in fact, showed that 20% of individuals with anorexia nervosa remain chronically ill and 63% relapse after completion of treatment (Steinhausen, 2002). Results for bulimia nervosa and binge eating disorder are similar and show that standard treatments are not effective for at least half of the patients (Wilson et al., 2007). One of the criticisms that has been made about current treatments is that they fail to make explicit the link between emotions and cognitions (Corstorphine, 2008). One approach that has recently been put forward to address this gap is Compassion Focused Therapy (CFT; Gilbert, 2010).

Compassion Focused Therapy (CFT) was specifically developed to address the concepts of shame, self-criticism and hostility towards the self by helping clients cultivate positive emotions and compassion (Gilbert, 2000, 2009, 2010; Gilbert & Irons, 2005). These concepts are seen as important problems for individuals with eating disorders (e.g. Allan & Goss, 2011). Different studies have demonstrated that helping individuals develop compassion for themselves and for others can

improve different mental health issues (e.g. Hoffmann, Grossman, & Hinton, 2011). Overall, there is increasing evidence showing that compassion can be taught and this has beneficial effects on a range of symptoms (e.g. Fredrickson, Cohn, Coffey, Pek, & Finkel, 2009; Hutcherson, Seppala, & Gross, 2008).

In the context of CFT, compassion is conceptualised from an evolutionary perspective, which focuses on the evolution of the affiliative system (Leaviss & Uttley, 2014). Gilbert (2010) identified three systems: the threat and protection system, the drive system and the soothing system. The threat and protection system is fundamental in detecting and responding to threat (LeDoux, 1998). When this system becomes activated, our attention becomes biased and focuses only on the threat, and negative emotions such as anger and anxiety arise. It is these emotions that give rise to "fight, flight or freeze" behaviours (Leaviss & Uttley, 2014). The drive system is linked to seeking and acquiring and has a motivational function. When this happens our attention becomes focused on rewards and resources and positive emotions such as excitement and vitality arise. The soothing system evolved with attachment and affiliation (Depue & Morrone-Strupinsky, 2005) and its function is that of managing distress and promoting bonding. This system also gives rise to positive emotions, however these are different from those elicited by the drive system. The soothing system in fact produces emotions such as peacefulness, well-being and contentment.

The aim of CFT is that of re-establishing a balance amongst the three systems in order to help individuals who find it difficult to access the soothing system when responding to threats (Gilbert, 2010). A key part of the therapy is to help individuals understand that many of the cognitive biases they experience are built-in and have been caused by biological and environmental processes (Leaviss & Uttley, 2014). Therefore, the aim of CFT is to help individuals respond to self-criticism with compassion and kindness, with the final goal of increasing well-being. There is growing research on the usefulness and effectiveness of introducing the skills of

compassion in the treatment of eating disorders (e.g. Goss & Allan, 2010; Holtom-Viesel, Allan, & Goss, 2014).

Gale and colleagues (2014) added CFT to CBT and reported significant improvements on an extensive range of eating disorders symptoms during the treatment. Individuals that seemed to benefit the most from the programme where those that had been diagnosed with bulimia nervosa, with three-quarters recovering by the end of treatment. In the same study, the authors reported that amongst individuals diagnosed with anorexia 33% recovered or improved and 26% could be classified in the 'functional' range of the EDE-Q. The authors conclude that for a population where there is limited evidence for the effectiveness of any treatment, these could be thought of as promising results. Amongst the components of compassion, self-compassion (i.e. compassion towards the self) has been found to be especially helpful for decreasing psychological distress and improving well-being (Gilbert, 2007; Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004; Neff, Kirkpatrick, & Rude, 2007).

Self-compassion is a construct that sees suffering and failure as human, and is based on the belief that everyone is worthy of compassion (Neff, 2003a). In one of her early publications, Neff (2003a) eloquently described self-compassion as: "*Self-compassion involves being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness*" (p.87). Self-compassion therefore involves self-kindness rather than self-criticism in the face of pain and failures; in addition, individuals see their worth as unconditional even after failure (Leary et al., 2007). Self-compassion can therefore be thought of as including three main elements: self-kindness, common humanity and mindfulness. Self-kindness refers to treating oneself non-judgementally, common humanity refers to seeing pain as part of the human experience and not a result of one's failures or inadequacies and mindfulness refers to being present in the moment without over-identifying with or

avoiding negative thoughts and feelings (Neff, 2003a). There is a growing amount of research linking self-compassion with different aspects of well-being (e.g. Barnard & Curry, 2011). Furthermore, self-compassion has received strong evidence for being an adaptive emotion regulation and coping strategy (e.g. Sirois, Kitner, & Hirsch, 2015).

The way in which self-compassion fosters well-being is by helping individuals feel cared for, connected and calm during difficult times (Gilbert, 2005). In particular, self-compassion helps individuals change their unhelpful cognitions and behaviours, while protecting against failure through effective coping mechanisms (Neff, 2003a; Neff, Hsieh, & Dejitterat, 2005). Research conducted on self-compassion suggests that higher levels of self-compassion are linked with decreased negative emotions, anxiety and depression, and increased positive emotions and happiness (Arimitsu & Hofmann, 2015; Neff, Kirkpatrick, & Rude, 2007). Furthermore, self-compassion positively correlates with life satisfaction (e.g. Neely et al., 2009; Seligowski, Miron, & Orcutt, 2014), and this finding was replicated across different cultures (Neff, Pisitsungkagarn, & Hsieh, 2008; Yang, 2016). Individuals with higher levels of self-compassion have been found to cope better with failure and have lower levels of rumination (Leary et al., 2007; Neff et al., 2005; Raes, 2010). Although these findings are mainly correlational and do not imply causation, they do suggest that the ability to experience self-compassion is correlated with well-being (Van Dam et al., 2011). A growing number of researchers has started to examine the correlation between eating disorders and self-compassion.

Different researchers found that individuals with higher levels of self-kindness and less fear of self-compassion show lower eating pathology (Braun, Park, & Gorin, 2016; Ferreira et al., 2014). Braun, Park and Gorin (2016) conducted a literature review on self-compassion, body image and eating disorders and reported positive findings that support the use of self-compassion in the treatment of eating

disorders. In fact, they reported that self-compassion appears to negatively correlate with body and eating disorder-related outcomes in both clinical and non-clinical populations. They also add that individuals diagnosed with eating disorders report higher levels of fear of self-compassion and lower levels of self-compassion. All of the studies that looked at self-compassion as a mediator found that low levels of self-compassion linked risk factors to eating pathology (Braun et al., 2016). For example, in a study of 252 Canadian women that exercise, self-compassion was negatively linked with social physique anxiety. In the same study, when self-esteem was controlled for, self-compassion inversely predicted social physique anxiety (Magnus et al., 2010). Therefore, although preliminary, these findings suggest that higher self-compassion might bypass risk factors that are known to nurture eating disorders (Braun et al., 2016). In conclusion, there is growing support for the hypothesis that self-compassion might be an important factor in the treatment of eating disorders; however, research that examines self-compassion has mainly focused on the general population and the methods utilised mainly involved quantitative methodologies, such as questionnaires or surveys.

For these reasons we conducted a qualitative study, which explored how individuals who struggle with eating difficulties experience self-compassion following an eight-week compassionate mind therapy group.

Methodology

The aim of this study was to explore the lived experiences of participants and learn from them without making any claims regarding possible causes for their thoughts, feelings or perceptions. Since for Interpretative Phenomenological Analysis (IPA) there is nothing more important than understanding individual subjective experience (Eatough and Smith, 2008), it seemed appropriate to choose this methodology for the analysis of the interview transcripts.

Methodological Procedures

Seven one-to-one, semi-structured interviews were conducted with individuals struggling with eating difficulties, who completed an eight-week compassionate mind therapy group. Interviews were conducted by the main author, and lasted between 40 and 80 minutes. The same author also transcribed the interviews and analysed them in accordance with IPA methodology as proposed by Smith et al., (2009).

Recruitment & Sampling

Once ethical approval was granted by City University, the recruitment process started. Participants, adults above the age of 18, were recruited in a private clinic for eating disorders in London using flyers that described the objectives of the research. One of the psychologists who had run the eight-week compassionate mind groups identified potential participants, as she was familiar with their histories and difficulties. The same psychologist emailed the flyers to potential participants.

Participants needed to have completed an eight-week compassionate mind therapy group. In addition, participants needed to present with eating difficulties, however a formal diagnosis was not required given the qualitative nature of the study. Individuals who were interested in participating were invited to an interview. All the interviews took place at City University. The seven participants had completed the group between 1 and 3 years prior to participating in this research and they were all part of different groups. All, apart from one (Elizabeth), had been in a group solely for individuals struggling with eating difficulties.

Procedure

The following procedure was replicated for every interview:

Before the start of the interview, participants were asked to complete a Demographic Questionnaire. At the end of every interview, a copy of the Debrief

Form was given to each participant. Lastly, a Resource Pack with a list of contacts they could approach if further support was needed was also handed to participants.

Recording, Transcription & Data Storage

The interviews were digitally recorded, care was taken during the interviews not to mention the participants' names in order to maintain anonymity. Interview transcripts included all spoken words, pauses, false starts and other important aspects (e.g., loud exhaling) as suggested by Smith et al., (2009). Transcripts were encrypted and stored securely. Participants were assigned a pseudonym to protect their identity. The participants pseudonyms were chosen by picking the first name that appeared for the first seven alphabetical letters depending on the interview order (e.g., first woman to be interviewed, letter A – Ava).

Results & Discussion

Through the analysis four super-ordinate themes were identified:

5. A Whole New World – Journey towards discovering and describing self-compassion
6. It's A Long Way To The Top – Journey towards finding self-compassion
7. Journey For Life – Journey towards integrating self-compassion in their lives
8. A Trouble Shared Is A Trouble Halved – The experience of being in a therapy group

Theme 1: A Whole New World

"*Mindfulness is like knowing the language and the self-compassion is like being in that country, and you are actually able to use the language*" (Danielle)

All participants mentioned that self-compassion was a completely new concept for them. In fact many described it as a "whole new world" which caused "fundamental changes" in their ways of thinking, feeling and behaving. These quotes support previous findings, which show individuals suffering with eating difficulties as having lower levels of self-compassion (e.g. Tylka et al., 2015; Taylor et al., 2015).

Many participants mentioned that they had no idea what self-compassion looked like or felt like and this was a major obstacle when trying to practice it.

Prior to starting the group, in fact, many participants were caught in a vicious cycle in which they would constantly criticise themselves about things that they would consider failures (e.g. not being able to lose weight); however, they would then get angry about being critical, thus starting this never ending stream of self-criticism and shame. The fact that individuals suffering with eating difficulties present with high levels of self-criticism and shame is not new. In fact, different researchers reported that high levels of self-criticism are common amongst all eating disorders diagnoses (e.g. Duarte, Ferreira, & Pinto-Gouveia, 2016; Goss, 2007). Furthermore, the literature on this topic suggests that individuals diagnosed with an eating disorder tend to be self-critical with the intent of harming and persecuting themselves rather than with the intent to promote self-improvement (e.g. Barrow, 2007). This was also found in this study, for example Brittany had referred to her self-criticism as being "caught in a persecutory place, which is a horrible place" and other participants had expressed similar views by adding that the self-criticism had caused them to become afraid of failures as well as feeling more ashamed.

Gilbert and Procter (2006) suggested that when individuals experience high levels of shame and self-criticism they perceive the world and themselves as hostile and threatening, which can feel overwhelming; in fact, they also add that during these episodes "*there is no safe place either inside or outside the self to help soothe or calm the self*" (Gilbert & Procter, 2006, p. 354). This was also expressed by participants, who felt that they were in a constant "fighting mode" until they learned about self-compassion, which allowed them to let go of the fight. The women in this study felt that self-compassion allowed them to become more accepting, which in turn decreased their levels of shame and their self-persecutory criticism. The quotes from participants support the idea that self-compassion is based on acceptance of suffering and failures as part of our common humanity (Braun et al.,

2016; Neff, 2003a). In addition, these findings support previous research, which demonstrated that self-compassion helps individuals to reduce self-criticism and to facilitate better regulation of internal experiences such as thoughts and emotions (Brennan et al., 2015; Neff & McGehee, 2010). As a matter of fact, there is strong evidence supporting self-compassion as an adaptive affect regulation and coping strategy (e.g. Braun et al., 2016; Sirois et al., 2015). It was this aspect of self-compassion that might have allowed these seven women to really get to know themselves, their strengths and their flaws. This also helped them to understand that they had a role in what was happening to them and they could change that. In their interviews, participants mentioned that self-compassion allowed them to sit with their feelings as well as being ok with their flaws. Thus supporting previous findings, which suggest that self-compassion acts as an adaptive emotion regulation mechanism and it helps transform negative emotions into positive ones (e.g. Neff & Dahm, 2015; Sirois, 2015).

Theme 2: It's a Long Way To The Top

"I expected relief and I didn't get relief…that's not what I got…and I was quite shocked that actually what I got was more pain and I didn't expect that" (Brittany)

All participants spoke about different hurdles that they had to jump through while trying to develop compassion for themselves. During the analysis stage, I was able to identify three main obstacles that were often spoken about in the interviews: self-compassion was easier said than done, the negative emotions that arose and, lastly, their critical voice and the fear of losing it.

All seven women felt that self-compassion was a concept that could be easily understood, however when it came to practicing it they felt they did not know what to do or what to say. This finding once again highlights the absence or low levels of self-compassion in individuals struggling with eating disorders. However, it also adds that it can be particularly difficult for these individuals to develop self-compassion as they might not have the right tools. This hypothesis was also

proposed by Gilbert and Procter (2006), who reported that "*it is clear that many patients […] have very little to guide them at first*" (p.373). This particular sentence appears to be in line with what participants from this study were talking about in their interviews. One of the reasons why individuals felt that they had little to guide them could be due to the fact they had never experienced compassion from others or for themselves. Some participants, in fact, added that they had not experienced compassion from a carer while they were growing up, hence they had no example to follow and this made it difficult to practice self-compassion as they did not know what it looked like or felt like. This concept was then expanded by Gilbert (2010), who suggested that compassion from others or self-compassion could evoke feelings of grief in individuals, as they would become aware of the absence of affection and care from significant others during their development.

Many participants, in fact, reflected that they had attended the group sessions as a way of finding relief from their issues, however what they ended up with was more pain. However, this was slightly different from the one described by Gilbert (2010). The pain was linked to the realisation of how much suffering they had been in and how unkind they had been to themselves. Participants used quite strong words to describe this feeling, with one participant mentioning that realising how uncompassionate she had been towards herself broke her heart. From the way participants describe this obstacle, it becomes possible to compare it to the 'depression stage' of grief as described by Kübler-Ross and Kessler (2005). The authors, in fact, describe this stage as a time when individuals begin to realise and feel the extent of their loss. In this study, it seems that participants were grieving the loss of self-compassion in their pasts and were becoming aware of the depth of their suffering. Perhaps, these findings add new information to what had been proposed by Gilbert (2010). In addition, for many participants the development of self-compassion was complicated by their critical voice.

The majority of participants said that the main reason for taking part in this therapy group was so it could help them find relief from their distress as well as modify their eating behaviours. However, they felt that one of the biggest obstacles they had to face when trying to develop self-compassion was their critical voice and, more specifically, their fear of losing this voice. Most women, in fact, felt that self-compassion was an essential component for dealing with their distress, however they also felt that most of the time it was not present and in its place there was the critical voice that was full of negativity. This supports previous research showing that the critical voice is often hostile and abusive (e.g. Noordenbos et al., 2014), as well as research which found that when individuals struggling with eating disorders try to modify their behaviours, they are often met with internal hostility brought on by their critical voice (e.g. Pugh, 2016). However, the quotes seem to add new information by suggesting that the critical voice was acting as a safety strategy against threat and would therefore become activated when the 'threat system' was triggered.

Theme 3: Journey For Life

"*It [self-compassion] completely changed my life. It completely changed the word. Changed me. […] It transforms every single aspect of my life one hundred percent"*
(Danielle)

All participants but one mentioned that self-compassion had huge impacts in their lives, including their relationships with other people as well as with food. The only participant (Elizabeth) that did not think self-compassion had helped her improve any aspect of her life also mentioned that she did not think she was ready to embark on this journey and she did not feel she had been able to develop self-compassion. All the other participants, however, felt that self-compassion had completely changed their lives and, although they might have entered the group to recover from an eating disorder, what they learnt had "ripple effects" in their lives.

Compassion and self-compassion are often taught as a range of skills, which involve creating feelings of warmth and kindness in a range of activities (Gilbert,

2009). One of these skills is that of “compassionate reasoning” where clients are taught to become aware of how they think about the world and themselves. In particular, clients are taught to pay attention to how they reason about their mood, their emotions and themselves. Participants often spoke about how they had acquired this skill by describing how critical they used to be of themselves and how this group had helped them develop a new way of thinking about themselves and of responding to their critical voice. Danielle, for example, had said that after the group “*everything comes from a different place. Everything comes from a place of kindness, rather than a place of discipline, a harsh discipline and struggle*”. Neff (2003a, 2003b) proposes that self-kindness can counteract self-criticism. The word self-kindness refers to the propensity to be caring and understanding with oneself by offering warmth and unconditional acceptance.

It was the unconditional acceptance, in particular, that seemed to be the most important aspect for these seven women. Many spoke about self-compassion as helping them accept themselves, their behaviours and their failures. In particular, this seemed to be especially important when recovering from an eating disorder. The majority of participants noticed that self-compassion had a very positive impact on their eating, however they also noticed that the effect had been different from what they had expected. In their interviews they often spoke about how they thought self-compassion and the group would make them “Zen-like” and this would help them prevent binges for example. However, what they found was that self-compassion impacted their eating in different ways, for example by making sure that they would have small snacks during the day so that they would not get the urge to binge or by accepting that sometimes they would go through setbacks. One of the skills taught by Compassion Focused therapists is that of “compassionate behaviour” (Gilbert, 2009). Compassionate behaviour helps individuals to decrease distress and increase growth. Furthermore, Compassion Focused Therapy helps clients to focus on their efforts, rather than on their results; in this case, participants were able to accept setbacks with ease without being critical of themselves and

this also helped them to “stop escalating things” (extract from Grace’s interview). A further skill that also helped participants to accept their setbacks was that of “common humanity” (Neff, 2003a, 2003b). Common humanity is an aspect of self-compassion that recognises that everyone in this world is imperfect and everyone makes mistakes. Faith, for example, reflected that this definitely helped her when dealing with setbacks in her recovery and commented “*it happens, it’s a part of recovery, everyone goes through this”*. Overall, these improvements seem to have helped these participants to develop and re-activate the soothing system, which allowed them feel reassured and calmed (e.g. Gilbert, 2009). This last point in particular appeared to be particularly important in the relationships that participants had with other people.

Many participants spoke about the positive impact that self-compassion and this group had on their relationships with others. Participants felt that self-compassion helped them in their relationships in three different ways: first, self-compassion allowed them to set boundaries in their relationships, second, self-compassion helped them feel equal in their relationships and third, participants felt that to feel compassion for others you had to experience it for yourself first. In the first instance, participants mentioned that self-compassion helped them to set boundaries in their relationships, which at times also meant saying no to the other person. Compassion and self-compassion advocate taking care of the self by trying to alleviate suffering and to heal oneself with kindness. When it comes to relationships then, being able to set boundaries actually means taking care of oneself as not setting them could mean exposing oneself to negative feelings. In her book The Gifts of Imperfection, Brown (2010) explains that in her research she had realised that compassionate people were actually boundaried people. In my research I also found that setting boundaries, apart from being linked to acceptance, also meant taking care of the self. By taking care of themselves, participants were also able to soothe themselves and this allowed them to create healthier, more equal relationships.

Many participants reflected on how self-compassion had helped them develop healthier relationships. One of the main reason they gave for this was that they felt they were now entering their relationships as equals. Chloe, for example, added that she felt this was the case as she did not need external validation anymore. This supports prior research, which found that individuals with high levels of self-compassion are able to meet their own needs in terms of kindness and self-comfort (Neff & Beretvas, 2012). Because individuals are able to meet their own needs, they are more likely to be able to find stability between independence and connectedness, which has been shown to be an important factor in healthy relationships (Deci & Ryan, 2000).

Theme 4: A Trouble Shared Is a Trouble Halved

"*But I think the group really helped, I think, working with other people really helped. And actually seeing that I was…kind of, not the only one. […] I wasn't alone in this*"
(Faith)

All participants remained in the group for the whole duration (i.e. eight weeks), with one participant deciding to participate in the group two times as she felt she had benefitted so much from the first time that she wanted to do it again. Furthermore, every woman I interviewed reported that they would recommend the group to a friend struggling with eating disorders and some had already done so. However, participants felt that being in personal therapy alongside being in the group was probably the best combination as they could further discuss things that had arisen in the group during their individual session.

Many participants reported that it took a while for members to develop trust in the group and they reflected that this could be due to the fact they felt ashamed and vulnerable. Riess and Rutan (1992) argued that individuals struggling with eating disorders often keep the latter secret, which elicits feelings of shame, guilt and self-hatred. The same authors also argued that group therapy could provide a safe space where participants can talk about their difficulties. This was also experienced

by participants in this group. One variable that seemed to be particularly important in the development of trust was knowing that they were not alone.

The majority of participants reported that their battles had been particularly lonely prior to the group and, at times they had felt like “freaks”. However, once they started the group, they described feeling less alone and more normal. Franko & George (2006) reported that group therapy can be beneficial for women struggling with eating disorders as they often keep their difficulties secret and, because of this, can experience difficulties in their relationships which can result in isolation. In addition, group therapy can help individuals experience having their feelings put into words by another member or by the group leader (e.g. Barth & Wurman, 1986). In addition, other group members can act as a mirror reflecting what one had been feeling or experiencing. Brennan and colleagues (2015) found that this was actually the most important thing for their participants as it helped them to gain insight into their own feelings and behaviours. This was also replicated in this study.

Different participants felt that in order to develop self-compassion, they needed someone to teach them about it and show them how it was done. Brittany, for example, felt that group leaders needed “to be the living embodiment of compassion” because this could help her think about what they would say when she was practicing self-compassion on her own. This seems particularly important as participants felt that they did not know what self-compassion was and did not know where to start when it came to practicing it. By having the group leader act as a mirror clients can learn the skills of compassion and direct them at themselves. This reflects the definition that Barth (1994) had given of group therapy in which she described the latter as a “group swimming lesson” in which everyone works together to develop the necessary skills.

Strengths and Limitations & Suggestions for future research

The main strength of this study is its qualitative nature as it has resulted in the production of new knowledge on the topic of self-compassion amongst individuals struggling with eating difficulties. However, assessing quality in a qualitative research is not easy as there are no set rules that have been established. Nevertheless, Yardley (2000) proposed four characteristics that good qualitative studies should have, which have been kept in mind throughout this research.

Sensitivity to context was initially ensured through the review of current and past literature on the phenomenon being studied, which allowed me to be familiar with the current theories around this topic. Furthermore, my placement in an inpatient unit for adolescents diagnosed with eating disorders provided me with an introduction to the clinical context of this study.

Commitment and rigour have been ensured throughout this research. Firstly, I engaged with the topic in depth by reviewing the literature, and then I continued to engage with it during data collection and analysis. Furthermore, I tried to to ensure that commitment and rigour were maintained during the analysis stage by making sure that themes were as rooted as possible to the text. Lastly, my commitment to professional and ethical standards was present throughout the study and, in particular, throughout data collection in which I kept participants' well being at forefront of my mind.

Transparency and coherence are evident in different aspects of this research. The method chosen to conduct this research and analyse the data appeared to be the best fit with the current theory and research question. Transparency was ensured throughout the study by making sure I described all the processes involved in this research, including the analysis, and by being reflexive throughout.

The impact and importance of this study was a key aspect for me going into this research. Participants were incredibly generous and have given me their time as well as in-depth interviews, which provided rich data and information. I believe that eating disorders are an important issues that needs to be addressed, and more research needs to be done to improve the outcomes of current treatments.

Although implying a qualitative design and ensuring that the quality of the study was good are important strengths, this study also presented with some limitations. The sample size of this study is in line with the recommendations (Smith, Flowers and Larkin, 2009) and it was believed that the seven interviews had yielded enough information. However, some people could argue that this is a limitation as there is no set number for qualitative studies. Nevertheless, having a small sample size allowed me to complete in-depth analyses of each interview, which ensured quality. Initially other individuals had been invited to take part in this study, but they had chosen not to participate. It might be that these individuals had different experiences and interviewing them could have yielded different results. Similarly, the study was initially open to both genders, however only females responded to the flyer. The majority of research in this area, particularly with regards to eating disorders, has been conducted with women although new studies are trying to include this population as well. It might be interesting to conduct a similar research to this one with male participants as this could yield different information. Furthermore, future studies could compare similarities and differences between men and women in order to ensure that interventions and theories reflect both points of view.

Smith and colleagues (2009) suggest that a homogenous sample should be used in qualitative research, particularly if using IPA to analyse the interviews. The sample for this study was homogenous in respect to shared experience of group therapy and eating difficulties, however participants were heterogeneous in different ways. Firstly, participants presented with different eating disorders self-

diagnoses. This study was interested in understanding the experience of self-compassion in individuals struggling with any eating difficulty, therefore the different diagnoses were not considered an issue. Furthermore, all participants interviewed had completed the therapy group in the same clinic and, although at different times, the group was always conducted by the same leaders. It could be possible that different groups offer different experiences and future research could explore this in more details. Lastly, this study included participants of different ages and it could be interesting to expand this research and compare participants' experiences according to their age to see if there are any differences.

A further limitation to this study is the lack of generalizability due to its qualitative nature. An important step for future research would be to include bigger sample sizes as well as incorporate both quantitative and qualitative methodologies.

Conclusion

Eating disorders are particularly common and are associated with a number of health problems as well as poorer social functioning. The treatments that are currently being employed to treat eating disorders seem to be helpful only for some individuals, with the remaining dropping out of therapy, relapsing or not reaching full recovery (Surgenor, Macguire, and Beaumont, 2004). A significant body of research found that individuals with eating disorders present emotional processing deficits; therefore treatments that focus on affect regulation could be efficient in helping this population. Compassion therapy derived from an evolutionary and neuroscientific model of affect regulation. During recovery, patients are helped to develop compassionate ways to manage their eating disorder and their self-criticism. Research that examines self-compassion has mainly focused on the general population and the methods utilised mainly involved quantitative methodologies. For these reasons, this study aimed to address this gap in the literature by exploring participants' experiences with regards to developing self-compassion after taking part in compassionate mind therapy group.

The study confirmed previous research, which showed that individuals struggling with eating difficulties present with little or no self-compassion. Many studies suggested that a main obstacle in the development of self-compassion is fear of compassion and of positive emotions, however this study found that the main obstacle was constituted by the negative emotions that arose. This process was likened to that of grieving as participants described having to come to terms with the absence of self-compassion in their lives. Once participants were able to move past the obstacles, they found that self-compassion had different positive impacts including on their relationship with food and with other people. At the end of the group, all women mentioned that they would definitely recommend the group to other people; however, they would also suggest having individual therapy in conjunction with the group. These findings highlight the need to explore self-compassion as a treatment for eating disorders further.

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