Exploring the use of self-compassion in the transition to motherhood: A thematic analysis

Bahar Felton

1528632

A thesis submitted in partial fulfilment of the requirements of the School of Psychology University of East London for the degree of Professional Doctorate in Counselling Psychology

February, 2021

Abstract

Objectives: Self-compassion has been shown to improve emotional wellbeing and act as a buffer against psychological issues. First-time mothers, who are at high risk of developing distress and psychological issues in the transition to motherhood, particularly in the first year after childbirth, could benefit greatly from this skill. Research into self-compassion among new mothers is currently very limited, however, the existing studies have shown the benefits of this skill and recommended self-compassion to be used in intervention and prevention strategies for perinatal mental health issues. This research aimed to explore how self-compassion is practised by first-time mothers in the transition to motherhood in order to learn from this group and implement practical strategies for new mothers who may struggle with self-compassion.

Design: Data from eleven first-time mothers, who identified as practising self-compassion, was collected through individual semi-structured interviews. The participants' ages were between 32 and 40 years and reported no symptoms of current psychological issues. The age of the participants' babies ranged from 6-24 months.

Methods: Thematic Analysis was used to analyse the transcribed interview data and critical realist epistemology was used.

Findings: Three themes that emerged from the data were: 'the building blocks of self-compassion', 'sudden changes and initial difficulties of maternity could block self-compassion' and 'becoming self-compassionate while embracing motherhood'. The subthemes are discussed under each theme, explaining the use of self-compassion by the participants.

Conclusions: The findings clearly indicate that first-time mothers are likely to struggle with self-compassion in early motherhood due to several practical and emotional barriers. However, changing their perspective about motherhood, the babies' growth and other people's support appeared to allow the participants to become more self-compassionate. This study has a strong potential to be a guide to enhance interventions in Counselling Psychology, as well as improve services working with new and expectant mothers, as recommended in the implications.

Contents

List of Appendices **Page**

List of Tables

Definitions

First-time mother: A woman who has given birth to her first child

New mother: A mother in the postpartum period

Perinatal: The period covering the pregnancy and the postpartum period

Postpartum: The period covering one year after giving birth

Abbreviations

BPS	The British Psychological Society
CBT	Cognitive Behavioural Therapy
CFT	Compassion-Focused Therapy
CMT	Compassionate Mind Training
GT	Grounded Theory
HCPC	The Health and Care Professions Council
IPA	Interpretative Phenomenological Analysis
NICE	The National Institute for Health and Care Excellence
NHS	The National Health Service (UK)
TA	Thematic Analysis
WHO	The World Health Organization

Acknowledgements

I would like to share my appreciation for several people, without their support, it would not have been possible to complete this research.

Firstly, I would like to say thank you to all of my research participants. I hugely appreciate you volunteering time from your busy schedule. Thank you for sharing your stories with me with great openness and allowing me to write about it.

I would like to thank my supervisor, Dr Cristina Harnagea, for her ongoing support, encouragement and valuable guidance throughout this project. She made the journey smoother and gave me the confidence to complete it.

I would also like to thank Dr Stelios Gkouskos and Dr Lisa Chiara Fellin for their feedback at the start of this project and helping me to shape my initial ideas.

Thank you to my dear parents and family to give me encouragement and always showing their interest in my research and training, as well as reminding me why I am doing it. I am also grateful to have a great group of fellow trainees for exchanging ideas and making sure I never felt lonely on this bumpy journey.

Finally, I would like to thank my husband, Dave, for providing me endless support, empathy and compassion on my journey and always believing in me. You have not only been amazing throughout my whole training, but also helped me to remember my teenage dream to become a psychologist, and gave me the courage to start the training to make that dream possible.

1. Chapter: Introduction and Literature Review

1.1. Overview

This chapter is comprised of three parts. The first part introduces the subject. The second part critically reviews the literature, initially focusing on experiences and challenges of first-time mothers and then moving on to self-compassion. Finally, the chapter concludes with a discussion of the gaps in the existing literature and the rationale for this research.

When considering the mother's physical recovery after childbirth, the postpartum (postnatal) period usually refers to the first 8-9 months (Romano et al., 2010). In a psychological context, it is regarded as a continuous period, with the first year after childbirth in particular being considered a crucial period for the psychological wellbeing of the mother and baby (Javadivar et al., 2016). Additionally, NICE guidelines (2014) define the postpartum period as the first year after childbirth. Therefore, in this study postpartum period is defined as the first year after childbirth, referring to the psychological and physical transition to motherhood.

1.2. Introduction

Becoming a parent is usually associated with happiness, excitement and other positive emotions. However, the transition can be extremely stressful for parents and may affect their psychological wellbeing (Wilkins, 2006). Studies show that although both parents experience challenges in this transition, mothers are more likely to experience distress, particularly after childbirth, due to significant physical, emotional and psychosocial changes (Edhborg, 2008; Wu & Hung, 2016). Some women may develop mental health issues ranging from low mood to psychosis in the pre- and postnatal period and the prevalence could be as high as 20% of mothers (Monteiro et al., 2019). Although the causes are still debated, distress experienced in this period is considered one of the main triggers of developing perinatal mental health issues (Navaratne et al., 2016). Studies show that one in five mothers who have developed perinatal mental health issues die by suicide which is the main cause of death in the postpartum period in the UK

(Knight et al., 2019; Wisner et al., 2013). There is evidence that the majority of completed suicides happen between 9-12 months after childbirth which highlights the importance of identifying any risks at an early stage of motherhood (Grigoriadis et al., 2017). First-time mothers in the postpartum period are more at risk of developing these issues, particularly if there is previous family or personal history (Munk-Olsen et al., 2006; Orsolini et al., 2016). Research comparing first-time mothers and fathers in the postpartum period also revealed that mothers scored higher in parental distress, postnatal anxiety and depression, suggesting first-time mothers have the highest vulnerability in the face of parental challenges (Vismara et al., 2016).

Addressing these issues at an early stage would not only benefit mothers but also their babies. When mothers suffer from psychological problems, research indicates that their babies are at higher risk of developing significant physical, cognitive and psychological problems in their first year due to impaired brain development and disrupted baby-mother bonding (Dawson et al., 1999). In the UK, the total cost of perinatal mental health issues to society for yearly total births is £8.1 billion, of which £1.2 billion is to the NHS. Therefore, 'even relatively modest improvements in outcomes' that result from service improvements would justify improving perinatal services and introducing early interventions (PSSRU, 2014, p.37). To combat the issue, the UK has introduced a strategic plan to increase investment in perinatal mental health. The NHS long term plan has committed to 'support at least 66,000 women' which aims to double the current number of supported women by 2023/24 and the services are committed to improve evidence-based treatments for mothers up to 24 months after giving birth (NHS, 2019, p.5). The interventions offered for perinatal mental health issues include self-help materials, psychoeducational support, peer groups and talking therapies such as Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), as well as other treatments including hypnosis and acupuncture (Easter et al., 2015; NICE, 2014). Medication could be prescribed by psychiatrists; however, it should be carefully evaluated if the mother is breastfeeding since medication might have side-effects on the child (Goodman, 2009). This is excellent progress, but the services are mainly aimed at women with moderate to severe mental health difficulties (NHS, 2019). This suggests that the opportunity to reach mothers struggling with parental distress and who remain at subclinical levels could be being missed.

Even if mothers show signs of psychological difficulties and are eligible to access services, the studies show that only a small number of them reach for support (Chew-Graham et al., 2009). Some barriers for not seeking help are fear of judgment and feelings of guilt for not meeting expectations from society or self. Fear of accessing psychological support might also be triggered by the belief and stigma that a mother could be deemed an unfit parent leading to their child being taken away from them (Dennis & Chung-Lee, 2006). If individuals do not consider symptoms of psychological distress 'bad enough', they may be even less likely to seek help (Glover, 2014; Henshaw et al., 2016, p.14). Studies suggest that more than 50% of perinatal mental health issues, particularly depression and anxiety, could remain undetected which may then escalate in the future to further problems for mothers and their children (PSSRU, 2014). It is likely that first-time mothers have idealised standards due to lack of awareness of the reality of motherhood. Therefore, they may try to cope with the difficulties by themselves, putting them at high risk of struggling in silence (Lazarus & Rossouw, 2015). Due to the internal barriers and the lack of services targeting these women, supportive intervention and prevention strategies, as recommended for prioritisation by NICE (2014) and WHO (2008) have become necessary. The interventions could include developing skills to cope with distress during the transition to motherhood, particularly in the first year after childbirth (Matthey, 2009). A key skill that could be highly beneficial for this group is self-compassion, which has been shown to support mental health for both clinical and non-clinical groups, particularly during stressful periods (Neff, 2003a,b; Vettese et al., 2011).

What is self-compassion?

Emerging from Buddhist fundamentals encouraging compassion towards self and others, self-compassion has recently been the focus of studies because of its psychological benefits (Neff, 2003a,b). Although there is not a single definition in the literature, the common elements of practising self-compassion are defined as noticing one's own suffering, connecting with it and responding with a motivation to heal from it (Gilbert, 2009a; Strauss et al., 2016). Self-compassion may also allow one to be non-judgemental towards one's own limitations and view them as part of being human. Furthermore, through self-compassion one may recognise one's own inadequacies with acceptance and open-mindedness instead of

perceiving them as a failure (Neff, 2003a,b). In her studies, Neff identified three components of self-compassion that have been widely accepted and used in the literature:

1. *Self-kindness* rather than self-criticism
2. *Mindfulness* through acknowledging unpleasant feelings rather than avoidance or over-identification
3. *Common humanity* through accepting that pain is experienced by everyone rather than experiencing an isolated feeling

There is extensive research on the relationship between self-compassion and improved psychological wellbeing, mainly using cross-sectional designs. However, it is unclear how self-compassion is practised by individuals, particularly by first-time mothers, who may already benefit from it in the transition to motherhood. Exploring the use of self-compassion by this group could help improve the interventions based on these practices applied by clinicians including counselling psychologists. This understanding could also form the foundation for further prevention and intervention programs for first-time mothers who may not have access to psychological services. These implementations could reduce mental health issues for this group and potentially save some of the NHS spending and even save lives that are currently being lost to suicide.

1.3. Literature Review

1.3.1. Maternal challenges of first-time mothers

Before exploring how self-compassion could be beneficial for first-time mothers, it would be helpful to first understand the most common challenges and causes of distress experienced in the transition to motherhood. Studies including several systematic reviews showed that the experiences and maternal challenges of first-time mothers were studied quantitatively, mostly with cross-sectional and longitudinal designs based on self-report questionnaires, as well as qualitatively (i.e. Brunton et al., 2011; Choi et al., 2005; Copeland & Harbaugh, 2019; Emmanuel & St John, 2010; Finlayson et al., 2020; Leahy-Warren et al., 2012). Researches also demonstrated that participants were from a wide range of

demographics and cultures, signposting similar outcomes as discussed below (i.e. Amangbey et al., 2017; Currie, 2009).

The maternal challenges were associated with feelings of isolation, loss, inadequacy, self-criticism and shame which could trigger distress and, in some cases, perinatal mental health issues (Law et al., 2018). Studies also found that all mothers experience challenges causing some level of distress, particularly in the postpartum period, which could fluctuate and are normal emotions of motherhood (Coates et al., 2014). Additionally, no differences were found between the needs of women in the postpartum period. Only the intensity varied, for those experiencing psychological issues versus those who did not (Slomian et al., 2017). This could suggest that all women experience similar challenges leading to distress in the transition to motherhood, regardless of whether they develop any psychological issues.

Studies identified that distress for first-time mothers could be caused by physiological and psychological changes such as lack of sleep, exhaustion, learning to breastfeed and parent a baby, as well as changes in societal role and relationships (Finlayson et al., 2020; Harwood et al., 2007; Law et al., 2018). Due to these sudden changes and the requirement to quickly adapt to new circumstances, the arrival of a first child into a family was associated with the transition period to motherhood where one may experience a crisis (Borovska, 2018; Darvill et al., 2010). This might be the reason why first-time mothers could be more significantly affected by the maternal challenges than experienced mothers (Hjalmhult & Lomborg, 2012).

A commonly reported distress in the transition to motherhood is the change of identity. Having a baby may lead to identity transformation for women due to significant life changes (Hennekam et al., 2019). The literature also discussed that motherhood brings an opportunity for the development of a female identity and maturation (Rogan et al., 1997; Rubin, 1984). However, it is reported that an identity confusion may occur for some women who identify motherhood with becoming an adult, after having faced the reality of motherhood. This is particularly a danger in Western societies which may exclude children and their caregivers from adult life (Price, 1988 as cited in Littlewood & McHugh, 1997). The identity confusion may trigger feelings of isolation and exclusion for new mothers. The feelings of loss could be intensified for women who had already

established an enjoyable and independent lifestyle through their career, friendship groups and hobbies (Brunton et al., 2011). Furthermore, separating from the old independent self and leaving the old lifestyle behind could affect career progression, and even friendships, leading to a further sense of loss of freedom and identity (Redshaw & Martin, 2011; Wilkins, 2006). Other feelings experienced due to these role changes were defined as resentment, anger and ambivalence, which may also disrupt the relationships with the partner and family, as well as the bonding with the baby (Cree, 2010; Nystrom & Ohrling, 2004).

Another commonly experienced distress is due to the constant attention required by and dependency of a new baby which may lead mothers to neglect their own needs (Hjalmhult & Lomborg, 2012). A meta-analysis of 33 studies exploring postpartum parental experiences showed that although women felt satisfied with motherhood, they were overwhelmed with the responsibilities and lack of time for self (Nystrom & Ohrling, 2004). It is suggested that having no time for self may cause increased distress and lead to a deterioration of psychological wellbeing. Supporting this, postnatal depression for first-time mothers was linked with perceiving motherhood as self-sacrificing and requiring the ignoring of one's own needs which may highlight the importance of self-care but also how it is perceived by mothers (Henshaw et al., 2014).

Lack of social support, particularly from a partner or family, was also shown to trigger distress for first-time mothers. One reason could be that having insufficient support may increase exhaustion and prevent self-care (Nystrom & Ohrling, 2004). Additionally, interpersonal conflicts and marital dissatisfaction were also shown as common causes of distress in the transition to motherhood (Hall et al., 1996). Studies also revealed that new mothers felt that their partners could not understand their difficulties which were considered as exclusive to mothers and this may lead to further relational issues, causing distress (Nystrom & Ohrling, 2004). Conversely, social support from partners and family is proven to be a key factor in helping women in the transition to motherhood and improving their psychological wellbeing (Copeland & Harbaugh, 2019). Additionally, having support from medical professionals also appeared to be considered a key factor for first-time mothers to feel more confident and better adjust to motherhood, which may help when experiencing distress (Leahy-Warren et al., 2012; Wilkins, 2006).

With or without support, transitioning to motherhood could be isolating which may trigger feelings of loneliness and depression (Lee et al., 2019; McLeish & Redshaw, 2017). There is a lack of published peer-reviewed studies in this area. However, surveys and polls conducted by institutions argued that women feel most lonely in their baby's first year. The numbers affected ranged from 28-82% of the samples, suggesting isolation could be a common issue in the postpartum period (AXA Healthcare, 2015; British Red Cross & Co-operative, 2018). Furthermore, if not sharing the maternal experiences with others, first-time mothers may feel isolated in their difficulties which may disrupt the adaptation process and cause distress triggered by self-criticism and self-doubt. This was particularly emphasised as a problem in Western individualistic cultures where childcare is not shared with others (Cree, 2010).

Another commonly experienced stressor appeared to be due to having high standards, particularly for younger, single or working mothers who may not have sufficient resources in the transition to motherhood (Emmanuel & St John, 2010). The idealised expectations of first-time mothers, which might be influenced by societal and cultural factors, could lead to a desire of 'doing it right', suggesting a tendency for perfectionism (McLeish & Redshaw, 2017, p.5). Research exploring different cultural backgrounds including African, Western and Eastern also revealed that first-time mothers felt a pressure from society to raise their babies in a certain way. Breastfeeding was the most commonly used example of being a 'good mother' (Amangbey et al., 2017; Gianni et al., 2019, p.6). Being unfamiliar with maternal concepts and unprepared for difficulties such as pain and discomfort may lead to the idealised expectations not being fulfilled, triggering feelings of failure, inadequacy and shame (Choi et al., 2005; McLeish & Redshaw, 2017). These feelings are identified as the key vulnerability factor for maternal distress and postnatal mental health issues (Vliegen & Luyten, 2009). Indeed, societal-oriented perfectionism was linked to difficulties in adjusting to parenting and the possibility of developing perinatal mental health issues (Lee et al., 2012).

According to the psychoanalytic approach, which lays the foundations for understanding early parenthood and infant development, Winnicott's (1953) 'good enough mothering' could support women with these idealist standards in the transition to motherhood. This concept describes the 'good enough mother'

who adapts to her baby's needs and fully devotes herself, but slowly and gradually withdraws her full attention regarding her baby's development. Although she is still responsive, she does not hurry to meet her baby's needs in order to allow them to learn to tolerate slight frustration. Therefore, she is good enough rather than perfect which allows her baby to learn to self-sooth and gain autonomy (Winnicott, 1960). Despite this widely accepted concept aiming to recognise the shortcomings of perfect mothering, some contemporary psychoanalytic theorists criticised it since the process of becoming 'good enough' itself is too perfect (Kenny, 2014, p.57). This may suggest that the idea of good enough mothering still conditions women for an idealised standard of reaching imperfection which may maintain feelings of inefficacy and self-criticism. An alternative approach was suggested where first-time mothers could gradually acknowledge the impossibility of perfect mothering through gaining experience (Kenny, 2014). This understanding could take the pressure off mothers as the process would happen naturally.

Although challenges and distress in the transition to motherhood have been researched widely as explained above, only limited studies explored how first-time mothers manage them. Several studies demonstrated that receiving support from partners and family, as well as learning from more experienced mothers were common strategies and are highly beneficial for new mothers to cope with maternal challenges (Bondas-Salonen, 2008; Currie, 2009). Perceived support is also considered essential for adjustment to motherhood, as well as cognitive reappraisals i.e. reinterpreting situations differently; suggesting the importance of perception (Tessier et al, 1992). Additionally, 'efficient use of time', 'taking time out', 'seeking knowledge', 'positive self-talk', 'mindfulness', 'setting achievable goals' were identified as coping strategies (Amangbey et al., 2017, p. 98; Currie, 2009). Studies also found a positive correlation between self-esteem and coping with maternal stresses (Hall et al., 1996; Terry et al., 1996), suggesting high self-esteem could help first-time mothers to manage maternal challenges.

Since these maternal challenges are interrelated, the overall impact on mothers should be considered carefully. Women who can more easily adapt to the changes of motherhood appeared to experience less distress and were less likely to develop postnatal mental health issues. Their resources and perceptions appeared to play an essential role in this adaptation (Copeland & Harbaugh,

2019; Henshaw et al., 2014). Therefore, in this crucial period, obtaining effective skills to manage distress could be beneficial in the transition to motherhood, particularly for first-time mothers (Matthey, 2009). This may help prevent further psychological issues for this group, as well as prevent disrupted bonding with the baby which may lead them to develop physical, cognitive and psychological development problems (Cree, 2010; Dawson et al., 1999).

1.3.2. Self-compassion and psychological wellbeing

Self-compassion has been extensively researched because of the associated benefits to psychological wellbeing (Neff, 2003a; b). There is evidence of the negative correlation between self-compassion and psychological distress in adult and adolescent populations (Marsh et al., 2018; Stutts et al., 2018; Vettese et al., 2011). Furthermore, two meta-analyses presented that self-compassion is significantly linked with improved emotional and overall wellbeing and the effect was stronger for female samples (MacBeth & Gumley, 2012; Zessin et al., 2015). Macbeth & Gumley's meta-analysis (2012) also concluded that self-compassion is linked with fewer psychological issues including depression, anxiety and psychosis and can be an effective coping skill against distress and traumatic events.

Therapeutic interventions based on improving self-compassion, i.e. Compassion-Focused Therapy (CFT), are offered to clients primarily suffering from depression, anxiety, and feelings of shame and guilt (Gilbert, 2010). The CFT model is based on three systems for emotion regulation (threat, drive-excitement and soothing) which are all closely connected (Gilbert, 2009b). Clinical outcomes showed a significant increase in self-compassion after completing the therapy, as well as a significant reduction in psychological distress ranging from depression to psychosis (McManus et al., 2018). Although CFT is not considered sufficiently evidence-based and needs further research to establish its efficiency, the outcomes are promising (Kirby et al., 2017).

To measure self-compassion in clinical and non-clinical populations, Neff's self-compassion scale (SCS) is extensively used in the literature (Neff, 2003b). SCS meets the criteria for reliability and validity, and is a 26-item questionnaire through which it measures 3 positive components of self-compassion: *self-kindness,*

mindfulness and *common humanity*, as well as 3 negative components: *self-judgement, over-identification* and *isolation* (which are reverse-coded) (Costa et al., 2015; Neff, 2016). The answers are rated in a 5-point Likert scale ranging from 'almost never' to 'almost always' (Neff, 2003b, pp.228-231). Different versions of SCS were developed in several countries, although their use is limited (i.e. Deniz et al., 2008; Dundas et al., 2016). The shorter version of SCS (SCS-SF) is a 12-item questionnaire and has 'near-perfect correlation' with SCS (r=0.98). However, it is only reliable for measuring overall self-compassion and was not found reliable for measuring the individual components of self-compassion (Raes et al., 2011, p.254).

1.3.3. Self-compassion and maternal challenges

This section explains how self-compassion could support first-time mothers when experiencing maternal challenges and distress, therefore preventing development of further issues. The existing literature suggests that practising self-compassion could be hugely beneficial in helping first-time mothers to adapt to changing conditions. Self-acceptance plays a vital role in the adjustment to change for first-time mothers and is correlated with fewer psychological issues in the postpartum period (Dimitrovsky et al., 1998). Self-compassion and self-acceptance are interrelated and could help to smooth transition periods (Neff, 2003a,b). A recent study suggested that self-compassionate individuals are more likely to accept their own and others' flaws (Zhang et al., 2020). Despite the focus on body-image, other studies also showed a positive association between self-compassion and self-acceptance for both clinical and non-clinical groups. An experimental study demonstrated that self-compassionate dieters experienced less distress when breaking their diet and ate less compared to less self-compassionate dieters (Leary et al., 2007). It could be due to reduced feeling of guilt and self-criticism over their actions and body-image as supported in female samples with eating-disorders (Kelly & Tasca, 2016). These findings may not be generalised to first-time mothers, however, there is an indication that self-compassion could allow them to accept their flaws such as changing body-image after giving birth, which may cause distress for some mothers (Copeland & Harbaugh, 2019).

Self-compassion could also support first-time mothers when facing feelings of loss of self-efficacy in the transition to motherhood which could trigger self-criticism and self-doubt, therefore, disrupting the adjustment (Mihelic et al., 2018). Combined experimental studies observed that self-compassionate individuals seemed to be more resilient towards loss and failure due to not ruminating over adversities, which could cause psychological distress (Leary et al., 2007). Although limited by its cross-sectional design, another study proposed similar findings showing that self-compassion is significantly correlated with acceptance of the situation if a goal is not accomplished (Neely et al., 2009). Furthermore, Neff et al.'s (2005) research suggested that self-compassionate individuals were less likely to fear failure and more open to a learning experience. These studies only focused on perceived results achieved in mid-terms by college students and did not assess their achievement motivation regarding the students' academic success, which could change their perception of failure (Atkinson & Feather, 1966). However, the results indicate that self-compassion could be beneficial for first-time mothers who are expected to experience unfamiliar situations such as breastfeeding which may take time to learn. Self-compassion could allow them to be more accepting of setbacks rather than personalising the outcome. Additionally, self-compassionate individuals tend to reach for medical support when needed, more than their counterparts (Terry & Leary, 2011). This suggests that through practising self-compassion, first-time mothers may not only accept the painful situation, but also look for the means to heal from the pain such as accessing treatment when experiencing postpartum distress.

Another significant challenge for first-time mothers appeared to be isolation and lack of support which could trigger loneliness and distress (Lee et al., 2019). Studies showed that self-compassion brings closeness to others due to its element of understanding that pain is experienced by everyone rather than feeling isolated (Neely et al., 2009). This could explain why self-compassionate individuals have higher perceived support and tend to have more connectedness to others including their partners (Neff & Beretvas, 2013). Furthermore, self-compassion may improve relationship functioning, forgiveness and reduce intrapersonal conflicts (Neff & Beretvas, 2013; Neff & Pommier, 2012; Yarnell & Neff, 2013). These studies did not assess the causality and it may be that the participants are in a satisfactory relationship which could cultivate self-compassion. However, the findings suggest that self-compassion may allow first-

time mothers to feel more supported and connected to others, including their partners, which could be beneficial when dealing with challenges in the transition to motherhood.

Extensive research also found evidence that self-compassion has a significant negative association with self-criticism which was identified as a key predictor for psychological distress (Falconer et al., 2015; Neff & McGehee, 2010). This could support the argument that practising self-compassion could be a buffer against feelings of self-criticism and inadequacy commonly experienced by first-time mothers. It was also suggested that self-compassion is linked to improved self-esteem and more resilience towards adversities (Neff & McGehee, 2010).

Although the literature on self-compassion is rich, the studies were primarily conducted with students or clinical samples. It is uncertain whether similar results could be replicated with a different sample, first-time mothers, who may use self-compassion differently. An empirical point of view domineered the literature, mainly relying on self-reported questionnaires and correlational studies, which makes it difficult to understand how self-compassion is used to support psychological wellbeing. Despite having limitations, the existing studies indicate that self-compassion could be key for first-time mothers who may struggle with feelings of self-criticism, loneliness and self-doubt in the transition to motherhood (Fonseca & Canavarro, 2017). It could also prevent perinatal mental health difficulties which are strongly associated with these feelings (Cree, 2015).

Additionally, self-compassion could be more effective than other skills including self-esteem, positive reappraisals and mindfulness that appeared to support first-time mothers when experiencing maternal challenges as discussed previously. Several studies compared self-esteem and self-compassion, finding that self-compassion is more effective in reducing psychological distress (Wasylkiw et al., 2012). One main reason could be that self-compassion does not fluctuate depending on the outcome of a situation as self-esteem does, it also offers a more balanced outlook when feeling inadequate which could be triggered by maternal challenges (Neff & Germer, 2013).

When comparing with acceptance and reappraisals, self-compassion also appeared to be a better mood regulation strategy and more effective in improving low mood in highly depressed individuals (Diedrich et al, 2014). In non-depressed

individuals, the effect was significant when compared to re-appraisals (Ehret et al., 2018). Other studies comparing mindfulness and self-compassion showed similar promising results. A cross-sectional study evaluated mindfulness and self-compassion as predictors of emotional wellbeing in individuals with comorbid depression and anxiety (VanDam et al., 2010). The results suggested that self-compassion is a better predictor than trait mindfulness. Since most of the participants (90.5%) had received psychotherapeutic interventions in the past and may experience self-compassion and mindfulness differently, a replication of this study with a non-clinical population could be beneficial to understand the link further. However, another research also supported this argument and proposed that the effectiveness of mindfulness-based practises in improving psychological wellbeing is due to the increase in self-compassion that mediates the link (Baer, 2010). These findings support the idea that self-compassion could be an effective emotional regulation strategy in the transition to motherhood, particularly when facing distress.

Self-compassion also has the benefit that it can be learnt and improved, as shown in clinical and non-clinical populations. Randomised control trials showed that training programmes aimed at improving self-compassion over 8 weekly sessions significantly increased levels of self-compassion and mindfulness, as well as significantly reducing symptoms of depression and anxiety. The results were still maintained after 1 year (Gilbert, 2010; Neff & Germer, 2013). An experiential study observed even short-term interventions could be effective and long-lasting (Shapira & Mongrain, 2010). However, the study had a high dropout rate (~79.7%). Therefore, the results should be viewed carefully since participants remaining in the follow-up period could be positively biased towards self-compassion due to already observing improvements to their mental health.

Self-compassion-based interventions focus on psychoeducation, formal and informal practises including mindfulness meditations, compassionate self-talk and letter writing. Participants are recommended to practise regularly, up to 40 minutes a day between sessions, since practise significantly improves outcomes (Neff & Germer, 2013). The interventions are effective in treating perinatal mental health issues (Cree, 2010). However, routinely practising self-compassion may not be possible for first-time mothers due to the burden of finding time for the exercises (Woolhouse et al., 2014). This suggests that more practical and flexible

strategies should be introduced to improve self-compassion for this group (Mitchell et al., 2018).

1.3.4. Studies of self-compassion in the perinatal period

The literature focusing on self-compassion in the perinatal period is very limited. However, interest has recently been growing since the findings are extremely promising. A research combining observations, self-report questionnaires and interviews revealed that higher self-compassion allowed mothers of young children to better cope with parental stress (Psychogiou et al., 2016). Although the study was only conducted on parents with a history of recurrent depression, the results are expected to be similar or better for non-depressed populations who tend to have higher levels of self-compassion (MacBeth & Gumley, 2012). More self-compassionate mothers were also less critical towards their children which may suggest that these children could learn to become more self-compassionate and therefore possibly have an improved psychological wellbeing (Gilbert et al., 2006). However, a larger sample was recommended to evidence it further. Additionally, a meta-analysis showed that using components of self-compassion as a parenting strategy appeared to be beneficial for managing distress, and reducing anxiety and depression related to parenting (Jefferson et al., 2020). Although there were limitations in the reviewed studies such as lack of a control group and publication bias, the findings indicated the benefits of self-compassion for first-time mothers.

Research conducted with postpartum women showed similarly promising results and further supports the argument that self-compassion could be an effective skill for first-time mothers when experiencing maternal challenges. A study with self-report data demonstrated that even controlling the current symptom intensity, pregnant and postpartum women with experiences of depression and anxiety scored significantly lower in all three elements of self-compassion (Felder et al., 2016). Since this research had a cross-sectional design, the causal effect needs to be examined further to understand whether self-compassion mediates the link to improved psychological wellbeing. However, the findings suggest that improving self-compassion could reduce the risk. Additionally, a recent study argued that self-compassion could act as a barrier for postnatal depression and

has a critical role in reducing self-critical thoughts and beliefs (Pedro et al., 2019). Other studies also evidenced similar findings, suggesting self-compassion has a significant negative association with postnatal depression and could protect at-risk women from developing it (Monteiro et al., 2019).

Based on the initial findings indicating the positive relationship between self-compassion and improved perinatal mental health, several studies investigated whether improving self-compassion could be an effective intervention. A pilot randomised trial comparing internet-based CBT and Compassionate Mind Training (CMT) observed that improving self-compassion through CMT reduced anxiety and depression, which CBT failed to do (Kelman et al., 2017). The pilot trial pioneered showing the effectiveness of CMT for women who are in the perinatal period or planning for a future pregnancy. The findings suggested that self-compassion-based interventions in the perinatal period could be more effective than CBT which is heavily used in the NHS due to its cost-effectiveness (PAN, 2015). Online interventions were utilised in the study due to the lack of access to psychological services and cost. However, similar or better results are expected when using face-to-face interventions considering therapeutic alignment (Carlbring et al., 2018).

A limitation with this research could be the selection of the randomised trial method. Although it allowed the researchers to compare the outcomes, a more detailed exploration could be beneficial to understand the differences between CBT and CMT interventions concerning participants' experiences. It was theorised that the reason for CMT's superiority in depressive symptom reduction could be due to the use of a friendly tone of voice in CMT encouraging change in participants' lives. However, these theories were not explored further with participants and could not be fully understood. Moreover, researchers suggested that although the short-term CMT was not able to improve the trait self-compassion, frequent practice could improve it. The barriers for not feeling self-compassionate within a short time frame were not identified, which could have been beneficial to developing the online interventions. As acknowledged by the researchers of this study, these points could be explored through follow-up semi-structured interviews or a focus group with some of the participants, allowing the researchers to enrich their knowledge. Despite the limitations, this study provides

valuable data as a pilot and encourages further research into practising self-compassion for first-time mothers.

Other studies also supported the previous findings. A research conducted with 262 mothers who gave birth within the previous 24 months assessed the effectiveness and accessibility of brief online self-compassion interventions, focusing on the mothers' birth and breastfeeding experiences (Mitchell et al., 2018). The results showed that self-compassion was improved after one month which was also associated with increased breastfeeding satisfaction and reduced post-traumatic stress. Although 96% of the participants agreed that self-compassion interventions were beneficial, almost half (49.8%) of the sample found that time was a barrier to practising the interventions. Conversely, the study found only a few participants had a fear of self-compassion which had previously been shown to be a barrier to practicing self-compassion due to unfamiliarity with the practice or associating it with weakness (Gilbert et al., 2011). The findings suggest that supporting new mothers, who appeared to be open to practising self-compassion, with finding time and introducing more flexible ways to practise could be an effective strategy.

Published clinical outcomes also supported the conclusion that improving self-compassion through CFT could be extremely effective in reducing postnatal mental health issues, particularly because of the neurobiological benefits of self-compassion (Cree, 2010, 2015). Previously explained maternal challenges including hormonal changes, exhaustion, lack of support and fears of being inadequate could trigger the threat system for postnatal women, overwhelming the soothing system. This could disrupt the emotional regulation and bonding for mother and baby, which may increase the risk of developing psychological issues. Self-compassion improves oxytocin release and gives a calming effect which is essential for bonding (Cree, 2010; Gilbert, 2010). This was also supported through research analysing heart-rate and cortisol using ECG, demonstrating self-compassion improves self-soothing and emotional regulation after stressful situations (Rockliff et al., 2008). Considering these factors, practising self-compassion could be essential for first-time mothers, particularly when faced with difficult situations such as 'distress of a crying baby' which may

trigger feelings of helplessness, inadequacy and self-criticism (Cree, 2010, p.161).

Although the above findings indicate the effectiveness of self-compassion for first-time mothers, the literature primarily relies on quantitative studies and the initial clinical outcomes which may miss a detailed exploration of self-compassion. The only qualitative study found was by Woekel & Ebbeck (2013) exploring how women, who had given birth within 12 months, related to self-compassion in regards to postpartum bodily changes, as well as the attached emotions, beliefs and values. A combination of weekly journals and semi-structured interviews were used for data collection. Since the study was conducted over the course of a month, the process also aimed to improve self-compassion through practice for women who may not have used it before (Gilbert, 2009b). Some themes identified were *balanced emotional perspective* and *a caring motivation*. The study evidenced that self-compassion is a familiar concept for new mothers and is already practiced when dealing with maternal challenges.

The analysis was through Thematic Analysis using a deductive approach based on 3 main components of self-compassion: self-kindness, mindfulness and common humanity (Neff, 2003a,b). Shaping interview questions deductively might be directive for some participants and limit their self-expression. However, it could also enable an improved understanding of an abstract concept such as self-compassion that may not be immediately available to some participants (Neff, 2003a,b). Interestingly, in the analysis an additional theme *caring motivation* emerged that was not covered by Neff's three components and which was theorised by Gilbert (2010). Acknowledging these findings, the researchers recommended to continue to study the concept qualitatively, while keeping an open mind for exploring uncovered aspects of self-compassion (Woekel & Ebbeck, 2013).

1.4. Rationale of this research

Studies clearly indicate that first-time mothers are more vulnerable to distress and further psychological problems, particularly during the postnatal period, due to feelings of inadequacy, self-criticism and self-doubt which could be triggered by

maternal challenges (Brassel et al., 2019; Murphey et al., 2017). Despite the high risk, these women may not receive sufficient support because of internal and external barriers as explained previously, which may escalate the issues (Murphey et al., 2017). It may suggest that the majority of this group deals with the difficulties without professional support. However, the literature is limited to show how first-time mothers, particularly non-clinical groups, manage their maternal challenges.

Previous research also demonstrated that self-compassion could be highly effective for first-time mothers in overcoming these challenges and improving their psychological wellbeing. Furthermore, it could prevent these women and their babies developing issues related to a disrupted bonding (Cree, 2010, 2015). Therefore, future researchers are recommended to investigate self-compassion as a prevention and intervention strategy for perinatal mental health (Felder et al., 2016). Although formal interventions to improve self-compassion exist and are implemented, mainly with clinical groups, non-clinical populations may not benefit from these interventions due to not perceiving their distress as being severe enough or having idealised standards to manage difficulties by themselves (Henshaw et al., 2016). Lack of time for self, which is a common challenge for first-time mothers, is also described as the main barrier to practising these interventions aimed at improving self-compassion (Mitchell et al., 2018). However, studies also recognised that self-compassion is a familiar practise and is used to manage maternal distress (Mitchell et al., 2018; Woekel & Ebbeck, 2013). Therefore, exploring the use of self-compassion by this group could be essential.

Additionally, exploring the phenomena, self-compassion, through the individuals' own words could benefit the self-compassion literature which is dominated with quantitative studies, mainly using cross-sectional designs based on self-reported questionnaires, designed to test theories (Willig, 2013). Self-reported questionnaires could be limited as participants may not be aware of their own emotional processes (Neff, 2003b). Another limitation of these studies is their heavy reliance on scales such as SCS to assess self-compassion, which do not allow participants to explain their use of self-compassion in their own words. For example, scoring low in this scale may not mean that an individual never practices

self-compassion, and they may still provide insight which could be valuable to explore further. This was observed in Woekel and Ebbeck's qualitative study (2013). Additionally, one study assessing the reliability of SCS with Buddhist monks showed that the SCS was not reliable for the sample, which contradicted the other studies (Zeng et al., 2016). This may suggest that the commonly used scales may not address all self-compassion practices.

Conversely, qualitative studies could be highly beneficial for the literature to explore the use of self-compassion by individuals who already practise it, and to learn from their experiences. There are only a limited number of qualitative studies in this area which mainly aimed at exploring the views and understandings of self-compassion for samples, who may or may not be practising this skill (Gilbert et al., 2014; Pauley & McPherson, 2010). No known research to date has explored the use of self-compassion by individuals, particularly first-time mothers, outside of clinical practice, which could provide a further understanding of self-compassion. It is suggested that the use of self-compassion has not been fully explored, missing an opportunity to enrich the understanding of the phenomena in detail.

This research aims to benefit counselling psychologists by enriching their knowledge of the use of self-compassion by first-time mothers, which may support their psychological wellbeing and prevent development of further issues during the transition to motherhood. The enhanced understanding of self-compassion by first-time mothers could also inform the clinical practice and advance the work with this group. Additionally, this research could benefit services aiming to improve the psychological wellbeing of first-time mothers. It could be a guide to develop programs based on the use of self-compassion, providing more flexible and suitable interventions considering this group's busy routine and lack of access to regular psychological therapies. The research also has the potential to inform policies benefiting first-time mothers.

Considering the above, this research has explored the following:

The research question:

How do first-time mothers practise self-compassion in the postpartum period?

The data has been collected by semi-structured interview questions and analysed by Thematic Analysis (Braun & Clarke, 2006; 2013).

2. Chapter: Methodology

2.1. Overview

This chapter provides a detailed description of how the research question is answered in this study. First, my position as a researcher is explained through the ontological and epistemological considerations. The use of the chosen method, Thematic Analysis (TA), and the reasoning for this choice is also described. Then the chapter outlines the ethical approval, sampling and data collection. The analysis procedure is also discussed in a step-by-step guide and finally, the standards of quality of the research are explained.

2.2. Research Paradigm and Epistemological Position

Research in counselling psychology can be used as an effective tool to develop interventions and better understand clients in clinical practice (Hansen, 2006). Paradigms, sets of assumptions to represent a worldview, prepare the basis of the underlying philosophies of the research and should not be alienated from the research process (Ritchie et al., 2014). Paradigms have four components: ontology (the nature and existence of reality which is represented in a continuum between realism and relativism), epistemology (how the knowledge is justified), methodology and method (Ponterotto, 2005). Historically, the main paradigm domineering publications in psychology was positivism, based on naïve realism, which aims to find observational generalisable facts, mainly generated from large quantitative data sets (Camic et al., 2003; McLeod, 2001). Quantitative researchers believe in one objective truth of knowledge which could be acquired regardless of researchers' beliefs and values. The researcher is excluded from the creation of the reality, therefore, reaching an absolute reality is possible (Willig, 2013). Although these studies are beneficial to the field, their limitations should also be considered. These studies may offer limited explanation for causal effects and fail to explore subjectivity which may conflict with the profession's phenomenological stance, viewing clients as an expert of their experience (Skourteli & Apostolopoulou, 2015; Trafimow, 2014).

Conversely, qualitative studies have been published more frequently in recent years in counselling and psychotherapy (Levitt et al., 2017). These studies enable participants to express themselves in their own words without being limited by any pre-given set of answers, which could serve the aims of counselling psychology in several ways (Ponterotto, 2005). The qualitative approach could decode the meaning of individual experiences, help to understand or explain a phenomenon in depth and develop theories which could improve the therapeutic process and interventions (Morrow, 2007). Additionally, qualitative research may fit well with the intention of non-pathologising clients who could be helped without devotion to a single method and through understanding their experience in detail (Morrow, 2007). The qualitative approach also addresses the importance of a collaborative and intimate relationship that is developed between the researcher and the participant due to the nature of disclosing mainly emotional data (Morrow, 2007).

It is important to understand the paradigms in qualitative approach since a lack of philosophical understanding, the core of research paradigms, may lead to poorly applied research (Ponterotto, 2005). Constructivist-interpretivism, based on relativism, believes in multiple realities as it is never possible to fully grasp the meaning of an individual's perspective. Realities are socially constructed by participants and researchers. Therefore, it is essential to explore the researcher's own biases and values (Ritchie et al.,2014). Similarly, the ideological-critical paradigm believes in different realities. This paradigm aims for social change because of power imbalance leading to oppression. The researcher has a role to critique the reality and facilitate change (Morrow, 2007). Conversely, postpositivism is an intermediate approach between positivism and constructivist-interpretivism and commonly used in counselling psychology. It differentiates itself from positivism by accepting that the researcher's biases, values and assumptions influence the observations. Hence, the researcher cannot be excluded from the process of reaching the reality. The researchers 'learn with' the participants and the reality evolves over time (Ryan, 2006, p.7; Willig, 2013).

Despite the advantages of qualitative studies, counselling psychologists should not completely ignore the positivist approach. Indeed, over-emphasising subjectivity could increase ambiguity in both research and clinical practice which may challenge counselling psychology as a scientific study (Trafimow, 2014).

Additionally, in clinical practice, counselling psychologists are expected to provide an evidence-based practice mainly relying on a medical-model derived from the research with quantitative data. This might suggest a balanced view of combining generalisable data-driven facts while allowing the uncovering of individual experiences in order to fully understand a phenomenon (Ponterotto, 2005). Considering this positioning and my research question, critical realism (a form of postpositivist paradigm) is used in this research.

2.2.1. My Epistemological Position

Methodology of a research, the rationale behind the chosen method, is strongly shaped by the epistemological stance of the researcher (Ritchie et al., 2014). My epistemological position has been influenced by my stance as a reflective scientist-practitioner, intending to learn from subjective personal experiences, while holding the existing theories and research evidence of the phenomenon (self-compassion) in mind (Bury & Strauss, 2006). Although it is important to consider the previous research findings and theories while conducting a new research, the critical-lens encourages the researcher to constantly question the reliability and validity of the existing findings (Strawbridge & Woolfe, 2003). This advocates critical review of the literature, which might have limitations and researchers' bias, leading to restricted knowledge of a phenomenon.

As a researcher, I believe in the existence of one true reality of self-compassion which is viewed differently by each participant depending on their values, beliefs and experiences, bringing an individual approach to the reality. I believe this position matches well with critical realism (CR) which represents my epistemological stance for this research. CR epistemology proposes an intermediate position between the two polarities of positivism and intepretivism (Ogland, 2017; Ponterotto, 2005). Critical realists believe that the reality is independent, but it is viewed subjectively because of individuals' experiences, perspectives and beliefs. The researcher interprets the reality through their own bias and believes that reaching a subjective reality is not possible, being critical of a certain reality (Howitt, 2010). The researcher's aim is to explain theories in detail in order to understand the phenomenon and come closer to the truth (Sorrell, 2018). CR believes in the importance of the existing theories and although not set in stone, considers the role of the existing proofs of knowledge

in order to help us explain and understand the reality (Bhaskar, 1998). CR also considers that existing knowledge can be shifted through collecting more evidence. Therefore, researchers should continue to seek the truth. As a researcher, I did not take the data at its face value and other underlying factors including history, society, culture and situations which may have contributed to the phenomenon's existence were considered in the analysis (Willig, 2013). Furthermore, this stance encouraged me to be open to discovering new evidence in the data, which may not have previously been theorised in the literature.

CR is highly relevant to counselling psychology and fits well with the subjective human experience perspective (Patomaki & Wight, 2002; Rennie, 2007). In counselling psychology, existing theories are important to improve a client's mental health. However, it is also essential to explore an individual's experiences and their context to fully grasp their difficulties which may not be explained by the existing knowledge. This approach could allow counselling psychologists to improve psychological wellbeing, by tailoring the evidence-based practice considering the individual needs (Rennie, 2007). Similarly, in counselling psychology research, owning this stance could lead to an improved understanding of a phenomenon and enhance clinical practice. Considering these aspects, positioning myself from a CR perspective appealed to me as a researcher as it addresses a wider context within one reality. The chosen analysis method, Thematic Analysis (TA), is well suited with my CR positioning and the reasons for choosing the method is further discussed in the next section.

2.3. Research Method: Thematic Analysis

TA is the chosen method of analysis, aiming to discover meaningful patterns and themes across the whole data to describe and interpret the sample's overall experiences, beliefs and assumptions. As explained in Chapter 1, self-compassion, particularly with a focus on transition to motherhood, has not been qualitatively researched extensively, therefore, exploring the topic in a broader level through TA was the aim of this study. TA also fits well with my research question which aims to gain a broader view of the phenomenon rather than partial aspects (Braun & Clarke, 2006, 2013). Therefore, other alternatives were

eliminated. Previously, I considered Grounded Theory (GT) which has similarities with TA considering the 'procedure of coding themes' or 'coding from data' (Alhojailan, 2012, p.2). GT has assumptions and limitations of how the knowledge is achieved which may not fit well with this research's intentions. One major difference with TA is that GT aims at reaching the reality through searching for a theory grounded in the dataset which was not my research interest (Strauss & Corbin, 1990; Willig, 2013). Furthermore, GT focuses on the social processes and not exploring the phenomena in detail as TA does (Braun & Clarke, 2006). Considering these aspects, I decided to reject GT for this research.

Similarly, another considered method, Interpretative Phenomenological Analysis (IPA), was found unsuitable for this research. IPA aims to explore the process of the reality and the meaning of individual perspectives. It also focuses on the double hermeneutic, the researcher's interpretation of the participants' meaning making rather than understanding the overall phenomenon, which my research aims to achieve. Approaching self-compassion from an idiographic perspective through IPA would be beneficial in the future, once the topic is further understood and more knowledge could only be gained through exploring the meaning of individual views. However, at this stage focusing on the themes and patterns within the overall data makes more sense, considering the lack of qualitative studies in the area. Additionally, an IPA researcher works with a phenomenological stance, believing there are multiple realities to be uncovered (Pietkiewicz & Smith, 2012). This did not fit with my CR positioning of belief in an objective reality independent of the individual experiences; therefore, IPA was also rejected.

TA has recently gained popularity in psychology due to its flexible approach. Unlike other research methodologies, thematic analysis is not tied to any theories, epistemological stance or framed research questions leaving the researcher free to choose their own (Braun & Clarke, 2006, 2013). Therefore, owning a CR position, I could approach the research question creatively without forcing myself to follow a dictated approach as in other methodologies. However, choosing the epistemological positioning on their own could be challenging for researchers due to the need to have consistency throughout the research process and avoid any contradictions (Holloway & Todres, 2003; Nowell et al., 2017). In order to provide

this consistency, I aimed to explain the steps I followed transparently and attended to the reflexivity.

Although some researchers stated that thematic analysis is not a method on its own, others argued that it should be considered as one if applied properly, emphasising the importance of conducting a rigorous and trustworthy research (King, 2004; Dewe & Koyle, 2014). Therefore, I explained the steps I followed in detail to achieve the quality as in section 2.6. Another advantage of TA is having fewer processes, suggesting the researcher could maintain the focus on the analysis rather than battling to understand a complex technique (Nowell et al., 2017). TA's practical approach allowed me to spend more time focusing on the data and providing a more comprehensive analysis, while trying to explore the use of self-compassion for first-time mothers.

It was also discussed that TA allows working with the qualitative data in a systematic way, suggesting that the data could be analysed to understand various aspects of the phenomenon (Nowell et al., 2017). This approach could suit my postpositivist paradigm well, considering the existing theories, mainly based on the empirical findings as explained in Chapter 1, however, without being restricted to them and allowing the discovery of new understandings. Thematic analysis using CR positioning also allows introducing interpretation of the data based on social contexts, which could be beneficial to answer my research question: how do first-time mothers practise self-compassion in the postpartum period?

2.4. Ethical Considerations

2.4.1. Ethical Approval

Ethical approval was obtained from the School of Psychology, University of East London Ethics Committee after an application of my proposed research (Appendix D). The recruitment started after the approval. To extend the potential participant pool, considering the availability and convenience of the target group and so as not to be restricted by the location of the researcher, an amendment was gained to conduct Skype and phone interviews alongside the face-to-face option (Appendix F).

2.4.2. Informed Consent

Individuals who showed an interest in the research were sent an email to explain the study in further detail (Appendix A). Any further questions were clarified and the eligibility criteria was confirmed by email or phone before arranging an interview. When participation was agreed, a written consent form was sent by email to be signed and returned before the interview (Appendix B). All participants were given the right to withdraw from the research within one month after completing the interview, as explained in the consent forms. None of the participants decided to withdraw.

Before conducting the interviews, consent was gained from the participants for the interviews to be audio-recorded and verbatim-transcribed. It was also explained verbally before the interview that they have the right not to answer any of the questions, to take breaks or reschedule the interview if needed. After finishing the interviews, all participants received a debriefing form by email as a reminder of the research's aim, alongside with the contact details of the services which support new mothers' emotional wellbeing in case of experiencing any distress in the future (Appendix C).

2.4.3. Anonymity and Confidentiality

The Code of Human Research Ethics (BPS, 2014) and Code of Practice for Research Ethics (UEL, 2015) were followed throughout the research process. To protect anonymity and confidentiality, all identifying information was changed and pseudonyms were used. The emails with the written and signed consents were deleted after saving the consents in a securely encrypted computer. It was explained to participants that their quotes may be used. Participants were given the option to partially accept the data usage (Appendix B).

It was emphasised verbally to all participants before starting the interviews that sharing information indicating serious harm to a child may result in breaching the confidentiality for safeguarding purposes (BPS, 2018). None of the participants reported any harm to their babies or raised any safeguarding issues which could have resulted in a breach of confidentiality. Additionally, no participants reported any thoughts or intentions of self-harming or feeling at risk from others before,

during or after the interviews, which was also stated to them as a reason for breaching confidentiality (BPS, 2014).

The data was audio-recorded on a mobile phone and also on a separate digital recorder. After the interviews the data was then transferred to an encrypted computer under a pseudonym and deleted from the recorder and mobile phone. The transcriptions were completed manually by myself, and saved on a securely encrypted computer using the same pseudonym. The recorded data will be destroyed after passing the Viva examination. Interview transcripts with anonymised participant information were only available to myself, the supervisors and the examiners and were not used for purposes other than those notified to participants in accordance with the General Data Protection Regulation, GDPR (2018). The anonymised data will be securely destroyed 6 years after submitting the thesis, in line with the GDPR guidelines.

2.5. Research Design

2.5.1. Recruitment

First-time mothers were purposefully sampled and eleven participants were selected who met all the recruitment criteria (Patton, 1990). The main approach for recruitment was word-of-mouth and social media such as Facebook where the research was advertised. Potential participants who had shown interest were sent the research's details by email (Appendix A). First-time mothers who met all the inclusion criteria were recruited as a result. Snowballing technique was also used to recruit further participants after the initial participants were recruited. Additionally, the research was advertised in two London children's centres which agreed to display the research poster in their buildings and advertise it at the end of their workshops aimed at mothers having a baby in the relevant age group. Although there was some interest through the children's centres, nobody met all the recruitment criteria.

2.5.2. Inclusion and exclusion criteria

The aim of this study was to explore how self-compassion is practised by first-time mothers, focusing on a non-clinical population, particularly when

experiencing maternal challenges. First-time mothers aged 20 and over were recruited for this study. Teenage mothers were excluded since they are associated with vulnerability factors for psychological distress which was an exclusion criterion as discussed below. Furthermore, they were shown to experience additional stressors in motherhood which could limit self-compassion or may influence their practices of self-compassion from the general sample of first-time mothers (Boyce, 2003; Paykel et al., 1980).

Practising self-compassion was an inclusion criterion. A detailed description of self-compassion was provided in the research adverts and the participants then decided whether the concept was a familiar practice (Appendix A).

Another inclusion criterion was that the participants' babies' age ranged between 6 and 24 months. This decision was based on the literature and my own judgement. The physical and psychological adjustment period to motherhood was defined to be approximately 6 months after birth (Thompson et al., 2002). This criterion aimed to give participants sufficient time to recover from the birth and adjust to motherhood to be able to reflect on their experiences. Although the focus was to explore practising self-compassion in the postpartum period, the participant pool was extended by including mothers who gave birth within 24 months. This was to collect meaningful data by including an expanded time for motherhood which might have been difficult to process in the first year for some mothers. Furthermore, similar sampling was used in the literature with first-time mothers including a study focusing on self-compassion (Mitchell et al., 2018).

Individuals who reported having severe distress were excluded from the study to protect their wellbeing and prevent possible triggering of further distress after the interview.

Only people fluent in English were included in participation in order to allow fluent conversation without the need of any translations that could cause loss of meaning of their experiences.

2.5.3. Brief Participant Profiles

The demographic information was completed before starting each interview (Table 2.1). The participants' ages ranged from 32 to 40. Six participants were mothers of a boy and five participants were mothers of a girl. The babies' ages

ranged between 6 and 23 months. The interview schedule focused on the first years' experience as a mother. Therefore, the analysis considers that two participants who were still within the first year of the motherhood shared their current experiences, whereas the rest of the sample reflected on their experience retrospectively.

The sample represented different cultural backgrounds, as presented in the table below. All participants were married and living with their spouses. They all completed higher education degrees. The sample consisted of five managers, three teachers, two engineers and one mental health professional. In Chapter 4, the potential impacts of the demographics are further discussed. Additionally, Carol, Elizabeth and Scarlette were my acquaintances and the possible impacts of interviewing acquaintances is discussed in 2.6.2.

Table 2.1 Participants' Demographic Information

Pseudonym	Age	Residency	Occupation	Education	Baby's age
Carol	34	UK (expat)	Mental Health Professional	Postgraduate	23 months
Elizabeth	37	UK (expat)	HR Manager	Undergraduate	14 months
Gail	34	UK (local)	Teacher	Undergraduate	21 months
Amelie	34	Germany (expat)	IT Manager	Undergraduate	15 months
Scarlette	34	Middle East (expat)	Project Manager	Postgraduate	22 months
Faraday	36	UK (expat)	Teacher	Undergraduate	12 months
Nelly	37	UK (local)	Engineer/ Business Owner	Undergraduate	6 months
Felicia	40	UK (expat)	Teacher	Undergraduate	6 months
Khloe	36	UK (expat)	Business Manager	Undergraduate	20 months

Fahi	32	UK (expat)	Marketing Manager	Undergraduate	19 months
Ivvy	34	Denmark (expat)	Engineer	Postgraduate	12 months

2.5.4. Interview design

The data was generated through one-to-one semi-structured interviews which lasted between 40 and 60 minutes. Interviews were started with a warm-up dialogue. The intention was to make participants feel at ease before starting the interviews and to answer any questions they might have (Jacob & Furgerson, 2012). The interview consisted of indicative open-ended questions. Prompts were utilised where necessary in order to support them in unpacking their responses (Leech, 2002) (Appendix G).

The interviews consisted of two parts: The initial part aimed at understanding the participants' general experiences as a first-time mother, focusing on the emotional experiences in the first year. Furthermore, it was designed to encourage the participants to prompt remembering and reflecting on the transition to motherhood. The second part focused on exploring how self-compassion is understood and practised by the participants as a mother, particularly when experiencing maternal challenges. It also intended to explore the factors playing a role in practising self-compassion. The questions in the second part were guided by Neff's 3 components of self-compassion (2003a,b), as well as Gilbert's description (2009a) which are commonly used in self-compassion studies as detailed in Chapter 1. This approach was appropriate considering my critical realist positioning which acknowledges existing theories.

The participants were offered face-to-face, Skype video call or telephone interviews. One interview was conducted face-to-face in a quiet room at a local library. Eight interviews took place via Skype video call due to convenience, geographical restrictions and childcare considerations. Two interviews were conducted over the phone, one due to an Internet connection problem and the other one due to childcare practicalities. Both of these participants were known to me and I had already established good rapport prior to the interview. The impacts of using telephone/Skype video call including rapport-building, non-verbal communication and ethics were considered (Iacono et al., 2015). Thematic analysis is suitable for all methods and the use of language and the details of

non-verbal cues were not necessary for this study as they might be relevant in other methodologies (Braun & Clarke, 2006, 2013). Therefore, conducting telephone interviews did not prevent a meaningful analysis. Additionally, most participants were recruited through word-of-mouth where a mutually known individual existed between me and the participant. Therefore, trust had already been established before offering telephone interviews as recommended (Burke & Miller, 2001). Regarding safety of participants, the ethical considerations were explained previously and planned with the supervisor before conducting the interviews (Appendix D, F).

The recruitment continued until the required data saturation was achieved for validity based on several factors (Ando et al., 2014): Thematic analysis allows working with larger data sets than other qualitative research methodologies including IPA where 6-8 participants are sufficient. Researchers should be aware of collecting 'small enough data' which would not handicap the engagement with the analysis, as well as 'large enough data' which would not affect the essence of the themes (Fugard & Potts, 2015, p.670). In TA, the data saturation could be reached within twelve interviews (Ando et al., 2014). However, Braun and Clarke (2016, 2019) encouraged the researchers to use their subjective judgements to make the decision on the numbers of participants. Considering these factors, eleven participants were recruited which was considered sufficient for my research. I believe that the data saturation was reached after the 10th participant based on the common codes and themes with the overall data. When the eleventh interview confirmed this, I decided to stop recruiting more participants.

Additional options considered

Other options including use of Self-Compassion Scale (SCS) and a self-compassion journal along with the interviews, were considered and eliminated before the interviews started (Appendix D). SCS was previously considered to inform the analysis by using the SCS results of each participant to compare whether high-scorers' self-compassion practices differed from the practices of low scorers. The reason for eliminating these methods was to maintain a higher level of engagement with the participants who may lack time due to childcare and drop out of the study (Woolhouse et al., 2014). Additionally, use of SCS could

have contradicted with the aim of this study which is exploring the phenomenon, self-compassion, in detail. Furthermore, one study indicated that SCS was mainly tested among college students and when it was re-tested among adult non-clinical group, it was recommended not to use the scale as a measure of self-compassion (López et al., 2015). Considering the sample of this study consisted of a non-clinical group, first-time mothers, this had to be taken into account.

Another scale, Edinburgh Postnatal Depression Scale, was also considered for screening the participants' psychological distress before participation in this study. However, the scale has limitations such as 'ambiguous items' and many positively screened women having only 'transient distress' which could result in incorrect assessments (Matthey & Agostini, 2017, p.351). This could have resulted in unnecessarily exempting individuals from participating in the study. Instead of relying on the scale, self-reported psychological disturbance was added as an exclusion criterion from the study, to protect participants from potential harm.

I believe using only semi-structured interviews allowed the participants to reflect on their experiences openly without any limitations from questionnaires, eliminating the data misalignment which could be caused by combining several methods (Harris & Brown, 2010). My decision on not using questionnaires was also shaped by my changing positioning as a researcher since starting the process which is further explained in the Reflexivity section in 2.6.2.

2.5.5. Pilot Interview

A pilot study was carried out with a 32-year-old first-time mother of an 18-month-old baby. She reported before the interview that she did not resonate with the self-compassion practice which was one of the inclusion criteria. Therefore, her interview data was not included in the full analysis. Her informed consent was obtained before the interview and it was explained that her participation was for pilot purposes and her data may not be included in the overall data which she agreed to. The semi-structured interview lasted for one hour, was conducted in a quiet room in a public library and was recorded on a phone recorder.

The pilot aimed to test and improve the interview schedule and practise engaging as a researcher rather than collecting data on self-compassion practices (Kim,

2011). The participant provided her verbal feedback on the interview questions and process. The interview schedule remained unchanged, although there were minor explanations added as a note to clarify some prompts in case they were needed for future interviews. Although the participant did not meet the criteria of practising self-compassion, she met all the other criteria suggesting that interviewing the participant could help me to understand some experiences of first-time mothers in the transition to motherhood and how self-compassion may be viewed. Furthermore, she had a good availability for participation and was interested in the study. She was known to me which ensured that she was willing to give open and honest feedback about the interview schedule and the process. Practising the interview as a pilot with a friend is also recommended in studies (Jacob & Furgerson, 2012).

I found the pilot interview experience beneficial for improving my skills as a researcher. After reflecting on the process and reading the transcript, I noticed that I needed to adjust to my role as a researcher. In some parts, I tried to explore the participant's emotions in detail which was not relevant to the study. This might have diverted the attention of the participant and myself from the subject. This realisation taught me to judge more carefully to what extent the participants' responses should be explored, as well as not to be tempted by unnecessary curiosity if the exploration was not relevant to the research question. On reflection, I also noticed that I had certain biases due to my initial literature review before the interview. I expected the participant to give me certain answers which might have caused me to be directive when prompting her. This reflection helped me to take a more objective stance as a researcher in the following interviews.

When I analysed the pilot data, I observed that it differed from the data of the other participants who identified themselves as practising self-compassion. For example, the pilot participant reported ongoing feelings of guilt and self-criticism. Although the sample reported similar feelings in the initial months of motherhood, these feelings appeared to diminish after a certain period. This shift seemed to be absent in the pilot data which was a crucial finding. However, several common codes such as 'letting things go' and 'connections' were identified in the pilot data. This may suggest that even individuals struggling with self-compassion could be practising some elements of it. Although these findings were not included in the

overall analysis, it helped me to further understand the use of self-compassion by first-time mothers.

2.5.6. Data analysis

Poor analysis could be a limitation of TA and researchers need to pay a significant attention to coherency and consistency in the analysis. A common mistake is using research questions as themes which should be avoided as it would mean there was no analysis (Braun & Clarke, 2006). A latent approach was followed through the analysis in order to interpret the meanings of the content rather than only describing the themes (Braun & Clarke, 2013). Through this method I attempted to provide a more complete and richer exploration of the phenomenon by uncovering the underlying layers of themes.

Additionally, an inductive approach was implemented during the analysis and the themes were closely linked to the data (Fereday & Muir-Cochrane, 2006). The participants' perspectives recurring in the data were reflected on, which may not have been explored in the existing theories. However, it is almost impossible to conduct a purely inductive analysis due to the ontological and epistemological considerations of the researcher. My positioning guided how I interpreted the data and theorised the meaning which is acknowledged in TA (Braun & Clarke, 2006). Considering these factors, I provided a transparent description of the analysis below and followed the quality standards of a qualitative research as detailed in section 2.6.

The interview transcripts were analysed using the guidance of Braun & Clarke's 6-phases approach (2006) based on its systematic design, reliability and validity (Nowell et al., 2017). The below phases were followed:

Phase 1. Familiarising with the data: This phase involves active engagement with the interviews and familiarising oneself by reading and re-reading multiple times with the aim of finding meaning and patterns. This phase is considered as key to the analysis by Braun & Clarke (2006). As suggested notes were also taken during the process to help with the coding. Transcription of the data by myself was also used as a first step of familiarisation with the data (Riessman, 1993).

Phase 2. Generating initial codes: Coding was done manually by taking notes. Any 'interesting' aspect of the data which could be relevant to the research

question, constituted a code. However, I also took note of the essence of each line in the transcript regardless of the relevance to the research question (Braun & Clarke, 2006, p.18). All data was coded individually and assembled together if similar codes were created. Any conflicts or inconsistencies within the data set were also recorded. The coding was done twice to complete a robust process as recommended for trustworthiness (Nowell et al., 2017).

Phase 3. Searching for themes: After completing the codes across all interviews, broader themes were identified. The connection between various codes and themes were also analysed to help the process. Any redundant codes and themes which did not fit with the others were grouped separately.

Phase 4. Reviewing themes: Themes were reviewed to ensure meaningful patterns emerged within the same categories and to see if themes needed to be separated into multiple groups to cover the subthemes consistently. Internal homogeneity and external heterogeneity were considered for categories (Patton, 1990). This was ensured by reviewing the extracts from each theme in individual interviews to confirm a consistent pattern. If there were inconsistencies within the theme, individual extracts were reviewed. It was then decided whether the theme needed to be amended or the extract needed to be separated from the theme. This process ensured the validity of the themes and was repeated until a thematic map was reached. Next, the same procedure was repeated for the overall data. If any data was not coded previously, when re-reading the extracts for the overall data, the new codes were added.

Phase 5. Defining and naming themes: In this phase the significance of each theme was identified. It was also considered how each theme fitted into the overall story of the data regarding the research question and if sub-themes needed to be introduced.

Phase 6. Producing the report: This final stage was about telling the story based on the final themes and make an argument to represent each theme in a consistent way.

2.6. Quality Standards of Qualitative Research

2.6.1. Trustworthiness

Trustworthiness is an important element in qualitative research and refers to the confidence and interpretation of the data through detailing methods which is also acknowledged in thematic coding (Roberts et al., 2019). Although there are set standards to accomplish trustworthiness in a quantitative research, there are various debates about how to establish it in qualitative studies.

The standards of good quality research differ based on the paradigms the researcher owns (Morrow, 2005). Lincoln & Guba's standards (2000) which are commonly accepted by researchers are suggested for postpositivist qualitative studies (Roberts et al., 2019). Based on this study's paradigmatic underpinnings, following Lincoln & Guba's standards (2000) seemed to be an appropriate starting point. Credibility, transferability, dependability and confirmability are the elements considered as standards which are explained below.

Credibility refers to the consistency of the data. It could be achieved through engaging with participants, using reflexivity and considering the context of the experiences. As recommended, this was demonstrated through the use of Braun & Clarke's Checklist (2006) which covers specific concerns of TA for good quality research. Therefore, it appealed to me as a standards guidance (Appendix H).

Transferability refers to sufficiency of the data and whether similar findings could be achieved in different contexts. Saturation of data was achieved as explained previously which suggested sufficient data collection. Furthermore, the demographics and conditions of the sample are explained in Chapter 2 and 4. This allowed the readers to gain a clear viewpoint about the participants and what factors might have shaped the sample's use of self-compassion.

Dependability refers to detailing methods used for the research clearly in order to make the study repeatable. As explained previously, a detailed and transparent explanation is provided for this research.

Confirmability refers to objective use of the data which could be achieved through the audit trail and reflexivity is an important element of it.

2.6.2. Reflexivity

Reflexivity is an essential part of the qualitative study and needs to be transparently explained to improve the quality of the research. It is also advocated for completing a rigorous and good quality TA (Braun et al., 2016). Although the researcher's biases and values should not be removed from the analysis, it is key to be aware of how the findings may have been affected by the researcher's position (Willig, 2013). I reflected on how my interpretations are shaped by my position as a researcher which is further explained in Chapter 4.

I tried to be mindful of my biases and assumptions about self-compassion due to having attended a training course and having experienced CFT which both helped me to improve my self-compassion. I was positively biased towards using self-compassion as a coping strategy in stressful periods as this skill has helped me to improve my mood when feeling low or experiencing challenges in life. Additionally, my views about first-time mothers were also a consideration in the process. Although I am not a mother myself, I know first-time mothers who have struggled with self-compassion and other maternal challenges. Initially, before starting this research, it came as a surprise to me why some mothers may experience emotional challenges after becoming a parent since it is viewed so positively in society. I held similar beliefs as the participants of this research, that the main challenges of motherhood are being sleep deprivation and the physical recovery from childbirth, however, I did not consider how one's emotions might fluctuate due to the changes experienced in the transition to motherhood. I also assumed that new mothers who were on maternity leave would have a lot of time on their hands and could use this period as a gap year to enjoy their babies while socialising with their friends and other mothers whenever they wished. On reflection, I realised that it was a wrong assumption due to my lack of knowledge of motherhood and that new babies require the majority of a mother's time and energy.

Most of the participants were recruited through word-of-mouth. This method may have influenced the sample's demographics, therefore, the data and how self-compassion is practised in the transition to motherhood by the participants, which is further explained in Chapter 4. Having a high degree of education, employment, spouse, and having established a life away from their roots as expats, as well as their verbal communication in the interviews appeared to indicate that these

women are likely to have autonomy, be ambitious and resourceful (Carolan, 2003). It needs to be considered that if the research had been with different participants who may not have sufficient resources, the use of self-compassion may have differed in their transition to motherhood. My assumption was that having financial resources and a partner may have given my sample an advantage of adjusting to motherhood which may have helped them to be more self-compassionate.

Another consideration is my own demographics which is similar to the sample. I am a 34-year-old, international, married woman living in the UK for 12 years and have completed several postgraduate degrees. My socio-cultural background, age and family dynamics might have shaped my assumptions of motherhood and self-compassion practices and therefore, my interpretations of the sample's experiences. I tried to take these points into account and maintain reflexivity during my analysis (Mruck & Breuer, 2003).

Additionally, while collecting the data, I started a placement in an NHS Perinatal Mental Health service which gave me an opportunity to work with first-time mothers who struggled with the concept of self-compassion. In my clinical practice, I have also integrated CFT to support my clients which allowed me to observe their difficulties and achievements in practising self-compassion (Cree, 2010; Gilbert, 2010). When working with new mothers, I could observe the importance of one's own parental experiences and how unresolved parental issues might influence the changing role as a parent (Fraiberg et al., 1975). My work experience helped me to further understand the challenges of new mothers and the impacts on their mental health and relationships including with their partners and babies. My role as a researcher and clinician were constantly affecting each other throughout the research journey. It is suggested this is a cyclical process and part of becoming a reflexive researcher as our experiences, values and biases change over time through affecting each other (Attia & Edge, 2017).

Another aspect to be considered was that some participants including Carol, Elizabeth and Scarlette were my acquaintances. One disadvantage could be that the participants might assume how much the researcher knows about the participant's idea of the topic. To overcome this assumption, I asked the participants to talk to me about their experiences in detail without assuming any

prior knowledge. Indeed, the participants' maternal experiences were mostly unknown to me, allowing me to explore their experiences in depth. It should also be kept in mind that being acquaintances, these participants may have withheld some parts of their experiences from me which may have induced guilt or shame in them, particularly when discussing the early challenges of motherhood and experiences associated with not good enough mothering. This might have been triggered by the internalised societal values and possible judgment from others, particularly non-mothers. However, using acquaintances or friends is not unusual in qualitative studies and can bring benefits when exploring sensitive topics in a trusting and less formal setting which could have been more difficult with a stranger (Forrester, 2010). I tried to create a non-judgemental space and I believe having already established a good rapport helped these participants to open up to me more than to an interviewer who is a stranger. Indeed, the use of a relaxed verbal communication style and discussing sensitive topics such as partner and in-law dynamics appeared to confirm the openness in the interview process, particularly for Scarlette and Elizabeth.

In order to practice reflexivity in this process, I kept a research journal to help me be aware of any existing biases, values and assumptions. This was also recommended as a quality standard in TA (Braun et al., 2016; Ortlipp, 2008). Extracts of my research journal can be viewed in Appendix I. Before the interviews, I also noted my assumptions about how first-time mothers might practise self-compassion. My initial interpretations were heavily influenced by my assumptions and biases, mainly shaped by the existing theories of self-compassion and motherhood which was contradictory to my inductive approach. This reflection allowed me to realise how in my initial interviews, I was focusing on certain answers or expecting my participants to express certain viewpoints, which is further discussed in Chapter 4. I believe that by becoming more aware of my biases, I started to uncover my blind spots as a researcher and provided a more impartial study.

3. Chapter: Analysis and Findings

3.1. Overview

This chapter summarises the findings of the research that emerged from the analysis which answers the research question: *How do first-time mothers practise self-compassion in the postpartum period?*

Three themes emerged from the data which was gathered through semi-structured interviews. The first theme is 'the building blocks of self-compassion', the second theme is 'sudden changes and initial difficulties of maternity could block self-compassion', the third theme is 'becoming self-compassionate while embracing motherhood' (Table 3.1).

3.2. Introduction to findings

All participants showed an understanding of self-compassion and expressed that they had practised this skill at some level when experiencing maternal challenges in the postpartum period. Self-compassion appeared to be an abstract concept and each participant had their own understanding of it. The data suggested that self-compassion could only be achieved by the participants when attending to their self-care needs and having an accepting, kind and non-judgemental mindset towards themselves. The data also showed that self-compassion was extremely difficult to practise in the initial period of motherhood due to expending all physical and mental energy on the needs of the baby. However, it was evident that the sample started to practise self-compassion after an adjustment period which was different for each participant. Being able to be more self-compassionate was achieved through reaching a kinder and more accepting perspective towards self, understanding the importance of their own self-care, through natural growth of their baby and adjusting to the role of motherhood which are further explained as subthemes.

The themes are detailed below with quotes from the participants to support the emerging patterns in the data. The subthemes provide a detailed analysis and the essence of the participants' stories.

Table 3.1. Themes and Subthemes

Themes	Subthemes
Theme 1: The building blocks of self-compassion	Subtheme 1.1: Self-compassion is self-care
	Subtheme 1.2: Self-compassion is a mindset
Theme 2: Sudden changes and initial difficulties of maternity could block self-compassion	Subtheme 2.1: Self-care is a luxury
	Subtheme 2.2: Grieving the end of pre-motherhood life
	Subtheme 2.3: Reality of motherhood falls short of idealised expectations
	Subtheme 2.4: Not receiving compassion hinders self-compassion
Theme 3: Becoming self-compassionate while embracing motherhood	Subtheme 3.1: Changing perspective
	Subtheme 3.2: Increased commitment to self-care
	Subtheme 3.3: Growth facilitates self-compassion

3.3. Theme 1: The building blocks of self-compassion

The data showed that the participants practiced self-compassion based on two elements of understanding which were introduced as subthemes. The first subtheme, *self-compassion is self-care*, exemplifies how the participants considered practising self-compassion as taking care of themselves and actively taking action to improve their mood when experiencing emotional challenges. The other subtheme, *self-compassion is a mindset*, represents that self-compassion was seen as acceptance towards one's own flaws and self-kindness. The data from participants evidenced that these two building blocks needed to co-exist in

order to be self-compassionate and if one did not exist, then participants struggled to be self-compassionate.

3.3.1. Subtheme 1.1. Self-compassion is self-care

Self-care was one of the two elements which was identified by all participants as a way of practising self-compassion. The most common examples used by the sample were pampering oneself through beauty or food 'treats' which were considered luxury items for a new mother who has very little free time due to dedicating herself to her baby.

> *'…go to do my hair, my nails, all of these which for me was also helping me, because it was me-time for me that I was taking time for myself.' (Scarlette, line:207-209)*

Scarlette expressed the importance of 'taking care' of herself as a first-time mother by dedicating time to herself in order to feel better and recognise her personal value. By having 'me-time', she seemed to be able to relax and return to her motherly duties reenergised. Attending to self-care appeared to provide her with a fresh outlook when experiencing challenges and remind her that she was not only a mother but her needs were also important, deserving of her own kindness and care.

Gail also explained how spoiling herself could lift her mood and allow her to relax and take time off from her motherly duties.

> *'I have so much to do that it does get on top of me…if I go out and treat myself with a nice piece of cake or, you should do, go and have a piece of chocolate, … go and find a nice pair of shoes, treating myself.' (Gail, line:169-172)*

Her self-kindness appeared to build her mental strength when experiencing challenges as a first-time mother, allowing her to remove herself from her 'overwhelming' emotions which were triggered by her daily challenges. Instead of feeling burnt out by motherhood, she was choosing to do something nice for herself whenever she could find time which she had described as self-compassion. This practice appeared to help her to hit her reset button and take a break when she was consumed by unpleasant emotions.

Another commonly mentioned self-care activity, which was described as self-compassion, was sleeping sufficiently. It seemed that by feeling rested, participants were able to 'think straight', have more mental and physical energy. When their mind was not clouded by their exhaustion, they also seemed to have a more self-compassionate mindset when experiencing the challenges of motherhood.

> *'I think it's something about general mood and I guess if I'm generally, I've slept enough, you know I feel good, my daughter is doing well, we had a good day, we've been out, like I've done most of the things I wanted to do, then I feel generally better about myself.' (Felicia, line:164-167)*

Felicia pinpointed that her self-compassion was related to her mood which appeared to improve when she was actively planning her days and felt that both her own and her baby's needs were being met. It appeared that she could feel more in control of her time when she was getting enough sleep which seemed to leave her with more energy for herself and her baby. This also appeared to bring a sense of achievement for her and allowed her to be kinder and more accepting towards herself.

Most participants also mentioned the importance of their own self-care by taking a quick break and allowing time for self-reflection when experiencing difficult moments as a mother.

> '…*sometimes it helps to go for one minute for tea and just breathe [giggles] and go back to the situation and it helps in a way to, you know be present and acknowledge that 'okay, she's like that and she feels that and it's okay, I tried everything and that's okay that nothing works.' (Amelie, line:239-242)*

Amelie echoed other participants' experiences by highlighting that staying in a difficult situation did not help her nor her baby and in order to resolve it, she needed to see it from a different perspective. It seemed that by physically separating herself from the situation and giving herself a mental break, she was able to calm herself down which also appeared to give her a fresh outlook. By not being overwhelmed by her emotions, she appeared to become more accepting and understanding towards herself which she described as self-kindness and practising self-compassion.

3.3.2. Subtheme 1.2. Self-compassion is a mindset

The data illustrated that the second element which was necessary for self-compassion was having a compassionate mindset towards oneself.

> *'…being a bit easier on yourself, I guess, like you're doing well and good. That's how I understand self-compassion.' (Elizabeth, line:416-417)*

Elizabeth echoed most participants who identified self-compassion by 'not being harsh on yourself' when experiencing challenges. She also explained in her interview, when she had a self-compassionate mindset, she appeared to show acceptance and understanding towards herself as a first-time mother, even if she was not doing everything completely right. It seemed that through obtaining this mindset, she was able to talk to herself in an encouraging way and appreciated her efforts instead of fixating on her flaws.

For others, like Carol, having a self-compassionate mindset meant being able to embrace their emotions without judgement, even when they were unpleasant.

> *'…just understanding those feelings and accepting them, really, was a good thing for me. Not necessarily trying to feel good all the time, pushing myself to feel good all the time.' (Carol, line:110-112)*

Carol seemed to be aware of what she felt in the moment and did not try to run away from her unpleasant emotions. She appeared to understand that by daring herself to acknowledge her emotions and giving herself time to process them, she could help herself to accept her situation which she saw as a self-compassionate practise.

> *'…even if you're not feeling good or emotionally down, I don't try to criticise myself too much and better to understand why do I feel that way see what I can do or maybe I can get some more help.' (Amelie, line:220-222)*

Similarly, Amelie experienced self-compassion as an accepting mindset towards her emotions which may be unpleasant or painful. Additionally, her openness and courage to explore her emotions seemed to allow her to identify and attend to her needs which may not have been met previously. She appeared to accept her own limitations and be willing to receive additional support if she thought that her needs could be best addressed by it. This mindset appeared to allow her to care

for herself and her baby and try to find a solution to relieve her from her difficult situation.

Another common element of having a self-compassionate mindset appeared to be the belief that unpleasant emotions and situations will not remain the same.

> *'…that's the sort of way I do practise self-compassion. I kind of talk to myself and say 'no, this is the reason why you're feeling this way and that's okay and it will change.' (Gail, line:167-169)*

Like most participants, Gail explained how when experiencing maternal challenges, she found it helpful to remember that it was a 'phase' and the difficult period would soon be over. She was able to practise self-compassion through an encouraging self-talk which appeared to motivate herself to keep going when experiencing difficulties. This hopeful mindset might have allowed her to step back from her challenges and think about the situation in a more accepting way, thus caring for herself.

3.4. Theme 2: Sudden changes and initial difficulties of maternity could block self-compassion

All participants reported experiencing emotional and physical difficulties in the initial period after giving birth, which appeared to make it difficult to practise self-compassion. The early stage of transition was defined as 'shocking' and like a 'roller coaster' referring to sudden changes in their lifestyle. Participants seemed to exhaust their whole physical and mental energy adjusting to the requirements of motherhood which appeared to diminish their capacity for self-compassion. Four subthemes were identified as *'self-care is a luxury', 'grieving the end of pre-motherhood life', 'reality of motherhood falls short of idealised expectations'* and *'not receiving compassion hinders self-compassion'* which are explained below.

3.4.1. Subtheme 2.1: Self-care is a luxury

All participants appeared to struggle with self-care in the transition to motherhood, which was considered one of the two building blocks for practising self-compassion. It appeared that in the initial period after giving birth, meeting their

basic needs including sleep, personal hygiene and rest was extremely difficult for all participants because of the constant dependency of the babies. The sample described their experience as a period of trying to 'survive' and adapting to sudden changes, regarding self-care as a luxurious experience which they often did not have time for in the early motherhood period. It is suggested that the participants experienced physical and mental challenges due to the lack of self-care which appeared to leave no space for self-compassion.

Although all participants talked about the difficulty in attending to their own needs, there appeared to be a distinction in the reasons for this lack, one being unwillingness and the other being the inability for self-care. Some participants such as Scarlette and Amelie expressed how they prioritised their babies over themselves as a choice, which appeared to be a mental block for self-kindness and self-compassion.

> *'At the beginning it was only my baby, there was no me. Now it's me and my baby together… I feel I always have self-compassion apart from the very beginning that I was not thinking, I was only thinking about my baby's needs and not my needs.' (Scarlette, line:300-305)*

Scarlette summarised how she had neglected her own needs in the transition period to motherhood. 'There was no me' suggested that her needs were ignored and she was focusing entirely on her baby. It is evident that she was preoccupied with her baby and was struggling to separate herself from her baby physically and mentally. She also reflected in her interview that she associated self-compassion mainly with attending to her own needs which was not initially possible. Her extract reflected that mental effort and space could be required to care for herself, which would allow her to be self-compassionate.

Similarly, Amelie echoed some participants and expressed her unwillingness for sharing childcare with others including her partner, despite having an opportunity to create more time for her own needs, even when practical support was available. This unwillingness to allow herself to take a break from motherly duties appeared to lead to a mental block for self-kindness and self-compassion.

> *'In the beginning when you first have your child, first few weeks, you think 'oh, if she's not with me 24/7, you know [she giggles], it's not okay, she*

won't be okay.' And it's hard to trust and let go, trust your partner for example.' (Amelie, line:279-281)

Amelie's extract is an example for her initial struggle with her emotional separation and letting go of her baby. Her giggling suggested that she had realised her unrealistic belief about being the only one responsible for the survival of her baby at a later stage in motherhood. She might have been trying to maintain a sense of control in the uncertainty of her new experience, giving herself no permission to be away from her baby which seemed to make it difficult to take time off for herself and attend to her self-care, which she considered an important element of self-compassion.

Unwillingness to self-care due to prioritisation of the babies was reported in various forms by the sample. Most participants appeared to know that self-reflection would have been helpful when experiencing daily stressors. However, finding time and mental space for reflection seemed to be difficult in early motherhood, leading to 'heightened emotions' which could also be incubated due to hormonal changes, as acknowledged by the sample. The fluctuating emotions and the lack of time and space for self-care appeared to leave some participants more vulnerable when trying to manage day-to-day tasks and relationships. In this period being self-compassionate seemed to be extremely difficult due to mainly living in the moment, without having enough time and space to reflect on difficulties.

'I would have spent more time pondering, you know [F giggles], but yeah, I just, you know, reacted in the moment and didn't care very much because I had other things and other feelings.' (Felicia, line:106-108)

Felicia's extract suggested that she did not think about the consequences of her reactions as she was mainly focused on her baby and nothing else mattered at that moment. She also acknowledged that she could have responded differently. However, due to the prioritisation of her baby, she did not have time for self-reflection and responding to what was happening more mindfully. This indicated that she might have also struggled to practise self-compassion due to lack of time and mental space as she acknowledged by her giggling.

While some participants struggled mentally to allow themselves to self-care, others reflected on their inability to attend to their own needs, despite their

willingness. It seemed that the babies' physical dependency was a restriction, making self-care impossible due to the lack of time for self. Some of these participants appeared to feel lonely and isolated in their experience in the transition to motherhood, which seemed to trigger their feelings of guilt and self-criticism, moving them away from a self-compassionate stance.

> *'Sometimes I was alone all day and I was just waiting for my husband to come back from work, just to be able to speak to someone. I have some other mother friends but obviously I wasn't seeing them every day, because sometimes I was feeling tired, sometimes I wasn't being able to do much because of being exhausted. So that was difficult. When I wasn't doing much outside, I was feeling, again, guilty, that my baby wasn't getting enough from me, from the outside world, as well.' (Carol, line:287-291)*

Carol explained how she had initially struggled with the lack of practical support due to her husband working full-time which was a view shared by most participants, making it challenging to attend to their own needs. It seemed that for Carol, being the only carer of her baby through the day and exhausting herself with childcare, left her with no energy to socialise with her friends. Her stay-at-home routine without any social contact and any 'adult conversation' appeared to trigger her loneliness, deteriorating her mood. In the meantime, she also thought that being outdoors would be a positive experience for her baby which seemed to cause an internal dilemma between her need to rest and attending to her baby's needs. It appears that she was not able to accept her limitations and started doubting herself as a mother due to this dilemma. It is suggested that her harshness towards herself could be triggered by having no time and space to reflect, as well as due to her exhaustion which could have 'heightened' her emotions. Carol's experience showcases how she moved away from a self-compassionate stance and became more critical towards herself as a mother due to the knock-on effect of not being able to attend to her own needs.

Similarly, taking care of the babies without sharing the childcare appeared to handicap other participants' ability for self-care activities which were seen as an important part of practising self-compassion.

'He refused to take a bottle and that meant he was very dependent on me, mmm, I couldn't really ever leave him, in terms of time, I couldn't really have a break' (Gail, line:23-25)

Gail's extract emphasises her willingness to find alternatives to breastfeeding in order to allow her more freedom. However, her baby's refusal meant that she was not able to separate herself physically from her baby which might have triggered her frustration and feelings of hopelessness. It appeared that her baby's full dependency did not allow her to take a break for herself and relax for a short moment, preventing her from practising self-compassion.

3.4.2. Subtheme 2.2: Grieving the end of pre-motherhood life

The sample described experiencing feelings of sorrow which could be likened to a sense of grief over the sudden loss of their old lifestyle, freedom, individuality, social connections and career. Their feelings included resentment, sadness and denial which needed to be processed over time until acceptance was reached. The adjustment period appeared to consume the participants' mental energy, preventing self-compassion.

'I was being invited to lots of events but they were always outside of my, working hours [giggles], I say. So I was unable to join my friends.' (Carol, line:284-285)

Carol explained she had to refuse invites from her friends and restrict social contacts due to taking care of her baby. 'Working hours' suggested that she might have seen her baby's care as work which restricted her freedom and increased feelings of isolation. Her giggles suggested that her 'working hours' changed from professional life to full-time motherhood which did not allow her to have a break as with a 9 to 5 job which her friends might have. It appeared that she felt she was missing out on life and was using humour to defuse feelings of frustration and loneliness.

Other participants also acknowledged a sense of loss in early motherhood, with 'identity' being a common one, which appeared to trigger mixed emotions. Faraday expressed that she had been preoccupied with her baby, neglecting everything else including herself due to being 'consumed' by her baby. It seemed that her old identity was lost in the transition.

'So you sort of, I don't know, lose your identity a little bit' (Faraday, line:102-103)

'just having the freedom and the chance to do whatever I want which I don't anymore. And often friends and family, they sort of, they forget to ask how I am, it's all about my son.' (Faraday, line:107-109)

Faraday's second extract suggested that her interactions with others confirmed that her baby had taken over her identity. Although she was aware of her prioritisation, she might have felt resentment towards others and felt neglected when their conversations were focused on her baby. While experiencing all these changes, it seemed to be difficult to be accepting of her situation and to practise self-compassion.

While experiencing a sense of loss, most participants appeared to project their unpleasant emotions such as resentment on to their partners who transitioned to parenthood but were able to maintain the old lifestyle, unlike themselves.

'…you have resentment towards your partner. I did, like 'oh, you must have had some coffees today! 'cause you can't have one fucking warm tea! Impossible!' (Elizabeth, line:197-199)

Elizabeth's swearing represented her anger over the unfairness of the situation which two partners with the same baby experienced: One had to stay at home and give up her own needs including even a cup of 'warm tea', whereas the other could continue living without significant changes. It appeared that Elizabeth was struggling with self-compassion which might have been prevented by her feelings of loss due to giving up her own needs.

'…that actually made me a little bit jealous … especially if you're breastfeeding, I was the only one who can take care of the baby in the sense that he needs in those first months. But I was in a bit of a denial, or protesting mood, I didn't want to but I was forced to and that made me even more angry towards it.' (Ivvy, line:129-133)

Similarly, Ivvy envied her partner's freedom and her reference to 'protesting mood' suggested that she was fighting with her situation instead of accepting her difficulties. She felt that she was made to sacrifice her old life which may indicate a sense of loss of control. She also expressed regret and rejection of her new

lifestyle. Being preoccupied with these unpleasant feelings appeared to move her away from a self-compassionate stance and allowed her no space to show acceptance towards herself and her position when she was experiencing these challenges.

3.4.3. Subtheme 2.3: Reality of motherhood falls short of idealised expectations

All participants talked about the disconnect between the reality and the expectations of motherhood which seemed to be mainly shaped by societal and cultural norms. Initially most participants seemed to have an idealised version of mothers who can easily sooth their babies, breastfeed regularly and intuitively know what to do. At the same time, the 'perfect mother' was expected to keep the house clean and tidy and cook regular meals for their partners while maintaining a good balance between her roles as a mother, partner and career woman. However, when the participants faced the reality, it appeared that their self-critical thoughts increased and sense of achievement diminished which made it difficult to be self-compassionate.

> *'You read about things being certain ways, the ideal case scenario and I put a lot of pressure on myself to be that way.' (Gail, line:87-88)*

Gail's extract represented this unfulfilled expectation. It appeared that she was trying to be the 'ideal' mother which might have triggered her feelings of failure and self-doubt. When she was not able to meet her high standards, it seemed that she struggled to accept her flaws and therefore, practising self-compassion became more difficult.

Another common example given by the participants was the expectation regarding breastfeeding which they had to fulfil since 'everybody' expected the mothers to be breastfeeding. It seemed that there was no acknowledgement of any potential difficulties of breastfeeding by society which could involve physical 'pain' or increased dependency of the baby on their mothers, making breastfeeding an unpleasant experience for some participants. Despite these challenges, the sample explained how they still tried to breastfeed their babies, which appeared to be an idealised motherhood duty and not fulfilling it would be a failure as a mother.

'I didn't feel really guilty about not breastfeeding but I think that was also a challenge, so I was annoyed because I was thinking in my head, my husband expects me to breastfeed. I mean he didn't say that to me but I just, in my mind, I was thinking I'm letting him down and I'm letting everybody down.' (Fahi, line:149-152)

Fahi's extract illustrated how she might have felt a sense of failure when she decided not to breastfeed her baby due to the difficulties she had experienced in breastfeeding. Although she managed not to be consumed by guilt, she also acknowledged being preoccupied by fear of disappointing the people closest to her, perhaps including her baby. It is evident that the perceived expectation from others were moving her away from a self-compassionate stance, although she was trying her best to justify that she needed to do it for her own wellbeing.

Felicia's extract is another example showing a contradiction between the expectations of herself and society, making it difficult to accept her limitations and be self-compassionate.

'…maybe it's a bit about societal, cultural expectations … rationally, I don't see why the women should be doing all the housework and looking after the child and stuff, so I don't agree with this. But somehow there's still a part of me, you know, apparently, still kind of feeling a bit, like I'm not doing enough.' (Felicia, line:152-156)

Although part of her found it acceptable to share the daily tasks with her husband, the other part seemed to judge herself when she did not carry out all responsibilities expected from a mother by society which she had internalised. It appeared that because of her 'rational' mind, she believed in a more equal task share between genders. However, it seemed that society's and cultural values created tension with her personal beliefs and became the root cause of her self-critical voice, making it difficult to have a self-compassionate stance.

'When I'm working I'm feeling guilty that I'm not fully looking after him. And when I'm looking after him, I feel guilty that I'm not doing the work.' (Nelly, line:119-120)

Similarly, Nelly echoed some participants who were conflicted in their desires to be the perfect mother while also attending to their work responsibilities. The unrealistic expectation of doing everything at the same time appeared to induce

negative emotions in Nelly, when facing the reality. It seemed that her inner battle made it difficult for Nelly to accept her limitations and have a self-compassionate mindset when she went back to work. It is also suggested that her desire to be perfect in both could be triggered by the internalised societal expectations which she may not even be aware of.

Another instance in which the participants seemed to find it extremely difficult to be self-compassionate, was when events occurred for which they were unprepared, and their performance failed to meet their idealised standards. When 'not knowing what to do' in these occasions, they appeared to start questioning their ability as a mother and struggled to be kind and accepting towards themselves.

> *'…if he was sick and everybody was telling me he's a child, maybe it's something that I'm doing, as well, right? So, I kept on doubting, you know, it makes you doubt every single thing you're doing.' (Khloe, line:247-249)*

Khloe's extract illustrated her sense of self-doubt when she lacked insight into taking care of her sick baby. It seemed that she experienced worries and felt overwhelmed by being responsible for the wellbeing of a fragile baby which could have been preoccupying her mind. This experience might have induced feelings of guilt and seemed to make it difficult to relax and accept her limitations, moving her away from a self-compassionate stance. It is suggested that her self-doubt occurred due to her unrealistic expectation of intuitively knowing her baby's needs at all times, as expected from a perfect mother.

In addition to the lack of knowledge concerning babies contributing to poor self-compassion, a lack of insight into motherhood exacerbated the issue, triggering self-doubt and guilt as shown in Elizabeth's extract.

> *'I didn't know it's gonna be this, really ground shaking. I knew, omg, like, okay I'm not gonna be free, you know it, don't you? Everyone knows it but you don't know what it really means, what is behind it. What it may make you feel, you don't have any idea about that, so, and no one talks about that and even now, especially, I don't talk to pregnant people like that or even my friends, they wanna have a child, if they want to talk, I would but you don't wanna scare people.' (Elizabeth, line:304-309)*

It appeared that Elizabeth had no idea about the emotional challenges of having a baby despite being prepared for a busy schedule. She explained how she had to overcome these challenges by herself without prior knowledge which seemed to be a difficult experience for her, making it difficult to be self-compassionate. Echoing other participants, she also mentioned in her interview that she became more self-critical when experiencing everything for the first time which seemed to be triggered by the lack of insight of motherhood and babies. Having good intentions, Elizabeth seemed to have joined others who purposefully withhold their difficult experiences. It is suggested that there might be a reluctance to share information openly with expectant mothers which could act as a barrier for self-compassion in first-time mothers who only expect idealistic experiences of motherhood.

3.4.4. Subtheme 2.4. Not receiving compassion hinders self-compassion

When participants were unsure of themselves in the early stage of motherhood, people's behaviour towards them appeared to play an essential role in their ability to be self-compassionate. When feeling misunderstood and judged by others, most participants found it difficult to practise self-compassion and to be kind to themselves.

> *'Your life is already hard when you're just a new mum…, you've got this whole world of emotion, but if you don't have somebody who's, you know, compassionate on the other hand, … speaking about health visitors, it becomes very hard to be compassionate on yourself!' (Khloe, line:575-578)*

Khloe's extract illustrates how other people's behaviour was preventing her from being self-compassionate. She emphasised that she was already struggling to cope with the mixture of emotions due to sudden changes and needed additional support from others to adjust to the new experience and make sense of it. The way the healthcare professionals treated her appeared to trigger her feelings of self-criticism and guilt as she thought she was not 'doing the right thing' when taking care of her baby. It seemed to make it difficult to accept her limitations as a first-time mother who lacked any expertise. It is suggested that she was

discouraged from seeking further support and advice from others which could have improved her understanding of babies and normalise her challenges.

> *'…just having encouragement, even just from the midwives to, you know just someone to tell you that you're doing the right thing and it's gonna be okay and reassurance, I guess, because you just don't know what you're doing [laughs].' (Faraday, line:51-53)*

Conversely, Faraday highlighted how receiving compassion and encouragement from others allowed her to feel more accepting towards her mistakes and decrease her self-doubt. Faraday's laughing suggested that she was already aware of not always 'doing the right thing' as a first-time mother and was far from perfect. However, she was able to be kind to herself and gradually gain confidence in her mothering because of the non-judgemental approach of the midwives.

Other participants, like Carol, also mentioned the importance of receiving compassion from other people around them to adjust to the changes, while their capacity for self-soothing appeared to be limited in the initial period.

> *'I sometimes need support from other people, while going through difficult times…so yeah, it could be challenging to deal with all these feelings, on my own, especially when I'm very tired, physically tired and busy all day.' (Carol, line:234-240)*

Carol reflected on her difficulties on managing her own emotions at the height of exhaustion and lack of time. It is suggested that without other people's support and compassion towards her, she was not able to process her emotions efficiently due to lack of physical and mental space, which may be a barrier for self-compassion.

Despite not personally experiencing difficulties, Elizabeth voiced her frustration over perceived judgement from others which might trigger the feeling of incompetence for first-time mothers.

> *'You don't sleep, you can't even comb your hair, when you go out, in a café, the last thing you want is people to judge you because you're trying to keep your baby alive who's not probably stopping to cry all the time,*

eyes of people looking at you when he's crying. I really didn't give a shit!' (Elizabeth, line:388-391)

'I've never had a problem with this but I know some people did and it's quite stressful.' (Elizabeth, line:406-307)

Elizabeth's extract suggested that mothers are expected to be responsible for the behaviour of their babies which could trigger self-guilt and self-criticism in certain uncontrollable situations like being with a crying baby in public. Her swearing indicated her frustration with the society's perception of mothers, although she did not change her behaviour in public. However, her second extract emphasised that some mothers might already be overwhelmed by the responsibilities of their new role and facing judgement might bring a sense of failing to be 'perfect mothers' which could make it even more difficult to be self-compassionate.

3.5. Theme 3: Becoming self-compassionate while embracing motherhood

This theme represents the participants' experiences of becoming self-compassionate in their journey as a first-time mother, while embracing motherhood. The quotes reflect that after an adjustment period, the participants were able to start practising self-compassion through *'changing perspective', 'increased commitment to self-care'* and *'growth facilitates self-compassion'* which are explained as subthemes below.

3.5.1. Subtheme 3.1. Changing perspective

All participants talked about a gradual change in their perspective which appeared to allow them to absolve themselves from the fear of not being a good enough mother and be kinder and more accepting towards their flaws and becoming more self-compassionate.

'…just being a bit fairer to yourself, in time I've learnt there's nothing like a very good mum, an average mum is the best mum. So you just try to figure it out, just recently I got there… trying to be a perfect mum with cooking for him. I was only in the kitchen all time, cooking, cleaning after him or

walking with him around. At the end of the day I wasn't very happy.' (Elizabeth, line:371-377)

Elizabeth's extract illustrated how she realised that 'perfect mothering' did not exist in reality. It appeared that by dedicating herself exclusively to her baby, she ignored her own needs and became exhausted and unhappy. It is also suggested that she might have felt guilty when she had not been able to meet her high standards, making her feel 'desperate'. After realising that her unrealistic expectations were not sustainable, she finally gave herself permission to relax and be kinder to herself, embracing good enough mothering. It appeared that shifting her perspective and arriving at a more self-compassionate stance was a long process and she needed time to 'get there'.

When realising the impossibility of being a perfect mother, most participants discussed how they had started recognising their achievements and stopped feeling self-critical about not being perfect. The new perspective allowed the participants to feel more accepting towards their challenges and take a more self-compassionate stance.

'If I didn't have sort of productive day, if I'd been to waste the day then I'd be annoyed at myself, whereas now sometimes it's just surviving the day and it's about being clean and dressed, it's sort of an achievement.' (Nelly, line:328-330)

Nelly explained how she initially used to have high expectations from herself and was harsh on herself when she did not meet her high standards. However, after realising that being the mother of a baby brought its limitations, she decided to adopt new standards which were more realistic. Her change of perspective appeared to allow her to be kinder to herself and recognise her 'achievements', no matter how small they were and take every day as it was rather than having overly ambitious expectations and impossibly high standards.

Changing priorities was also mentioned by many participants, allowing them to drop their unrealistic standards, focus on what really mattered and become more self-compassionate.

'We had to bring him into hospital… Until he was out, fortunately, he recovered quickly but yeah, he was extremely ill, which delayed my start

to work. But actually funnily enough, that put a lot of things into perspective for me.' (Gail, line:47-49)

Gail explained how she had been 'blaming' herself for not being able to wean her baby by the time which she had been aiming for. This would have allowed her to return to work as she could rely on others to feed him. It appeared that she had been self-critical about this until her baby became ill which allowed her to 'put things into perspective'. Saying 'funnily enough' suggested that she considered the shift in her mindset positively even though it resulted from an unpleasant event, the illness of her baby. It appeared that after her experience, she started appreciating what she had, a healthy and 'happy baby', gaining a more grateful attitude instead of ruminating on what could be better. This perspective change appeared to help her to accept her limitations, relieve her from feelings of guilt and allow her to become more self-compassionate.

While some participants' difficult experiences helped them to change perspective, most participants emphasised the importance of having a safe space to reflect, process their emotions and receive compassion to be able to make this shift. Through talking to a trusted person, the sample started seeing their difficulties from a different viewpoint which appeared to help them to become more self-compassionate.

'…what I was looking for, somebody to tell me 'wow, you're so brave!' nobody said that…. I liked the fact that she [therapist] talked to me like that and then she said 'I think you shouldn't be that harsh on yourself.' And I think it just stuck with me… this is how I made the decision, and I think that was the changing moment after that I was a happy person.' (Fahi, line:270-277)

Fahi's extract illustrated how she had experienced an epiphany moment when talking to her therapist who seemed to be the first person to validate the difficulties she had experienced as a first-time mother. Fahi explained how she had been forcing herself to breastfeed her baby even though she did 'not enjoy' it, which she felt 'guilty' about. It appeared that she was trying to be an ideal mother, sacrificing her own happiness to 'do the right thing'. Her therapist's understanding and encouragement seemed to help her to realise how harsh she had been with herself and she needed more self-compassion to experience a more enjoyable

motherhood, which she deserved. It seemed that hearing someone else's perspective, who she could open up to, enabled her to reflect and view her situation differently, suggesting the importance of other people's attitude towards her.

Partners also appeared to play a crucial role in containing difficult emotions of participants and helping them to shift their perspective towards becoming more self-compassionate when they struggled with the challenges of motherhood.

> *'It took a very long while to realise that, you know, we, like, kind of, like, looking at the situations and saying 'we don't know', obviously the doctors who are specialised people do not know, either, so, I shouldn't be, you know, I shouldn't be as hard on myself!' (Khloe, line:250-253)*
>
> *'…it's just like talking it through with him [husband] why I felt this way.' (Khloe, line:277-278)*

Khloe's extracts showed how she was able to start accepting her limitations. She appeared to identify her unrealistic expectation from herself that she had to know everything about her baby. Having 'several conversations' with her husband seemed to help her to understand that nobody including the experts were perfect and it was unrealistic to try to be so. Realising that she was being too harsh on herself, she seemed to allow herself to be more self-compassionate. Moving from her self-doubt and self-critical thoughts towards a more self-compassionate stance appeared to be a 'very long' process where she needed continuous empathy and compassion from her husband.

Being part of a mothers' group was also identified by the majority of participants as helping to shift their perspective from feeling isolated to being more accepting and kinder to themselves, therefore becoming more self-compassionate. Through the emotional connection, the sample started realising that other mothers were going through similar challenges and they were 'not lonely' in their experiences. Most participants obtained this connection either through talking to other mothers who they already knew such as sisters, mothers and friends or developing new connections. Some found the same connection through reading mothering blogs and books where they read about similar mothering styles. This connection appeared to help them to feel 'less guilty' about their mothering and take the pressure off themselves, for example, when not following a 'strict routine'

with their babies as expected by society. Regardless of the platform for establishing those connections, self-compassion was achieved through a change of perspective after experiencing a sense of belonging and connectedness.

> *'I was always thinking that so many mothers outside have gone through the same, as well, so it's not the end of the world. And then, so this thought was helping me a lot, just to put things into perspective and not feeling that I'm going through something, you know, so, so, no one has experienced it before.' (Scarlette, line:94-97)*

Scarlette highlighted how she had started normalising her emotions in the transition to motherhood through the connection she had built with other mothers. Her experience seemed to give her hope that there was light at the end of the tunnel, providing her with strength to carry on when experiencing difficulties and enabling her to believe that she can also cope with her challenges as others did. Through knowing that others have also 'gone through the same', she seemed to be able to sooth herself when feeling scared and overwhelmed rather than being carried away by her unpleasant emotions, which could have moved her away from a self-compassionate stance.

Connecting to others also appeared to help the participants to view themselves from a more accepting perspective which seemed to stop them personalising their babies' behaviour and blaming themselves.

> *'…just knowing that others are going through it meant that I knew that it wasn't something that I was doing. It's just what babies do.'* (Gail, *line:*64-66)

Gail experienced a sense of relief after realising that her baby's behaviour was natural when he refused to eat or had sleeping difficulties. Talking to other mothers experiencing similar challenges appeared to help her to understand that her baby's behaviour was a part of his development and she did not do anything wrong as a mother. She seemed to shift from self-doubt and self-criticism towards accepting and normalising her difficulties by learning more about other people's experiences. It appeared that her realisation helped her to start trusting herself as a mother and become more self-compassionate by not blaming herself for her baby's reactions which were 'normal' for babies.

3.5.2. Subtheme 3.2. Increased commitment to self-care

The sample reflected on deciding to have an increased commitment to attending to their self-care in order to improve their mood after noticing the negative impacts of their maternal struggles on themselves and their babies. It appeared that by having more motivation to take care of themselves, the participants were also able to take a break from their maternal challenges which was described as a way of practising self-compassion.

> *'…you take a shower and things like that, basic things which you need. I felt like if I don't do these things that I need them, I'm not feeling good all day and maybe I'm not a good mum for my child, you know, more or less, a good wife to my husband and things like that. So the way I felt helped me to get motivation and do the things I need.' (Amelie, line:199-203)*

Amelie talked about the importance of following her self-care routine which appeared to remind her of her own existence as a human being and help her regulate her mood. She described how she initially avoided her daily tasks and was absorbed by her unpleasant emotions which appeared to maintain her low mood. However, the responsibility of looking after her baby seemed to increase her commitment to take care of herself in order to move out of her inactive mental state and pull herself together. It appeared that by allowing herself to do the 'basic things', she was able to be kind to herself and practise self-compassion.

> *'Like in early stages it was difficult, but sometimes, you just want to stay inside, especially in this horrible weather [laughs], but yeah, you have to remind yourself, when you're not feeling great, you know I might talk to my partner, have a bad day, you know, have a cry or do what I needed to do to make sure I was still doing my best as a mum, mentally.' (Faraday, line:97-101)*

Faraday described a similar commitment to herself when she decided to improve her mood by taking care of her own needs in order to make her best as a mother. Her laughing suggested that she acknowledged the convenience of finding excuses to remain inactive and do nothing to change her situation. However, she appeared to make a decision to be kind to herself and push herself to actively engage in her self-care in order to bounce back from her unpleasant emotions and regain the mental energy required to look after her baby.

'When I get that time off when I'm more able to do it and then a bit like, after one year, where I'm like 'okay, I need a bit of treat, I need a bit of a rest.' (Khloe, line:511-512)

As Khloe described in her extract above, most participants expressed that taking time off was an important part of self-care which allowed them to reenergise when they felt 'consumed' by their motherly duties. Khloe explained how she had only recently started to give herself permission to take a break, after becoming more self-compassionate and dropping her unrealistic expectations from herself. She described how she was initially trying to do everything by herself which resulted in her feeling physically and mentally exhausted. It appeared that she had started to become kinder to herself and more self-compassionate, when she decided to identify and act on her own needs, reminding herself that she was also a human who needed a break.

Even if the mothers have a commitment to attend to their needs, other people's opinions may play a role for them to maintain this motivation. When Nelly started to take time off from her motherly duties, she was challenged by her friends who seemed to be surprised by her leaving her baby with her partner.

'The first time that I've been all day away from him and everybody was sort of going 'oh, you're not missing him? You're not worried about him being with your partner all day?' And I was like 'no, I'm just enjoying my time! Not being with my son is okay at the moment and I just want to enjoy my time, not feel guilty about it'… I think it's important that, you know, I do it every now and then.' (Nelly, line:375-382)

It is suggested that the expectation from society was that a mother should dedicate all of her time to caring for her baby which could make it difficult to take a break and attend on their own self-care. Nelly seemed to feel the need to justify what she was doing and might have felt pressured by her friends. However, after the initial period of motherhood, she was able to start practising self-compassion through accepting the difficulty of being a full-time mother and acknowledging the importance of her own self-care to herself and her baby.

The importance of identifying and expressing one's own needs to others also seemed to help participants to improve their mood when experiencing maternal

challenges. Committing to improve a difficult situation was described as a way of practising self-compassion.

> *'Although my husband wasn't very happy because he wanted me to cook and stuff but I just stuck to what I was like 'I can't do it because I just need to have more time.' So this is my self-compassion bit, you know the things that I did to make myself feel better and free up my time and add it into my life.' (Fahi, line:384-387)*

Fahi's extract illustrated how she practised self-compassion by openly communicating with her husband about what she needed rather than continuing to do what was expected from her due to fear of disappointing him. It appeared that she remained truthful to her needs and challenged her partner which she described as 'freeing', suggesting that she was showing kindness to herself. It also seemed that through self-compassion, she was able to find a solution to improve her difficult situation which allowed her to be more present with her baby and spend more quality time thanks to being less preoccupied with other daily tasks such as cooking.

Participants also talked about becoming motivated to improve their situation by socialising and connecting with other parents when feeling lonely as a new mother.

> *'I started meeting those people and, and we became regulars... I started filling out the days with activities and that was the main thing that actually helped me because like, being alone, home and not knowing what to do all day and counting down all the minutes wasn't helping me. But, but then I actually started doing some things, it was maybe the time that turned things around. I needed more human contact.' (Ivvy, line:155-161)*

Ivvy discussed how she reached out to baby groups after starting to notice the impact of her isolation on her mood. It is evident that she started practising self-compassion by showing the courage to get out of her comfort zone in order to take care of her own needs. This experience seemed to support her in finding a sense of purpose and joy in her new life as a mother, allowing her to recover from boredom and 'resentment' towards losing her pre-motherhood freedom.

> *'There's lots of baby things you could do. Like, there was baby classes and going to like baby-friendly cinemas and things like that. It was just*

basically finding other things with my time that wasn't, you know, taking the dog for a walk or going out for a massive walk in the parks.' (Gail, line:133-136)

Similarly, after observing that she had not been 'feeling like her usual self', Gail decided to commit to her self-care in order to change her situation. She explained how she had started to find alternative activities to her usual ones which she could engage in while taking care of her baby. Her extract suggested that she started accepting her physical limitations as a new mother and decided to make her baby a part of new activities which she could also enjoy. It is also evident that she became more self-compassionate through showing acceptance and kindness towards herself allowing her to stop feeling low and being hard on herself when she was not able to continue with the activities she used to do before motherhood.

3.5.3. Subtheme 3.3. Growth facilitates self-compassion

When participants were inexperienced in motherhood, they appeared to personalise their babies' behaviour. They also seemed to easily become self-critical when the babies could not be soothed, feeling responsible for not being able to 'help' their babies. However, it appeared that adjusting to motherhood by gaining experience and learning more about the babies' behaviour allowed most participants to be kinder to themselves and become more self-compassionate.

'They don't know what they're doing because at the beginning, you take it personal sometimes, like 'why are you still crying?' I just became from this to this 'oh, I know, okay.' … because probably you don't know, your brain is not developed.' (Elizabeth, line:279-282)

Elizabeth's extract showed how she had initially struggled to make sense of her baby's behaviour and perhaps thought that he was purposefully trying to antagonise her when he did not stop crying. It seemed that she might have questioned her ability as a mother and felt guilty for not being able to attend to her baby's needs. However, by gaining insight through reading educational books on babies' development, Elizabeth was able to understand what could be happening for her baby when he was constantly crying and accept that it was a part of her baby's natural developmental process. Having increased knowledge

of her baby's behaviour appeared to help her to approach her challenges more compassionately, without blaming herself and her baby.

Similarly, after getting to know her baby, Amelie was able to understand that babies have their own minds which appeared to help her to separate herself emotionally from her baby.

> *'…that's a moment when I don't feel like I'm guilty for it. So I also learnt that sometimes I don't know what is going in her head.' (Amelie, line:242-243)*

Initially Amelie might have thought that it was her fault when she was not able to calm her baby down since she had an unrealistic expectation that mothers should always know instinctually what their babies need from them. However, it seemed that through gaining more experience as a mother, she had started to accept that she was not a bad mother and it was not her fault when she did not understand what her baby was trying to communicate with her. Her improved understanding appeared to allow her to accept her challenges and become more self-compassionate by being less self-critical and kinder to herself.

All participants also acknowledged their diminishing self-doubt through gaining experience as a mother and how it had helped them to be less self-critical, particularly when their babies got sick.

> *'Experiencing everything for the first time was a bit difficult. But now, you know, again, maybe after 6 months or so, I'm a bit more okay with that 'cause I know what to do and when to do for my baby, when he gets sick.' (Carol, line:61-63)*

Carol's extract illustrated that her adjustment to motherhood had allowed her to be more confident as a mother and stopped her from worrying excessively when she experienced difficulties. It is suggested that her experience might have helped her to become more self-compassionate by shifting from doubting herself and feeling guilty about not looking after her baby properly to being accepting and normalising her challenges.

While the participants were growing in their new role and adjusting to motherhood, the babies' natural growth also seemed to help the sample to have

more time and energy to take care of their needs, allowing them to practise self-compassion.

> *'They start expressing themselves in another way rather than crying. Because at the beginning, the only way for them to communicate is crying. So other people can also understand what they want, so little things. And it made me feel more comfortable that, okay, I can leave the house, she'll play with the friends.' (Scarlette, line:67-70)*

Scarlette explained how she had been able to start leaving her baby with others which appeared to help her to take time off from her motherly duties. This was considered by her to be self-compassionate. Her baby's development seemed to allow her to start trusting others and sharing her baby's care with them since she could observe that her baby could be more independent from her. It also seemed that she felt 'more comfortable' about leaving her baby without feeling guilty as her baby was happily interacting with her peers and was not helpless and fragile, requiring constant attention from Scarlette.

> *'He's a bit bigger now, he would happily sleep in his pram when I'm gardening or I can work and my partner will look after him for couple of hours, so it's becoming easier to do these kind of things.' (Nelly, line:132-134)*

Nelly also expressed that she could start engaging in activities which she enjoyed after her baby started settling into the world and was not as fully dependent on her as he was in the initial period. She realised that she did not need to be with her baby continuously which appeared to allow her to give herself permission to leave her baby with her husband without feeling self-judgemental or guilt. Her baby's growth seemed to allow her to take care of herself and remember who she was before becoming a mother which she considered as a self-compassionate practice.

During the process of growth and adjustment, receiving practical support was seen as crucial for participants when struggling with the challenges of motherhood. It appeared that most participants felt more comfortable asking for help when their babies started growing. Practical support seemed to allow the sample to have more time and energy for their own self-care and to take a break from their challenges which was seen as self-compassion.

'I've got my bed to myself to sleep peacefully without somebody waking up crying. Yeah, it was just like, I guess, when I reached that milestone of 1 year and the fact that it combined with my birthday, where I was like, I'm allowed to something nice, as well. (Khloe, line:497-499)

Khloe talked about asking her mother to look after her baby overnight as her birthday present. She acknowledged how hard she had been working as a mother and that she deserved to have a treat where she could sleep uninterrupted in order to regain her energy. Her baby's growing and 'reaching that milestone' appeared to allow her to ask for help from her mother without feeling guilty about putting her into a 'painful' situation and to feel comfortable about sharing the night care. It was evident how she started regarding herself kindlier and practising self-compassion thanks to her baby's growth.

3.6. Summary of findings

The themes summarise the reflections of the participants on their experiences of practising self-compassion as a first-time mother in the postpartum period. Although some participants had passed the one-year term of the postpartum period which was the focus of this study, they reflected on their overall experiences of self-compassion. However, it emerged from the data that self-compassion could be viewed as a spectrum and the participants could experience different levels of it at different points of their journey as a first-time mother. A variety of factors appeared to influence the level of self-compassion experienced and practised by the participants which is explained in the analysis.

A common theme that emerged was that practising self-compassion required taking care of oneself and having an accepting, understanding, emphatic mindset towards self when experiencing difficulties as a first-time mother. It was evident that these two elements nurtured each other and allowed the participants to be self-compassionate. When participants were able to attend to their own needs, they started feeling better about themselves and obtained a more self-compassionate mindset by accepting their difficulties and being less harsh on themselves. Similarly, when participants had a self-compassionate mindset, they started attending to their needs more, particularly when experiencing challenges as a mother, in order to improve their mood and be able to continue caring for

their babies. It seemed that self-compassion enabled them to seek solutions for their difficulties or accept the situation rather than being consumed by it.

All participants recounted the difficulties of practising self-compassion in the initial stage of motherhood due to the complete dependency of their babies which appeared to leave them with little mental and physical capacity for self-compassion. A common challenge to practise self-compassion appeared to be the participants' lack of energy and time when prioritising the wellbeing and survival of their babies over anything else. It could be inferred that self-compassion required mental and physical effort for the participants and could only be addressed after the basic needs of survival and care of self and the baby including food, sleep, hygiene and protection were completely met.

Additionally, the participants described a sense of grief due to lost freedom, social connections and activities when taking care of their babies as full-time mothers, which seemed to consume their mental energy. Most of the participants seemed to have limited practical support from others which prevented them from attending to their own self-care. Their mind also seemed to be preoccupied with the sudden loss of the pre-motherhood life which required time for adaptation, making it difficult to practise self-compassion.

Another factor which seemed to initially block self-compassion for the sample was trying to meet the expectations from self and society. All participants seemed to have an idealised version of motherhood which was unrealistic and unachievable in reality. By not being able to achieve these standards, the sample seemed to become self-critical, guilty and doubting of their fitness to be a mother.

However, after a certain period, all participants described experiencing a shift towards becoming more self-compassionate. One of the most important elements to help the participants make this shift appeared to be the physical and mental adjustment to motherhood and embracing the new role. It seemed that the sample started to take better care of themselves rather than ignoring their own needs, as well as discarding their perfectionist standards and accepting their limitations. The babies' natural growth and development also seemed to enable the participants to improve their self-care by allowing them to physically and mentally separate themselves from their babies, giving them the time and space required.

It seems evident that receiving practical and emotional support played an essential role in this shift to self-compassion. When participants decided to attend to their self-care, mostly they were given a helping hand to share the childcare from their partners and families which allowed them to attend to their needs. Similarly, most participants emphasised the difficulty of managing their emotions by themselves due to hormonal changes, exhaustion and sleep deprivation, particularly in early motherhood. A compassionate approach from others seemed to enable the sample to better adjust to the changes, see their challenges differently, normalise their difficulties and have a more self-compassionate mindset. This could suggest that compassion cultivated self-compassion for the participants and could not be considered as a separate element.

4. Chapter: Discussion & Conclusion

4.1. Overview

This research aimed at exploring how self-compassion is practised by first-time mothers in the postpartum period. This chapter presents the research findings in relation to the existing literature, while pinpointing any similarities and differences. The implications of this research on the Counselling Psychology field is then discussed, followed by a discussion of the originality of the research and reflections on the analysis process. The chapter continues with the recommendations for further research, a discussion of limitations of this study and finishes with conclusions.

4.2. Discussion of the main findings

4.2.1. Theme 1: The building blocks of self-compassion

It is evident from the data that self-compassion was considered to have two building blocks, self-care and mindset, which needed to co-exist in order to practise self-compassion. It appeared that in the absence of either of these, the participants struggled to be self-compassionate. The subthemes are discussed below.

4.2.1.1. Self-compassion is self-care

The participants described self-compassion as ‘caring for themselves’ and attending to their physical and mental needs as a mother and an individual. Self-care appeared to be essential for the sample in order to relax and regain their energy in the challenging times of motherhood and allow them to take a step back from their difficulties. The main self-care activities were identified as having adequate sleep, taking time off from motherly duties through activities such as socialising with friends, talking to others for emotional support, pampering oneself, engaging in enjoyable activities with the babies such as going for a walk or attending play groups. It was pinpointed that by taking care of their own needs

and protecting their wellbeing, the participants were able to have a more accepting, kind and self-compassionate mindset.

In the literature, self-compassion was defined as a nurturing and caring relationship with self (Neff, 2003b). Neff (2003b, p.225) also emphasised the importance of 'taking time off' particularly at times when feeling stressed, in order to balance wellbeing. Therefore, it is not surprising that it emerged from the research data that self-care was considered an important element of self-compassion. Although there is limited research on the links between self-compassion and self-care, the existing studies showed that self-compassion is strongly related with self-care and a significant predictor of it (Miller et al., 2019).

4.2.1.2. Self-compassion is a mindset

The findings also show that self-compassion was considered a mindset which allowed the participants to be more accepting and kinder towards themselves when experiencing maternal challenges. The participants explained how self-compassion meant treating themselves kindly when going through maternal challenges and accepting them as part of motherhood rather than personalising the difficulties. Some participants also stressed that practising self-compassion allowed them to embrace their unpleasant emotions and accept them non-judgementally instead of pushing them away. This emphasises that self-compassion was not considered as absence of negative emotions but having an accepting attitude towards them, as explained in the literature (Neff, 2003a,b). Furthermore, the findings also suggest that these participants did not pretend to always be happy as a mother, even though it could be judged as failing by some societal beliefs which associated motherhood with absolute happiness (Johnston & Swanson, 2006). Additionally, through self-compassion, these participants appeared to acknowledge their self-critical thoughts without ruminating which allowed them to accept their feelings as being temporary while believing that 'it will pass', as found in the literature (Ferrari et al., 2018).

Neff (2003a) also described self-compassion as acknowledging one's experience as part of the common human experience instead of inadequacy or weakness. Connecting to others was recognised as a part of self-compassion and could help bring relief from self-critical and unaccepting thoughts as observed in this

research data. The sample praised their connection to other mothers and how it helped them to view themselves and their challenges with a more self-compassionate mindset. The participants also appeared to feel less judgemental and self-blaming since they could relate to other people going through similar difficulties and feel that they were not alone.

These findings are consistent with the literature. Neff (2003a,b) identified self-compassion as a mindset with three components including self-kindness, mindfulness and common humanity as described in Chapter 1. The data from the current study reveals that Neff's three components could be found in self-compassion practices for this sample which are further explained in section 4.2.3.

4.2.2. Theme 2: Sudden changes and initial difficulties of maternity could block self-compassion

The analysis shows that the participants went through sudden changes in their life after becoming a mother which appeared to lead to emotional and physical difficulties. The literature supports that first-time mothers experience the adjustment period of motherhood as life-changing which might be a significant stressor for them, bringing instability and lack of control over their lives (Barclay et al., 1997). This period could have a negative impact on the emotional wellbeing and confidence of first-time mothers, which could act as a barrier to practise self-compassion as discussed in detail below.

4.2.2.1. Self-care is a luxury

All participants stressed the difficulty in attending to their self-care in the early stage of motherhood, when the babies needed their constant attention and devotion to survive. The sample appeared to prioritise their babies' needs over their own which seemed to have a negative impact on their physical and emotional wellbeing. When participants were not able to meet their basic needs such as rest and sustenance, they found it difficult to practise self-compassion due to increased stress levels and heightened emotions triggered by exhaustion. This is consistent with the previous studies which showed that sleep deprivation could impair emotion regulation and increase 'sensitivity to low level stressors'. It was also suggested that parents who did not sleep sufficiently may find it more

difficult to cope with stress and their daily functioning could be impaired (McQuillan et al., 2019, p.3). Studies also found a relationship between sleep deprivation and postnatal depression which could suggest that poor sleep may disrupt emotion regulation for new mothers (Iranpour et al., 2016). These findings could explain why this research sample was struggling with their emotions when sleep deprived which appeared to be a barrier for self-compassion.

Additionally, the participants reported that their hormonal changes after giving birth contributed to a decrease in their tolerance level for daily challenges. They explained how they were driven by those turbulent emotions when reacting to situations which appeared to be perceived as being more stressful than in the pre-motherhood period. It appeared that when self-care was neglected in these challenging times, the participants became more self-critical and less accepting towards their flaws, moving away from a self-compassionate mindset. This is consistent with the previous studies showing that self-care is important for new mothers to help them cope with stress (Barkin & Wisner, 2013). Having little time for introspection due to the participants' busy schedule also seemed to play a role in them struggling with self-compassion as most participants were driven by their emotions instead of taking time to 'think straight'. Studies showed that self-compassion was significantly negatively correlated with threat-response triggered by the survival mechanism which might act as a prevention for the soothing system (Gilbert, 2014). It could explain that when participants' emotion regulation was disrupted due to lack of self-care, their soothing system which is essential for self-compassion might also be weakened.

Another commonly described difficulty with self-care was a lack of physical separation from the babies in the initial months. The dependency of the baby, leading to tiredness and lack of time, appeared to be a barrier to taking time off from motherly duties, disrupting the participants' self-care. Some participants explained how they had to hold their babies for hours, when breastfeeding, which made it impossible for them to eat or drink anything. This suggested that they were prioritising their babies' needs over their own. There is evidence in the literature that emotion regulation has strong links with nutrition and sudden glucose level drops could lead to increased stress levels, triggering low mood (Horman et al., 2018). This might suggest that a self-compassionate approach

could be difficult when the participants ignored their own nutrition, which may lead to disruption of emotion regulation and increased mood swings.

Additionally, the physical dependency of the babies appeared to increase the loneliness of participants by leading to a lack of human contact. This finding is consistent with the literature which identified first-time mothers at risk of loneliness due to a pressure to prioritise their baby's needs that could decrease social interactions (Lee et al., 2019). Furthermore, lack of social contact seemed to result in the participants being unaware of others who experience similar challenges. Feeling isolated in their difficulties appeared to increase the participants' self-critical and self-blaming thoughts. Loneliness was linked to a negative self-evaluation and interference with the expectations from self and others, consistent with this study's findings (Lee et al., 2019). Additionally, social isolation appeared to be a barrier to enjoying motherhood for some participants, suggesting over-identification with their maternal challenges, which is a negative component of self-compassion (Neff, 2003a).

Experiencing these challenges in early motherhood, the sample appreciated practical and emotional support from others in order to attend to their self-care and find space to reflect and normalise their difficulties as a new mother. Although most participants could find emotional support, particularly from their partners, the majority mentioned struggling with a lack of practical support, making self-care a luxurious and valuable experience. It appears that self-compassion was difficult to practise for the participants when their basic needs were not met, which could be due to the strong links between body, brain function and emotion regulation, as suggested in the literature (Gómez-Pinilla, 2008).

When discussing these factors, it is also important to consider that the majority of the sample were comprised of expats, living away from their families. These participants articulated that having limited family support for childcare was one of their main challenges as a first-time mother. This lack of support resulted in them being the only carers for their babies during the day when their husbands were working, which appeared to make it difficult to attend to their self-care. Thus, the lack of support also seemed to reduce their mental and physical energy for practicing self-compassion since self-care was described by the participants as a crucial element of self-compassion.

Conversely, even when support was available for some participants, they reported still struggling to accept help due to the full dependency of the baby while breastfeeding in the initial period of motherhood. Some participants also mentioned that they did not want to ask for support from others as they thought that it was their responsibility to care for their babies or they were not able to trust others such as their partners. It appeared that the sample's self-care was compromised because of the difficulty in separation and the expectation of being a 'perfect mother' who devoted themselves full-time to their babies which is discussed further below. Previous research also showed that these factors are common concerns for new mothers, suggesting that in the early weeks of motherhood, self-care could be difficult (Barkin & Wisner, 2013). However, other studies suggested that new mothers mostly appreciated support from trusted people, particularly from more experienced mothers (Barclay et al., 1997).

4.2.2.2. Grieving the end of pre-motherhood life

The findings reveal that most participants appeared to feel a sense of mourning over loss of identity, lifestyle, freedom and self-care in the initial stage of motherhood. It seemed that most participants struggled to accept their new role as a mother and be self-compassionate in this period of transformation. The literature also evidenced that first-time mothers could experience feelings of grief for their lost pre-motherhood identity as found in this research. Grief theories are recommended to be utilised in order to understand the distress experienced in the initial motherhood period (Barclay & Lloyd, 1996; Rubin, 1984). Grief and experience of loss is considered a process where feelings may fluctuate, disrupting emotional, cognitive and behavioural functions. This could suggest that self-compassion could not be experienced easily due to the disruption of these functions (Zisook & Shear, 2009). Additionally, studies also showed that self-compassion was negatively associated with the experiences of grief. Although the causal relationship is not clear, it was evidenced that less self-compassionate individuals struggled to accept their difficult emotions of grief and were more likely to avoid them (Lenferink et al., 2017). This might suggest that the disruptive process of the grief experienced in early motherhood may have caused some participants to be more pre-occupied with the loss of their old lifestyle and leave

less mental space for self-compassion. This is consistent with the literature suggesting that self-compassion requires mental capacity (Neff, 2003b).

A significant event for the participants appeared to be the loss of old friendships, increasing their loneliness and leaving them with limited social interaction when taking care of the babies. It is suggested that the loss of social connections is mainly related to the lack of time and exhaustion as explained in section 4.2.2.1, but also due to changing identity as a mother. Some participants explained how they had outgrown their old friendships and developed different interests as a mother, suggesting a loss of their old identity (Nolan et al. 2012). It was also reported that their new role as a mother sometimes meant that they had to take a back seat in their own life and prioritise the baby's needs which might lead them to feel neglected. Faraday related how others were only asking about her baby in their conversations, suggesting that the participants' identity outside of motherhood might also be forgotten by others which could also trigger feelings of loss. The literature also evidenced that new mothers could experience loss of sense of self, self-esteem and confidence (Nystrom & Ohrling, 2004).

The pre-occupation with the losses of pre-motherhood life appeared to bring unpleasant emotions for some participants such as Ivvy and Elizabeth, which might also have disrupted their relationships with their partners (Nystrom & Ohrling, 2004). They reflected on their feelings of resentment and jealousy towards their partners who were continuing their old lifestyles without significant changes, despite becoming parents. Although receiving support from their partners was mostly appreciated by the participants, some mothers explained how they perceived their partners as 'not understanding' their maternal challenges. An example used by Nelly was comparing her partner's tiredness after a busy working day, when she was exhausted from having sleepless nights for months. Such experiences appeared to trigger some mothers' loneliness and increased their longing for their old lifestyle. It seemed that these mothers were moving away from a self-compassionate stance due to not having a common shared experience with their partners (Neff, 2003a,b). Thus, the findings reinforce that the family dynamics and the partner relationship could play an important part in accepting the new role as a mother and practising self-compassion.

4.2.2.3. Reality of motherhood falls short of idealised expectations

The analysis shows that in the initial period of motherhood, the participants were harsh on themselves and felt doubtful about their maternal capabilities when they were not able to live up to the expectations of themselves and others. It emerged from the data that most participants seemed to have an idealised version of motherhood, mainly internalised by societal and cultural norms. These findings were consistent with the existing studies (Barclay & Lloyd, 1996). The sample also articulated the initial pressure of becoming the 'perfect' mother which appeared to relate to some level of 'guilt', 'self-doubt' and 'self-criticism', moving them away from a self-compassionate mindset.

Some participants also discussed their expectations of meeting certain developmental milestones for their babies such as weaning or rolling. When they were not reached on their expected timelines, it appeared to cause disappointment and a sense of failure as a mother. Other participants explained how they blamed themselves for 'doing something wrong' when their babies got sick, which appeared to shatter their confidence as a mother due to experiencing a sense of failure. At other times, the participants experienced self-doubt and self-criticism, when they did not know how to sooth their babies or understand what they needed, again, blaming themselves as a mother for failing to meet idealised standards. Additionally, as stressed by Elizabeth, not knowing what to expect as a first-time mother and being unaware of the emotional challenges appeared to trigger self-doubt and self-criticism for the sample. Studies also found that first-time mothers were ill-prepared for taking care of a baby, and did not perceive themselves having sufficient information related to babies (De Sousa Machado et al., 2020). It is suggested that this lack of knowledge led the participants to consider the babies' behaviour, development or health as personal achievements. It seemed to be a barrier for self-compassion, when the participants benchmarked everything related to the baby against an idealised version, which appeared to trigger feelings of failure.

'Doing it right' also emerged as a finding in other studies, emphasising the perfectionist standards of first-time mothers which appeared to be unrealistic and difficult to achieve (Wilkins, 2006). Researches evidenced the pressure of perfect mothering and how the internalised values of society could lead to increased guilt and anxiety and lower self-efficacy as a mother (Henderson et al., 2016; Rotkirch

& Janhunen, 2009). It might suggest that the pressure of being a perfect mother could be internalised by some women without realising, even for people who value their own needs, regard their self-care separately from motherhood, and prefer equal roles in parenting and household chores with their partners. This internalisation was also verbalised by many participants of this research who seemed to experience a tension between their own values and those of society. This tension appeared to be a barrier to be accepting and kind towards themselves when they were not able to meet their idealised standards of the different roles as mother, wife and professional, which appeared to stand on the way of practising self-compassion. This is consistent with the contemporary views about mothering, acknowledging that mothers may confuse motherhood with completing household chores or achieving milestones quickly rather than developing a relationship, which may often go unrecognised by society (Stadlen, 2004). Similarly, in this research, in the initial motherhood the sample appeared to struggle with understanding that a new mother's real achievement could be getting to know their babies and learning their needs, which could increase feelings of self-criticism and self-efficacy.

This pressure also appeared to cause burn-out and exhaustion for some participants, when they were trying to strive to reach perfection without receiving adequate support. A previous research also supported the idea that internalised societal values could lead to increased stress and burn-out for mothers. An interesting finding of that study was that the pressure of being a perfect mother was positively linked with high career ambitions (Meeussen & VanLaar, 2018). The sample of this research came from a highly educated background and a few participants already mentioned in their interviews that they considered themselves ambitious in their careers. These factors could also explain the pressure of being 'perfect mothers' for the sample and how it acted as a barrier for practising self-compassion in the early stage of motherhood, when they were adjusting to the new role.

4.2.2.4. Not receiving compassion hinders self-compassion

An interesting finding of this study is that the participants appeared to experience feelings of self-criticism and loneliness when they felt misunderstood and judged by others around them. In this situation, most participants found it difficult to

accept their limitations and practise self-compassion. They also seemed to feel guilty about not 'doing the right thing' and not meeting the idealised standards of motherhood. Studies showed that it is common for first-time mothers to feel inadequate and experience self-doubt due to loss of control of their own life while navigating the unknown territory of motherhood, which could lead to a lack of self-reassurance (Javadifar et al., 2016). In this initial adaptation period, mothers are required to build new mental resources, while prioritising their babies' survival. As this process leads them to feel physically and mentally exhausted, a supportive environment is necessary to cope with these difficulties (Cree, 2015; Nystrom & Ohrling, 2004). Similarly, in this research, when the participants were surrounded with people who were non-judgemental and understanding, it appeared to help them to feel more accepting towards their flaws and normalise their challenges as a first-time mother.

Additionally, a previous finding showed that people were less likely to disclose their distress if they were untrusting of others being compassionate, which was echoed by some of the participants such as Khloe (Dupasquier et al., 2018). It is suggested that the sample became reluctant to open up and seek support which could be triggered by feelings of shame and loneliness when they were surrounded by judgemental and unempathic people. Another study supported this finding that first-time mothers may feel lonely in their difficulties if they perceive their healthcare professionals as not listening or being unsupportive, which may increase their distress and feelings of self-doubt and self-criticism (Ranch et al., 2019). Other studies also presented that when people felt judged and blamed by others, it could be internalised through 'silencing self' that may trigger psychological symptoms such as depression, which is strongly associated with self-criticism (Joeng & Turner, 2015). Receiving 'evaluative comments' was also associated with feelings of self-criticism and perfectionism (Bayir & Lomas, 2016). Therefore, the findings suggest that feeling judged and not receiving compassion from others could act as a barrier to practising self-compassion and may increase levels of distress.

4.2.3. Theme 3: Becoming self-compassionate while embracing motherhood

The analysis shows that although the sample struggled to practise self-compassion in early motherhood as explained above, the participants started to become more self-compassionate once they began embracing their new role as a mother. The duration of this change seemed to differ for each individual depending on their experiences, but most participants described starting to practise self-compassion after the initial few months. In the transition to motherhood, self-compassion seemed to play an important role in adapting to the changing identity. It also appeared that in this process, they changed their perspective and became more accepting and kinder towards themselves when experiencing maternal challenges. They also seemed to understand the importance of their self-care and become more committed to attend to their needs for the benefit of themselves and their babies. Additionally, while the mothers started to adjust to their role, the babies also started to grow which seemed to help the mothers separate from their babies. All these aspects appeared to help the sample to become more self-compassionate, which are discussed below.

4.2.3.1. Changing perspective

An interesting finding reveals that the participants started practising self-compassion after experiencing a change of perspective regarding themselves and motherhood. It appeared that they dropped their unrealistic expectations of being a perfect mother after realising that such a thing does not exist, and adapted their views to the reality of motherhood. The participants explained how they were trying to achieve an idealised version of motherhood by completing every task perfectly including childcare, household chores and work. It appeared that failing to meet their unachievable expectations or attended to one task and not the other led to neglecting their own needs and induced guilt and self-criticism. However, the participants soon realised that their schedule was ‘not sustainable’ and they were ‘too harsh’ on themselves which was not realistic. After this realisation, they appeared to be kinder towards themselves and more accepting of their limitations as a mother, developing a more self-compassionate mindset (Neff, 2003a,b). Acknowledging the maternal challenges appeared to allow the sample to give themselves permission to ‘let go’, ease their unrealistic

high standards and start becoming self-compassionate. Self-compassion appeared to prevent them from feeling guilty about not always doing the 'right thing' as per the internalised societal values previously discussed.

This is also consistent with previous findings showing that self-compassion moderates perfectionism which could result in hopelessness and self-criticism such as 'I am never good enough' (Ferrari et al., 2018). Another study suggested that self-compassion could act as a mediator for parental burn-out experienced as a result of societal pressures such as being a perfect mother (Sorkkila & Aunola, 2020). It is also suggested that through self-compassion, the participants were able to accept their performance, independent of the outcomes as shown in the literature (Finlay-Jones et al., 2015). The data also shows that by becoming more self-compassionate, the participants were able to accept their limitations and proudly recognise their achievements, suggesting an increased self-worth and self-esteem as a mother.

Additionally, it appeared that through changing perspective and becoming self-compassionate, the participants became more accepting of their situation. An important aspect of this acceptance appeared to be adjusting to the role and identity change in the transition to motherhood. This research indicates that self-compassion appears to facilitate the environment for accepting the new identity for all participants, helping them to move away from feelings of loss of pre-motherhood identity, resentment and frustration due to the challenges experienced. Some participants also started to accept their 'choice' of becoming a mother which seemed to help to relieve them from feelings of resentment, anger and regret. This could explain how the participants' relationship with themselves and motherhood appeared to improve during the process of becoming self-compassionate, as well as helped them to adjust to the new identity. This is consistent with the existing findings linking self-compassion with improved adaptability, adjustment to role changes and losses (Hope et al., 2014). Neff (2003a) also suggested that theories of self-compassion could be highly relevant to researchers dealing with identity and self, indicating a possible link between these concepts. The transition in identity could be particularly challenging and confusing for working mothers, particularly when they return to work after giving birth (Hennekam et al., 2019). Considering this research sample was mostly comprised of working mothers, this could also support the theory that through

self-compassion, they were better able to adjust to this transformation and embrace motherhood.

During the transition of becoming more accepting and self-compassionate, several participants experienced unpleasant events such as their baby becoming ill, which appeared to allow them to accept their current situation by changing their priorities and appreciating what was really important. Having more gratitude through this perspective change also seemed to help them to be more forgiving towards themselves even if motherhood was not perfect. Previous research also highlighted a relationship between gratitude and having less critical and more 'compassionate relationship with the self' (Petrocchi & Couyoumdjian, 2016, p.1). This could also support that self-compassion may play a role in changing some aspects of one's identity and personality.

Although some participants had a perspective change triggered by sudden events, the shift did not happen overnight for most mothers and it was a long process where they needed constant support from others. Systematic reviews showed that spousal support is particularly important and acts as a buffer against mood related issues in the postnatal period (Pilkington et al., 2016). Other studies also emphasised that perceived social support was a crucial element to prevent distress and improve wellbeing for first-time mothers (De Sousa Machado et al., 2020). Similar findings emerged from this research showing that the participants appreciated other people's support and having a safe space to reflect on and normalise their emotions which seemed to help them to self-sooth. They also explained how receiving compassion from others helped them to see their challenges from a different perspective, to gain a more accepting and kinder approach towards themselves and to become more self-compassionate.

While support from partner, family and healthcare professionals is essential, the sample also considered connecting to other mothers an important element in changing perspective and becoming more self-compassionate. Through this additional support network, the participants received advice and reassurance which appeared to improve their knowledge on babies, allow them to become more realistic about motherhood, normalise their emotions and accept their limitations as a mother. Additionally, through having a shared experience, the sample appeared to feel less lonely in their challenges thanks to a sense of belonging to an exclusive network of mothers which may not be understood by

others, including their partners (De Sousa Machado et al., 2020). Some women might feel more inadequate and lonely in these groups due to a sense of competitiveness and the sample of this research also acknowledged the difficulty of not comparing themselves with other mothers, as found in other studies (Dennis & Chung-Lee, 2006). However, practising self-compassion appeared to help the sample to accept their emotions and focus on the positive aspects of these groups. This could be explained through having common humanity which is an important element of self-compassion (Neff, 2003a).

4.2.3.2. Increased commitment to self-care

It is evident from the data that after a period of adjustment to motherhood, the participants had an increased commitment to their self-care which had been previously neglected. This motivation seemed to be driven by their improved self-kindness and self-compassion, aiming to overcome their difficulties (Gilbert, 2009a). This finding was supported in the literature which suggested that by devoting time to attending to self and treating themselves as their own best friend, parents were able to start practising self-compassion in this 'relational process' (Bögels et al., 2010, p.112).

Additionally, identifying and addressing their needs appeared to help the participants to improve their mood when experiencing maternal challenges. The participants also stopped feeling that they were not a good mother, if they did not dedicate all their time to their babies which seemed to leave them feeling 'like a zombie' due to exhaustion. Dedicating time for themselves allowed the sample to take a break from motherly duties and mentally recharge. This self-compassionate mindset also appeared to allow the participants to spend more quality time with their babies, increasing their enjoyment of motherhood. This finding is consistent with an existing study showing a positive association between self-compassion and life satisfaction (Kim & Ko, 2018). This could explain the increased maternal satisfaction observed in this study.

Some participants also stressed that they had started to accept their limitations as first-time mothers and replaced their previous pastimes with new ones which could be completed while taking care of their babies. Starting to engage in baby-led activities such as playgroups allowed them to meet other mothers who shared

similar difficulties, suggesting an improvement in their common humanity (Neff, 2003a,b). It appeared to help most participants to reduce their loneliness and embrace their new identity as a mother. These social interactions also led to new friendships for some participants who appeared to initiate deeper connections with like-minded people, further helping to improve their mood. Indeed, studies showed that first-time mothers, particularly whose families did not live locally, could experience less loneliness and develop friendships through attending mother and child playgroups (De Sousa Machado et al., 2020).

The participants also emphasised that introducing their babies to the outside world helped their babies to learn to interact with others. Observing their baby's increased happiness appeared to improve the mood of the participants, as well as providing a sense of achievement as a mother. As pointed out by some participants, through recognising their achievements as a mother, they appeared to become less self-critical and more accepting towards their flaws which was a way of practising self-compassion. This is also consistent with the literature, suggesting that self-compassion allows individuals to have an improved perceived competence (Neff et al., 2015).

Attending to their own needs in the process of becoming self-compassionate also appeared to encourage the sample to seek psychological help when needed. Some participants explained how they had started seeing a counsellor in order to receive psychological support for their difficulties triggered by motherhood. This could suggest that these participants were treating themselves kindly and acknowledging their emotional difficulties instead of avoiding them or being critical towards themselves. This is also consistent with the existing study findings suggesting self-compassion allows individuals to seek psychological support even if there was stigma (Heath et al., 2018). This could be an important finding considering the stigma associated with seeking psychological support among first time mothers, as discussed previously.

In Buddhist practice, the Dalai Lama and others (1995, as cited in Gilbert, 2014, p.19) defined self-compassion as 'a sensitivity to suffering in self' and 'commitment to try to alleviate and prevent it'. This proactive approach also seemed to enable the participants to regain control of their lives and feel more powerful in their new role as a mother. It could also help them to have a positive self-attitude and become more aware of their coping resources which could

further improve their self-acceptance (Neff, 2003b). This could explain how the participants had a renewed commitment to their self-care while becoming more self-compassionate, after realising its impact on their own and their babies' physical and emotional wellbeing.

4.2.3.3. Growth facilitates self-compassion

The findings show that the participants became more self-compassionate while they were growing as a mother and settling into the role of motherhood. Gaining more knowledge and experience of motherhood appeared to allow the participants to accept that their babies were separate humans with 'their own minds' which helped them to stop personalising their babies' behaviour such as excessive crying or 'tantrums'. The sample's new understanding seemed to relieve them from self-critical thoughts and guilt when not always 'doing the right thing'. It also appeared to allow them to perceive their challenges as part of motherhood instead of being their fault, which is consistent with the previous studies associating self-compassion with less personalising (Leary et al., 2007).

Some participants also explained how they considered these challenges as part of developing a relationship with a human being and non-judgementally accepted their own unpleasant feelings such as frustration triggered by the relationship, which is consistent with the existing studies (Neff, 2003a). This self-compassionate approach appeared to help them to stop feeling like a bad mother when they were not able to understand their babies' needs and did not know how to sooth them appropriately. Self-compassion appeared to allow the participants to accept the imperfections of themselves and their babies, acknowledging that they are learning and settling into the world, which is consistent with literature (Zhang et al., 2020). It is suggested that their approach could help them to feel less resentful and frustrated with the babies and behave more calmly which may help them sooth the babies and improve their bonding (Cree, 2015). Additionally, the sample also seemed to understand that a mother's real achievement is spending quality time with their babies and developing a relationship with them by becoming more self-compassionate (Stadlen, 2004). This understanding appeared to help the participants feel less judgemental of themselves and enjoy motherhood and therefore their babies.

Additionally, acquiring more skills and confidence as a mother appeared to help the participants deal with unexpected situations in a calmer manner without being harsh on themselves or personalising the situation. After facing similar difficulties such as sickness of a baby, the sample appeared to start accepting the situation as a natural part of the baby's development which they could learn from and acknowledge as a common experience of motherhood. They also seemed to understand that it was not in their control and having a sick baby did not make them a failure as a mother. This is consistent with the literature suggesting that self-compassion could allow individuals to accept new situations as learning experiences and development opportunities (Leary et al., 2007).

While the participants were adjusting to motherhood, their growing babies also seemed to help them to become more self-compassionate. The sample explained how their babies' development allowed them to have more time and energy for their own needs which was considered as self-compassion. It was stressed that by being able to regain some of their independence, they were able to take time off from motherhood, socialise or enjoy 'me-time', which appeared to allow them to be kind to themselves. Some participants also mentioned that they had started to feel less guilty about asking for help from others after observing that their babies were settling into the world. When the babies became less fragile and more independent, it meant that other people could look after them without requiring the participants' constant attention. The babies' growth seemed to allow the participants to attend to their self-care and increase their enjoyment of motherhood as they were able to take a break when needed. It is suggested that the enhanced motherhood experience might have further improved the participants' bonding with their babies which also enabled them to have a kinder attitude towards themselves, lessen their self-doubt and increase their self-compassion (Cree, 2015).

4.2.4. Summary

Several important findings emerge from this study. One finding is that all physical and emotional aspects of motherhood, as described above, closely relate to each other and have an impact on the participants' ability to practise self-compassion. It is suggested that it may be difficult to be self-compassionate in the initial period of motherhood due to emotional and physical challenges. This finding also

suggests that in order to be able to practice self-compassion, basic needs must first be addressed, which could allow sufficient physical and mental capacity for self-compassion.

The analysis also emphasises the connection between self-care and self-compassion for the participants which appeared to nurture each other. When the participants were able to take care of their needs, it appeared to give them a break from their challenges and allow them to return to the situation refreshed, feeling more accepting and less self-critical. It also seemed to help them accept that their challenges were part of motherhood, allowing them to feel less lonely in their difficulties.

Another important finding of this study is other people's role in the participants practising of self-compassion. It is evident that the attitude of others made a great difference to the sample, either allowing them to accept their limitations or compounding the feelings of self-criticism and guilt. It appeared that by receiving compassion from others, the participants seemed to have a kinder, more accepting attitude towards themselves. Furthermore, they could normalise their emotions related to motherhood and feel less lonely in their experiences. Compassionate people also appeared to provide practical support for mothers, allowing them to have more time and energy for themselves and their babies, which was seen as an important part of self-compassion.

Finally, the findings also show that self-compassion is a process for first-time mothers in the transition to motherhood. It is initially challenging to be self-compassionate. However, embracing the role of motherhood, as well as the babies' growth appeared to allow the participants to find more time and physical and mental energy for themselves and their babies. Self-compassion seemed to play an important role in helping the participants to adjust to motherhood and changing identity. During the process, the sample also seemed to realise that their idealistic expectations of motherhood were not sustainable which appeared to help them to drop these unrealistic standards and become more self-compassionate.

4.3. Critical Review of the Research

4.3.1. Originality

To date, I have not come across a published study exploring the prerequisites of self-compassion. My findings demonstrate that first-time mothers may struggle to be self-compassionate in early motherhood due to their idealised expectations, not meeting their basic needs and experiencing loss of pre-motherhood life. Self-compassion may only be experienced when the adjustment period has been completed to allow them more physical and mental energy for self-compassion.

Although the barriers to practising self-compassion have been previously researched, the exploration has been limited to internal barriers of an individual, mainly focusing on the negative assumptions and fear of self-compassion (Gilbert et al., 2011).

Several studies evidenced the role of childhood experiences and parental upbringing for the ability to generate self-compassion later in life (Bayir & Lomas, 2016). However, to my knowledge, there is no study that explores how meeting self-care needs and the current context of an individual such as being in a supportive environment, surrounded by compassionate people could improve self-compassion, which my study emphasises.

Considering these new findings, counselling psychologists could play an important role to support first-time mothers in becoming more self-compassionate which is further discussed in section 4.4.

4.3.2. Further reflexivity

The importance of reflexivity has already been discussed in Chapter 2. In this section, I record my reflections on the interview and analysis process, along with my learnings from this research.

Since self-compassion is an abstract concept which may have a different definition and meaning for each individual, during the analysis I sometimes found myself struggling to identify self-compassion practices. Some participants appeared to be unsure whether some of their practices could be considered as self-compassion. I took the decision to include them in the analysis if the same practice emerged in other interviews, without looking to fit it into the definition of

self-compassion given to the participants prior to the interviews. I believe my approach helped the analysis to be more inclusive.

It appeared that some participants had realised during the interview process that they were more self-compassionate than they had perceived themselves due to a prior assumption that self-compassion is the absence of self-criticism. Although it was shown in the literature that positive and negative components of self-compassion could co-exist, I could not grasp the idea fully before this research (Neff, 2003a). Talking to my participants helped me realise that I had a similar assumption which appeared to be an idealised version of self-compassion. This research has also taught me that self-compassion is a spectrum which can fluctuate and first-time mothers could reside at different points of this spectrum at different times, depending on their physical and emotional experiences.

Another important learning from my research is understanding how the existing theories could miss the contextual aspects. Exploring my participants' understandings and values more reflectively helped me to recognise my own blind spots as a researcher. During the analysis, I realised that I was mainly searching for Neff's three components (self-kindness, mindfulness and common humanity) (2003a) in my interviews despite conducting an inductive analysis. Therefore, I tried to truly understand my participants' stories and how they practiced self-compassion by attending to the codes and themes which may not be covered by Neff's components. For example, when a participant told me that she felt judged by others, my initial interpretation was that she was lonely in her experience and not connecting to others. However, in my further attempts of analysing her story, I could interpret that their self-compassion was diminished by feeling judged by others and the themes could not only be captured by feeling lonely. This realisation helped me to move away from a more theory-driven approach and brought me closer to an inductive approach by being more curious about the different views of the participants which might have been missed in the theories. This approach is also aligned with my critical realist position which acknowledges different perspectives when considering the reality of self-compassion. In the existing studies, self-compassion is mainly introduced as a skill which is encouraged to be practised at an individual level (Dale-Hewitt & Irons, 2015). It appears that social factors which appeared to be an important

element in practising self-compassion for my sample may have not have drawn enough attention previously.

My reflexivity allowed me to think about self-compassion more integratively, considering various contextual issues, as encouraged in Counselling Psychology, rather than focusing on an individualistic framework promoted in Western-oriented psychology (Cooper, 2015). When I developed my research question '*how do first-time mothers practise self-compassion'*, I assumed that the themes could focus on the literal, physical acts of self-compassion such as talking to others, self-soothing, self-care. However, while analysing the data, I have realised that the wider context of an individual is equally important for practising self-compassion which should be reflected by the analysis. I have also realised that my previous assumption would not cover the richness of the data and I could answer my research question more broadly by including the elements contributing to how the skill is practised, as aligned with my critical realist position. This shift in my approach led me to consider the fundamentals of practising self-compassion such as understanding of the phenomenon, barriers and prerequisites. The reflective process of developing the research question based on the wider context is also discussed as a common practice for doctoral students and encouraged when conducting qualitative research (Agee, 2009).

4.4. Implications for Counselling Psychology

4.4.1. Context of the current practice

Before discussing the implications of this study, it is useful to understand the existing governmental policies on perinatal mental health and the resources currently available to support first-time mothers. Perinatal mental health has drawn attention in recent years in the UK. Researches showed that new mothers' mental health has significant effects on both the mothers' and their children's wellbeing. For yearly total births in the UK, the total cost of perinatal mental health issues to society is £8.1 billion, of which £1.2 billion is to the NHS. 'Even a relatively modest improvement in outcomes as a result of better services' would justify improving perinatal services and introducing early interventions (PSSRU,

2014, p.37). Therefore, the government has committed to increase funding in this area and published an implementation strategy (NHS, 2019).

Despite these benefits, support services which could help improve perinatal mental health are encountering spending cuts, indicating a challenge for presenting helpful strategies to new mothers. In 1999, the government introduced "Sure Start Children's Centres", a programme aimed at supporting young children and their families by providing services such as free childcare, parental information and activities. Although the programme is primarily aimed at less affluent demographic groups, children's centres are widely used in all areas of the UK, irrespective of prosperity. The centres are also connected to NHS maternity services with healthcare professionals including clinical/counselling psychologists to provide practical advice to new mothers who can build their support network. The programme has been successful in reducing parental distress and saving £65 million for the NHS through reduced hospital admissions thanks to more knowledgeable and supported parents (IFS, 2015).

Despite these benefits, children's centres are facing increased closure rates due to budget cuts in local councils, particularly in poorer areas. It is suggested that this could result in first-time mothers being more at risk of social isolation, lacking parental information and a supportive environment which could have a negative impact on their mental health. Limiting availability of children's services may also lead to an increased demand on other professional support services available for first-time mothers including midwives and healthcare visitors who provide advice and support in the early months of motherhood (NHS, 2018).

4.4.2. Clinical implications of the research

This research has the potential to be a guide for clinicians working with first-time mothers by improving their understanding of how self-compassion is practised by this group. It could also benefit counselling psychologists developing more practical and flexible interventions for first-time mothers to improve self-compassion. The findings show that in order to support first-time mothers, it would be best to focus on the earlier stages of motherhood, because that is the period they appeared to struggle with self-compassion and are most at risk of developing psychological issues such as depression (Munk-Olsen et al., 2006). Additionally,

the findings indicate that ‘changing perspective’ towards self-compassion could take time and mothers are pre-occupied with physical and emotional challenges in early motherhood. These findings suggest that introducing the interventions at the earliest opportunity, even during pregnancy, when women have more time and mental space for self-compassion, would be highly beneficial.

The findings strongly evidence that self-care is related to self-compassion for the participants. Therefore, strategies to improve self-care in early motherhood could be incorporated in the interventions when working with these women. As shown in the findings, mothers are likely to have ‘increased commitment to self-care’ after realising the psychological benefits for themselves and their babies. Therefore, emphasising these benefits could be used as a motivational strategy for mothers. Although promoting self-care opportunities for first-time mothers is important, it may not be sufficient due to several challenges including dependency of the baby and reluctance to trust others as identified in the findings (Barclay et al., 1997). Therefore, addressing these challenges first should also be considered to allow first-time mothers to be more self-compassionate.

The findings show that due to the physical and emotional changes first-time mothers may initially need additional practical and emotional support from others in order for them to develop a more self-compassionate mindset and attend to their self-care. This information should be considered carefully when working with mothers who are likely to lack available support, such as socially isolated single mothers (Rousou et al., 2016). The findings suggest that these mothers may have increased difficulties in practising self-compassion, which may lead them to develop more severe psychological issues in the future. Counselling psychologists could identify these individuals and work with them at an early stage, even during pregnancy, to support them in changing their perspective about motherhood and babies in order to improve their self-compassion.

Additionally, it is essential for counselling psychologists to work with the partners of first-time mothers in the transition to motherhood. It could be beneficial to provide therapeutic support for partners to improve their understanding of the psychological impacts of maternal challenges, the changing role dynamics and the importance of self-compassion for mothers. The partners could be encouraged to provide a compassionate approach to the mothers to improve their self-compassion. These sessions could also aim at assessing the partners’

psychological wellbeing. Any issues which could be triggered through parental challenges could be identified and they could be referred to the father-focused services as recommended by the NHS perinatal guidelines (2019).

Although partner's support could allow mothers to become more self-compassionate, the findings also show that some mothers may have difficulties in accepting support due to their idealised standards. It appeared to be a barrier for practising self-compassion by triggering feelings of self-criticism and guilt about not being self-sufficient and making it difficult to attend to their self-care. However, the findings also indicated that a 'perspective change' could allow first-time mothers to drop their unrealistic expectations and become more self-compassionate. Counselling psychologists could play a crucial role in this perspective change through providing psychoeducation which is an effective tool to improve perinatal mental health (Rahman et al., 2018). Therefore, psychoeducational programmes based on the principles of good enough mothering and the reality of motherhood could be introduced for first-time mothers (Hoghughi & Speight, 1998; Winnicott, 1965). This could be done through psychological sessions, videos and flyers which aim at enlightening these women regarding the unspoken truths about motherhood.

Considering that social-oriented perfectionism and idealistic standards may lead to distress in the transition to motherhood, counselling psychologists could also explore how cultural expectations might play a role when working with new mothers (Lee et al., 2012). Additionally, it could be beneficial for counselling psychologists to explore the family dynamics when growing up and the transgenerational dimension of self-compassion. Although it did not occur as a theme in this research, two participants mentioned how they initially struggled with self-criticism which they linked to growing up with critical parents having high expectations from them. This was supported in the literature, suggesting that people with critical parents may struggle with self-compassion (Bayir & Lomas, 2016; Neff, K. D. & McGehee, 2010). Therefore, when working with new mothers, their own parental dynamics could be considered in terms of self-compassion and early perspective change could be targeted for these women.

My findings also show that 'not knowing what to do' as a first-time mother could trigger self-doubt and self-criticism which may act as a barrier for self-compassion. Therefore, interventions could also focus on the emotional triggers

of ‘not doing the right thing’ such as breastfeeding which are promoted by traditional societal values and how to think about it more self-compassionately, considering a mother’s own needs. Additionally, my findings suggest that improved understanding of babies’ emotional and physical development could prevent first-time mothers from having feelings of self-doubt and self-criticism and to become more self-compassionate. The baby’s natural growth is also an element for improving self-compassion for mothers. Although the development cannot be controlled, increasing the mothers’ awareness that the baby’s full dependency is only a short-lived phase could help improve their acceptance, thus, self-compassion. Counselling psychologists could work with first-time mothers to improve their understanding of babies’ age-appropriate behaviour and mother-baby interaction, which might also help them to develop compassion for themselves and their babies.

Another finding for counselling psychologists to consider is regarding the setting when providing the interventions. Connecting to other mothers and learning from their experiences appeared to be an important aspect of changing perspective and becoming more self-compassionate for the participants. This may suggest that counselling psychologists may achieve more effective results when working with first-time mothers in a group setting rather than individually. However, this needs to be tested in clinical trials, comparing the effectiveness of the outcome between individual and group sessions.

4.4.3. Service improvement and societal implications

Counselling psychologists work with maternity units, perinatal mental health community and primary care services, providing an opportunity to reach new mothers seeking psychological help (National Collaborating Centre for Mental Health, 2019). However, first-time mothers mainly seek information from midwives in the initial weeks after birth in order to receive reassurance and normalise their experiences (Osman et al., 2010). Additionally, the barriers for psychological help seeking were also discussed in Chapter 1. Considering that midwives could be the main contacts and sources of information for coping with maternal distress; working with midwives and health visitors would be essential to target a wider population of first-time mothers. Counselling Psychologists have

a crucial role to train, supervise and consult these professionals working directly with new mothers, as part of their role (BPS, 2017).

As discussed, improving understanding of motherhood and babies could help women to change perspective and feel less self-critical and guilty about attending to their own needs. However, some women may lack support which could also be addressed by making self-care more accessible in order to allow them to have more time and mental space for self-compassion. The Dutch healthcare model might address this gap in the UK by providing support for new mothers through a home-visiting maternity nurse, kraamverzorger. These nurses are responsible for educating women on the basics of taking care of a baby and appropriately responding to their needs which aims at improving self-efficacy of first-time mothers (Puckering, 2015). They also provide care for these mothers by preparing food and doing some light household chores to allow them to sufficiently rest and physically recover from the birth which may also improve their emotional state as discussed previously. This system could be helpful for first-time mothers to allow them to start practising self-compassion in early motherhood. Improvement of services is within the role of counselling psychologists who could help to plan a similar system in the UK (HCPC, 2015). This could be achieved by preparing the psychoeducational information as introduced above, as well as training and supervising maternity nurses.

My findings also show that developing connections with other mothers could help first-time mothers to improve their knowledge through receiving advice, normalising their maternal challenges and the related emotions, which seemed to allow them to feel less self-doubt, and more self-acceptance and self-compassion. A peer support programme focused on breastfeeding was introduced in Plymouth and found to be effective for new mothers (NICE, 2012). A similar peer support programme could be introduced which would allow first-time mothers to learn from the experiences of other mothers, not only limited to breastfeeding. The programme could act as a reflective space to share and learn from each other's experiences. Since these programmes would be open for everyone, it could also de-stigmatise accessing support and normalising the mothers' need to reach out for others.

Similarly, the reality of motherhood could also be clarified for women who are pregnant or planning to be in the future. The findings suggest that improving

knowledge of motherhood would help normalise the emotions of first-time mothers and allow them to have a more self-compassionate mindset. However, most antenatal workshops seemed to focus on pregnancy and birth, missing the opportunity to provide information about the psychological impacts of becoming a mother (De Sousa Machado et al., 2020). This information could be incorporated in perinatal workshops and counselling psychologists could train and supervise other professionals delivering this information.

While introducing all the above interventions, online and telephone alternatives are recommended which could attract new mothers who may not have sufficient time and energy to leave the home for face-to-face appointments (Nystrom & Ohrling, 2004). Additionally, social media could be used as an effective tool, within the practise guidelines, to reach first-time mothers who are unaware of the reality of motherhood (BPS, 2017). Social media focusing on the idealised version of mothering was shown to trigger anxiety, depression and perfectionist standards in mothers due to the elements of comparison (Padoa et al., 2018). Conversely, counselling psychologists could promote campaigns encouraging first-time mothers to share the challenging experiences of motherhood which could help society to have more realistic expectations and reduce first-time mothers' guilt and self-criticism over not meeting the impossible ideal. These strategies could help change the perspective of first-time mothers by bringing their expectations closer to reality, which may also help them to become more accepting towards their flaws and consider their own needs, and thus, start practising self-compassion.

Most importantly, my findings indicate that receiving compassion, including from healthcare professionals, may help first-time mothers to become more self-compassionate. Counselling Psychology's values include a compassionate, non-judgemental approach, as well as self-awareness which could help identify barriers for a compassionate approach. For example, burn-out could be one of these barriers and increased self-awareness could prevent it (Hernandez et al., 2015). Through promoting these values and supervising the healthcare professionals working with first-time mothers, the counselling psychologists could indirectly help first-time mothers to receive more compassion which may also allow them to become more self-compassionate.

The next step could be changing policies, educating the relevant parties on the challenges of first-time mothers and introducing a compassionate approach towards them. For example, employers could be assisted to provide a smoother transition for returning mothers including an induction for the old role and providing appropriate allowances for child's sickness and self-care which may help new mothers feel less guilty about being a working mother. Counselling psychologists have a role in leadership and helping improve society (BPS, 2017). Therefore, they could advocate these changes by working with managers and industry leaders and preparing programmes aimed at revealing the costly impacts not only on new mothers but also on their babies and society as discussed previously.

4.5. Limitations

The demographics of the sample could be a limitation. As described in the methodology, all participants were over 30-years-old, married, had a high socio-economic status and had completed at least one graduate degree. The sample mostly consisted of white European expat women living in the UK. Therefore, it may not be representative of a wider population of first-time mothers. Although self-compassion is a universal concept, the demographics including age, as well as socio-cultural factors and family dynamics could play a role in shaping the use of self-compassion (Hwang et al., 2016; Neff et al., 2008).

Another limitation could be the perception and understanding of self-compassion by the sample. Since the participants were interested in the subject, they were reflective and open to talking about their personal experiences of motherhood and self-compassion in depth which enabled me to capture rich data. Although the sample appeared to have a good understanding of self-compassion, I noticed that some participants gave me examples of self-compassion in their interviews without naming it as self-compassion but defining its components including *self-kindness, mindfulness and common humanity* (Neff, 2003a). When it happened, I tried to pinpoint it to them and used these examples as a prompt for the other questions in order to receive richer data if they struggled to remember their experiences. Despite my efforts, the participants might not have reported some of their practices which may not be considered as self-compassion. Future

researchers could keep this potential limitation in mind and might consider using a different, simpler terminology or an imagery which could help people to fully grasp the concept of self-compassion.

Additionally, the majority of the sample explained their experiences retrospectively and some self-compassion practices might not have been fully remembered at the time of the interview. Only three participants discussed their practices of self-compassion while still being in the postpartum period. However, the analysis shows that all these participants' use of self-compassion appeared to be similar, although the maternal challenges might differ due to different developmental experiences of the babies.

Talking about their experiences retrospectively, when these participants reflected on the interview process, they explained how the interview helped them to recall their journey into motherhood. The interview process seemed to generate a discovery and reminded them of their maternal challenges, as well as their ways of coping. The process of remembering appeared to reinforce their resilience and sense of achievement as a mother. Although most participants explained their overall experiences of motherhood, they may not have mentioned some of their experiences as the questions focused on the first year as the postpartum period. While conducting my research, the NHS published a strategy stating that perinatal mental health services should consider the first 24 months after giving birth (NHS, 2019). If this had happened prior to my interviews, I would not have focused on the postpartum period, when asking my interview questions. These factors should also be considered when reading this study.

4.6. Recommendations for further research and conclusions

An important finding of my research is the importance of receiving compassion to facilitate practising self-compassion. I would recommend that the relation between these two elements be explored further in the future. A quantitative research could investigate the correlational relationship with larger samples that may not only be limited to first-time mothers, which could also provide generalisability of the results. It could expand to the existing theories and improve understanding of how self-compassion can be improved for individuals.

Additionally, the role of family dynamics could also be researched further. As explained before, the majority of the sample lived in the UK and other European countries which may have an individualistic approach to childcare. It could be beneficial to conduct a study with participants living in a more collective society where childcare is undertaken by all adults in a family, and new mothers receive more practical support (Humenick, 2003). Combined with a compassionate approach, it might provide a more supportive environment for self-compassion. The study could investigate whether these mothers start practising self-compassion at an earlier stage in motherhood and whether the practices are similar to this study's findings.

Using TA from a critical realist position appeared to fit well for exploring how self-compassion is practised by the sample and allowed me to analyse the overall data to find the patterns. This positioning provided me with a chance to consider the wider context of the participants when answering the research question. However, different methodologies could explore these contexts more in detail. For example, future research could be beneficial for exploring the impacts of social and cultural factors in practising self-compassion and the transition to motherhood. This could be through a discourse analysis of the language used in social media and news articles. The findings could inform the policies recommended in the implications.

My research also shows that self-compassion could be enhanced through fulfilling the basic needs of the participants including sleep, hygiene and nutrition which could improve their bodily and mental wellbeing. My findings suggested that not being able to attend to basic needs may disrupt emotion regulation and act as a barrier for self-compassion. Limited research found a relationship between self-compassion and sleep. Studies suggested that self-compassion could improve sleep quality (Butz & Stahlberg, 2018, 2020). Although they did not test whether self-compassion could be improved by better sleep, the researchers recommended to further explore this link in the future. As my findings also suggested, exploring this link further through an experimental research would be beneficial to test whether improving sleep, rest and nutrition could improve self-compassion.

Similarly, another interesting finding of this research is that the sudden emotional and physical changes of motherhood appeared to act as a barrier for self-

compassion for the sample. As explained previously, in this period first-time mothers found themselves struggling with feelings of loss and grief which appeared to trigger feelings of self-criticism and guilt. Although the literature identified self-compassion as a mediator for these feelings, the evidence is poor regarding whether sudden changes could reduce self-compassion (Lenferink et al., 2017). Unpacking the causality through an experimental study could help to explore these barriers and test whether self-compassion requires mental capacity which might be difficult to achieve while going through upheavals. This might help practitioners to develop interventions to enhance self-compassion for individuals experiencing sudden transformations which are not limited to maternity.

In conclusion, this research attempted to explore how self-compassion is practised by first-time mothers, with a focus on the transition to motherhood, from a critical realist perspective, using thematic analysis. The findings suggest that in the early motherhood, the sample was struggling to practise self-compassion due to the sudden changes which appeared to exhaust them mentally and physically. Additionally, not meeting their self-care needs appropriately appeared to be a barrier for self-compassion. However, starting to settle into the new role seemed to help the sample to understand the reality of motherhood, change perspective and become more self-compassionate. The findings also highlight that receiving practical and emotional support from others was crucial for the participants to be kinder and more accepting towards their flaws and thus, become more self-compassionate. These findings also emphasise the importance of context in practising self-compassion. The study has a potential to contribute to the current theories, as well as inform interventions and enhance services supporting not only first-time mothers but also women preparing for motherhood.

References

Agee, J. (2009). Developing qualitative research questions: A reflective process. *International Journal of Qualitative Studies in Education, 22*(4), 431–447. https://doi.org/10.1080/09518390902736512

Alhojailan, M. I. (2012). Thematic Analysis: A Critical Review of its Process and Evaluation. *WEI International European Academic Conference Proceedings*, 14-17. https://www.westeastinstitute.com/wp-content/uploads/2012/10/ZG12-191-Mohammed-Ibrahim-Alhojailan-Full-Paper.pdf

Amangbey, E., Gando, T., Baba, A. A., & Akuu, J.A. (2017). Early Motherhood: Maternal Challenges and Coping Strategies Among First-Time Ghanaian Mothers. *Journal of Health, Medicine and Nursing*, *43*, 98-105.

Ando, H., Cousins, R., & Young, C. (2014). Achieving Saturation in Thematic Analysis: Development and Refinement of a Codebook. *Comprehensive Psychology*, *3*. https://doi.org/10.2466/03.CP.3.4

Atkinson, J., & Feather, N. (1966). *A theory of achievement motivation*. 1st ed. Wiley and Sons.

Attia, M., & Edge, J. (2017). Be(com)ing a reflexive researcher: a developmental approach to research methodology. *Open Review of Educational Research*, *4*(1), 33-45.

AXA Healthcare, (2015). Social isolation putting first-time mums at risk. https://www.axappphealthcare.co.uk/health-information/pregnancy/overcoming-feelings-of-isolation-as-a-new-parent/

Baer, R. A. (2010). Self-compassion as a mechanism of change in mindfulness- and acceptance-based treatments. In R. A. Baer & R. A. Baer (Eds.), *Assessing mindfulness and acceptance processes in clients: Illuminating the theory and practice of change* (pp. 135–153). New Harbinger Publications.

Barclay, L., Everitt, L., Rogan, F., Schmied, V., & Wyllie, A. (1997). Becoming a mother—An analysis of women's experience of early motherhood. *Journal of Advanced Nursing, 25*(4), 719–728. https://doi.org/10.1046/j.1365-2648.1997.t01-1-1997025719.x

Barclay, L. M., & Lloyd, B. (1996). The misery of motherhood: alternative approaches to maternal distress. *Midwifery*, *12*(3), 136–139. https://doi.org/10.1016/s0266-6138(96)90057-1

Barkin, J. L., & Wisner, K. L. (2013). The role of maternal self-care in new motherhood. *Midwifery*, *29*(9), 1050–1055. https://doi.org/10.1016/j.midw.2012.10.001

Bayir, A. & Lomas, T. (2016). Difficulties generating self-compassion: An interpretative phenomenological analysis. *The Journal of Happiness & Well-Being*, *4*(1), 15-33.

Bhaskar, R. (1998). Philosophy and scientific realism. In Margaret Scotford Archer (ed.), *Critical Realism: Essential Readings* (pp.16-47). Routledge.

Bondas-Salonen, T. (2008). New mothers' experiences of postpartum care — a phenomenological follow-up study. *Journal of Clinical Nursing*, *7*(2), 165-174. https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1365-2702.1998.00138.x

Borovska, V. (2018). Impact of Motherhood on Women's Identity. *Annual of Institute for sociological, political and juridical research. XLII*, 107-116. https://www.academia.edu/37447298/IMPACT_OF_MOTHERHOOD_ON_WOMENS_IDENTITY

Boyce P. M. (2003). Risk factors for postnatal depression: a review and risk factors in Australian populations. *Archives of women's mental health*, *6 Suppl 2*, S43–S50. https://doi.org/10.1007/s00737-003-0005-9

Bögels, S. M., Lehtonen, A., & Restifo, K. (2010). Mindful Parenting in Mental Health Care. *Mindfulness*, *1*(2), 107–120. https://doi.org/10.1007/s12671-010-0014-5

Brassel, A., Townsend, M. L., Pickard, J. A., & Grenyer, B. F.S. (2019). Maternal perinatal mental health: Associations with bonding, mindfulness, and self-criticism at 18 months' postpartum. *Infant Mental Health Journal, Online First*, 1-10. https://doi.org/10.1002/imhj.21827

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. DOI: 10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, *26*(2),120-123.

Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. In B. Smith & A. C. Sparkes (Eds.), *Routledge handbook of qualitative research in sport and exercise* (pp. 191-205). Routledge.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Journal of Qualitative Research in Sport, Exercise and Health*, *11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

British Psychological Society (BPS). (2014). *Code of Human Research Ethics*. BPS. https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

British Psychological Society (BPS). (2017). *Practice Guidelines.* (Third Edition). BPS. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Practice%20Guidelines%20%28Third%20Edition%29.pdf

British Psychological Society (BPS). (2018). *Safeguarding children and young people: every psychologist's responsibility.* BPS. https://www.bps.org.uk/sites/bps.org.uk/files/Policy

British Red Cross & Co-operative. (2018). *Tackling Loneliness Together: British Red Cross and Co-op end of partnership report.* Research and Publications. https://www.redcross.org.uk/about-us/what-we-do/research-publications

Brunton, G., Wiggins, M., & Oakley, A. (2011). *Becoming a mother: A research synthesis of women's views on the experience of first-time motherhood*. London: EPPI Centre, Social Science Research Unit, Institute of Education, University of London.

Burke, L., & Miller, M. (2001). Phone interviewing as a means of data collection: Lessons learned and practical recommendations. *Forum: Qualitative Social Research, 2*(2). http://www.qualitative-research.net/fqs-texte/2-01/2-01burkemiller-e.htm.

Bury, D., & Strauss, S. M. (2006). The Scientist-Practitioner in a Counselling Psychology Setting. In: Lane, D. A. and Corrie, S. (Eds.), *The Modern Scientist-Practitioner: A Guide to Practice in Psychology*. (pp. 112-126). Routledge.

Butz, S., & Stahlberg, D. (2018). Can self-compassion improve sleep quality via reduced rumination? *Self and Identity*, *17*(6), 666-686. DOI: 10.1080/15298868.2018.1456482

Butz, S., & Stahlberg, D. (2020). The Relationship between Self-Compassion and Sleep Quality: An Overview of a Seven-Year German Research Program. *Behavioral sciences*, *10*(3), 64. https://doi.org/10.3390/bs10030064

Camic, P. M., Rhodes, J. E., & Yardley, L. (Eds.). (2003). *Qualitative research in psychology: Expanding perspectives in methodology and design*. American Psychological Association.

Carlbring, P., Andersson, G., Cuijpers, P., Riper, H., & Hedman-Lagerlöf, E. (2018). Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: an updated systematic review and meta-analysis. *Cognitive behaviour therapy*, *47*(1), 1-18. doi: 10.1080/16506073.2017.1401115.

Carolan M. (2003). Late motherhood: the experience of parturition for first time mothers aged over 35 years. *Australian journal of midwifery: professional journal of the Australian College of Midwives Incorporated*, *16*(2), 17–20. https://doi.org/10.1016/s1031-170x(03)80004-1

Chew-Graham, C. A., Sharp, D., Chamberlain, E., Folkes, L., & Turner, K. M. (2009). Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. *BMC family practice*, *10*, 7. https://doi.org/10.1186/1471-2296-10-7

Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology*, *23*(2), 167–180. https://doi.org/10.1080/02646830500129487

Coates, R., Ayers, S., & de Visser, R. (2014). Women's experiences of postnatal distress: a qualitative study. *BMC pregnancy and childbirth*, *14*(359). https://doi.org/10.1186/1471-2393-14-359.

Cooper, M. (2015). Social change from the counselling room. *BACP Journals: Therapy Today, 26*(1). https://www.bacp.co.uk/bacp-journals/therapy-today/2015/february-2015/social-change-from-the-counselling-room/

Copeland, D. B., & Harbaugh, B. L. (2019). "It's Hard Being a Mama": Validation of the Maternal Distress Concept in Becoming a Mother. *The Journal of perinatal education*, *28*(1), 28–42. https://doi.org/10.1891/1058-1243.28.1.28.

Costa, J., Marôco, J., Pinto-Gouveia, J., Ferreira, C., & Castilho, P. (2016). Validation of the Psychometric Properties of the Self-Compassion Scale. Testing the Factorial Validity and Factorial Invariance of the Measure among Borderline Personality Disorder, Anxiety Disorder, Eating Disorder and General Populations. *Clinical psychology & psychotherapy*, *23*(5), 460-468. doi: 10.1002/cpp.1974.

Cree, M. (2010). Compassion Focused Therapy with Perinatal and Mother-Infant Distress. *International Journal of Cognitive Therapy*, 3, 159-171. https://doi.org/10.1521/ijct.2010.3.2.159

Cree, M. (2015). *The Compassionate Mind Approach To Postnatal Depression: Using Compassion Focused Therapy to Enhance Mood, Confidence and Bonding.* Robinson.

Currie, J. (2009). Healthy, Wealthy, and Wise: Socioeconomic Status, Poor Health in Childhood, and Human Capital Development. *Journal of Economic Literature*, *47*(1), 87-122. DOI: 10.1257/jel.47.1.87

Dale-Hewitt, V., & Irons, C. (2015). Compassion Focused Therapy in Dawson, D. L. & Moghaddam, N. G. (eds), *Formulation in Action: Applying Psychological Theory to Clinical Practice* (pp. 161-179). De Gruyter Open.

Darvill, R., Skirton, H., & Farrand, P. (2010). Psychological factors that impact on women's experiences of first-time motherhood: a qualitative study of the transition. *Midwifery*, *26*(3), 357–366. https://doi.org/10.1016/j.midw.2008.07.006

Dawson, G., Frey, K., Self, J., Panagiotides, H., Hessl, D., Yamada, E., & Rinaldi, J. (1999). Frontal brain electrical activity in infants of depressed and nondepressed mothers: Relation to variations in infant behavior. *Development and Psychopathology, 11*(3), 589–605. https://doi.org/10.1017/S0954579499002229

Deniz, M. E., Kesici, Ş., & Sümer, A. S. (2008). The validity and reliability study of the Turkish version of self-compassion scale. *Social Behavior and Personality*, *36*(9), 1151- 1160. https://doi.org/10.2224/sbp.2008.36.9.1151

Dennis, C. L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: a qualitative systematic review. *Birth (Berkeley, Calif.)*, *33*(4), 323–331. https://doi.org/10.1111/j.1523-536X.2006.00130.x

De Sousa Machado, T., Chur-Hansen, A., & Due, C. (2020). First-time mothers' perceptions of social support: Recommendations for best practice. *Health psychology open*, *7*(1), https://doi.org/10.1177/2055102919898611

Dewe, M. A., & Koyle, A. (2014). Reflections on a study of responses to research on smoking: A pragmatic, pluralist variation on a qualitative psychological theme. *Review of Social Studies (RoSS)*, *1*(1).

Diedrich, A., Grant, M., Hofmann, S. G., Hiller, W., & Berking, M. (2014). Self-compassion as an emotion regulation strategy in major depressive disorder. *Behaviour Research and Therapy*, *58*, 43-51. doi: 10.1016/j.brat.2014.05.006.

Dimitrovsky, L., Lev, S., & Itskowitz, R. (1998). Relationship of maternal and general self-acceptance to pre- and postpartum affective experience. *The Journal of psychology*, *132*(5), 507–516. https://doi.org/10.1080/00223989809599283

Dundas, I., Svendsen, J. L., Wiker, A. S., Granli, K. V., & Schanche, E. (2016). Selfcompassion and depressive symptoms in a Norwegian student sample. *Nordic Psychology*, *68*(1), 58-72. http://dx.doi.org/10.1080/19012276.2015.1071203

Dupasquier, J. R., Kelly, A. C., Moscovitch, D. A., & Vidovic, V. (2018). Practicing self-compassion weakens the relationship between fear of receiving compassion and the desire to conceal negative experiences from others. *Mindfulness, 9*(2), 500–511. https://doi.org/10.1007/s12671-017-0792-0.

Easter, A., Howells, H., & Pawlby, S. (2015). *Talking therapies for mild perinatal anxiety and depression.* NCT's journal on preparing parents for birth and early parenthood. https://www.nct.org.uk/sites/default/files/related_documents/Easter%20et%20al

%20Talking%20therapies%20for%20mild%20perinatal%20anxiety%20and%20depression.pdf

Edhborg, M. (2008). Comparisons of different instruments to measure blues and to predict depressive symptoms 2 months postpartum: a study of new mothers and fathers. *Scandinavian Journal of Caring Sciences*, *22*, 186–195.

Ehret, A.M., Joormann, J., & Berking, M. (2018). Self-compassion is more effective than acceptance and reappraisal in decreasing depressed mood in currently and formerly depressed individuals. *Journal of Affective Disorders*, *226*, 220-226. https://doi.org/10.1016/j.jad.2017.10.006

Emmanuel, E., & St John, W. (2010). Maternal distress: concept analysis. *Journal of Advanced Nursing*, *66*(9), 2104–2115. https://doi.org/10.1111/j.1365-2648.2010.05371.x

Falconer, C. J., King, J. A., & Brewin, C. R. (2015). Demonstrating mood repair with a situation-based measure of self-compassion and self-criticism. *Psychology and psychotherapy*, *88*(4), 351–365. https://doi.org/10.1111/papt.12056

Felder, J. N., Lemon, E., Shea, K., Kripke, K., & Dimidjian, S. (2016). Role of self-compassion in psychological well-being among perinatal women. *Archives of Women's Mental Health, 19*(4), 687–690. https://doi.org/10.1007/s00737-016-0628-2

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods*, *5*(1), 80–92. https://doi.org/10.1177/160940690600500107

Ferrari, M., Yap, K., Scott, N., Einstein, D. A., & Ciarrochi, J. (2018). Self-compassion moderates the perfectionism and depression link in both adolescence and adulthood. *PloS one*, *13*(2), https://doi.org/10.1371/journal.pone.0192022

Finlay-Jones, A. L., Rees, C. S., & Kane, R. T. (2015). Self-Compassion, Emotion Regulation and Stress among Australian Psychologists: Testing an Emotion Regulation Model of Self-Compassion Using Structural Equation

Modeling. *PloS one*, *10*(7), e0133481. https://doi.org/10.1371/journal.pone.0133481

Finlayson, K., Crossland, N., Bonet, M., & Downe, S. (2020). What matters to women in the postnatal period: A meta-synthesis of qualitative studies. *PloS one*, *15*(4), e0231415. https://doi.org/10.1371/journal.pone.0231415

Fonseca, A., & Canavarro, M. C. (2017). Women's intentions of informal and formal help-seeking for mental health problems during the perinatal period: The role of perceived encouragement from the partner. *Midwifery*, *50*, 78-85. doi: 10.1016/j.midw.2017.04.001.

Forrester, M. (2010). *Doing qualitative research in psychology: A practical guide.* Sage.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, *14*(3), 387–421. https://doi.org/10.1016/s0002-7138(09)61442-4

Fugard, A. J. B., & Potts, H. W. W. (2015). Supporting thinking on sample sizes for thematic analyses: a quantitative tool. *International Journal of Social Research Methodology*, *18*(6), 669–684, http://dx.doi.org/10.1080/13645579.2015.1005453

General Data Protection Regulation (GDPR). (2018). *Guide to the General Data Protection Regulation (GDPR)*. Information Commissioner's Office. https://ico.org.uk/media/for-organisations/guide-to-the-general-data-protection-regulation-gdpr-1-0.pdf

Gianni, M. L., Bettinelli, M. E., Manfra, P., Sorrentino, G., Bezze, E., Plevani, L., Cavallaro, G., Raffaeli, G., Crippa, B. L., Colombo, L., Morniroli, D., Liotto, N., Roggero, P., Villamor, E., Marchisio, P., & Mosca, F. (2019). Breastfeeding Difficulties and Risk for Early Breastfeeding Cessation. *Nutrients*, *11*(10), [E2266]. https://doi.org/10.3390/nu11102266

Gilbert, P. (2009a). *The compassionate mind: A new approach to life's challenges.* New Harbinger.

Gilbert P, (2009b). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, *15*(3), 199–208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2010). Compassion focused therapy: A special section. *International Journal of Cognitive Therapy, 3*(2), 95–96. https://doi.org/10.1521/ijct.2010.3.2.95

Gilbert P. (2014). The origins and nature of compassion focused therapy. *The British journal of clinical psychology, 53*(1), 6-41. doi: 10.1111/bjc.12043. PMID: 245887

Gilbert, P., Baldwin, M. W., Irons, C., Baccus, J. R., & Palmer, M. (2006). Self-Criticism and Self-Warmth: An Imagery Study Exploring Their Relation to Depression. *Journal of Cognitive Psychotherapy, 20*(2), 183–200. https://doi.org/10.1891/jcop.20.2.183

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: development of three self-report measures. *Psychology and Psychotherapy-theory Research and Practice*, *84*(3), 239-255. DOI: 10.1348/147608310X526511

Gilbert, J., Stubbs, R.J., Gale, C., Gilbert, P., Dunk, L., & Thomson, L. (2014). A qualitative study of the understanding and use of 'compassion focused coping strategies' in people who suffer from serious weight difficulties. *Journal of Compassionate Health Care, 1*, 9. https://doi.org/10.1186/s40639-014-0009-5

Glover V. (2014). Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. *Best practice & research. Clinical obstetrics & gynaecology*, *28*(1), 25–35. https://doi.org/10.1016/j.bpobgyn.2013.08.017

Gómez-Pinilla F. (2008). Brain foods: the effects of nutrients on brain function. *Nature reviews Neuroscience*, *9*(7), 568–578. https://doi.org/10.1038/nrn2421

Goodman, J. H. (2009). Women's Attitudes, Preferences, and Perceived Barriers to Treatment for Perinatal Depression. *Birth issues in Perinatal Care*, *36*(1), 60-69. https://doi.org/10.1111/j.1523-536X.2008.00296.x

Grigoriadis, S., Wilton, A. S., Kurdyak, P. A., Rhodes, A. E., VonderPorten, E. H., Levitt, A., Cheung, A., & Vigod, S. N. (2017). Perinatal suicide in Ontario, Canada: a 15-year population-based study. *CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne*, *189*(34), E1085–E1092. https://doi.org/10.1503/cmaj.170088

Hall, L.A., Kotch, J. B., Browne, D., & Rayens, M. K. (1996). Self-esteem as a mediator of the effects of stressors and social resources on depressive symptoms in postpartum mothers. *Nursing Research*, *45*(4), 231-238. https://doi.org/10.1097/00006199-199607000-00007

Hansen, J. T. (2006). Counseling Theories Within a Postmodernist Epistemology: New Roles for Theories in Counseling Practice. *American Counseling Association*, *84(3)*, 291-297. DOI:10.1002/j.1556-6678.2006.tb00408.x

Harris, L. R., & Brown, G. T. L. (2010). Mixing interview & questionnaire methods. *Practical Assessment, Research & Evaluation*, *15*(1).

Harwood, K., McLean, N., & Durkin, K. (2007). First-time mothers' expectations of parenthood: What happens when optimistic expectations are not matched by later experiences? *Developmental Psychology*, *43*(1), 1-12. doi: 10.1037/0012-1649.43.1.1.

Health & Care Professionals Council (HCPC). (2015). *Standards of Proficiency – Practitioner Psychologists*. HCPC. https://www.hcpc-uk.org/resources/standards/standards-of-proficiency-practitioner-psychologists/

Heath, P. J., Brenner, R. E., Lannin, D. G., & Vogel, D. L. (2018). Self-compassion moderates the relationship of perceived public and anticipated self-stigma of seeking help. *Stigma and Health, 3*(1), 65–68. https://doi.org/10.1037/sah0000072

Henderson, A., Harmon, S., & Newman, H. (2016). The price mothers pay, even when they are not buying it: mental health consequences of idealized motherhood. *Sex Roles*, *74*, 512–526. doi: 10.1007/s11199-015-05345

Hennekam, S., Syed, J., Ali, F., & Dumazert, J. (2019). A multilevel perspective of the identity transition to motherhood. *Gender, Work and Organization*, *26*(7), 915-933. https://doi.org/10.1111/gwao.12334

Henshaw, E. J., Durkin, K. M., & Snell, R. J. (2016). First-time parents' shared representation of postpartum depressive symptoms: A qualitative analysis. *Social Science & Medicine, 160,* 102–110. https://doi.org/10.1016/j.socscimed.2016.05.025

Henshaw, E. J., Fried, R., Teeters, J. B., & Siskind, E. E. (2014). Maternal expectations and postpartum emotional adjustment in first-time mothers: results of a questionnaire survey. *Journal of psychosomatic obstetrics and gynaecology*, *35*(3), 69-75. doi: 10.3109/0167482X.2014.937802.

Hernandez, W., Luthanen, A., Ramsel, D., & Osatuke, K. (2015). The mediating relationship of self-awareness on supervisor burnout and workgroup Civility & Psychological Safety: A multilevel path analysis. *Burnout Research*, *2*(1), 36-49. https://doi.org/10.1016/j.burn.2015.02.002

Hjalmhult, E., & Lomborg, K. (2012). Managing the first period at home with a newborn: a grounded theory study of mothers' experiences. *Scandinavian journal of caring sciences*, *26*(4), 654–662. https://doi.org/10.1111/j.1471-6712.2012.00974.x

Hoghughi, M., & Speight, A. N. (1998). Good enough parenting for all children--a strategy for a healthier society. *Archives of disease in childhood*, *78*(4), 293–296. https://doi.org/10.1136/adc.78.4.293

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3*(3), 345–357. https://doi.org/10.1177/1468794103033004

Hope, N., Koestner, R., & Milyavskaya, M. (2014) The Role of Self-Compassion in Goal Pursuit and Well-Being Among University Freshmen, *Self and Identity*, *13*(5), 579-593, DOI: 10.1080/15298868.2014.889032

Horman, T., Fernandes, M. F., Zhou, Y., Fuller, B., Tigert, M., & Leri, F. (2018). An exploration of the aversive properties of 2-deoxy-D-glucose in rats. *Psychopharmacology*, *235*(10), 3055–3063. https://doi.org/10.1007/s00213-018-4998-1

Howitt, D. (2010). *Introduction to Qualitative Methods in Psychology.* Pearson Education.

Humenick S. S. (2003). Overcoming isolation of the new mother. *The Journal of perinatal education*, *12*(4), iv–v. https://doi.org/10.1624/105812403X106991

Hwang, S., Kim, G., Yang, J., & Yang, E. (2016). The Moderating Effects of Age on the Relationships of Self-Compassion, Self-Esteem, and Mental Health. *Japanese Psychological Research*, *58*(2), 194-205. https://doi.org/10.1111/jpr.12109

Iacono, V. L., Symonds, P., & Brown, D. H. K. (2015). Skype as a tool for qualitative research interviews. *Sociological Research Online*, *21*(2), 103-117. https://doi.org/10.5153/sro.3952

Institute for Fiscal Studies (IFS). (2015). *The health effects of Sure Start*. IFS. https://www.ifs.org.uk/uploads/R155-The-health-effects-of-Sure-Start.pdf

Iranpour, S., Kheirabadi, G. R., Esmaillzadeh, A., Heidari-Beni, M., & Maracy, M. R. (2016). Association between sleep quality and postpartum depression. *Journal of research in medical sciences: the official journal of Isfahan University of Medical Sciences*, *21*, 110. https://doi.org/10.4103/1735-1995.193500

Jacob, S. A., & Furgerson, S. P. (2012). Writing Interview Protocols and Conducting Interviews: Tips for Students New to the Field of Qualitative Research. *The Qualitative Report*, *17*(6), 1-10.

Javadifar, N., Majlesi, F., Nikbakht, A., Nedjat, S., & Montazeri, A. (2016). Journey to Motherhood in the First Year After Child Birth. *Journal of family & reproductive health*, *10*(3), 146–153. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5241359/

Jefferson, F.A., Shires, A., & McAloon, J. (2020). Parenting Self-compassion: a Systematic Review and Meta-analysis. *Mindfulness*, *11*, 2067–2088. https://doi.org/10.1007/s12671-020-01401-x

Joeng, J. R., & Turner, S. L. (2015). Mediators between self-criticism and depression: Fear of compassion, self-compassion, and importance to others. *Journal of Counseling Psychology, 62*(3), 453–463. https://doi.org/10.1037/cou0000071

Johnston, D. D., & Swanson, D. H. (2006). Constructing the "good mother": The experience of mothering ideologies by work status. *Sex Roles: A Journal of Research, 54*(7-8), 509–519. https://doi.org/10.1007/s11199-006-9021-3

Kelly, A.C., & Tasca, G.A. (2016). Within-persons predictors of change during eating disorders treatment: An examination of self-compassion, self-criticism, shame, and eating disorder symptoms. *International Journal of Eating Disorders*, *49*(7), 716-22. https://doi.org/10.1002/eat.22527

Kelman, A. R., Evare, B. S., Barrera, A. Z., Muñoz, R. F., & Gilbert, P. (2018). A proof-of-concept pilot randomized comparative trial of brief Internet-based compassionate mind training and cognitive-behavioral therapy for perinatal and intending to become pregnant women. *Clinical psychology & psychotherapy*, 10.1002/cpp.2185. Advance online publication. https://doi.org/10.1002/cpp.2185

Kenny, D.T. (2014). *The "Mother" in Attachment Theory and Attachment Informed Psychotherapy*. Demeter Press.

Kim, Y. (2011). The Pilot Study in Qualitative Inquiry: Identifying Issues and Learning Lessons for Culturally Competent Research. *Qualitative Social Work*, *10*(2), 190–206. https://doi.org/10.1177/1473325010362001

Kim, C., & Ko, H. (2018). The impact of self-compassion on mental health, sleep, quality of life and life satisfaction among older adults. *Geriatric nursing*, *39*(6), 623–628. https://doi.org/10.1016/j.gerinurse.2018.06.005

King, N. (2004). Using templates in the thematic analysis of text. In Cassell C., Symon G. (Eds.), *Essential guide to qualitative methods in organizational research* (pp. 257–270). Sage.

Kirby, J. N., Tellegen, C. L., & Steindl, S. R. (2017). A meta-analysis of compassion-based interventions: Current state of knowledge and future directions. *Behavior Therapy, 48*(6), 778–792. https://doi.org/10.1016/j.beth.2017.06.003

Knight, M., Tuffnell, D., Kenyon, S., Shakespeare, J., Gray, R., Kurinczuk, J. J. (Eds.) on behalf of MBRRACE-UK. (2015). *Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13.* National Perinatal Epidemiology Unit,

University of Oxford. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

Law, K. H., Jackson, B., Guelfi, K., Nguyen, T., & Dimmock, J. A. (2018). Understanding and alleviating maternal postpartum distress: Perspectives from first-time mothers in Australia. *Social science & medicine (1982)*, *204*, 59–66. https://doi.org/10.1016/j.socscimed.2018.03.022

Lazarus, K., & Rossouw, P. J. (2015). Mother's expectations of parenthood: The impact of prenatal expectations on self-esteem, depression, anxiety, and stress post birth. *International Journal of Neuropsychotherapy*, *3*(2), 102–123. doi: 10.12744/ijnpt.2015.0102-0123.

Leahy-Warren, P., McCarthy, G., & Corcoran, P. (2012). First-time mothers: social support, maternal parental self-efficacy and postnatal depression. *Journal of clinical nursing*, *21*(3-4), 388–397. https://doi.org/10.1111/j.1365-2702.2011.03701.x

Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: the implications of treating oneself kindly. *Journal of Personality and Social Psychology*, *92*(5), 887-904. doi:10.1037/0022-3514.92.5.887

Lee, K., Vasileiou, K., & Barnett, J. (2019). 'Lonely within the mother': An exploratory study of first-time mothers' experiences of loneliness. *Journal of Health Psychology*, *24*(10), 1334–1344. https://doi.org/10.1177/1359105317723451

Lee, M. A., Schoppe-Sullivan, S. J., & Kamp Dush, C. M. (2012). Parenting Perfectionism and Parental Adjustment. *Personality and individual differences*, *52*(3), 454–457. https://doi.org/10.1016/j.paid.2011.10.047

Leech, B.L. (2002). Asking questions: techniques for semi structured interviews. *Political Science and Politics Journal*, *35*(4), 665-668. https://itp.nyu.edu/classes/fungus/interview_technique/AskingQuestions.pdf

Lenferink, L., Eisma, M. C., de Keijser, J., & Boelen, P. A. (2017). Grief rumination mediates the association between self-compassion and psychopathology in relatives of missing persons. *European journal of*

psychotraumatology, *8*(sup6), 1378052. https://doi.org/10.1080/20008198.2017.1378052

Levitt, H. M., Motulsky, S. L., Wertz, F. J., Morrow, S. L., & Ponterotto, J. G. (2017). Recommendations for designing and reviewing qualitative research in psychology: Promoting methodological integrity. *Qualitative Psychology, 4*(1), 2–22. https://doi.org/10.1037/qup0000082

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (pp. 1065-1122). Sage Publications.

Littlewood, J. & McHugh, N. (1997). *Maternal Distress and Postnatal Depression: The Myth of Madonna.* Macmillian Press.

López, A., Sanderman, R., Smink, A., Zhang, Y., van Sonderen, E., Ranchor, A., & Schroevers, M. J. (2015). A Reconsideration of the Self-Compassion Scale's Total Score: Self-Compassion versus Self-Criticism. *PloS one*, *10*(7), e0132940. https://doi.org/10.1371/journal.pone.0132940.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*(6), 545–552. https://doi.org/10.1016/j.cpr.2012.06.003

Marsh, I. C., Chan, S., & MacBeth, A. (2018). Self-compassion and Psychological Distress in Adolescents-a Meta-analysis. *Mindfulness*, *9*(4), 1011–1027. https://doi.org/10.1007/s12671-017-0850-7

Matthey, S. (2009). Women's perceptions of the causes of their postnatal distress: Development of the reasons for postnatal distress checklist. *Depression and anxiety*, *26*(10), 938–948. https://doi.org/10.1002/da.20485.

Matthey, S., & Agostini, F. (2017). Using the Edinburgh Postnatal Depression Scale for women and men—some cautionary thoughts. *Archives of Women's Mental Health, 20*(2), 345–354. https://doi.org/10.1007/s00737-016-0710-9

McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: a qualitative study. *BMC pregnancy and childbirth*, *17*(1), 28. https://doi.org/10.1186/s12884-017-1220-0

McLeod, J. (2001). *Qualitative research in counseling and psychotherapy.* Sage.

McManus, J., Tsivos, Z., Woodward, S., Fraser, J., & Hartwell, R. (2018). Compassion Focused Therapy Groups: Evidence from Routine Clinical Practice. *Behaviour Change*, *35*, 167–173.

McQuillan, M. E., Bates, J. E., Staples, A. D., & Deater-Deckard, K. (2019). Maternal stress, sleep, and parenting. *Journal of family psychology*, *33*(3), 349–359. https://doi.org/10.1037/fam0000516

Meeussen, L., & Van Laar, C. (2018). Feeling Pressure to Be a Perfect Mother Relates to Parental Burnout and Career Ambitions. *Frontiers in psychology*, *9*, 2113. https://doi.org/10.3389/fpsyg.2018.02113

Mihelic, M., Morawska, A., & Filus, A. (2018). Preparing parents for parenthood: protocol for a randomized controlled trial of a preventative parenting intervention for expectant parents. *BMC pregnancy and childbirth*, *18*(1), 311. https://doi.org/10.1186/s12884-018-1939-2.

Miller, J. J., Lee, J., Niu, C., Grise-Owens, E., & Bode, M. (2019). Self-Compassion as a Predictor of Self-Care: A Study of Social Work Clinicians. *Clinical Social Work Journal*, *47*, 321–331. https://doi.org/10.1007/s10615-019-00710-6

Mitchell, A. E., Whittingham, K., Steindl, S., & Kirby, J. (2018). Feasibility and acceptability of a brief online self-compassion intervention for mothers of infants. *Archives of women's mental health*, *21*(5), 553–561. https://doi.org/10.1007/s00737-018-0829-y

Monteiro, F., Fonseca, A., Pereira, M., Alves, S., & Canavarro, M. C. (2019). What protects at-risk postpartum women from developing depressive and anxiety symptoms? The role of acceptance-focused processes and self-compassion. *Journal of affective disorders*, *246*, 522–529. https://doi.org/10.1016/j.jad.2018.12.124

Morrow, S.L. (2007). Qualitative Research in Counseling Psychology: Conceptual Foundations. *The Counseling Psychologist*, *35*(2), 209-235. https://doi.org/10.1177/0011000006286990

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250–260. https://doi.org/10.1037/0022-0167.52.2.250

Mruck, K., & Breuer, F. (2003). Subjectivity and Reflexivity in Qualitative Research. *The FQS (Forum Qualitative Social Research) Issues*, *4*(2), 3.

Munk-Olsen, T., Laursen, T. M., Pedersen, C. B., Mors, O., & Mortensen, P. B. (2006). New Parents and Mental Disorders: A Population-Based Register Study. *JAMA: Journal of the American Medical Association, 296*(21), 2582–2589. https://doi.org/10.1001/jama.296.21.2582

Murphey, C., Carter, P., Price, L. R., Champion, J. D., & Nichols, F. (2017). Psychological Distress in Healthy Low-Risk First-Time Mothers during the Postpartum Period: An Exploratory Study. *Nursing research and practice*, *2017*. https://doi.org/10.1155/2017/8415083

National Collaborating Centre for Mental Health. (2018). *The Perinatal Mental Health Care Pathways. Full implementation guidance.* National Collaborating Centre for Mental Health. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/perinatal/nccmh-the-perinatal-mental-health-care-pathways-full-implementation-guidance.pdf?sfvrsn=73c19277_2

National Healthcare Services (NHS). (2018). *Services and support for parents: Your pregnancy and baby guide*. NHS. https://www.nhs.uk/conditions/pregnancy-and-baby/services-support-for-parents/

National Healthcare Services (NHS). (2019). *NHS Mental Health Implementation Plan 2019/20-2023/24*. NHS. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

National Institute for Health and Care Excellence (NICE). (2012). *Improved access to breastfeeding peer support*. NICE. https://www.nice.org.uk/sharedlearning/improved-access-to-breastfeeding-peer-support

National Institute for Health and Care Excellence (NICE). (2014). *Antenatal and Postnatal Mental Health*. NICE. https://www.nice.org.uk/guidance/cg192

Navaratne, P., Foo, X. Y., & Kumar, S. (2016). Impact of a high Edinburgh Postnatal Depression Scale score on obstetric and perinatal outcomes. *Scientific reports*, *6*, 33544. https://doi.org/10.1038/srep33544

Neely, M. E., Schallert, D. L., Mohammed, S. S., Roberts, R. M., & Chen, Y.-J. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students' well-being. *Motivation and Emotion, 33*(1), 88–97. https://doi.org/10.1007/s11031-008-9119-8

Neff, K. D. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*(3), 223-250. https://doi.org/10.1080/15298860309027

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and identity*, *2*(2), 85-101. https://doi.org/10.1080/15298860309032

Neff, K.D. (2016). The Self-Compassion Scale is a Valid and Theoretically Coherent Measure of Self-Compassion. *Mindfulness*, *7*, 264–274. https://doi.org/10.1007/s12671-015-0479-3

Neff, K. D., & Beretvas, S. N. (2013). The role of self-compassion in romantic relationships. *Self and Identity, 12*(1), 78–98. https://doi.org/10.1080/15298868.2011.639548

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*(1), 28–44. https://doi.org/10.1002/jclp.21923

Neff, K. D., Hsieh, Y. P., & Dejitterat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, *4*(3), 263-287. https://doi.org/10.1080/13576500444000317

Neff, K. D., & McGehee, P. (2010). Self-compassion and psychological resilience among adolescents and young adults. *Self and Identity, 9*(3), 225-240. https://doi.org/10.1080/15298860902979307

Neff, K. D., Pisitsungkagarn, K., & Hsieh, Y.-P. (2008). Self-Compassion and Self-Construal in the United States, Thailand, and Taiwan. *Journal of Cross-Cultural Psychology*, *39*(3), 267–285. https://doi.org/10.1177/0022022108314544

Neff, K. D., & Pommier, E. (2012). The relationship between self-compassion and other-focused concern among college undergraduates, community adults, and practicing meditators. *Self and Identity, 12*(2), 160-176. DOI:10.1080/15298868.2011.649546

Nolan, M. L., Mason, V., Snow, S., Messenger, W., Catling, J., & Upton, P. (2012). Making friends at antenatal classes: a qualitative exploration of friendship across the transition to motherhood. *The Journal of perinatal education*, *21*(3), 178–185. https://doi.org/10.1891/1058-1243.21.3.178

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, *16*, 1-13. https://doi.org/10.1177/1609406917733847

Nystrom, K., & Ohrling, K. (2004). Parenthood experiences during the child's first year: literature review. *Journal of advanced nursing*, *46*(3), 319-30. doi: 10.1111/j.1365-2648.2004.02991.x.

Ogland, P. (2017). What are the benefits of using critical realism as a basis for information systems research? *Department of Informatics, University of Oslo*. http://heim.ifi.uio.no/~petterog/Publications/Ogland_2017_CR_seminar.pdf

Orsolini, L., Valchera, A., Vecchiotti, R., Tomasetti, C., Iasevoli, F., Fornaro, M., De Berardis, D., Perna, G., Pompili, M., & Bellantuono, C. (2016). Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates. *Frontiers in psychiatry*, *7*, 138. https://doi.org/10.3389/fpsyt.2016.00138

Ortlipp, M. (2008). Keeping and Using Reflective Journals in the Qualitative Research Process. *The Qualitative Report*, *13*(4), 695-705.

Osman, H., Chaaya, M., El Zein, L., Naassan, G., & Wick, L. (2010). What do first-time mothers worry about? A study of usage patterns and content of calls made to a postpartum support telephone hotline. *BMC public health*, *10*, 611. https://doi.org/10.1186/1471-2458-10-611

Padoa, T., Berle, D., & Roberts, L. (2018). Comparative Social Media Use and the Mental Health of Mothers With High Levels of Perfectionism. *Journal of Social and Clinical Psychology*, *37*(7), 514-535.

PAN London Mental Health Network. (2015). *Perinatal Mental Health Care Pathways*. NHS London Clinical Networks. http://www.londonscn.nhs.uk/wp-content/uploads/2015/10/mh-care-pathway-231015.pdf

Patomaki, H., & Wight, C. (2002). After postpositivism? The promises of critical realism. *International Studies Quarterly*, *44*(2), 213-237. https://doi.org/10.1111/0020-8833.00156

Patton, M. Q. (1990). *Qualitative evaluation and research methods.* (2nd ed.). Sage.

Pauley, G., & McPherson, S. (2010). The experience and meaning of compassion and self-compassion for individuals with depression or anxiety. *Psychology and psychotherapy*, *83*(2), 129–143. https://doi.org/10.1348/147608309X471000

Paykel, E. S., Emms, E. M., Fletcher, J., & Rassaby, E. S. (1980). Life events and social support in puerperal depression. *The British journal of psychiatry: the journal of mental science*, *136*, 339–346. https://doi.org/10.1192/bjp.136.4.339

Pedro, L., Branquinho, M., Canavarro, M. C., & Fonseca, A. (2019). Self-criticism, negative automatic thoughts and postpartum depressive symptoms: the buffering effect of self-compassion. *Journal of reproductive and infant psychology*, *37*(5), 539–553. https://doi.org/10.1080/02646838.2019.1597969

Personal Social Services Research Unit Centre for Mental Health Maternal Mental Health Alliance (PSSRU). (2014). *Costs of perinatal mental health problems.* London School of Economics and Political Science. http://eprints.lse.ac.uk/59885/

Petrocchi, N., & Couyoumdjian, A. (2016). The impact of gratitude on depression and anxiety: The mediating role of criticizing, attacking, and reassuring the self. *Self and Identity, 15*(2), 191–205. https://doi.org/10.1080/15298868.2015.1095794

Pietkiewicz, I., & Smith, J.A. (2012). Praktyczny przewodnik interpretacyjnej analizy fenomenologicznej w badaniach jakościowych w psychologii (A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology). *Czasopismo Psychologiczne*, *18*(2), 361-369.

Pilkington, P., Milne, L., Cairns, K., & Whelan, T. (2016). Enhancing reciprocal partner support to prevent perinatal depression and anxiety: a Delphi consensus study. *BMC Psychiatry*, *16*, 23. https://doi.org/10.1186/s12888-016-0721-0

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Psychogiou, L., Legge, K., Parry, E., Mann, J., Nath, S., Ford, T., & Kuyken, W. (2016). Self-Compassion and Parenting in Mothers and Fathers with Depression. *Mindfulness*, *7*, 896–908. https://doi.org/10.1007/s12671-016-0528-6

Puckering, C. (2015). *Putting the Baby First in Perinatal Mental Health*. Winston Churchill Memorial Trust. https://www.wcmt.org.uk/sites/default/files/report-documents/Puckering%20C%20Report%202015%20FINAL.pdf

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy, 18*(3), 250–255. https://doi.org/10.1002/cpp.702

Rahman, A., Fisher, J., Waqas, A., Hamdani, S. U., Zafar, W., Suleman, N., Huma, Z., Zeng, R., Holton, S., & Le, M. (2018). *World Health Organization recommendation on psychotherapeutic interventions for common maternal mental health problems among women to improve early childhood development in low and middle income countries: Report of systematic review and meta-analysis of RCTs*. WHO. https://www.who.int/maternal_child_adolescent/guidelines/SR_Psych_Therapeutic_interventions_ECD_Rahman_Final_Sept2018.pdf?ua=1

Ranch, M. M., Jamten, S., Thorstensson, S., & Ekstrom-Bergstrom, A. (2019). First-Time Mothers Have a Desire to Be Offered Professional Breastfeeding Support by Pediatric Nurses: An Evaluation of the Mother-Perceived-Professional Support Scale. *Nursing Research and Practice*, *2019*, 1-11. https://doi.org/10.1155/2019/8731705

Redshaw, M., & Martin, C. (2011). Motherhood: a natural progression and a major transition. *Journal of Reproductive and Infant Psychology*, *29*(4), 305–307. https://doi.org/10.1080/02646838.2011.639510

Rennie, D. L. (1994). Human science and counselling psychology: Closing the gap between research and practice. *Counselling Psychology Quarterly, 7*(3), 235–250. https://doi.org/10.1080/09515079408254149

Riessman, C. K. (1993). *Narrative Analysis.* Sage.

Ritchie, J., Lewis, J., Nicholls, C., & Ormston, R. (2014). *Qualitative Research Practice: A Guide for Social Science Students & Researchers.* Sage.

Roberts, K., Dowell, A., & Nie, J. (2019). Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. *BMC Medical Research Methodology*, *19*(66). https://doi.org/10.1186/s12874-019-0707-y

Rockliff, H., Gilbert, P., McEwan, K., Lightman, S., & Glover, D. (2008). A pilot exploration of heart rate variability and salivary cortisol responses to compassion-focused imagery. *Clinical Neuropsychiatry: Journal of Treatment Evaluation, 5*(3), 132–139.

Rogan, F., Shmied, V., Barclay, L., Everitt, L., & Wyllie, A. (1997). "Becoming a mother'--developing a new theory of early motherhood. *Journal of advanced nursing*, *25*(5), 877–885. https://doi.org/10.1046/j.1365-2648.1997.1997025877.x

Romano, M., Cacciatore, A., Giordano, R., & La Rosa, B. (2010). Postpartum period: three distinct but continuous phases. *Journal of prenatal medicine*, *4*(2), 22–25.

Rousou, E., Kouta, C., & Middleton, N. (2016). Association of social support and socio-demographic characteristics with poor self-rated health and depressive symptomatology among single mothers in Cyprus: a descriptive cross-sectional study. *BMC nursing*, *15*, 15. https://doi.org/10.1186/s12912-016-0134-x

Rotkirch, A., & Janhunen, K. (2009). Maternal guilt. *Evolutionary Psycholo*gy, *8*, 90–106.

Rubin, R. (1984). *Maternal identity and the maternal experience.* Springer.

Ryan, Anne B. (2006) *Post-Positivist Approaches to Research.* In: Researching and Writing your thesis: a guide for postgraduate students. MACE: Maynooth Adult and Community Education, pp. 12-26.

Shapira, L. B., & Mongrain, M. (2010). The benefits of self-compassion and optimism exercises for individuals vulnerable to depression. *The Journal of Positive Psychology, 5*(5), 377–389. https://doi.org/10.1080/17439760.2010.516763

Skourteli, M. C., & Apostolopoulou, A. (2015). An interpretative phenomenological analysis into counselling psychologists' relationship with research: Motives, facilitators and barriers -a contextual perspective. *Counselling Psychology Review, 30*(4), 16–33.

Slomian, J., Emonts, P., Vigneron, L., Acconcia, A., Glowacz, F., Reginster, J. Y., Oumourgh, M., & Bruyère, O. (2017). Identifying maternal needs following childbirth: A qualitative study among mothers, fathers and professionals. *BMC pregnancy and childbirth*, *17*(1), 213. https://doi.org/10.1186/s12884-017-1398-1

Sorkkila, M., & Aunola, K. (2020). Risk Factors for Parental Burnout among Finnish Parents: The Role of Socially Prescribed Perfectionism. *Journal of Child and Family Studies*, *29*, 648–659. https://doi.org/10.1007/s10826-019-01607-1

Sorrell, S. (2018). Explaining sociotechnical transitions: A critical realist perspective. *Research Policy*, *47*(7), 1267-1282. https://doi.org/10.1016/j.respol.2018.04.008

Stadlen, N. (2004). *What Mothers Do: especially when it looks like nothing.* Hachette Digital.

Strauss, A.L., & Corbin, J.M. (1990). *Basics of qualitative research: grounded theory procedures and techniques.* Sage Publications.

Strauss, C., Lever Taylor, B., Gu, J., Kuyken, W., Baer, R., Jones, F., & Cavanagh, K. (2016). What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review, 47,* 15–27. https://doi.org/10.1016/j.cpr.2016.05.004

Strawbridge, S., & Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (2nd ed., pp. 3–23.). Sage.

Stutts, L. A., Leary, M. R., Zeveney, A. S., & Hufnagle, A. S. (2018). A longitudinal analysis of the relationship between self-compassion and the psychological effects of perceived stress. *Self and Identity*, *17*(6), 609-626, DOI: 10.1080/15298868.2017.1422537

Terry, D. J., Mayocchi, L., & Hynes, G. J. (1996). Depressive symptomatology in new mothers: A stress and coping perspective. *Journal of Abnormal Psychology, 105*(2), 220–231. https://doi.org/10.1037/0021-843X.105.2.220

Terry, M. L., & Leary, M. R. (2011). Self-compassion, self-regulation, and health. *Self and Identity, 10*(3), 352–362. https://doi.org/10.1080/15298868.2011.558404

Tessier, R., Piche, C., Tarabulsy, G.M., & Muckle, G. (1992). Mothers' Experience of Stress Following the Birth of a First Child: Identification of Stressors and Coping Resources. *Journal of Applied Social Psychology*, *22*(17), 1319-1339. https://doi.org/10.1111/j.1559-1816.1992.tb00952.x

Thompson, J. F., Roberts, C. L., Currie, M., & Ellwood, D. A. (2002). Prevalence and persistence of health problems after childbirth: associations with parity and method of birth. *Birth (Berkeley, Calif.)*, *29*(2), 83–94. https://doi.org/10.1046/j.1523-536x.2002.00167.x

Trafimow, D. (2014). Considering Quantitative and Qualitative Issues Together. *Qualitative Research in Psychology*, *11*, 15–24. https://doi.org/10.1080/14780887.2012.743202

University of East London (UEL). (2015). *Code of Practice for Research Ethics Policy*. UEL. https://www.uel.ac.uk/wwwmedia/schools/graduate/documents/UEL-Code-of-Practice-for-Research-Ethics-2015-16.doc

Van Dam, N. T., Sheppard, S. C., Forsyth, J. P., & Earleywine, M. (2011). Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of anxiety disorders*, *25*(1), 123–130. https://doi.org/10.1016/j.janxdis.2010.08.011

Vettese, L. C., Dyer, C. E., Li, W. L., & Wekerle, C. (2011). Does self-compassion mitigate the association between childhood maltreatment and later emotion regulation difficulties? A preliminary investigation. *International Journal of Mental Health and Addiction, 9*(5), 480–491. https://doi.org/10.1007/s11469-011-9340-7

Vismara, L., Rollè, L., Agostini, F., Sechi, C., Fenaroli, V., Molgora, S., Neri, E., Prino, L. E., Odorisio, F., Trovato, A., Polizzi, C., Brustia, P., Lucarelli, L., Monti, F., Saita, E., & Tambelli, R. (2016). Perinatal Parenting Stress, Anxiety, and Depression Outcomes in First-Time Mothers and Fathers: A 3- to 6-Months Postpartum Follow-Up Study. *Frontiers in psychology*, *7*, 938. https://doi.org/10.3389/fpsyg.2016.00938

Vliegen, N., & Luyten, P. (2009). Dependency and self-criticism in post-partum depression and anxiety: a case control study. *Clinical psychology & psychotherapy*, *16*(1), 22–32. https://doi.org/10.1002/cpp.597

Wasylkiw, L., MacKinnon, A.L., & MacLennan, A.M. (2012). Exploring the link between self-compassion and body image in university women. *Body Image*, *9*(2), 236-45. https://doi.org/10.1016/j.bodyim.2012.01.007

Wilkins C. (2006). A qualitative study exploring the support needs of first-time mothers on their journey towards intuitive parenting. *Midwifery*, *22*(2), 169–180. https://doi.org/10.1016/j.midw.2005.07.001

Willig, C. (2013). *Introducing Qualitative Research in Psychology.* Open University Press.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena; a study of the first not-me possession. *The International Journal of Psychoanalysis, 34,* 89–97.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *The International journal of psycho-analysis*, *41*, 585–595.

Winnicott, D. W. (1965) *The maturational process and the facilitative environment.* International Universities Press.

Wisner, K. L., Sit, D. K., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., Eng, H. F., Luther, J. F., Wisniewski, S. R., Costantino, M. L., Confer, A. L., Moses-Kolko, E. L., Famy, C. S., & Hanusa, B. H. (2013). Onset timing,

thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA psychiatry*, *70*(5), 490–498. https://doi.org/10.1001/jamapsychiatry.2013.87

Woekel, E., & Ebbeck, V. (2013). Transitional bodies: a qualitative investigation of postpartum body self-compassion. *Qualitative Research in Sport, Exercise and Health*, *5*(2), 245-266. https://doi.org/10.1080/2159676X.2013.766813

Woolhouse, H., Mercuri, K., Judd, F., & Brown, S.J. (2014). Antenatal mindfulness intervention to reduce depression, anxiety and stress: a pilot randomised controlled trial of the MindBabyBody program in an Australian tertiary maternity hospital. *BMC Pregnancy and Childbirth*, *14*, 369. doi: 10.1186/s12884-014-0369-z

World Health Organisation (WHO). (2008). *Millenium Development Goal 5-Improving Mental Health*. WHO. https://www.who.int/mental_health/prevention/suicide/Perinatal_depression_mmh_final.pdf?ua=1

Wu, W. R., & Hung, C. H. (2016). First-Time Mothers Psychiatric Health Status During the Transition to Motherhood. *Community mental health journal*, *52*(8), 937–943. https://doi.org/10.1007/s10597-015-9892-2

Yarnell, L. M., & Neff, K. D. (2013). Self-compassion, interpersonal conflict resolutions, and well-being. *Self and Identity, 12*(2), 146–159. https://doi.org/10.1080/15298868.2011.649545

Zeng, X., Wei, J., Oei, T. P., & Liu, X. (2016). The Self-Compassion Scale is Not Validated in a Buddhist Sample. *Journal of religion and health*, *55*(6), 1996–2009. https://doi.org/10.1007/s10943-016-0205-z

Zessin, U., Dickhäuser, O., & Garbade, S. (2015). The Relationship Between Self-Compassion and Well-Being: A Meta-Analysis. *Applied Psychology: Health and Well Being*, *7*(3), 340-64. doi: 10.1111/aphw.12051.

Zhang, J. W., Chen, S., & Tomova Shakur, T. K. (2020). From me to you: Self-compassion predicts acceptance of own and others' imperfections. *Personality and Social Psychology Bulletin, 46*(2), 228-242. https://doi.org/10.1177/0146167219853846

Zisook, S., & Shear, K. (2009). Grief and bereavement: what psychiatrists need to know. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, *8*(2), 67–74. https://doi.org/10.1002/j.2051-5545.2009.tb00217.x

Appendix A

Research Advertising 1

Are you a
first-time mother
who is willing to share their experiences in the transition to motherhood?

I am a Professional Doctorate Counselling Psychology student at University of East London. For my research project I am exploring new mothers' challenges in the transition to motherhood and how they cope with these challenges. I am particularly interested in the use of self-compassion.

If you are:

- Aged 20 and over
- A first-time mother who gave birth to one healthy baby in the past 6-24 months
- Have no signs of severe psychological distress
- practicing self-compassion*
- Fluent in English

then I would really value your help by volunteering some of your time to be interviewed about your experience as a first-time mother and use of self-compassion.

***What is self-compassion?**

Are you kind and understanding towards others? Do you try to empathise with what they might be going through when experiencing emotional challenges? Do you think you might show similar understanding towards yourself? Then you might be practicing self-compassion.

Self-compassion may not have a clear definition which is the same for everyone.

Even if you're not sure about your use of self-compassion but interested in this research, please contact me for a confidential chat.

What will I gain?

This is a voluntary research. Your experience will be very valuable and be used as part of an analysis to understand how new mothers cope with their emotional challenges in the transition to motherhood.

Please note that all your data will be kept **confidential and anonymous** throughout this research.

If you're interested in this research and want to find out more about it, please drop me an email to Bahar Kuzubasioglu

Research Advertising 2

Are you a first-time mother?

Would you like to share your experiences with others who may learn from your stories?

I'm a final year female Doctorate Counselling Psychology student and conducting my research to understand how new mothers cope emotionally in the first year after having a baby. I'm especially interested in the use of self-compassion*.

If you're interested in finding out more about this research**, please contact me for a confidential chat (even if you're not sure about what self-compassion means or if you're self-compassionate).

Bahar Kuzubasioglu:

*Are you kind and understanding towards others? Do you try to empathise with what they might be going through when experiencing emotional challenges? Do you think you might show similar understanding towards yourself? Then you might already be practicing self-compassion.

On return, I will appreciate your valuable volunteering time for an **anonymous and confidential interview (phone/Skype or face-to-face) which would take 30-60 minutes.

Appendix B

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title

Exploration of first-time mothers' emotional challenges in the transition to motherhood and practice of self-compassion

Project Description

This study aims to explore the practice of self-compassion as a coping strategy in the transition to motherhood as a first-time mother when experiencing emotional challenges.

The study involves an interview which should take no longer than one hour. The interview will discuss your experiences and beliefs about your self-compassion practices and your (emotional) challenges as a first-time mother. To be eligible you have to be aged 20 and over, a first-time mother who gave birth to one healthy baby in the past 6-24 months, have no signs of severe psychological distress, practicing self-compassion and fluent in English. If you have any questions concerning your eligibility or the interview, please ask the researcher.

Confidentiality of the Data

Confidentiality will be ensured, all data will be anonymised and only identifiable by pseudonyms which will replace your name and will represent you for the remainder of the study as well as in the dissemination of the research findings. All interviews will be audio-recorded for later transcription and analysis. Names and identifying references will be changed in this transcription process. Only the researcher will be able to link the pseudonyms to the original source and isolate participant information should you wish to withdraw your data.

Only interview extracts with pseudonyms from the transcribed interviews will be used in any publication of the research. Any identifiable information will be changed. All anonymised participant information and interview transcripts will be stored securely on a password protected computer only accessible by the researcher for up to 6 years, in line with Research Councils UK (RCUK) guidance, and will not be used for purposes other than those notified to data participants. After this period all data will be securely destroyed and all files deleted.

Location

The interview can take place either over the telephone, via skype or through a face-to-face interview at the University of East London, or at a mutually convenient public location to both you and the researcher.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during the interview or free not to answer all questions. Should you choose to withdraw from the programme up to one month after the interview date you may do so without disadvantage to yourself and without any obligation to give a reason.

Interview Consent Form

Exploration of first-time mothers' emotional challenges in the transition to motherhood and practice of self-compassion

Interview number

Please initial each box

I confirm that I have read and understand the information sheet this study I have had the opportunity to consider the information, ask questions, and have my questions answered	
I agree to take part in the study	
I understand that my participation is voluntary and that I am free to withdraw at any time within one month after the interview without my legal rights being affected	
I understand the interview will be recorded. I understand that the interview is confidential and that I will not be individually identified in any way in the report	
I agree to my anonymous quotations being used for the project report and publications	
I understand that the records of my participation in this study are maintained in accordance with the Data Protection Act and I have the right to access this record at any time in accordance with the Freedom of Information Act	

Name of participant: ……..

Signature: ……...

Date: ……

Name of researcher: ……..

Signature: ……...

Date: ……

Appendix C

PARTICIPANT DEBRIEF SHEET

Exploration of first-time mothers' emotional challenges in the transition to motherhood and practice of self-compassion

Thank you for taking the time to participate in our study. Your time and effort is very much appreciated and very valuable. Your data will be used to understand the struggles of new mothers in the transition to motherhood and particularly explore use of self-compassion.

Self-compassion (feeling for oneself through one's own suffering) has recently attracted attention from researchers due to offering various psychological benefits. Studies showed that highly self-compassionate individuals experience improved well-being, fewer psychological difficulties (MacBeth & Gumley, 2012) and better ability to cope with distressing events (Vettese et al.,2011). Furthermore, self-compassion is positively correlated with happiness, optimism (Lutz, Lawrence, Greischar, Ricard, & Davidson, 2004; Neff, Kirkpatrick & Rude, 2007) and resilience (Neff & McGehee, 2010).

Experiencing distress in the transition to motherhood is common, particularly as a first-time mother, due to the physical, emotional and sociological changes (Wu & Hung, 2016; Edhborg, 2008; Munk-Olsen, Laursen, Pedersen, Mors & Mortensen, 2006). Therefore, my research aims to explore how self-compassion is practiced in the transition to motherhood and how it could support new mothers.

If participation in the study has raised concerns for you about yourself or health in any way, you might find it helpful to discuss these concerns with your **general practitioner (GP)** or you can also contact

NHS Direct on 0845 4647 or https://www.england.nhs.uk/mental-health/perinatal/

There are also a number of voluntary agencies that may be able to help or be of interest to you, including

Family Lives 24-hour helpline: 0808 800 2222 https://familylives.org.uk

PANDAS pandasfoundation.org.uk

Anxiety UK 0844 477 5774 anxietyuk.org.uk

Mind Perinatal Mental Health https://www.mind.org.uk/information-support/types-of-mental-health-problems/postnatal-depression-and-perinatal-mental-health

The Samaritans 24-hour helpline: 08457 909090 www.samaritans.org

Appendix D

Ethics Approval/ Application for Research Ethics Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Mark Holloway

SUPERVISOR: **Lisa Fellin**

STUDENT: Bahar Kuzubasioglu

Course: Professional Doctorate Counselling Psychology

Title of proposed study: How do first-time mothers practice self-compassion to support their emotional maternal challenges in the post-partum period?

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved with minor amendments

Minor amendments required *(for reviewer)*:

Section 10. You should either interview face to face or by Skype. I think phone and email interviews are so different that you risk inconsistency in your findings. You will also be unable to identify stress levels over the phone. I recommend you do not interview in participants' homes, even if they are known to you through personal connections
Section 11. You need to be clear on the circumstances under which you will use Neff's Self-Compassion Scale and the Edinburgh Post-Natal Depression Scale. It's not at all clear from your description at the moment. All you say is they may be used.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Bahar Kuzubasioglu
Student number: u1528632

Date: 18/04/2019

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ **MEDIUM** (Please approve but with appropriate recommendations)

☐ LOW

Reviewer comments in relation to researcher risk (if any).

Interviewing in participants' homes

Reviewer *(Typed name to act as signature)*: Mark Holloway

Date: 17th April 2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

If you need to apply for ethical clearance from HRA (through IRIS) for research involving the NHS you DO NOT need to apply to the School of Psychology for ethical clearance also. Please see details on
https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/NHS-Research-Ethics-Committees.aspx

Among other things this site will tell you about UEL sponsorship

PLEASE NOTE that HRA approval for research involving NHS employees is not required when data collection will take place off NHS premises and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

If you are employed by the NHS and plan to recruit participants from the NHS Trust you work for, it please seek permission from an appropriate person at your place of work (and better to collect data off NHS premises).

PLEASE NOTE that the School Research Ethics Committee does not recommend BSc and MSc/MA students designing research that requires HRA approval for research involving the NHS as this can be a demanding and lengthy process.

Before completing this application please familiarise yourself with:

The *Code of Ethics and Conduct (2018)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website

https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

And please also see the UEL Code of Practice for Research Ethics (2015-16)

https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Documents/Ethics%20forms/UEL-Code-of-Practice-for-Research-Ethics-2015-16.pdf

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.

2. Type your name in the 'student's signature' section (5.1).

3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc**

4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. Your supervisor will then look over your application.

5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' (section 5) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See section 4)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the participant invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants.

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external institution or organisation if you need it (e.g. a charity, school, local authority, workplace etc.). Permissions must be attached to this application. If you require ethical clearance from an external organisation your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation (see Section 5).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. If you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice.

- DBS clearance is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

  If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Tim Lomas (Chair of the School Research Ethics Committee) at t.lomas@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see Section 4 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another for the duration of your studies in order to conduct research with vulnerable populations.

Please read all guidance notes in blue carefully to avoid incorrect or insufficient applications

If yours is an online study using Qualtrics please see the example ethics application in the Ethics folder in the Psychology Noticeboard

SECTION 1. Your details

1. Your name: Bahar Kuzubasioglu

2. Your supervisor's name: Dr Lisa Fellin

3. Title of your programme: Professional Doctorate Counselling Psychology

4. Submission date for your BSc/MSc/MA research: July 2020

5. Please tick if your application includes a copy of a DBS certificate (see page 3) ☐

6. Please tick if your research requires DBS clearance but you are a Prof Doc student and have applied for DBS clearance – or had existing clearance verified – when you registered on your programme (see page 3)

☐

7. Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Tim Lomas for confidentiality reasons (Chair of the School Research Ethics Committee) t.lomas@uel.ac.uk ☐

8. Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2009) and the UEL Code of Practice for Research Ethics (See links on page 1)

X

SECTION 2. About your research

9. What your proposed research is about:

Please be clear and detailed in outlining what your proposed research is about. Include the research question (i.e. what will your proposed investigate?)

Studies show that mothers may experience distress due to physical, emotional and psychosocial changes after childbirth. Some women may develop mental health issues ranging from low mood to psychosis in the pre and postnatal period and the prevalence could be as high as 20% of mothers. First-time mothers in the post-partum period are more at risk. Children of these women are at a higher risk of developing significant physical, cognitive and psychological problems. Although support is available, only a small number of these women reach for it. Some barriers for not accessing help are fear of judgment and feelings of guilt for not meeting self or societal expectations, as well as fear of the baby being taken away. Therefore, it is essential for these women to develop skills to cope during this challenging period. A key skill that could be highly beneficial for this group is self-compassion (feeling for oneself through one's own suffering) which has been shown to support emotional wellbeing for both clinical and non-clinical groups, particularly during stressful periods. Some studies suggest self-compassion is used by new mothers but it is not clear how they do it. This research will explore how self-compassion is used by first-time mothers. The learnings could be used to develop programs tailored for new mothers to improve their emotional wellbeing.

The research question is: How do first-time mothers practice self-compassion to support their emotional maternal challenges in the post-partum period?

10. Design of the research:

Type of experimental design, variables, questionnaire, survey etc., as relevant to your research. If the research is qualitative what approach will be used and what will the data be?

A qualitative study with a critical realist epistemological stance will be used to explore this area. The research design will rely on semi-structural interviews in order to allow experiences, practices and beliefs of the phenomenon of self-compassion to naturally arise during the interview interaction. As a research task, participants may be asked to bring a weekly journal where they note their self-compassion practices and discuss them in the interview.

10. Recruitment and participants (Your sample):

Proposed number of participants, method/s of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research.

Proposed number of participants: 8-15

Recruitment methods: personal connections, snowballing, social media (Facebook, Twitter, forums like Mumsnet), organisations targeting new mothers e.g. National Childbirth Trust (NCT) and other mother/baby classes, local hospitals, local baby shops (Berg, 2009)

Snowballing approach involves asking interviewees to give my contacts to other known first-time mothers who may want to approach me for participation in the study. Additionally, an advert will be displayed in the university, student webmail and mother forums to attract participants (see Appendix).

The inclusion & exclusion criteria will be as follows:

- Adult (aged 20 and over): as explained below
- First-time mothers who have given birth to one healthy baby in the past 6-24 months: The adjustment in the post-partum period has been defined as approximately 6 months after the birth and this criterion aims to limit the vulnerability factor (Thompson, Roberts, Currie & Ellwood, 2002).
- Use of self-compassion: A detailed description of 'self-compassion' will be given in the research adverts. Participants can then decide whether the concept is familiar.
- No signs of severe psychological distress (self-reported)
- Fluent in English

Since the aim of the research is to focus on the maternal challenges only, some additional criteria are set to limit additional stressors and vulnerability factors in the postpartum period. Therefore, teenage and single mothers will be excluded (WHO, 2004; Boyce, 2003; Paykel; Emms, Fletcher & Rassaby, 1980).

Participants will be interviewed either over the telephone, via Skype, email or in person at a mutually agreed place, whichever is the most appropriate given the wishes of the participant. The locations may include UEL campuses, local communal areas and participants' home (only if participant is known through personal connections and there is no risk identified).

11. Measures, materials or equipment:

Give details about what will be used during the course of the research. For example: equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application.

Interview schedule (in the Appendix)

Neff's Self-compassion Scale and the Edinburgh Postnatal Depression Scale may also be used to assess self-reported self-compassion and postnatal depression to inform the analysis. (see Appendix)

A voice recording tool will be used to record face-to-face and phone/Skype interviews. If the interviews are conducted via Skype or a mobile phone, these interviews may also be directly recorded using the recording feature of the app/mobile phones. An interview schedule is attached in this form for review. NVivo software may be used to help the qualitative analysis but this will be used alongside the manual handwriting method.

12. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

YES

13. Outline the data collection procedure involved in your research:

Describe in detail what will be involved in data collection. For example, what will participants be asked to do, where, and for how long? If using online surveys will you be using Qualtrics? Detail what you will include in the Qualtrics page that you intend to make available to potential participants (see the example ethics application for a student study using Qualtrics in the Ethics

folder of the Psychology Noticeboard).

The participants will be asked to answer semi-structured interview questions. They may also be asked to fill in the Edinburgh Postnatal Depression questionnaire to identify if they have any undetected postnatal depression. If anyone meets the criteria for severe postnatal depression, these people may be excluded from the interview due to the risk of potential harm and they will be encouraged to contact specialised services (as in the debriefing form).

Additionally, all participants may be asked to fill in the SCS questionnaire to assess the level of self-compassion. The questionnaires will only be used to inform the analysis and will not be taken as a basis.

As an option, participants may be asked to keep a personal journal for a short time (eg. one week) before the interview. This journal task aims to encourage the participants to reflect on self-compassion before the interview. It may include participants' thoughts, emotional challenges, daily activities and use of self-compassionate practices for the specified timeframe.

SECTION 3. Ethical considerations

14. Fully informing participants about the research (and parents/guardians if necessary):

How will you fully inform your participants when inviting them to participate? Will the participant invitation letter be written in a style appropriate for children and young people, if necessary?

Participants will be given an information letter (see Appendix) to explain the details of the research. The information letter will be shared with each participant at least one day before the interview date either face-to-face or by email or if this is not possible then the information will be given verbally before the interview. All participants who will be interviewed via telephone, Skype or email will be sent the information letter prior to the interview via email or Skype.

15. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

Is the consent form written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians? How will you gain consent if your research is collecting data online (e.g. using Qualtrics)?

All participants will be interviewed individually following a fully informed consent (See the Appendix for the Consent Form). The Consent Form will explain all the rights of participants including withdrawal, anonymity and confidentiality of the research. The Consent Form will be

shared with each participant at least one day before the interview date and they will be asked to sign and return it to the researcher before starting the interview (ideally within one day of receiving the form). All participants will be sent the Consent Form via face-to-face, email or skype.

The consent form will be signed by the participant and the researcher before starting the interview (see Appendix for the Consent Form).

16. Engaging in deception, if relevant:

What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.

Not applicable, participants will be informed about the true nature of the study prior to participating (see the Appendix for the information letter)

17. Right of withdrawal:

In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve (1) participants being able to decide to not continue with participation in your research, and (2) the right to have the data they have supplied destroyed on request. You are asked to give participants a three-week window from the time they participate in your study to when they can withdraw their data. Make this clear in your participant invitation letter.

Note: If your study involves data collection through Qualtrics, it is essential that you ask participants to provide their own participant code on Qualtrics (e.g. two letters and two numbers) so that you will be able to identify them if they later want to withdraw their data.

It will be explained to the participants that they have the right to withdraw at any point during the interview and within one month from the interview date ; also they do not have to answer questions if they do not want to. If any participant would like to withdraw from the research after the interview and before data analysis has started, their data will be removed completely as soon as they confirm the withdrawal and the data will not be used for the analysis. Depending on timelines, the researcher may need to start the analysis earlier than one month after the interview, in which case the participant will be informed of the date the analysis will start. The interview will only take place if the participant agrees on the above condition.

18. Will the data be gathered anonymously?

This is where you will not know the names and contact details of your participants? In qualitative research that involves interviews, data is not collected anonymously because you will know the names and contact details of your participants.

NO

19. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually data will be destroyed after a study is over but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? (suggested time is two years). It is advised that you destroy all names and contact details of participants at the end of your study regardless of how long will keep your data for. Make this clear in your participant invitation letter.

The names and contact information of the participants will only be available to the researcher in order to arrange the interviews and conduct the research. This information will be kept separate from their data/transcripts. Data will only be recognisable by their pseudonyms and any personal information including name of people and places will be changed, therefore, there will be no identifying information. All voice recordings will be destroyed after gaining the doctorate degree (successfully passing Viva). Only interview extracts with pseudonyms from the transcribed interviews will be used in any publication of the research for up to 6 years. All anonymised participant information and interview transcripts will be stored securely on a password protected computer only accessible by the researcher in line with Research Councils UK (RCUK) guidance, and will not be used for any purposes other than those notified to data participants in accordance with the General Data Protection Regulation, GDPR (2018). After the period stated in GDPR, all data will be securely destroyed.

20. Will participants be paid or reimbursed?

This is not necessary but payment/reimbursement must be in the form of redeemable vouchers and not cash. Please note that the School cannot fund participant payment.

NO

If YES, why is payment/reimbursement necessary and how much will the vouchers be worth?

SECTION 4. Other permissions and ethical clearances

21. Research involving the NHS in England

Is HRA approval for research involving the NHS required? NO

Please see Page 1 of this application for important information and link

Will the research involve NHS employees who will not be directly recruited through the NHS and where data from NHS employees will not be collected on NHS premises?

NO

If you work for an NHS Trust and plan to recruit colleagues from the Trust will permission from an appropriate member of staff at the Trust be sought and is a copy of this permission (can be an email from the Trust) attached to this application?

NO

22. Permission(s) from an external institution/organisation (e.g. a school, charity, workplace, local authority, care home etc.)?

You need to attach written permission from external institutions/organisations/workplaces if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation.

Is permission from an external institution/organisation/workplace required? NO

If YES please give the name and address of the institution/organisation/workplace:

COPIES OF PERMISSIONS (LETTER OR EMAIL) MUST BE ATTACHED TO THIS APPLICATION

In some cases you may be required to have formal ethical clearance from the external institution or organisation or workplace too.

23. Is ethical clearance required from any other ethics committee?

NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? N/A

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation confirming its ethical clearance is acceptable.

Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

SECTION 5. Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible.

If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

24. Protection of participants:

Are there any potential hazards to participants or any risk of accident or injury to them? What is the nature of these hazards or risks (can be physical, emotional or psychological)? How will the safety and well-being of participants be ensured? Will contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?

The support organisation or agency that you refer participants to in your debrief letter should be appropriate. That is, is there a more appropriate support organisation than the Samaritans, for example (i.e. anxiety, mental health, young people telephone support help-lines?

1) If a participant shows sign of distress during the interview:
- Monitor participants' stress levels during the interview
- Remind participants the right to withdraw or reschedule the interview, remind them the contact details for bespoke services including perinatal mental health and counselling to reach out (will be explained in the debriefing forms), for face-to-face interviews: inform another staff/researcher or call 999 in case distress level is severe and urgent attention

is needed

1) Fire in the building during the interview: Know the fire exits when arriving at the building. Both be informed in advance of H&S procedure

25. Protection of the researcher:

Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you and how will you mitigate this? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant's house?

Inform another researcher/colleague before and after the interview

Call for help and contact the nearest staff member

26. Debriefing participants:

How will participants be de-briefed? Will participants be informed about the true nature of the research if they are not told beforehand? Will contact details of a support organisation be made available to participants via the debrief letter? All student research must involve a debrief letter for participants (unless the research involves anonymous surveys) so please attach a copy of your debrief letter to this application (see page 12).

All participants will be provided a debriefing form (See Appendix 3) which contains information on the nature of the research and the contact details of support services in case participants show signs of distress after the interview. The support services will include mental health counselling and perinatal services.

27. Other: Is there anything else the reviewer of this application needs to know to make a properly informed assessment?

28. Will your research involve working with children or vulnerable adults?*

NO

If YES have you obtained and attached a DBS certificate? YES / NO

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

YES / NO

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see:

https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/Research-involving-children.aspx

29 Will you be collecting data overseas? NO

This includes collecting data while you are away from the UK on holiday or visiting your country of origin, and distance learning students who will be collecting data in their overseas country of residence.

If YES in what country or countries (and province if appropriate) will you be collecting data?

Please click on this link https://www.gov.uk/foreign-travel-advice and note in the space below what the UK Government is recommending about travel to that country/province (Please note that you MUST NOT travel to a country/province/area that is deemed to be high risk or where essential travel only is recommended by the UK Government. If you are unsure it is essential that you speak to your supervisor or the UEL Travel Office – travelúel.ac.uk / (0)20 8223 6801).

SECTION 6. Declarations

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: *Bahar Kuzubasioglu*

Student's number: 1528632 Date: 17/04/2019

Supervisor's declaration of support is given upon their electronic submission of the application

Appendix E

Ethics Approval For Title Change

University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the 'student's signature' section (page 2).
9. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
10. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

4. A copy of the approval of your initial ethics application.

Name of applicant: Bahar Felton

Programme of study: Professional Doctorate Counselling Psychology

Name of supervisor: Dr Cristina Harnagea

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: Exploration of first-time mothers' emotional challenges in the transition to motherhood and practice of self-compassion	I believe that the new title represents the research's aim and the methodology better than the old title
New Title: Exploring the use of self-compassion in the transition to motherhood: A thematic analysis	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student's signature (please type your name): Bahar Felton

Date: 02/10/2020

TO BE COMPLETED BY REVIEWER		
Title changes approved	Yes	
Comments		

Reviewer: Tim Lomas

Date: 5.10.20

Appendix F

Ethics Amendment Approval for interviewing participants

UNIVERSITY OF EAST LONDON

School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

11. Complete the request form electronically and accurately.
12. Type your name in the 'student's signature' section (page 2).
13. When submitting this request form, ensure that all necessary documents are attached (see below).
14. Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk
15. Your request form will be returned to you via your UEL email address with reviewer's

response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

16. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

5. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
6. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
7. A copy of the approval of your initial ethics application.

Name of applicant: Bahar Kuzubasioglu

Programme of study: Professional Doctorate Counselling Psychology

Title of research: How do first-time mothers practice self-compassion to support their emotional maternal challenges in the post-partum period?

Name of supervisor: Dr Lisa Fellin/Dr Stelios Gkouskos

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Interviewing participants either face-to-face or via phone or Skype call (instead of only face-to-face interviews)	New mothers are very busy with their babies and their daily schedule is always changing to adapt the needs of their babies. Therefore, it may be very difficult to arrange time for them to meet for a face-to-face interview. Allowing a Skype/phone call when the baby is sleeping at home could allow

	some mothers to be interviewed without any distraction. Giving them an option to have the interview on a Skype or phone call may attract some participants. I believe this option will not create any inconsistency as the questions do not involve the participants to physically view/interact with any task, some participants may be more comfortable face-to-face, whereas some others may prefer a call due to confidentiality. The approach, Thematic Analysis, which I am planning to use is aimed to find the themes and patterns within the whole data which would eliminate the inconsistencies for both methods. I will also reflect on the used method for participants in my analysis to eliminate any inconsistencies. The stress level of the participants will be constantly reviewed by the researcher. Also the participant group is not vulnerable and mothers who struggle with severe stress will not be interviewed by the researcher (as explained in the ethics form).

Please tick	**YES**	**NO**
Is your supervisor aware of your proposed amendment(s) and agree to them?	Yes	

Student's signature (please type your name): Bahar Kuzubasioglu

Date: 18/07/2019

TO BE COMPLETED BY REVIEWER

Amendment(s) approved	YES	NO
Comments Amendment approved.		

Reviewer: Dr Rpna Hart

Date: 22nd July

Appendix G

Interview Schedule

Part 1: Transition to motherhood, emotional experiences and challenges/difficulties

1. Warm up questions:
   - How long have you been a mother for? *(if not known already)*
   - Could you please tell me your (emotional) experience as a new mother (please refer to your first 12 months)?
2. What would you consider as your main difficulties as a new mother (if any)?
   a. What makes it difficult for you?
   b. How do you cope with these difficulties?
3. When you experience challenges/difficulties as a mother, how do you cope with them? Could you please give some examples?

Part 2: Self-compassion practices

4. How do you understand 'self-compassion'?
   - *Prompt: how do you understand 'compassion'?*
5. Could you please give an example of a situation where you were compassionate towards yourself? (please refer to your maternal experiences)
   - *Prompt: Could you please give an example of when you were compassionate towards someone else? Have you treated yourself in a similar way? How?*
6. Can you give examples of things that you do to be kind/less judgemental towards yourself as a mother *(prompt: when experiencing emotional challenges as a mother)* (if any)? How?
7. Is there anything you do to connect with others/feel less lonely *(prompt: when experiencing emotional challenges as a mother)*? How?
8. Can you give examples of things that you do to be more mindful/aware of your emotions *(prompt: when experiencing challenges as a mother)* (if any)? How?
9. How do you motivate yourself to overcome your emotional difficulties/challenges as a mother (if any mentioned previously)?
10. Are there any other examples of when you are compassionate towards yourself *(prompt: when experiencing emotional challenges-if any)* as a mother?
11. Is there anything else you'd like to add?

Appendix H

Additional Considerations for TA

Process	No.	Criteria	Applied as
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for „accuracy".	Followed
Coding	2	Each data item has been given equal attention in the coding process.	Coding example (Appendix J)
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.	Coding example (Appendix J)
	4	All relevant extracts for all each theme have been collated.	i.e. Followed in phase 4
	5	Themes have been checked against each other and back to the original data set.	i.e. Followed in phase 3
	6	Themes are internally coherent, consistent, and distinctive.	Themes were described in detail and reviewed by my supervisor
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.	Codes and themes were reviewed multiple times and the meaning was explored
	8	Analysis and data match each other – the extracts illustrate the analytic claims.	i.e. Followed in phase 4
	9	Analysis tells a convincing and well-organised story about the data and topic.	i.e. Followed in phase 6
	10	A good balance between analytic narrative and illustrative extracts is provided.	See the Analysis chapter
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.	The analysis process took approximately 8 months. Each phase was followed and reviewed carefully.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.	See the Analysis chapter
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.	See the Methodology chapter
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.	Critical realist stance was taken as explained in the Methodology and Analysis chapters
	15	The researcher is positioned as *active* in the research process; themes do not just „emerge".	Semi-structured interviews were shaped by my positioning as a researcher. Reflexivity was also utilised.

Table: A 15-Point Checklist of Criteria for Good Thematic Analysis (Braun & Clarke, 2006)

Appendix I

Reflexive Journal Extracts

19.12.2019 Assumptions:

When I was reading the last research interview, I noticed my biases, even when asking research questions to my participant. For example, I had assumed that reading some baby-related books might have been helpful to her as they were to my other participants. Then, at the end of the interview, I noticed that I had completely ignored what she told me and I focused on my own assumption!

What she actually meant was: she couldn't talk to her in-laws (because of culture, family expectations?)**.** I wish I could do this part of the interview, again! But at least, it made me realise that I still have blind spots and I need to be aware of them.

14.02.2020 Difference of self-care and me-time:

I have noticed there might be a slight difference between self-care and me-time which I have used identically in my analysis so far. Self-care is probably an expansion of me-time. One definition says taking care of your physical and mental wellbeing. However, me-time is more referring to the time and activities you enjoy doing by yourself. I am still a bit confused whether these two definitions can be used interchangeably in my research's context, so I need to read more about them.

Appendix J

TA Phase 2: Coding example

I: Hmm, so when were the times when you could understand that those feelings were normal?	
C: I think when I had enough sleep [I and C laugh]. That's the feeling, well, that's the main problem I had, being sleep-deprived I wasn't able to think straight and I was always like, I couldn't bring myself up, emotionally. But you know, whenever I had time away, or when my husband was helping, those feelings were able to come up and I was able to support myself [smiles].	Sleeping improves self-compassion Emotional support from husband Improved self-soothing
I: [smiles] So for you, sleep was an important factor then to get back to normal?	
C: Yeah, I mean, not feeling tired. Other than that, well, speaking with someone else, so my husband made me realise my feelings, too. So it comes from inside but also from the conversations I had with my husband, too. So, yeah, that's how he also normalised, he was able to show me how I was feeling, you know, why I was feeling that, as well. So yeah, that helped.	Talking to others i.e. husband Normalising feelings Awareness of emotions Being around compassionate people (husband)
I: Hmm, you've also talked about some guilty feelings that you should have done this and that…	
C: Uh-hmmm.	
I: Do you have any examples, so when you felt guilty?	Cultural differences/ society's expectations (sleep routine, breastfeeding)
C: Obviously, like, there's all sorts of parenting styles, coming from a different culture. I'm living in a different country with a different culture. I'm always thinking I'm always breastfeeding to have my baby to sleep, 'am I doing it right?', 'am I doing something wrong?' You know and I was always more baby-led and people around me were stricter with their schedules and everything and I was thinking 'am I making it wrong? Is that gonna be a bad decision in the long run?' So all these questions, questioning my parenting style, my schedule about sleep and feeding etc., all these things made me stressed.	Self-doubt/ not feeling confident as a mother Comparing self with other mothers
I: It sounds like maybe looking at other people was kind of giving you more guilt and questioning the way you do things?	

C: Mmm, I wasn't thinking about what other people would say but I was hearing stories about other people whose babies were sleeping etc. but my baby was up all night and he was teething etc. I was questioning myself but I knew what I wanted to do, obviously, I wanted to be baby-led, child-led but those questions were still puzzling my mind at times.	Self-doubt Not being able to trust own decisions/ not feeling confident

First coding

Second coding (additional codes)

Potential quotes

TA Phase 3 and 4 (Searching for themes/reviewing themes) Example:

Potential Theme 1 Self-compassion is initially difficult after birth

Potential Theme 2 Shift towards becoming more self-compassionate

Potential Theme 3 Compassion nurtures regrowth?

S: Yes, nothing specific to babies, no, but what I was doing on the phone, yes, I was reading articles about babies, about you know, like, you know, other experiences of other mummies, how to handle different situations, yes, I was doing this, but it's not specific book to read specifically for the baby. This, whatever was related to the babies was only on the internet, I was checking on the internet.	Feeling connected/not feeling lonely in her difficulties Motivation
I: Okay and was it helping you?	
S: Yes, it's helped, I mean, it was difficult but it wasn't extremely difficult. For me, the most difficult part, again, explain different situations, right, at the beginning with my parents-in-law, then the fact that the baby was not sleeping well for a long time. In the beginning it was normal but then when it's happened for a long long time it becomes very difficult. So all of these were possibly difficult but then the most most most difficult part was that, at the very very beginning was my in-laws, for that you cannot read any books, you know [S giggles] [I: Yeah], but, yes, all the articles that I was reading, about other cases, the experiences of other mums, of course they were helping a lot, you know. You were feeling that you're not alone, that there are so many people. And also because sometimes, some thoughts in your mind are, okay, 'now I'm doing something really wrong, because what's happening is not normal, so I'm doing something wrong with my baby'. And then, when you read about other cases, you understand that it's happened, you know, it is what it is, this is how things are at the beginning. So it's not that you're doing something wrong, it is how, you know, how life goes after you have a baby. But yeah, it's helped a lot. I remember I was so emotional, I was crying, crying all the time, but out of happiness, I was crying when I was reading stories about mummies talking about their babies, you know, how, the fact that, I remember, there was a video and they were saying, actually the story was about the fact you know, you have very long nights when the babies are very young and when they become teenagers, also the nights are very long because you're concerned where they are, when they will come back home, they follow their own life, anyway. So the message was that it passes so quickly, so what you might think now, a few months are a struggle, you know, they will pass by and you'll forget about it. And it's true because now I'm talking to you about all of these, it seems to me like history, so now I cannot even, I remember my feelings but they don't affect me. I remember how I was feeling then, but it seems so distant like it was a long time ago, you know.	Sleep deprivation (worse after a period) Negative experience with in-laws/ feeling helpless Connecting to others/ not feeling lonely in her difficulties Self-doubt Realisation/change in perspective Normalising feelings Relief It's a phase Not ruminating