

# **A qualitative exploration of responses to self-compassion in a non-clinical sample**

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## **Abstract**

Research suggests that being self-compassionate can have myriad benefits, including life satisfaction, health-promoting behaviours and improved mental health. Given the possible advantages of being self-compassionate, it seems critical to explore how to promote this in the general population. This qualitative study aimed to understand responses to the idea of being compassionate to oneself within the general population. Semi-structured interviews were conducted in the North East of England between October 2014 and February 2015, they were analysed using Thematic Analysis. As part of an intervention study, non-clinical volunteers watched a psychoeducation video about the concept of self-compassion and then participated in one of four meditation exercises. Following this, participants were interviewed about their responses to the idea of being self-compassionate. Three themes were identified: *Benefits of Self-Compassion*; *Being Self-Compassionate* and *Barriers to Self-Compassion*. Participants believed that being self-compassionate would be beneficial, for both themselves and the world, but they believed that self-compassion would make them vulnerable and that others would judge them. Thus, participants were afraid to be the first ones to be self-compassionate and stated that, in order for self-compassion to be acceptable, we need to change the perspective of Western Culture. These findings underscore the importance of understanding society's role in a person's ability to be self-compassionate. In order to reap the benefits of self-compassion, we need to create a culture that accepts and encourages this. As practitioners, we are in a position to lead in self-compassion and to encourage other leaders to promote this as a preventative mental health strategy.

**Keywords:** *self-compassion; prevention; community health; well-being*

### **What is Known About This Topic**

- People who are more self-compassionate are more likely to have higher life satisfaction, make better health decisions and have fewer mental health problems.
- People in clinical populations can find being self-compassionate threatening and often believe it is not possible.

### **What This Paper Adds**

- Participants from a non-clinical sample reported that they were concerned that being self-compassionate would be difficult due to their old habits and the feelings of guilt and vulnerability it generated.
- When considering using compassion-focussed work as an intervention or preventative strategy in mental health settings and organisations, it is imperative to consider the wider social discourses around this idea in order to understand potential barriers.

## **Introduction**

Western psychologists have conceptualised self-compassion as comprising of three elements – mindfulness, common humanity and self-kindness (Neff, 2003). That is, in order to be self-compassionate, people must be aware of their own experiences and able to recognise when they are suffering (mindfulness). Within this, it is important to accept that everybody has challenging life experiences and makes mistakes (common humanity) and being self-compassionate means responding to these feelings and actions with kindness and understanding (self-kindness).

Research into self-compassion consistently suggests that those who are more frequently compassionate to themselves are less likely to have mental health problems and more likely to report higher life satisfaction, more effective coping skills and to be higher in emotional intelligence (Barnard & Curry, 2011). Self-compassion has also been related to a range of health-promoting behaviours, including healthier diets, regular exercise patterns and better sleeping habits (Sirois, Kitner & Hirsch, 2015).

Induction studies have suggested that self-compassion can be increased and this benefits well-being (e.g. Leary, Tate, Adams, Allen & Hancock; 2007). Compassion-related therapies are now being developed and evaluated across the United Kingdom and the United States of America (e.g. Germer & Neff, 2013; Gilbert, 2009). Although evidence is still being generated, it seems such interventions can decrease self-attacking and self-critical ways of relating to oneself (Gilbert & Irons, 2004) and increase self-compassion and self-reported well-being (Neff & Germer, 2013). Overall, therefore, it seems that being self-compassionate can benefit mental health and well-being, which in turn makes it easier to cope with challenging life

circumstances and to regulate emotions. It appears that self-compassion can be taught and enhanced.

Given the benefits of self-compassion, it seems valuable to develop this way of being within the wider population, potentially as a method to promote and maintain well-being. Research with clinical populations suggests that people with mental health problems believed it would be difficult for them to learn to be self-compassionate because of a long-standing history of being unkind to themselves, and they believe that their experiences of anxiety and depression made it impossible for them to begin showing themselves kindness (Pauley & McPherson, 2010). Gilbert, McEwan, Matos and Rivis (2011) reported that clients often seem to be fearful of receiving compassion from others, as well as from themselves. Together, these studies suggest that, within clinical settings, clients may experience compassion as threatening and find self-compassion difficult.

To date, however, there has been little research investigating qualitative responses to information about self-compassion from a community population. It seems critical to investigate this area in order to tease apart the challenge that mental health problems pose to being self-compassionate from the barriers to self-compassion caused by wider cultural discourses. This seems particularly pertinent as self-compassion has been drawn from Eastern cultures and understandings. This study seeks to augment our understanding of how the general population respond to ideas about self-compassion, in order to inform the method by which we approach teaching and enhancing self-compassion within both clinical populations and the general public as a health promotion strategy.

As part of a larger pilot study exploring participants' experiences of a compassionate imagery exercise (Anonymised, submitted), participants were asked about their responses to a short

psychoeducation video. This video explained the concept of self-compassion and suggestions of how self-compassion could be beneficial (Gilbert, 2004). Participants were then asked to complete a meditation or compassionate imagery task, after which they were interviewed about their responses to both the psychoeducation video and the exercise. Quantitative and qualitative results from the meditation exercises are reported elsewhere (Anonymised, submitted)<sup>1</sup>. This paper reports responses regarding the following research questions:

- How do participants respond to information about self-compassion?
- What do participants think is involved in self-compassion?
- What do participants perceive are the barriers and facilitators to practising self-compassion?

## **Method**

### *Design*

This paper reports results from a larger pilot study that used mixed methods to investigate the effects of learning about self-compassion from a psychoeducation video, and participating in a meditation/compassionate imagery exercise. A semi-structured interview was used to explore participants' responses to both the video and the exercise. The data relating to the psychoeducation video is presented here. Responses were analysed using Thematic Analysis (Braun & Clarke, 2006).

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<sup>1</sup> Participants were interviewed about both elements of the intervention (psychoeducation and meditation/compassionate imagery exercise), and their responses clearly distinguished between their feelings about being self-compassionate and their experiences of the meditation/self-compassion exercise. Results have been written into separate studies as they address different research questions and highlight distinct issues related to the two areas investigated.

## *Participants*

A convenience sample was recruited using email and poster advertisements, from a university population and the local community in the North East of England, between October 2014 and February 2015. Participants had not had previous contact with the researcher, although they were informed that she was a Trainee Clinical Psychologist. Participants were included if English was their primary language and they had capacity to consent. Participants were excluded if they had any knowledge of self-compassion through psychology, Buddhist practice, or research, as the psychoeducation was aimed at people who had little to no prior knowledge of the psychological concept of compassion and its potential benefits.

Twelve participants were asked to engage in interviews and all agreed. The interview from the second participant did not record and so a thirteenth participant was interviewed. The mean age for participants was 40.83 years (SD=11.72; range 23-55years); 8 of the twelve participants were female and all were either staff or post-graduate students at the university.

## *Materials*

### ***Psychoeducation Video***

A psychoeducation video using cartoons and pictures was developed by the first named author to offer information regarding what is meant by self-compassion and common reasons why people worry about being self-compassionate. The video lasted 8:43 minutes and mainly drew upon research and theory by Neff (e.g. 2003) and Gilbert (e.g. 2004; 2009). The video was piloted to ensure that information was clear and accessible, all responses were positive and no changes were made. The video can be viewed at <https://www.youtube.com/watch?v=Z3SGX6Fz0Vo>.

### *Interview Schedule*

To develop the interview schedule, papers investigating responses to self-compassion in clinical samples (e.g. Pauley & McPherson, 2010) were reviewed as well as those that explored the effects of compassion-focused therapies (e.g. Gilbert & Irons, 2004). First author reviewed these papers for outcomes, gaps and ideas for further investigation and this informed the creation of the interview schedule, which was piloted on the first four participants.

### *Data Collection*

Ethical approval was sought and gained from the University Ethics Committee. For full details of the experimental procedure, please see Anonymised (submitted). Participants were given information sheets and consented to taking part in the study, having been offered the chance to clarify anything that seemed unclear. Following this, demographic data including age, gender and history of meditation were gathered. Participants completed measures of attachment, affect and self-compassion, then watched a psychoeducation video explaining what self-compassion is and is not, and why it may be a helpful and valuable way to relate to oneself. Participants had the opportunity to ask any questions about the video and were then randomly allocated to one of four interventions (Meditation, Imagery, Sensations or Posture<sup>2</sup>), each of which lasted eight minutes. Following this, participants were again asked to complete measures of affect and self-compassion. After this, twelve participants were interviewed about their responses to

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<sup>2</sup> In each group, participants first completed a guided body scan and then instructions varied slightly. In the meditation group, participants focused on their breath, with occasional reminders to bring their awareness back to their breath. In the remaining three groups, participants were asked to create a compassionate image and then the focus of their attention varied per group. In the Images group, participants focused on the image. In the Sensations group, participants focused on the sensations brought about by the image. In the Posture group, participants moved their bodies to reflect the feelings brought about by the image.

the psychoeducation video and the exercise, and these interviews were recorded on a Dictaphone. The average length of each interview was 15:38 minutes:seconds (range = 12:00-23:14). The majority of participants' discussions centred on their thoughts about self-compassion. Often, participants spent the most time exploring their perceptions of what gets in the way of them reaping the benefits they thought self-compassion could offer.

Responses from the first four participants were reviewed to ensure the tasks were easy to understand and engage with, and no changes were made following their responses.

### *Data Analysis and Quality Checking*

Participants' interviews were analysed using Thematic Analysis (Braun & Clarke, 2006). This was based upon essentialist/realist assumptions and aimed to explore the semantic content of participants' responses.

First author conducted and transcribed the interviews verbatim in order to ensure that as much of their original meaning was maintained. Following this, first author began active reading, searching for patterns within the data, generated from codes. This was an iterative process, as the more codes were found, the more patterns were developed and other codes could be sought. The codes were kept as direct participant quotes, and it was hoped that, in doing this, the researcher's interpretation bias would be lessened. A peer also read and coded the transcripts to ensure that codes had not been missed, results were compared and any differences were discussed and extra codes were included. Codes were grouped together and these groups were then reviewed and revised, while considering the meaning of these within the overall data, these groups then became themes. These were discussed at a qualitative research group and with second author. It was at this point that it became clear that participants seemed to discuss the experience of participating in the exercise separately from their responses to the idea of

self-compassion, and it seemed that considering these issues separately would offer a chance to explore each area more fully.

Throughout the research process, first author kept a reflexive and reflective research journal in order to consider the extent to which her own biases and assumptions might be influencing the data. Reviewing this helped to ensure that themes were as balanced and true to participants' experiences as possible. The researcher was alert to her own influence on the outcomes of the research and biases in interpreting the findings. For example, having been educated about self-compassion and its benefits, the researcher was conscious that she might elicit responses from participants that reflected enthusiasm for this concept. However, the researcher was also aware of the challenges of being self-compassionate, through personal experiences, and this ambivalent approach may have influenced the interpretation of the findings.

## **Findings**

Participants spoke about their perceptions of the possible *Benefits of Self-Compassion*. Participants also discussed *Being Self-Compassionate* and what this entailed, including *Connecting with Others; Doing Things for Ourselves; Acknowledging and Accepting*. While participants believed that being self-compassionate would benefit people both individually and globally, they also highlighted that there were several *Barriers to Self-Compassion*, including the belief that *Self-Compassion does not fit with current norms and expectations; There's not enough time; It's easier for people who aren't like me; Self-Compassion creates feelings of guilt and vulnerability; and Society needs to permit self-compassion first*. Quotes to illuminate these themes and sub-themes are presented with pseudonyms below.

Table 1

*Themes and subthemes drawn from participants' responses with number of participants whose responses could be incorporated into these*

<u>Theme</u>	<u>Subtheme</u>	<u>Number of participants</u>
Benefits of self-compassion		11
Being self-compassionate	Connecting with others	5
	Doing things for ourselves	11
	Acknowledging and	10
	Accepting	
Barriers to self-compassion	Self-compassion does not fit	11
	with current norms and	
	expectations	
	There's not enough time	6
	Easier for people who aren't	4
	like me	
	Self-compassion creates	8
feelings of guilt and		
vulnerability		
Society needs to permit self-	9	
compassion first		

Participants spoke about personal benefits they believed they would experience from being self-compassionate.

"I probably would have had an easier time I've suffered... with depression and I think that a lot of those issues... I probably would have dealt with them better and I wouldn't have had a lot of angst" Abigail

In addition, participants believed that if everybody felt able to be self-compassionate, we would live in a happier world.

"I think it would make the world better... Creating a kind and compassionate and safe place for all people would definitely make some positive change" Lydia

"There's not enough [compassion] in the world y'know otherwise we wouldn't be in these stupid wars" Pam

### ***Being Self-Compassionate***

Although participants initially struggled to think about how they might be compassionate to themselves, ideas began to emerge regarding what being self-compassionate would involve.

### ***Connecting with Others***

Participants spoke about the need for social connection and how this would facilitate understanding of the fallibility of being human and how to accept and allow for this.

"Being around other people... And genuinely sharing what's going on with us... Everybody would find it easier to be compassionate to themselves and to one another if they were more connected to other people and had the time to be more connected" George.

### *Doing things for ourselves*

Participants also believed that being self-compassionate would involve doing things for themselves, particularly things that they may have put off.

"If that's spending time... acknowledging whatever's going on or just doing something just purely for ourselves" George

### *Acknowledging and Accepting*

In addition, participants highlighted the need to be aware of our needs and acknowledge when we are in need of compassion.

"You've got to realise that you could or should be [compassionate to yourself]... The whole sort of being aware of suffering thing... If you don't even realise that you're bothered by something then you can't respond to that" Isabella

Once we have acknowledged our needs, participants spoke about the need for acceptance of who we are and what we are experiencing.

"I think that for me compassion it's not so much like actively the things that you do but it's almost like seeing the things that maybe you're not so happy about and just saying that's ok you know" Lucy

Self-compassion also seemed to be about allowing others to help us and accepting their kindness. In order to do this one has to be open to receiving compassion and aware of its presence.

"You have to recognise that [self-compassion is] coming" Abigail

### *Barriers to Self-Compassion*

Although participants liked the idea of being self-compassionate, they also believed it would be a challenge.

"Practising being kind and bringing yourself back and reminding yourself that you're just a person... It's very beneficial but yeah it's very difficult" Lydia

Participants suggested that it was particularly hard to be compassionate to themselves because they had not developed it as a habit or a way of being.

"If you get used to being a certain way to yourself it's almost like totally alien to be kind to yourself" Sophia

### *Self-Compassion does not fit with current norms and expectations*

Participants' responses suggested that the idea of being compassionate to themselves was something that seemed sensible and yet not something they had previously considered.

"It seems to make a lot of sense almost like... why have I not heard of [self-compassion] before"

Lucy

Participants went on to explore why they had not previously heard about self-compassion. They talked about the social messages available within Western society from childhood. First, they considered the expectation that we be kind to others.

"We learn to be compassionate to others and we're always taught that as a child aren't we that we have to think about other people and be courteous and compassionate towards them and we're not really taught to do it to ourselves" Selena

In addition, participants discussed how they did not treat themselves as kindly as they would treat others.

"If my kid falls over I sort of go over and try and help him feel better and all that kind of thing you know but... I don't know how much I do that to myself" Isabella

In contrast to the expectation that we prioritise the needs of others, participants also highlighted the social expectation that an individual should promote his/her needs above those of others. This seemed to cause a confusing conflict for between 'loving thy neighbour' and 'looking out for number 1'.

"[Being kind to others] is something I do it's been built into me since I was a young person but then sometimes I forget to look after myself and I get worked up because I've been doing everything for everybody else... Which I know sounds silly because obviously I'm number one" Rose

This expectation fitted more into discussions around the capitalist and individualist nature of Western culture and how these ideals seem to conflict with principles of self-compassion.

"United States capitalist individualistic based society... That does not create an environment for compassion or kindness... Anybody who's not in a place that they like is just not doing anything to change it is the common conception" Lydia

In addition, participants spoke about British norms of stoicism, which they believed also conflict with self-compassion.

"The idea of being kind to yourself I can see is a good idea but on the other hand somehow I... feel like it's ah not British... Like just bloody well get on with it rather than paying attention to yourself" Isabella

"I don't know whether it's our upbringing or our culture... We're taught not to be self-absorbed or you're frightened that you get a bit self-obsessed... Stiff upper lip and carry on regardless and it'll get better tomorrow" Selena

#### *There's not enough time*

Participants also seemed to perceive that being self-compassionate would take time, which they did not believe they had.

"It's also hard to create that time and space for yourself" Lydia

There seemed to be a belief that taking time for oneself stole time away from doing things for others.

"To say I'm not going to do such and such for somebody else I'm actually gonna purposefully put this piece of time in place to be compassionate for myself" George

#### *It's easier for people who aren't like me*

In exploring elements of compassion, participants discussed their perceptions of differences across genders and generations. It seemed that, due to culturally derived gender roles, women

believed being self-compassionate was harder for women and men believed it was harder for men.

"We're always told to put others before ourselves, particularly women I think... I do think as women we are kind of taught that it's feminine to be that way" Selena

"The whole boy code around...you're not meant to show big feelings and not meant to you know kind of have feelings and... women... [are] more able to socially connect with other people and more likely to share feelings more likely to you know notice them within themselves far more easy going about crying... and... expressing... and knowing themselves and perhaps ... knowing their own bodies" George

There was also a suggestion that with each generation, the population becomes more open about their feelings and that this might change the extent to which people are able to accept the idea of being self-compassionate.

"Possibly a generation difference I can see that I'm different from my parents and certainly from my grandparents you know I'm sorta more open and willing to talk about issues but I can see generations... coming through sort of very open and self aware" Graham

#### *Self-compassion creates feelings of guilt and vulnerability*

There seemed to be a sense that being self-compassionate would seem selfish to others and this made participants feel guilty, which made them avoid being self-compassionate.

"People think that if you take time to be compassionate to yourself oh it's a waste of time or it's selfish" Lucy

"You do tend to think of yourself as being a bit self-absorbed or self-involved or whatever if you... start focusing on yourself" Selena

In addition to feeling guilty for being kind to themselves, participants discussed feeling vulnerable when sharing a need for compassion and accepting it from others.

"If you're open with people as well so you have to let people come in and that's probably one of the hardest things is letting people come in" Abigail

Participants expressed that there were some times when they particularly believed that self-compassion would not be a helpful or safe method for relating to themselves.

"I've got a sort of long term condition and uh I'm very much in the frame that you don't feel sorry for yourself and I sort of worry a bit that I'd become a bit of a liability if I start to engage in self behaviour... I don't think there's a need at the moment" Graham

### ***Society needs to permit self-compassion first***

Participants suggested that they felt as though they needed permission from others to be compassionate to themselves.

"If somebody's told you to be compassionate or to... relax then OK it's like given you permission almost" George

Participants suggested that in order to feel permitted, ways of being self-compassionate would have to be encouraged from an early age and that we would need to be taught how to be self-compassionate, as it is not something that comes naturally.

"Maybe if it was a bit more in our kind of culture and our upbringing from an early age"

Selena

Participants also seemed to be reluctant to be self-compassionate unless others were doing it first and held that it was the responsibility of others to model self-compassion.

"The responsibility for imparting compassion is the responsibility of everybody around you"

Isabella

## **Discussion**

This study aimed to qualitatively explore reactions to the concept of self-compassion, in a non-clinical sample. Overall, findings seemed to converge with reports from Pauley and McPherson (2010). Similar to their clinical sample, the community sample in this study stated that they believed self-compassion was a good idea and that they thought it would be beneficial for their own mental health and well-being as well as the well-being of the world. Furthermore, participants expressed that they thought being self-compassionate would be difficult because they had not developed this as a 'habit' and, like participants in Pauley and McPherson's study and Gilbert et al. (2011), participants found it easier to be cruel and punishing to themselves than to be self-compassionate.

When considering the findings presented in this study, it is important to be aware of its limitations. Firstly, participants volunteered to participate in a study about compassion, thus it is likely that they had some level of interest in this area already and may have been more likely to respond to the ideas favourably. Nevertheless, although the information was not completely new to some participants, most expressed that they had not considered this concept previously. Secondly, compassion-related interventions tend to offer clients weeks of psychoeducation

about the concept of self-compassion, the benefits of being self-compassionate and how we might approach this (e.g. Gilbert, 2009). Participants in this study were shown a short psychoeducation video and then asked to complete a meditation exercise, and responses may have been different if participants had had a chance to explore the concept of self-compassion more fully.

Nevertheless, this study contributes to our understanding of how self-compassion is perceived to fit into Western culture, allowing us to develop appropriate and successful interventions and well-being promotion strategies. That participants from a non-clinical sample had similar beliefs about self-compassion being challenging and easier for others than themselves to those in a clinical sample, invites exploration of the challenges posed by the idea of self-compassion (Pauley & McPherson, 2010). Participants suggested that accepting compassion from either the self or others created feelings of guilt and vulnerability and this seemed to be fuelled by available discourses, which suggest that taking time for oneself is selfish. Complicating the matter further, participants mentioned the conflicting discourse of 'looking after number one', which suggests that a person should promote their own self-interest and should not expect help from others. Although promoting one's own needs could be related to self-compassion, participants hinted that the lack of connection with others involved in 'looking after number one', was not compatible with self-compassion.

Theories about the evolution of compassion could further aid our understanding of the conflict between 'looking after number one' and putting others first, highlighted by participants. Spikins, Rutherford and Needham (2010) explain that compassion may have evolved as a means for furthering social relationships, which, in turn can help to advance the self. Thus, in its primary form, it is possible that compassion developed as a means of survival. As we have evolved, we have come to thrive on the sensations we associate with being compassionate to

others and having others be compassionate to us, and this sense of affiliation has become one method for regulating our affect (Gilbert, 2004). However, being compassionate to others also makes us vulnerable to exploitation and this can trigger our threat system, which also affects our affective state. Thus, humans have to balance their need for compassion (i.e. the affiliation system) with the need for self-protection (i.e. the threat system) and the drive to further one's own interests (i.e. the drive system). This could deepen our understanding of the evolutionary model of affect regulation presented by Gilbert (2004). Understanding the evolutionary roots of compassion could inform the way in which we present information, offering a broader explanation than rooting problems within the individual.

While participants expressed that, on a deeper level, they felt better when they were able to accept and connect with themselves and others; this seemed at odds with the pressures of Western culture. As clinicians, it seems important to be aware of the influence of the wider systems on the perceptions of what is achievable for participants. Clinical Psychology often emphasises the importance of parental influences on the development of personality, thus suggesting that children of parents who struggle to be self-compassionate often develop similar difficulties (e.g. Neff & McGehee, 2010). The present considers how social discourses can influence and shape parental responses to their own needs and those of their children and, therefore, how children and adults learn to respond to themselves. Thus, in order to change this on a wider scale, we will need to challenge social discourses around the acceptability of being compassionate to oneself. Primarily, we can do this by modelling this to colleagues, family and friends; having open discussions about being self-compassionate and exploring some of the beliefs and fears around it. Additionally, this study suggests that a short psychoeducation video can stimulate thinking about such ideas in others and offers a further medium through which

we can begin to challenge current ideas about what is involved in being 'self-compassionate', and whether this is selfish or could be beneficial for oneself and for those around him.

These discussions highlight the importance of considering cultural norms and systems around individuals when encouraging them to be self-compassionate. Participants spoke about feeling vulnerable and guilty about being self-compassionate and, as a result, they wanted others to model self-compassion. This emphasises the need to create a feeling of 'permission' within society, which will encourage its members to feel increasingly safe to be compassionate to themselves. The need for social acceptance is considered a core human need and social psychology demonstrates how perceptions of others can influence the perception of the self (Cialdini & Goldstein, 2004). As a result of this, people are more likely to act in ways that conform to those around them, in order to maintain important social connections. Given that this need for connection is also a facet of self-compassion it seems essential that we create a society in which being self-compassionate promotes belonging rather than ostracising individuals.

This has been supported by organisational literature, which emphasises the importance of creating a business-wide ethos of care and a system that notices, experiences and responds to suffering as a whole is now being emphasised (Kanov et al., 2012; Lawrence & Maitlis, 2012). Rynes, Bartunek, Dutton and Margolis (2012) note that modelling compassionate and caring interactions is critical in developing an ethos of care in an organisation. Although Rynes et al. note that these responsibilities do not solely rest with persons in positions of leadership, some of these changes can only be made by managers and, thus, it seems that encouraging a compassionate environment from the 'top-down' may be beneficial within systems. As practitioners, there is a responsibility for us to create a sense of permission for our clients and those working around us to be self-compassionate. In order to do this, it seems vital that we

‘practise what we preach’, becoming versed in extending compassion towards ourselves before attempting to instil it in others.

Within the UK, there is currently an emphasis on the importance of ‘living well’ and developing methods of prevention and early intervention in order to reduce both physical and mental health costs to society (Department of Health, 2011; Prince et al., 2007). Additionally there is a drive to create a ‘compassionate National Health Service’ (NHS; Department of Health, 2012); indeed, Fraser (2015) has recently discussed the importance of promoting self-compassion for nurses. Participants from a community sample are those who would most benefit from health promotion and prevention strategies, as well as being people who might work within the NHS. These participants highlighted that the barriers to self-compassion in a community sample are similar to those in clinical populations and these derive from cultural messages and a feeling of not being supported within both micro and macro systems. It seems crucial to work across these levels in order to promote living well, given the value of self-compassion that research is now highlighting in mental health, physical health and productivity (e.g. Barnard & Curry, 2011).

From here, it seems valuable to explore how people from non-clinical samples envisage self-compassion and what they believe it may involve. Investigations into the impact of learning about self-compassion and how people incorporate this into their lives would help to inform clinical practice of its potential. Awareness of the tenets of self-compassion could be spread via education systems and Internet health promotion videos in order to embed self-compassion as a habit in forthcoming generations. The Internet serves as a resource to share such information and ideas, via video and social media and the findings presented here support the use of such media for promoting mental health and well-being. Empowering people to feel

permitted to be self-compassionate is a fundamental next step to embedding this way of being into our societies.

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