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MIRRORING AND COMPASSION IN EARLY MOTHERHOOD

Section A: Empirical studies of mirroring and theoretical connections: A literature review.
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Section B: “They say it's a good thing in principle but…” - New mothers’ experiences of compassion in society: An Interpretative Phenomenological Analysis.
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Summary of Major Research Project

Section A provides a summary of key theories of mirroring and evaluates them against a review of current empirical studies. The main associations with mirroring, different definitions and methodologies were summarised. Existing constructs and coding strategies were critiqued for western-centric assumptions. Parts of the key theories were supported but some elements were not covered by the existing literature, including mechanisms of the development of the self in healthy and problematic environments. As the relationship with self may be influenced by compassionate relating, suggestions for further exploration included compassion in early life.

Given the methodological challenges of understanding an infant's inner world, Section B instead focused on the mother's experience of compassion with her baby and others. Compassion has associations with wellbeing and resilience and theories suggest it evolved within the mother-baby relationship, later generalising to other close kin and wider social connections. Therefore, this study also explored mothers' experiences of compassion in a wider societal context. Participants valued compassion highly but felt that society could be judgemental and contradictory in its standards for mothers. Implications include a need for societal systems to be evaluated with a compassionate lens, and a collective effort to facilitate more compassion for mothers.

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Section A

Empirical studies of mirroring and theoretical connections: A literature review.

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Abstract

The act of a mother mirroring her infant is situated within an intricate combination of maternal behaviours and has been the subject of many developmental theories of identity formation, emotional recognition and emotional regulation. However, most theories rely on individual case studies and adult therapeutic work, recalling and interpreting the influence of historical parenting experiences; empirical evidence for theories of mirroring is limited. Biological theories, Mirror-Role theory and the Social-Biofeedback Theory were summarised and evaluated against empirical studies. Seven databases were searched using the terms: ("mirror" OR "mirroring") AND ("mother" OR "maternal" OR "parent") AND ("baby" OR "babies" OR "infant" OR "child"). Nine studies were included in the review, none of which involved randomisation, controls or a direct intervention. The studies varied in definitions and measurement of mirroring, setting, age and nationality. Mirroring was associated with infant social behaviours and neural activity, maternal attachment and mind-mindedness, and showed bidirectional effects. Elements of each theory were well-supported but each had parts that could not be evaluated by the current literature. Future research should investigate these gaps, cultural differences, associations with attachment, mirroring in fathers and the mother's experience of her infant's development of and relationship with elements of the self.

Key words: Mirroring, Mothers, Infants, Perinatal, Review

Introduction

'Mirroring' is a long-standing concept that has been theorised by many prominent psychological scholars over time however, relatively few empirical studies have investigated the concept directly. Instead, many theories are based on clinical case studies, extrapolating from adult therapeutic discoveries to make sense of early childhood mechanisms. This review will situate mirroring within the wider context of mother-infant experience[1], define the concept in more detail, describe and evaluate relevant empirical studies of early childhood mirroring and discuss the extent to which these studies contribute to or question key theories. Finally, the limitations of this review, gaps in the literature and future directions for research will be discussed.

Situating and defining 'mirroring'

It is well established across psychological schools of thought that an infant's early experiences can shape their later life (O'Connor, 2003), for example in their ways of relating to other people (Greenberg, 1983), beliefs about self and the world (Beck, 1995) and likelihood of experiencing mental health problems and physical health inequalities (Bellis et al., 2016). The experience of early childhood is a fluid, complex, ever-evolving process within and between mother and child; it encompasses many different psychological concepts that, although distinguished for theoretical and experimental purposes, are in fact often highly connected to each other. For example, in order to attune to an infant's needs, the mother must also somewhat be able to recognise her infant's inner world; such "maternal sensitivity" (Ainsworth et al., 1978) is in turn dependent on the mother having learnt about her infant's tendencies and on the infant having learnt over time how to express their needs. Thus, it has been suggested that this is not a uni-directional process of purely maternal onus, but a bi-directional process involving agency on the part of the infant (Stern, 1971); nonetheless, the caregiver with their greater interactive skills will usually carry more of the responsibility for attunement (Kochanska & Aksan, 2004). Provenzi et al. (2018) helpfully provide the metaphor of a "dyadic dance": an interactive, collaborative process that mother and infant (the 'dyad') move through together and develop over time; they highlight the importance of labelling specific behaviours that the mother or infant

[1] This review will refer to mothers instead of parents or caregivers as the vast majority of the literature is focused on the maternal relationship. However, it is acknowledged that not all caregivers would identify as mothers and the implications of this bias in research will be considered in the discussion. Predominantly, the term "infant" will be used instead of baby or child, to align with the vocabulary of most empirical literature.

carry out, whilst also paying attention to the space between the dyad and the interactions within.

One such specific construct within the dyadic dance is that of 'mirroring'. Different boundaries and nuances have been used to define the concept but broadly, mirroring first involves the infant carrying out a particular behaviour (a movement, expression or vocalisation); the mother then recognises the behaviour (and the meaning behind it if there was an emotional response or expression of need), and reflects this back to the infant in a similar, matched, appropriate and timely fashion (Provenzi et al., 2018). Other definitions specify that mirroring is also "marked" (Gergely & Watson, 1996); the mother does not simply imitate the infant but alters or exaggerates the response.

Thus, mirroring can be situated within other maternal processes; it often comes from attunement, although for the rudimentary mirroring of a gesture, the mother may not need to be fully attuned to all of the infant's needs. In a sense, mirroring is a form of contingency and coordination; a responsive and timely behaviour that may follow a pattern. As Provenzi et al. (2018) demonstrate, each of these concepts are situated within a wider umbrella of mutuality and reciprocity.

For the purposes of this review, mirroring has been defined broadly - as above - but also distinctively. Hence, although in some ways it overlaps with nuanced definitions of other maternal behaviours, it will be considered as a separate construct and reviewed accordingly. The implications of this and the variations in definitions across the literature will be discussed latterly.

Biological approaches to mirroring

Human infants, compared to other animals, have particularly large brains with great potential for adaptation through plasticity (Trevathan, 2015) and are especially dependent on their caregivers for survival and development (Swain et al., 2007). Infants are predisposed to favour looking at faces from birth and have great ability for interaction and eliciting care (Johnson et al., 1991; Murray & Trevarthen, 1986; Darwin, 1872). Likewise, even before birth, mothers' brains undergo unique changes to grey-matter regions related to maternal responding which can subsequently predict attachment (Hoekzema et al., 2017); hormones also surge and drive further changes in neuroendocrine systems (Brunton & Russell, 2008) suggesting an evolutionary mechanism for fostering connection, caring and responsiveness. Similarly, many maternal responses, including mirroring, happen so quickly and adapt to the infant so efficiently that it suggests

automatic, intuitive parenting with an instinctual, biological origin (Papoušek & Papoušek, 2002).

Hypotheses have also been made regarding mirror-neurons and their links with mimicry, empathy, mentalising, and perception of gestures and vocalisations (Rhode, 2005; Tramacere & Ferrari, 2016; Woodruff, 2018). For example, it may be that the presence of mirror-neuron mechanisms allows the infant to apperceive their mother's mirroring response and, with repeated instances, gradually make sense of their own expressions, gestures, vocalisations and emotions, as their mother identifies them and reflects them back (Rhode, 2005). Later, this understanding of one's own inner state and corresponding facial expressions, in association with those of another (their mother), may be the early formation of empathy and mentalisation (Tramacere & Ferrari, 2016), whereby two beings have similarly activated mirror networks and are able to form shared representations of an experience (Legerstee, Haley, & Bornstein, 2013). However, most empirical mirror-neuron research does not consider the act of maternal mirroring, despite the similarity of the terms, focusing instead on infants imitating their caregivers.

Theoretical approaches to mirroring

Winnicott's Mirror-Role

Many theoretical interpretations of mirroring and its implications have been posited over time but these are seldom linked to empirical research, instead appearing to use widely accepted psychological theories combined with practice-based observations to suggest potential mechanisms at play. One of the most often cited is that of Winnicott from his classic text, "Playing and Reality" (1971), where he draws on examples from his therapeutic work with adults to demonstrate the difficulties they were facing and how these could be explained by a lack of adequate mirroring in childhood. Winnicott suggests that the way for an infant to see himself[2] in his early life is by looking into his mother's face. The mother's face displays what she sees in her infant. If the mother reflects a positive, loving display, the infant will sense that he is a positive, loved self; if the mother does not mirror her infant due to preoccupation elsewhere or the absence of such an instinct, the infant will not learn how to see himself and may seek his sense of self from other parts of his environment; finally, if the mother does not accurately reflect the infant's behaviours but instead misjudges the meaning,

[2] Infants will be referred to using male pronouns where applicable, for ease of distinction from the mother's female pronouns.

or shows her own emotions or defences, then the infant's sense of self will not be congruent with his true feelings.

Winnicott emphasises that these are not completely distinct categories and most infants can experience an occasional selection of the unfavourable scenarios and still fall within "normal" development for sense of self, creativity and connection to the mother. For those who have more frequent negative responses, some may look more closely at their mothers and learn to act according to their mother's mood to protect their sense of self from repeated rejection, in accordance with Attachment Theory (Bowlby, 1969). However, for infants where there is no consistency, Winnicott suggests this could lean towards pathology: "a baby so treated will grow up puzzled about mirrors and what the mirror has to offer. If the mother's face is unresponsive, then a mirror is a thing to be looked at but not to be looked into" (Winnicott, 1971, p.152).

Winnicott goes on to describe how as children age, they gradually rely less on the mother's reflection as they see themselves in others around them and, as they continue to mature, form an embodied, more enduring sense of self, independent of other's momentary responses. However, regarding those children who did not receive adequate mirroring, Winnicott gives examples of his patients whom he suggests had to be their own mirrors, could never see themselves as others saw them, or were perpetually searching for faces and perceptions of others. He provides the following statement on the implications of this theory for psychotherapeutic work:

> Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings. It is a complex derivative of the face that reflects what is there to be seen. I like to think of my work this way, and to think that if I do this well enough the patient will find his or her own self, and will be able to exist and to feel real. Feeling real is more than existing; it is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self into which to retreat for relaxation. (Winnicott, 1971, p.158)

Social-Biofeedback Model

Another commonly cited theory provides a different way of understanding mirroring and its effects: the Social-Biofeedback Model. Gergely and Watson (1996; 1999) provide a thoroughly detailed explanation of

their theory which will be briefly summarised here. The Social-Biofeedback Model is explicit in its key assumptions, some of which contrast with prominent developmental theorists: that infants' emotions are hard-wired, instinctual and not in conscious awareness at birth; and that "the perceptual system is set with a bias to attend to and explore the external world and builds representations primarily on the basis of exteroceptive stimuli" (1999, p.110). Therefore, they suggest that emotional self-control can only become possible through external monitoring and regulation that is then learned by the infant; for example, through the mother's mirroring.

The Social-Biofeedback Model suggests that through the mother's contingent mirroring responses to the infant's behaviours, the infant learns a sense of control and agency which in itself is rewarding and soothing (e.g. in the case of negative affect displays). The infant then displays a marginally more regulated feeling, which the mother may mirror again. Through repetition of this cycle, the infant becomes regulated and over time also learns that their own agency can play a role in the reduction of negative affect, forming a foundation for emotional self-regulation.

Gergely and Watson (1999) also highlight the role of maternal mirroring in providing a tangible, visual representation of a hitherto unknown emotional state, in a similar way to adult biofeedback training procedures (DiCara, 1970). When an infant feels a particular emotion and the mother consistently mirrors this, the mother's expression or vocalisation becomes a predictable marker of the emotion, which the infant over time associates as a contingent response to his own selection of internal feelings and thus the infant develops emotional sensitisation.

The model also highlights the distinction between mirroring and imitation, whereby affect mirroring is usually a "marked" or exaggerated representation of the infant's emotional display, not an exact copy. This enables the infant to distinguish between the mother's representations of his emotions and the mother's expression of her own emotions. For example, a mirroring response to the infant's sadness might be an exaggerated downturned mouth and pout with sympathetic vocalisation, whereas a mother's own sadness would be displayed more subtly. Likewise, the environmental cues and extent of the infant's agency in eliciting these different responses from the mother are quite different. Thus, the infant learns to differentiate others' emotions as well as his own, finds variance in his agency and can make associations between environmental cues for each scenario.

Purpose of this review

Gergely and Watson's (1996) theory is situated within empirical evidence more so than Winnicott's (1971) however, much of the supporting evidence cited involves the integration of other mechanisms (e.g. contingency, attunement) to postulate about mirroring. This review will find empirical studies specifically investigating mirroring and evaluate the extent to which these key theories are supported by the literature.

Methodology

Seven databases (see Figure 1) were searched using the following terms: ("mirror" OR "mirroring") AND ("mother" OR "maternal" OR "parent") AND ("baby" OR "babies" OR "infant" OR "child") in titles and abstracts. As mirroring is a well-established term, it was not deemed necessary to widen this criterion to include more general maternal processes (e.g. attunement) or similar but separate constructs (e.g. imitation) as it was predicted that this would produce studies too broad for the focus of this review. "Father" was not used as a search term as the theories that were selected to be evaluated by this review only covered maternal mirroring.

After duplicates were removed, studies were further narrowed to include only psychological disciplines, human participants, English language, empirical and peer-reviewed studies. Adult-only studies (e.g. retrospective case studies or studies of the therapeutic relationship) were excluded as were dyads with mental or physical health problems so that this review could focus on the typical development of mirroring.

The search obtained nine results for full review (see Table 1 for summaries). None of the studies involved randomisation, controls or a direct intervention and therefore most quality assessment tools were inapplicable (Ma et al., 2020). Instead the studies were exploratory, observational and/or correlational. Therefore, the National Institute for Health and Care Excellence (2012) quality appraisal checklist for quantitative studies reporting correlations and associations was deemed most appropriate for assessing validity, although it's medical origins meant some aspects of the checklist were less relevant (see Table 2).

Figure 1
PRISMA flow diagram showing literature search results at each stage

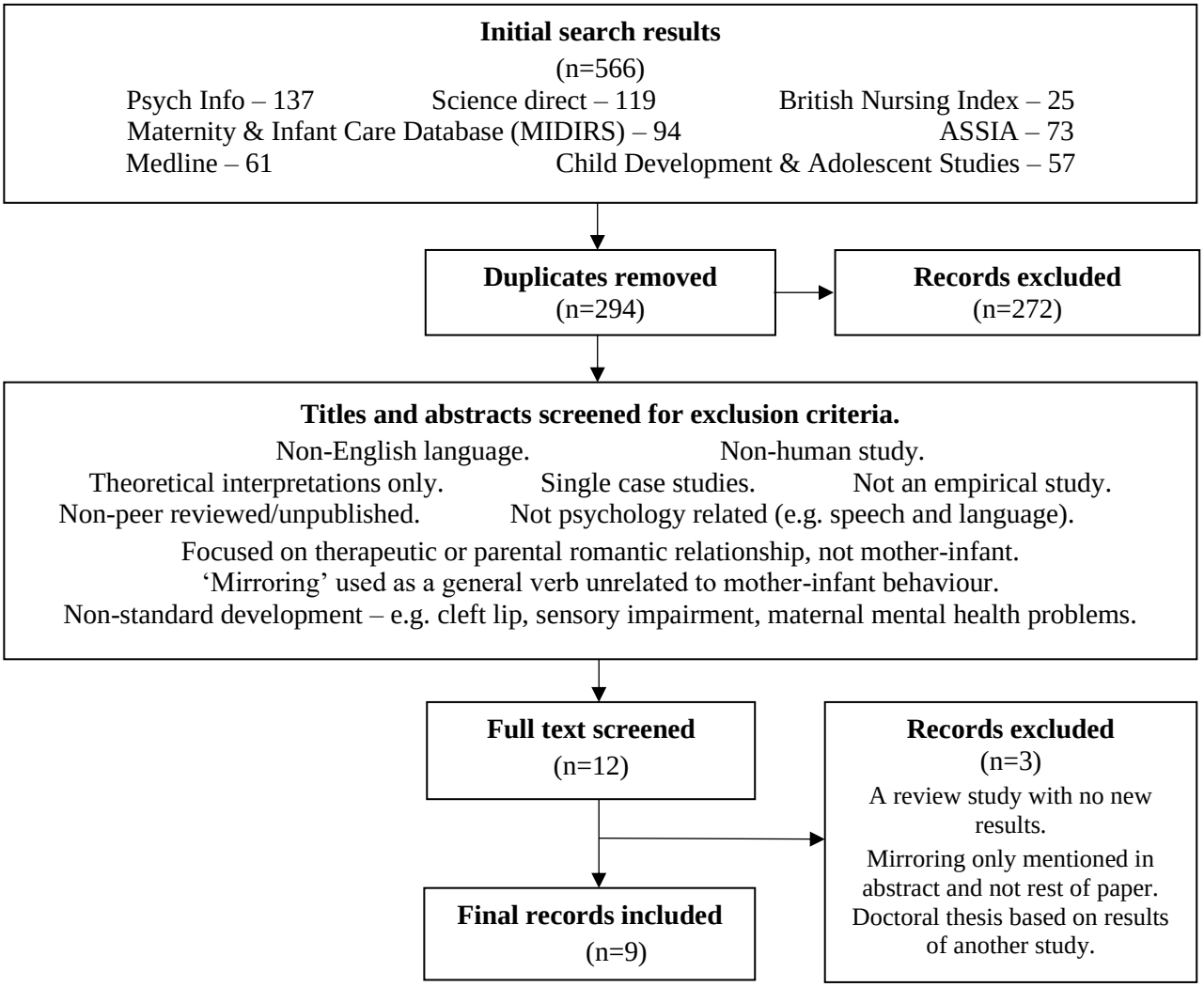

Table 1

Summary of studies included in the review

Study	Location and setting	Infants (n, age and gender)	Mothers (Demographics)	Methodology	Definition of mirroring	Key findings
1. Bigelow & Walden (2009). Infants' Response to Maternal Mirroring in the Still Face and Replay Tasks.	Canada Laboratory setting	n=38 $\bar{x}$ age: 4.1 months 18 male, 20 female Excluded for: excessive crying (n=2), fell asleep (n=1)	$\bar{x}$ SES*: 49.27 89% non-Hispanic White, 3% African Canadian, 8% mixed non-Hispanic White African Canadian	Separate booths, video link. Still face task** and replay task***. ~ 3 minutes per task, ~ 6 minutes in total. Infants coded**** for duration of visual attention, smiles, grimaces, positive vocalizations, and negative vocalizations. Mothers coded as above and also for frequency and duration of mirroring. Infants also coded for frequency of social bids (visually attending to mother whilst smiling or making non-distress vocalisation).	Salient, exaggerated reflections of infant's behaviours. Same or different modality (e.g. facial expression mirrored by facial expression and/or vocal). Similar affect, intensity and tempo. Temporally contingent (within 1 second of infant's behaviour).	34% of mothers showed mirroring. Most maternal mirroring was in same modality as infant's behaviour. No negative vocalisations and few grimaces from mothers. Mirroring did not correlate with other maternal behaviours. Mirroring correlated with infants' social bids during still face phase and with smiling and positive vocalisations during interactive phases. Infants with maternal mirroring showed more visual attention to their mothers, smiled more and made more positive vocalisations. Infants without maternal mirroring did not distinguish between live video and replay.
2. Bigelow et al. (2015). The relation between mothers' mirroring of infants' behavior and maternal mind-mindedness.	Canada Laboratory setting	n=31 $\bar{x}$ age: 5.2 months 16 male, 15 female Excluded for: excessive crying (n=2), fussiness/ inattentiveness (n=1), equipment failure (n=4)	$\bar{x}$ SES: 61.53 $\bar{x}$ age: 32.5 years 100% non-Hispanic White	Face to face interaction, videoed. Still face task. 5 minutes. Infants and mothers coded for durations of visual attention, facial affect, and vocalisations. Mothers also coded for frequency of mirroring. Mother then shown video and asked to describe what her infant was thinking/feeling. Responses coded for mind-mindedness, and categorised as	Salient, matched or exaggerated reflections of infant's expressions, gestures or vocalisations. Same or different modality (e.g. facial expression mirrored by facial expression and/or vocal). Similar affect, intensity and tempo. Temporally contingent (within 1 second of infant's behaviour).	77% of mothers showed mirroring, usually in same modality. All mothers made appropriately attuned mind-minded comments, only one mother made a non-attuned comment. Mind-mindedness was correlated with maternal mirroring but no other maternal behaviours. Mirroring was correlated with infant non-distress vocalisations but no other infant behaviours. Infants' non-distress vocalizations and maternal mind-mindedness predicted mirroring, accounting for 43.4% and 12.8% of the variance respectively.

				appropriately or non-attuned.		
3. Bigelow et al. (2018). The effect of maternal mirroring behavior on infants' early social bidding during the still-face task.	Canada Laboratory setting	Same participants as study above n=31 $\bar{x}$ age: 5.2 months 16 male, 15 female Excluded for: excessive crying (n=2), fussiness/ inattentiveness (n=1), equipment failure (n=4)	$\bar{x}$ SES: 61.53 $\bar{x}$ age: 32.5 years 100% non-Hispanic White	Face to face interaction, videoed. Still face task. 5 minutes. Infants and mothers coded for durations of visual attention, facial affect, and vocalisations. Mothers also coded for frequency of mirroring. Infants also coded for frequency of social bids (visually attending to mother whilst smiling or making non-distress vocalisation).	Salient, matched or exaggerated reflections of infant's expressions, gestures or vocalisations. Same or different modality (e.g. facial expression mirrored by facial expression and/or vocal). Similar affect, intensity and tempo. Temporally contingent (within 1 second of infant's behaviour).	77% of mothers mirrored at least once, usually in same modality as infant. No negative vocalisations and few grimaces from mothers. Few negative vocalisations from infants. Maternal mirroring significantly predicted infants' social bids, accounting for 14.0% of the variance over and above that accounted for by infants' visual attention. Infants who had higher mirroring from mothers showed more non-distress vocalisations (social bids) in the still-face phase. Infants who had lower maternal mirroring showed little change in non-distress vocalisations across phases, suggesting less awareness of agency.
4. Broesch et al. (2016). Similarities and Differences in Maternal Responsiveness in Three Societies: Evidence From Fiji, Kenya, and the United States.	Fijian islands, rural Kenya and urban USA Home settings in Fiji and Kenya. Laboratory setting in USA	n=66 $\bar{x}$ age: 7 months 35 male, 31 female (12 Fiji, 11 USA, 8 Kenya) Excluded for: >12 months old (n=6), experimenter error (n=1)	$\bar{x}$ age: 28 years USA: upper middle class. SES not reported for Fiji or Kenya. Ethnicity not reported.	Face to face normal interaction, videoed for 10 mins, cut down to 3 mins of uninterrupted activity for analysis. Infants and mothers coded for various facial, vocal and gaze behaviours, further categorised as positive, negative or neutral. Mothers also coded for different tactile behaviours. Maternal behaviours were also examined for their contingency (responding to a change in behaviour within 1 second) and mirroring. Maternal expectations of infant development/ milestones were also investigated.	Contingent response, within 1 second of infant's behaviour. Matched in modality (facial or vocal) and valence (positive or negative)	No difference in infant behaviours across cultures. No difference in frequency of contingent responding between three societies but Fijian mothers responded more than US to negative facial bids, and US mothers responded more to positive vocal bids. No significant differences between societies in frequency of maternal mirroring, but frequency was low for all so may not have had sufficient power. When split into those who mirrored at least once (67%) and those who did not mirror at all (33%), US mothers were more likely to mirror (75%) than Fijian (62%) or Kenyan (38%). Fijian mothers produced more negative facial expressions. US mothers rested hands on their infants more. Kenyan mothers did not touch their infants as frequently. Some differences in maternal expectations, such as US mothers expecting children to have a psychological life

						earlier than Fijian or Kenyan mothers expected.
5. Kim et al. (2014). Mothers who are securely attached in pregnancy show more attuned infant mirroring 7 months postpartum.	USA Laboratory setting	n=41 $\bar{x}$ age: 6.5 months 19 male, 22 female	$\bar{x}$ age: 27.9 SES: mid-high Excluded for: substance misuse, nicotine during pregnancy, current psychotropic medication 56% White, 44% non-White	Adult Attachment Interview (AAI) was used to assess maternal attachment prenatally and mothers were split into two groups: secure and insecure/dismissing. (Other insecure types were too small in number to be included) 7 months later, mother and infant in same room, seated in parallel with mirrors to see each other, videoed. Still face task. ~ 6 minutes. Mothers coded for types of mirroring. Infants coded for gaze fixation.	Direct mirroring: non-verbal, direct imitation of infant behaviour. Could be facial/gestural or vocal. Intention mirroring: non-imitative, marked, verbal attunement reflecting infant's experience.	Direct and intention mirroring did not correlate with each other. Maternal attachment did not predict direct mirroring but did predict intention mirroring. Securely attached mothers displayed more than twice the frequency of intention mirroring than insecurely attached mothers. Infants of securely attached mothers looked at their mothers more frequently than those of insecurely attached mothers. Infants of insecurely attached mothers looked away more often. Non-significant mediating effect of maternal intention mirroring on this relationship.
6. Lavelli & Fogel (2013). Interdyad differences in early mother-infant face-to-face communication: Real-time dynamics and developmental pathways	Italy Home settings	n=24 Age: 1 week old 16 male, 8 female Excluded for: pregnancy complications, abnormal birth weight	$\bar{x}$ age: 29.7 $\bar{x}$ SES: 58.29	Face to face normal interaction. Videoed for 3 mins, once per week for 14 weeks. Infants had to be in an alert state. Microgenetic research design with a multi-level modelling technique and additional qualitative analysis of 4 specific dyads	Imitation and/or emphasis and/or reproduction of affective quality of infant behaviour. Same or different modality. May be accompanied by smile/encouragement/supportive comment on the infant's behaviour.	Maternal mirroring increased from month to month. Correlations were found between maternal mirroring and smile (13 out of 24 dyads), and cooing expression (20 out of 24 dyads). Infant smiling increased maternal mirroring which then (showing a bidirectional effect) increased infant repetition of smiling and attempted vocalisations. However, dyads that did not show a significant correlation between maternal mirroring and smile/cooing, did not show such bidirectional links or were delayed. Two distinct phases: mutual attentiveness ~ 2 to ~ 6 weeks old and then mutual engagement from ~ 6 to 14+ weeks with more turn taking, infant answering and maternal mirroring of facial and vocal behaviours. Patterns from the first phase, seem to carry over to the second phase to facilitate new learning and new ways of interacting and then reduce once new ways are more established.

						Infants who were given little space/time to respond, because mother did not pause, seemed to show slower change/development. Infants with demanding mothers seemed to show less sense of agency.
7. Legerstee & Varghese (2001). The role of maternal affect mirroring on social expectancies in three-month-old infants.	Canada Laboratory setting	n=41 $\bar{x}$ age: 3.1 months 23 male, 18 female Excluded for: excessive crying or sleepiness (n=19)	Lower to upper middle-class	Separate booths, video link. Replay task. 3 mins live and 3 min replay, counterbalanced. Mothers filmed during first visit and then the footage was used during the replay phase of second visit. Mothers coded for maintaining attention, warm sensitivity, social responsiveness, gazes, smiles and vocalisations. Infants coded for gazes at mother, smiles, negative expression and melodic vocalization.	Affect mirroring comprised three categories: maintaining attention (e.g. requests/comments on infant activity), warm sensitivity (e.g. sensitivity to affective cues, including promptness and appropriateness) and social responsiveness (e.g. imitations of infant smiles/vocalisations or modulations of infant negative affect).	Correlations between maintaining attention/warm sensitivity, and maintaining attention/social responsiveness. Correlations showed consistency in maternal behaviour across the two visits. Infants with high affect mirroring mothers gazed longer at them, smiled more and produced more melodic vocalizations. Infants with high affect mirroring mothers gazed longer at their mothers during the live phase than replay phase, regardless of the order of the phase. Infants of low affect mirroring mothers only gazed less during replay when the live phase was first. Infants with high affect mirroring mothers smiled more and produced more melodic vocalizations during the live phase than replay phase. Infants of low affect mirroring mothers did not show a difference.
8. Murray et al. (2016). The functional architecture of mother-infant communication, and the development of infant social expressiveness in the first two months.	United Kingdom Home settings	n=20 $\bar{x}$ age: 1.5 weeks 12 male, 8 female	$\bar{x}$ age: 33.7 years 90% White Excluded for: mental health problems	Face to face normal interaction. Videoed for 3 mins once a fortnight from 1 week until 9 weeks old. Videos were event coded per second for key infant and mother behaviours e.g. pre-speech, smiles, biological events. Mother's responses were also coded for contingency (if within 2 seconds of infant behaviour), mirroring, marking, negative responses and prominence	Exact matches or match of main features of infant behaviour with minor modification (e.g. adding vocalisation). Same valence and intensity as infant behaviour.	Contingent responses were approx. 30% of all maternal behaviours. Mothers responded to social and negative behaviours more than biological events. Infant social expressiveness, maternal mirroring and maternal positive marking increased with infant age. When infants showed social behaviour mothers were more likely to show mirroring or positive marking. Different maternal responses were more likely to follow specific infant behaviours. Time between infant social behaviours decreased as age increased, particularly when mothers positively marked the first instance of infant social behaviour. More maternal mirroring and positive marking towards

				(percentage of behaviours that were direct responses to infant).		infant social behaviour in earlier sessions predicted higher rates of social behaviour in subsequent sessions. Maternal neutral marking and negative responses predicted a reduction in infant social expressiveness in later sessions.
9. Rayson et al. (2017). Early maternal mirroring predicts infant motor system activation during facial expression observation.	United Kingdom Home and laboratory settings	n=19 $\bar{x}$ age: 2.1 months at time of video recording, 9.2 months at time of EEG (electro-encephalo-gram) 11 male, 8 female Excluded for: fussiness, technical problems, unusable observation trials	$\bar{x}$ age: 30.9 years 95% White	Mothers and infants were recorded interacting at home at 2 months old. Videos were event coded per second for key infant and mother behaviours (same as study above). At 9 months old, infants were shown short videos of women showing different facial expressions (positive, negative, non-emotional, scrambled face) whilst connected to an EEG. Infants were recorded again and videos were coded for facial expressions.	Exact matches or match of main features of infant behaviour with minor modification (e.g. adding vocalisation). Same valence and intensity as infant behaviour.	Motor regions were activated when infants made facial expressions and when they observed others. For infants of high-mirroring mothers compared to infants of low-mirroring mothers, when looking at happy faces, mu desynchronization (an index of motor and action-perception system activity) was higher in the right hemisphere and lower in the left hemisphere. For infants of high-mirroring mothers compared to infants of low-mirroring mothers, when looking at mouth opening faces, mu desynchronization was higher in the left hemisphere. Results suggest that maternal mirroring supports the development of an action-perception matching mechanism by strengthening links between observing and forming specific expressions.

Note. * For detailed definitions of SES (Socio-Economic Status) please see respective studies.
** The Still Face Task involves an initial stage of normal mother-infant interaction, followed by a stage where the mother stops interacting with her infant, followed by a second normal reaction stage
*** The Replay Task involves having mother and infant interact via video link and filming the interaction, then replaying the video to the infant for the second stage.
**** For detailed coding methods, please see respective studies.

Table 2

Quality appraisal using National Institute for Health and Care Excellence (2012) checklist for quantitative studies reporting correlations and associations

Quality Criteria	Study								
	Bigelow & Walden (2009)	2. Bigelow et al. (2015)	3. Bigelow et al. (2018)	4. Broesch et al. (2016)	5. Kim et al. (2014)	6. Lavelli & Fogel (2013)	7. Legerstee & Varghese (2001)	8. Murray et al. (2016)	9. Rayson et al. (2017)
Section 1: Population	+	+	+	++	+	++	+	+	+
1.1 Is the source population or source area well described? *Was the country (e.g. developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described?*	Mostly described	Mostly described	Mostly described	Clearly described for Kenya and Fiji, less so for USA	Mostly described	Mostly described, including information on father	Some demographic info not reported	Mostly described	Mostly described
1.2 Is the eligible population or area representative of the source population or area? *Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? Was the eligible population representative of the source? Were important groups underrepresented?*	++	+	+	++	++	++	+	++	++
1.3 Do the selected participants or areas represent the eligible population or area? *Was the method of selection of participants from the eligible population well described? What % of*	NR % unclear, exclusion criteria explicit	NR % unclear, exclusion criteria explicit	NR % unclear, exclusion criteria explicit	++	NR % unclear, exclusion criteria explicit	++ % clear, exclusion criteria thorough and explicit	NR % unclear, exclusion criteria explicit	NR % unclear, exclusion criteria explicit	NR % unclear, exclusion criteria explicit

selected individuals/clusters agreed to participate? Were there any sources of bias?Were the inclusion or exclusion criteria explicit and appropriate?									
Section 2: Method of selection of exposure (or comparison) group	NR	NR	NR	NR	NR	NR	NR	NR	NR
2.1 Selection of exposure (and comparison) group. How was selection bias minimised? *How was selection bias minimised?*									
2.2 Was the selection of explanatory variables based on a sound theoretical basis? *How sound was the theoretical basis for selecting the explanatory variables?*	++	++	++	++	++	++	++	++	++
2.3 Was the contamination acceptably low? *Did any in the comparison group receive the exposure? If so, was it sufficient to cause important bias?*	– Split into high and low, so both groups experience some mirroring	NA	– Split into high and low, so both groups experience some mirroring	NA	+ Split into attachment styles but less common insecure types excluded	NA	– Split into high and low, so both groups experience some "maintaining"	NA	– Split into high and low, so both groups experience some mirroring
2.4 How well were likely confounding factors identified and controlled? *Were there likely to be other confounding factors not considered or appropriately adjusted for? Was this sufficient to cause important bias?*	– No confounds considered e.g. attachment style, depression	– No confounds considered e.g. attachment style, depression	– No confounds considered e.g. attachment style, depression	– No confounds considered e.g. attachment style, depression	++ Considered depression, personality disorders, stress, temperament, day-care status and development-al delay.	– No confounds considered e.g. attachment style, depression	+ Considered depression	– Screened for depression but no confounds considered	– No confounds considered e.g. attachment style, depression
2.5 Is the setting applicable to the UK?	++	++	++	++	++	++	++	++	++

Did the setting differ significantly from the UK?	Canada	Canada	Canada	USA and although Kenya and Fiji are less applicable, universality is discussed	USA	Italy	Canada	UK	UK
Section 3: Outcomes	++	++	++	++	++	++	++	++	++
3.1 Were the outcome measures and procedures reliable? *Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking −)? How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?*	Good inter-rater reliability.	Good inter-rater reliability.	Good inter-rater reliability. One coder blind to study's hypotheses.	100% inter-rater reliability. Independent coders.	Well validated measures. Good inter-rater reliability. Coders blind to mother's attachment status.	Good inter-rater reliability. Two independent coders and two involved.	Specific but different definition of mirroring. Good inter-rater reliability. One coder blind to study's hypotheses.	Good inter-rater reliability. All coders blind to study hypotheses and mothers' backgrounds	Minimum execution trials and control analyses used for EEG Good inter-rater reliability. One coder blind to study's hypotheses.
3.2 Were the outcome measurements complete? *Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?*	++	++	+ Some excluded due to equipment failure	+ Some details missing due to study changes over time	++	++	+ Many unable to complete second visit.	++ 91% available	++ Not included if not complete/ not enough EEG trials
3.3 Were all the important outcomes assessed? *Were all the important benefits and harms assessed? Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?*	+ Not pauses Benefits and harms not assessed	+ Not pauses Benefits and harms not assessed	+ Not pauses Benefits and harms not assessed	++ Very detailed coding, including valence of behaviours but not pauses Benefits and harms not assessed	++ Benefits and harms not assessed	++ Many different constructs considered, including pauses. Benefits and harms not assessed	++ Detailed coding. Benefits and harms not assessed	++ Detailed coding, not pauses but prominence/ responsiveness. Benefits and harms not assessed	++ Detailed coding, not pauses but prominence/ responsiveness. Benefits and harms not assessed
3.4 Was there a similar follow-up time	NA	NA	NA	NA	NA	++	++	++	NA

in exposure and comparison groups? *If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison.* *Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).*					Not a follow up but similar time between attachment assessment and videoing.	All seen at very similar intervals.	All seen at very similar intervals.	All seen at very similar intervals.	Not a follow up but similar time between mirroring assessment and EEG.
3.5 Was follow-up time meaningful? *Was follow-up long enough to assess long-term benefits and harms? Was it too long, e.g. participants lost to follow-up?*	NA	NA	NA	NA	NA	++	++	++	NA
Section 4: Analyses	NR	NR	NR	−	NR	NR	NR	NR	NR
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)? *A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?*	Quite small sample size	Quite small sample size	Quite small sample size	Small sample size for each country so some comparisons were not sufficiently powered. Any effect sizes were small.	Quite small sample size	Small sample size but multiple data points	Quite small sample size	Small sample size but multiple data points	Small sample size
4.2 Were multiple explanatory variables considered in the analyses? *Were there sufficient explanatory variables considered in the analysis?*	−	+ Only mind-mindedness	−	+ Demographics compared. Cultural differences were considered but not as separate variables	++ Many considered	++	+ Depression considered and mirroring was split into different constructs	+ Many different behaviours considered but not extraneous	+ Many different behaviours considered but not extraneous
4.3 Were the analytical methods appropriate?	++	++	++	+	++	++	++	++	++

Were important differences in follow-up time and likely confounders adjusted for?				Different comparisons made due to small sample size.					
4.6 Was the precision of association given or calculable? Is association meaningful? *Were confidence intervals or p values for effect estimates given or possible to calculate? Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?*	++ Only p values	++ Only p values	++ Only p values	++ Only p values. Low frequency of mirroring meant certain comparisons may have been under-powered.	++ P values and CIs reported	++ Only p values	++ Only p values	++ Only p values	++ Only p values
Section 5: Summary 5.1 Are the study results internally valid (i.e. unbiased)? *How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? Were there significant flaws in the study design?*	+	+	+	+	++	++	+ Separate mirroring constructs were not fully independent	++	++
5.2 Are the findings generalisable to the source population (i.e. externally valid)? *Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.*	++	++	++	++	++	++	++	++	++

Note. ++ Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimise the risk of bias.

\+ Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design.

\- Indicates aspects of the study design in which significant sources of bias may persist.

NR Not reported. Indicates aspects in which the study under review fails to report how they have (or might have) been considered.

NA Not applicable. Indicates aspects that are not applicable given the study design under review.

Review

Definitions of mirroring

Across the nine studies, henceforth referred to by number for brevity (see Table-1), there was variation in the terms used to define mirroring. Study 6 focused purely on affect mirroring where the mother mirrored and interpreted only emotional displays; study 5 distinguished between attuned or "intention" mirroring and "direct" imitation of non-emotional behaviour; however, the majority of studies (1,2,3,4,8,9) encompassed both definitions under one umbrella term. Study 7 appeared to focus on purely affect mirroring, similarly to study 6, but on closer inspection this construct was split into three parts, one of which did not involve emotional links; however, due to significant correlations between the three constructs, they were combined for most of the analyses.

Studies also varied on their stringency towards the modality with which the mother mirrored the infant's behaviour. Most studies (1,2,3,5,6,7) accepted mirroring in the same or a different modality, for example, an infant's smile mirrored by a positive vocalisation; some only coded a response as mirroring when the modality was an exact match (4) or an exact match with minor modification (8,9). All studies required that the mirroring was of a similar intensity (a slight exaggeration was acceptable), affect and valence to the infant's behaviour, if applicable.

These differences bring into question the conclusions that can be drawn about mirroring as one broad construct. Study 5 distinguished between attuned mirroring and direct mirroring and found that the two types did not correlate with each other, and only attuned mirroring correlated with maternal attachment, suggesting these are separate constructs that should not be combined. On the other hand, study 7 found different types of mirroring did correlate with each other.

Winnicott's (1971) mirror-role theory seems to focus mostly on what these studies have referred to as "attuned", "affect" or "intention" mirroring: maternal responses related to emotions. Conversely, the S-

BF model (Gergely & Watson, 1996) and biological theories of mirror-neurons (Legerstee et al., 2013) could be relevant to "direct" mirroring as well; the contingency of "direct" mirroring would still facilitate learning, even without an emotional focus.

Measurement

The studies also varied in how they measured mirroring, meaning it is more difficult to make direct comparisons. Some reported the proportion of mothers who displayed any mirroring (1,2,3,4,7) and/or counted the frequency of mirroring behaviours (1,2,3,5) others calculated the proportion of all maternal behaviours that were mirroring (8) or the duration of time spent mirroring (1,2,3,6,7,9).

Setting

The studies varied in settings with some taking place in a laboratory with mother and infant in separate rooms using video links (1,7), laboratory using mirrors in the same room (5), laboratory face-to-face (2,3) or home settings face-to-face (6,8). Study 4 used home settings for Fijian and Kenyan dyads but laboratory settings for United States dyads, all face-to-face, and study 9 used face-to-face home settings to record the dyad's interaction but laboratory settings for the EEG. Given the subtleties involved in mother-infant interaction, using separate rooms and video links, although necessary for the methodology of these studies, may have created a barrier or biased the natural interactions in some way. Similarly, working in an unfamiliar laboratory could have influenced the mothers and infants, even if unconsciously. An approximate comparison can be provided by studies that reported the percentage of mothers who mirrored their infants at least once; studies 1 and 7 (laboratory/video) reported 34% and 58% mirroring respectively, studies 2 and 3 (laboratory/face-to-face; using the same sample) reported 77% mirroring and study 4 (home or laboratory/face-to-face) reported 67% mirroring but with a higher percentage for United States mothers (75%; laboratory/face-to-face). This may suggest that the use of video did reduce likelihood of mirroring, but a laboratory setting did not. However, this is a crude comparison and would need to be examined more rigorously to draw concrete conclusions. Nonetheless, in most of these studies

the majority of mothers exhibited mirroring, in line with Winnicott's assumptions.

Age

The studies varied in the ages investigated from 1 week to 12 months old and in the age ranges within each study. At a time of such physical, mental and emotional growth, it is unsurprising that results varied across the samples. Studies 6 and 8 observed the dyads at regular intervals across 14 weeks and 9 weeks respectively and both showed an increase in mirroring over time. This somewhat supports Gergely and Watson's (1996) S-BF model as they suggest that a mother's contingent mirroring response can have a positive effect on an infant's mood, which in return increases the likelihood that the mother would mirror such a reaction, resulting in a positive feedback loop of mirroring, which could be expected to continue over time, causing a net increase. Most other studies involved infants older than these age ranges but given the aforementioned variation in measurement methods, the trajectory of mirroring is somewhat unclear past 14 weeks.

Associations with mirroring

Mirroring was found to have significant positive correlations with many aspects of infants' behaviours such as social bids and social behaviours (1,3,8), smiling (1,6,7 but not 2), positive vocalisations (1 but not 2), non-distress vocalisations (2,3), cooing (6), melodic vocalisations (7) and gaze towards mother (1,7 but not 2,5). As these are correlations, the direction of effect cannot be inferred. It could be suggested that mirroring results in infants increasing such behaviours but it may be that in fact infants who express more pleasant behaviours and look more often at their mothers, compel their mothers to mirror them more. Alternatively, it may be that both processes are at play as theorised in Gergely and Watson's (1996) S-BF model.

Studies 6 and 8 used multiple observations to investigate associations over time. Study 6 found that infants' smiling increased maternal mirroring which in turn increased the infant's repetition of smiling

and vocalisation attempts. Similarly, study 8 found that when infants showed social behaviours (e.g. smiles, cooing, pre-speech), their mothers increased their mirroring responses and positive marking. It was also found that higher maternal mirroring and marking towards social behaviours in early sessions could predict higher rates of social behaviours in subsequent sessions but negative responses reduced the likelihood of these infant behaviours. Thus, these studies provide strong evidence for bidirectional effects, the role of contingent maternal responses in reinforcing behaviours (Gergely & Watson, 1999) and show the nuances of the "dyadic dance" (Provenzi et al., 2018).

Study 8's findings around negative responses also provide evidence for Winnicott's (1971) theory of infants learning to restrain their responses based on their mother's receptiveness. This theory also suggests that infants receiving inadequate responses look more carefully at their mothers in an attempt to predict their reactions but studies 1 and 7 found the opposite: higher mirroring was correlated with increased gaze, although studies 2 and 5 found no significant relationship. Perhaps instead, studies 1 and 7 support Winnicott's suggestion that infants whose mothers are less responsive turn away from their mothers towards other aspects of their environments in their search for self. Study 5 appeared to find a non-significant mediating effect of mirroring on the relationship between maternal attachment and infant gaze, suggesting that indeed these concepts are in some way related, but further investigation is warranted.

Mirroring also correlated with maternal mind-mindedness (2) and in study 5, maternal attachment style was able to predict "intention" mirroring but not "direct" mirroring; specifically, securely attached mothers showed significantly more "intention" mirroring than insecure-dismissing mothers. These findings would support both Winnicott's (1971) and Gergely and Watson's (1996) assumptions that successful mirroring involves a mother's accurate understanding and reflection of her infant's inner world.

Infants who experienced low maternal mirroring did not appear to distinguish (i.e. did not behave

differently) between a live video of their mothers and a replay condition (1) and similarly, did not change their social bidding behaviours in the different phases of the still-face task (3). These findings may suggest that infants who experience less mirroring are less responsive to changes in their mothers' behaviours, although again, causality cannot be inferred purely from these correlations. Gergely and Watson's (1996) theory suggests that mirroring enables children to better identify their own and their mother's emotions, and fosters a sense of agency in the infant, as he learns that his behaviours elicit contingent responses from others. Therefore, these findings would support the idea that infants experiencing less mirroring are less able to discern their mothers' change in emotion, have a weaker sense of agency and therefore show fewer attempts to change their mother's response. This is further supported by study 8 which showed that early negative responses or neutral marking from the mother predicted less social expressiveness in later sessions. From Winnicott's (1971) theory, this finding could also support the idea that infants act according to their mother's responses in a way that will protect them from potential rejection, and so they would be less likely to risk socially expressive behaviours.

Study 9 found that infants who experienced more maternal mirroring at two months old had greater activity of motor action-perception systems in particular brain regions at nine months old when viewing videos of happy or mouth-opening faces. The study also found that motor regions were activated when infants formed facial expressions and observed others' expressions. These findings may support theories linking mirror-neurons to mirroring (Legerstee et al., 2013; Woodruff, 2018) whereby maternal mirroring appears to strengthen an infant's neural capacity to recognise, form and respond to facial expressions.

Cultural considerations

Most of the studies used participants from North America (1,2,3,5,7), two were based in the United Kingdom (8,9) and one in Italy (6). Unfortunately, due to variations in measurement and design, it is not possible to meaningfully compare differences between these studies based on location or culture. Only one study (4) directly compared dyads from different cultures (United States, Fiji and Kenya). Study 4's

thorough description of Fijian and Kenyan culture and mothering practices highlighted the lack of equivalent detail given by most other studies, and the Western-centric assumptions of much of the developmental evidence base.

Study 4 found that infants from across cultures did not differ in the frequency of their behaviours and that mothers were similar in the frequency of their contingent responses and frequency of mirroring, indicating a universality to basic mother-infant interactions. Some subtle differences were found between the types of behaviours to which mothers responded, such as United States mothers responding more to positive vocal bids, in line with other studies in the review (1,3), and Fijian mothers responding more to negative facial bids. The authors also acknowledged that the lack of difference in mirroring frequency may have been due to a low frequency overall resulting in less power for the analyses. When comparing mothers who mirrored at least once to those who did not mirror, there were differences between cultures with United States mothers more likely to mirror (75%) than Fijian (62%) or Kenyan (38%) mothers. However, it is also worth noting that United States dyads were observed in laboratory settings and Fijian and Kenyan dyads at home; this provides a key difference in addition to culture that may have resulted in bias.

Study 4 also found differences in the expectations mothers held of their infants' development, for example, United States mothers expected their infants to have a 'psychological life' earlier than Fijian or Kenyan mothers. The study specifically chose cultures for their contrast and separation from Western cultural practices and media. Therefore, it may be that mothers in the United States are more influenced by psychological research which leads them to expect psychological responses from their infants earlier than mothers from other, more traditional, cultures.

Quality and bias

As outlined in Table-2, each of the studies endeavoured to limit potential bias but most had areas where improvements could have been made. Only a minority (4,6) gave thorough demographic details or

outlined the representativeness of the sample and none reported attempts to minimise selection bias; this causes potential difficulty for replication. However, all studies clearly described exclusion criteria and the theoretical basis for their analyses.

Studies 1, 3, 4, 7 and 9 split their sample for some or all analyses into high and low mirroring groups based on the mother's presentation over a short observation. This may have affected the strength of effect given that even those in low mirroring groups experienced some mirroring. Also, a short observation (3-6 minutes) in an experimental setting may not be representative of the dyad's usual interaction, especially considering the finding that mirroring frequency increases over time (6,8).

Only three studies (5,7,8) considered potential confounds such as maternal depression and only study 5 took this further and assessed other variables such as infant temperament, stress levels or personality disorder. Given that study 5 found a significant relationship between maternal attachment style and mirroring, but no others assessed this, it could be that attachment styles (of mother or infant), or other traits not investigated, were influencing results across the studies.

All studies used multiple raters, many blind and/or independent (3,4,5,6,7,8,9), with good inter-rater reliability. All studies had explicit and detailed coding strategies but many ignored neutral behaviours and/or pauses (1,2,3,4,8,9). This is potentially reductive given that study 6 found that infants who were given little space or time to respond, because their mothers did not pause, seemed to show slower development over time.

Finally, all studies had relatively small sample sizes ranging from nineteen (study 9) to sixty-six (study 4, split between three countries) and only one reported effect sizes, which were small (4). Two studies used the same group of participants (2,3) meaning the review covered a total of 280 different dyads. Such sample sizes in quantitative research increase the risk for type II error and limit the generalisability of findings (Faber & Fonseca, 2014), although those studies with multiple data points (6,8) may have had more power to detect effects.

Summary

Together, the nine studies in this review present a variety of findings that broaden our understanding of mirroring and its relationship to various infant behaviours and maternal characteristics. However, most results were correlational and therefore the conclusions that can be drawn regarding causality are limited. Some studies also provided an account of the development of mirroring in early life using multiple time points for observation, allowing stronger conclusions to be drawn about direction of effects, and highlighting the bidirectional nature of mother-infant interaction.

The studies varied in definition and measurement of mirroring, age of participants, and settings, meaning that the potential for accumulative conclusions and meaningful comparisons between studies were somewhat limited. Only one study (9) contributed to biological theories of mirroring (Legerstee et al., 2013; Woodruff, 2018) but certain aspects of Winnicott's (1971) theory were supported by a number of studies in the review (1,2,3,5,7,8), although at times only loosely. Gergely and Watson's Social-Biofeedback Model (1996; 1999) had clearer empirical research links (1,2,3,5,6,7,8) but nonetheless had some key concepts that were not fully investigated by the studies in this review.

Discussion

Critique

Methodologies

A key limitation of this review was the methodological type of studies available. None of the studies involved an intervention, control group or randomisation; to do so may be difficult to justify ethically given the potential negative outcomes associated with a lack of mirroring and also may be difficult to ensure validity, given the natural nuance involved in mirroring or not mirroring. However, without a randomised control trial methodology, conclusions of effect are less robust and may be more susceptible

to selection bias, experimenter bias, demand characteristics or confounding variables such as attachment style (5). Additionally, the small sample sizes restrict the generalisability of the findings and limit the power of the studies to find any effects.

As previously discussed, the use of video links or face to face interaction may have affected mother and/or infant behaviour frequency and/or quality. Future research could directly investigate whether dyad interactions differ significantly between such conditions; conclusions of such comparisons would also have important implications for the wider body of developmental research.

The methodology of the review itself can also be critiqued. For example, by focusing on infant studies, the implications of mirroring for therapeutic work have been overlooked. Reviews of empirical literature featuring adult, clinical work could help to more fully understand Winnicott's (1971) theory in particular.

Definitions

Another critique involves the definitions of mirroring used throughout the review. As discussed previously, the nine studies used a variety of constraints when coding for mirroring; such inconsistency casts doubt upon the validity of the term and any general conclusions that can be drawn about 'mirroring' as a whole. Furthermore, study 5 directly contradicted the amalgamation of "direct" and "intention" mirroring in other studies by showing them to be separate constructs in the context of maternal attachment styles, although study 7 found their different elements of mirroring to be related to each other.

Correspondingly, in a epistemological stance of critical realism (Cruickshank, 2003), 'mirroring' was conceived as an existing, isolated construct for this review; however, as other reviews have described (Provenzi et al., 2018), mirroring behaviours are situated within a wide array of similar, associated, nuanced behaviours and concepts that comprise mother-infant interaction. Arguably, it is impracticable to separate one construct arbitrarily when it exists within the context of other behaviours and circumstances.

Future research could potentially use concept mapping and network analysis (Beard et al., 2016; Goldman & Kane, 2014; McNally, 2016) to analyse mother-infant interactions and the relationships between the constructs, building on Provenzi's (2018) work. Nonetheless, by separating 'mirroring' it was possible for this review to analyse particular theories and studies in more depth and specificity.

Other caregivers

Although a handful of studies in the broader literature focus on both parents (Kochanska & Aksan, 2004) and occasionally specifically fathers (Berman, 2020), this review's search revealed no empirical studies of mirroring in fathers, non-biological mothers or other caregivers and only one study directly reported demographic information of the father (6). Given the search did not use "father" as a search term and only revealed nine results relating to mothers, this is perhaps unsurprising but fathers are increasingly becoming the primary caregiver for their children in modern society (McVeigh, 2012) and therefore it is regrettable to have such little empirical research to appraise. It would be interesting to investigate whether classic theories of mothering and mirroring are equally applicable to fathers, or if theories need to be examined through a non-heteronormative lens.

Developmental differences and confounding variables

The review purposely included only mothers and infants who had standard development and no clear mental or physical health problems. The rationale for this was to fit with the chosen theories which also mainly focused on standard development. However, by excluding such studies, it may be that some understanding was lost. For example, a study involving children with a cleft lip (Murray et al., 2018) may have contributed to biological theories by showing that slower development in communication compared to controls was mediated by maternal mirroring which was in turn influenced by reduced gaze to the infant's mouth.

Only theoretical case studies were available to examine the influence of maternal personality

disorder diagnoses on mirroring (Chlebowski, 2013) and any of the studies in the review that discussed depression excluded mothers on this basis (5,7,8). It may be that empirical research into mothers with a diagnosis of personality disorder, severe depression or insecure attachment styles, for example, could provide further evidence for or against Winnicott's (1971) different mirroring scenarios.

A key shortcoming of most of the studies in this review (1,2,3,4,6,9) was their general lack of investigation into potential confounds. This is especially conspicuous given the lack of reported attempts to control for selection bias across all studies and the results from studies 2 and 5 showing that maternal characteristics can significantly affect mirroring. This highlights that individual differences in mothers could have been biasing results across the studies, but due to limitations in methodology this cannot be investigated.

Negative, neutral and absent behaviours

Most studies coded for a large number of maternal and infant behaviours but some did not code for negative behaviours (5,6) and only one considered the absence of behaviours, such as pauses (6). In qualitative analyses, study 6 showed that when a mother hardly paused in her communication, her infant was left with little time to respond to her and this seemed to cause a delay in the infant's development of self-regulation, expressiveness and patterns of communication. Unfortunately, no other studies specifically analysed such patterns so conclusions are very limited but this finding along with wider literature focusing on temporal contingency of parental responding (Keller et al., 1999) provides an interesting avenue for further investigation.

Likewise, many studies (1,2,3,7,9) excluded infants on the basis of excessive crying or "fussiness" and subsequently reported low frequencies of negative affect in their observations. Excluding these infants may have biased the samples to those who were happier or more content in general, thus excluding those who may have responded differently to mirroring.

Cultural considerations

As this review's inclusion criteria involved only papers written in English, it could be expected that the results would have a slightly Western-centric bias but this was further narrowed by most studies coming from Canada and the United States. Even study 4, which analysed Fijian and Kenyan cultures, was conducted by researchers based mainly in the United States and Canada with one author in Hungary. This calls into question the validity of coding procedures as it could be that Western researchers were assessing based on their culturally biased assumptions, hence why other cultures were seen to mirror slightly less; the interrater reliability would still be high as the researchers would all be coming from similar cultural biases. Similarly, in a form of experimenter expectancy (Finn, 2006), coding criteria were decided by Western researchers and may have missed behaviours that could be seen as important in other cultures; this could potentially explain the frequent disregard of pauses across studies.

Likewise, the theories discussed in this review were formed using evidence from Western research, case studies or therapeutic practice, by Western theorists, predominantly studying White dyads from many years ago. Although this review has found some support for the various theories, their universality and generalisability cross-culturally and temporally should not be assumed. Future research, perhaps in collaboration with different universities worldwide using participants from those countries, could develop a culturally sensitive coding framework and further investigate dyads from other cultures.

Theory-evidence disparities

Different aspects of the aforementioned theories were supported, to an extent, by various studies as outlined throughout the review and there were no clear contradictions of the theories. However, each of the theories also maintained elements that were not directly investigated or supported by the empirical literature. Only one study examined neurological relationships to mirroring (9) but, despite findings around motor action-perception systems, the EEGs were not actually conducted whilst mirroring was occurring. Therefore, any theories relating to biological mechanisms of mirroring would require more

thorough investigation before any substantial conclusions could be drawn. Similarly, empirical evidence for key aspects of Winnicott's (1971) theory was slightly lacking. However, this is somewhat unsurprising given that the theory mainly concerns the pre-verbal infant's inner experience which is not directly observable or easily quantifiable.

Winnicott's (1971) theory focuses on the development of the self over time but as only two studies (6,8) observed dyads at more than one time point and none investigated children above 12 months old, this review was unable to provide support to such aspects of the theory. Gecas et al. (1974) found that adolescents' self-concept was associated with their parents' perceptions of them more so than with the parent's own self-concept, suggesting that the image the parent reflects back to the child could indeed influence the child's sense of self. Longitudinal investigations observing mirroring in early life and later childhood, and then comparing this with measures of identity or sense of self in adolescence or adulthood, could provide stronger evidence for the Mirror-Role theory (1971). Additionally, Winnicott mainly focuses on mirroring of affect and therefore it may be more suitable for future research to distinguish between, not amalgamate, the different definitions of mirroring discussed previously.

Gergely and Watson's (1996) Social-Biofeedback model was better supported but nevertheless had aspects that were not covered by the nine reviewed studies. For example, the authors suggest that mirroring can facilitate an infant's early self-regulation of emotions, but many studies excluded babies who were expressing strong negative emotions, and none specifically investigated emotional regulation. Study 6 did find a bidirectional relationship between mirroring and smiling which suggests that mirroring was able to influence infants' emotions, but further research would be needed to conclude its effects on the regulation of negative affect. Using biofeedback measurement (Wass et al., 2016) could be a way of representing such changes in emotional states at a pre-verbal level.

The Social-Biofeedback Model (1996; 1999) also posits that mirroring, through its marked, contingent and predictable nature, enables infants to begin recognising representations of emotions and,

subsequently, become sensitised to their own internal experiences of emotions. Studies 6 and 8 showed that when positive behaviours were marked and mirrored by mothers, infants were more likely to express these in future sessions; suggesting that marking and mirroring can indeed affect an infant's likelihood of feeling and expressing particular emotions. However, the relationship between mirroring and infants' ability to recognise emotions is still unclear and future research could investigate this further.

Implications and future research

This review has summarised the findings of studies which have investigated the relationship between mirroring and different aspects of maternal and infant experience. Nonetheless, there are many areas of the current literature that could be developed such as further investigation into the different definitions of mirroring and how these relate to other mother-infant behaviours; more consideration of what occurs in the dyad during pauses, neutral and negative behaviours; thorough analysis of cultural differences in mirroring and other maternal behaviours using culturally validated coding frameworks; and the relationship between mirroring, attachment and maternal mental health. For example, Macdonald (1992) distinguishes between protective attachments and warm attachments similarly to the distinction between different forms of mirroring; it may be that these different aspects of attachment interplay with the mother's reflective responses to her infant.

The review has also highlighted areas with very little research, such as with fathers or other caregivers, and gaps in the evidence for key aspects of mirroring theories. The theoretical understanding of an infant's inner-world provides an interesting challenge methodologically when seeking empirical corroboration. As discussed previously, biological markers of arousal such as heart rate, brain region responses or electro-dermal activity (Rayson et al., 2017; Wass et al., 2016) could potentially be used to infer more about infants' inner experiences. This could investigate aspects of the Social-Biofeedback Model (Gergely & Watson, 1996; 1999) that were not substantiated by this review such as the role of mirroring in emotional regulation and sensitisation.

Alternatively, perhaps more in line with Winnicott's (1971) theory of the development of self, another, perhaps indirect, way of understanding the infant's inner world could be to investigate the mother's perspective of mirroring and her infant's identity development using qualitative methods to provide a deeper, more nuanced interpretation of the process. However, as shown in study 4, mothers from the United States expected their child to have a "psychological life" earlier than Fijian or Kenyan mothers did; indicating that the mother's perspective of her child's development may be biased by her own culturally-influenced expectations.

Additionally, the concept of a "self" is nuanced; Luepnitz (2009) provides a helpful history of the development of the term and highlights that Winnicott (1971) was not explicit in his definition. An infant's self could encompass many different features and the developmental process of inadequate mirroring leading to "pathology" in later life is not entirely explained in Winnicott's brief chapter. One aspect of the self that may be able to explain a connection between the mother's reflection of the infant and later emotional difficulties is the extent to which the individual forms a compassionate self. Theories concerning the development of compassion and self-compassion suggest that one's capacity to relate to one's own emotions originates from the responses to emotions that one received as a child (Neff, 2003); thus, if the mother reflects a loving, empathic responses to her infant's emotions, the infant will develop a similar response to their emotions and self; hence, self-compassion can have a protective influence on psychological wellbeing (Farnsworth et al., 2016). Similarly, the mother's ability to respond to her infant's emotions in a compassionate way is likely to be related to her own past experiences of compassion (Neff, 2003) in a similar way to the transmission of attachment styles through maternal sensitivity (Sette et al., 2015). This may be another avenue for developing the literature by aiming to understand this process more fully and perhaps developing an intervention to increase maternal compassionate responding.

Due to the mix of research questions, definitions and methodologies used in the nine studies, coupled with small sample sizes, it is difficult to draw general conclusions about mirroring beyond a summary of

key findings. Therefore, the main implications of this review are perhaps limited to highlighting gaps in the literature and questioning often-cited theories. The key theories of mirroring that have been considered in this review each include some areas that were supported and others that were not substantiated by the nine studies; this calls into question the extent to which they can be validated in full, despite their intuitive sense and support from clinical case studies. Before such confidence can be granted to the theories, further research is necessary, and this review has highlighted some of the many different interesting avenues that such exploration could take.

Conclusion

This paper has summarised key theories of mirroring and evaluated them against the current empirical literature. Despite methodological variation, the literature provided a broad account of many different concepts associated with mirroring. Two studies with multiple time-points tentatively enabled a better understanding of effect directions. To an extent the theories were well-supported but nonetheless, gaps remain for further investigation. Likewise, the existing literature suggests many avenues for further research to expand our understanding of an important mechanism in the mother-infant bond and infant identity development.

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Section B

“They say it's a good thing in principle but…” - New mothers’ experiences of compassion in society: an Interpretative Phenomenological Analysis.

Word Count: 8000

Abstract

Compassion has associations with resilience, positive wellbeing and physical health improvements. Theories suggest that compassion evolved within the mother-baby relationship and later expanded to include others, benefitting societal groups. This study aimed to explore mothers' compassionate experiences in the context of wider society. Eight new mothers from South-East England were interviewed and Interpretative Phenomenological Analysis was used to explore their sense-making of the three flows of compassion (self-other, other-self, self-self), motherhood and societal narratives. Participants experienced compassion as valuable, immense, complex and sometimes effortful. They emphasised the importance of understanding needs and prioritising their babies. Society felt harsh, judgmental and contradictory towards mothers, but acts of compassion helped participants to persevere. The results support other qualitative research, and theories of compassion and parenting. Implications include co-constructing compassion-focused interventions for mothers, evaluating societal systems to remove barriers to compassion, providing more compassionate spaces for mothers and focusing future research on fathers.

Key words: Compassion, Motherhood, Society, Perinatal, Wellbeing

Introduction

As is customary in qualitative research, this introduction will be brief to allow more focus on the results and discussion of the analysis, in a bottom-up, data-driven process (Gheondea-Eladi, 2014). Definitions and theories of compassion will be summarised along with research regarding compassion, motherhood and early life.

Defining compassion

Compassion has been identified and valued across many different cultures and systems, including the NHS constitution (Department of Health, 2013), with varying nuance. Strauss et al. (2016) consolidated different definitions of compassion into five elements: 'recognising suffering'; 'understanding the universality of suffering'; 'emotional resonance'; 'tolerating uncomfortable feelings'; and 'motivation to act or acting to alleviate suffering'. They also highlight intersections with understandings of other constructs such as empathy and kindness.

Compassion can be further considered in terms of three "flows": from self to others, others to self and self to self (Gilbert, 2014). An association between self-compassion and compassion to others was found in regular meditators but Neff and Pommier (2013) found weak or no correlations in community and undergraduate samples, respectively, suggesting a divergence of constructs and showing distinctions between populations.

Evolution of compassion

Gilbert (2014; 2015) suggests that compassion evolved within the mother-baby relationship, enhancing the safety provided by the proximity of attachment to better meet the baby's needs. Gilbert proposes that compassion later evolved to include other kin and community members, providing a benefit to the wider group and to the individual through social acceptance and stronger bonds. Indeed, similar

neural activity in pain-recognition areas has been shown during parental nurturing and compassion to others (Simon-Thomas et al., 2012). Gilbert (2015) suggests this progression was possible due to a combination of cognitive skills, emotions, motives and behaviours in humans, termed 'social mentalities' that lead people to fill particular social roles.

Self-compassion is theorised as the process of directing compassionate social mentalities, such as care-giving and care-seeking, towards oneself (Gilbert, 2015). Hermanto and Zuroff (2016) found that self-compassion was predicted by care-seeking tendencies more so than care-giving, again suggesting that self-compassion may be a separate construct, although their sample of university students may not be widely representative.

Compassion and wellbeing

Compassion has associations with emotional expression, emotional regulation and positive affect (Kogan et al., 2014) along with various neural mechanisms (Simon-Thomas et al., 2012; Weng et al., 2013). Self-compassion is also related to health-promoting behaviours, immunity, sleep and global physical health (Phillips & Hine, 2019). Higher levels of self-compassion and compassion satisfaction in nurses was associated with less burnout, better wellbeing and more compassion for others (Durkin et al., 2016).

Klimecki et al. (2014) found that while empathy training increased negative affect and activity in pain-related brain regions when observing human suffering, compassion training reversed such effects, seemingly strengthening resilience to suffering. Similarly, Crocker and Canevello (2008) found that compassionate goals attenuated the negative effects of self-image focused goals, and improved wellbeing and relationships. Conversely, low self-compassion is strongly associated with psychopathology (MacBeth & Gumley, 2012) which could be explained by a fear of compassion combined with high self-critique and shame (Kirby et al., 2019).

Barriers to compassion

Campion and Glover's (2017) participants felt self-compassion would have benefits but discussed many barriers including a sense that self-compassion seemed difficult, unfamiliar, selfish and time consuming, could elicit judgement, and did not fit with society's individualistic and capitalist systems. Likewise, Robinson et al. (2016) found conflicting views whereby participants associated self-compassion with positive wellbeing but also self-indulgence and low motivation.

Gilbert (2015) suggests that other barriers to compassion include competing social mentalities and motivations such as internal self-interests for resources, tribalistic responses to out-groups and navigating dominance. Compassion is also less likely to be offered to outgroups (Loewenstein & Small, 2007) or people who appear less happy or successful (Hauser et al., 2014).

Additionally, lower levels of self-compassion in adulthood were related to early parenting experiences of low-warmth, rejection and overprotection, mediated by attachment anxiety (Pepping et al., 2015), and parental invalidation, mediated by fear of emotion, particularly for women (Farnsworth et al., 2016).

Parental impact

The literature shows an influence of abuse, neglect, insecure attachments, rejection and lack of warmth on the development of negative self-concepts and internal working models of caregiving, resulting in self-criticism, difficulties in interpersonal relating and mental health problems (Blatt & Homann, 1992; Irons et al., 2006; O'Connor, 2003).

Likewise, parents are influenced by their own early experiences and attachments in how they relate to their baby and own emotions (Sette et al., 2015). Maternal depression, particularly in the context of stress, low socio-economic status and poorer social–marital support, is often associated with disadvantageous parenting dynamics and associated consequences for the child's mental health (Atkinson

et al., 2000; Farnsworth et al., 2016; Gelfand & Teti, 1990; Lovejoy et al., 2000). Hence, NICE guidelines suggest early screening for maternal mental health (National Institute for Health and Care Excellence, 2014).

Self-compassion in parents is associated with lower depression and anxiety (Felder et al., 2016), less self-criticism and self-blame, better ability to cope with children's emotional reactions (Psychogiou et al., 2016) and less guilt and shame around challenging parenting events (Sirois et al., 2019). Self-compassion also mediates the relationship between maternal attachment insecurity and child quality of life (Moreira et al., 2015). A recent meta-analysis (Jefferson et al., 2020) found that self-compassion interventions have positive effects on parental stress, depression and anxiety but found mixed results for impact on children; however, methodological quality issues and evidence of publication bias limit generalisability; the authors suggest further research is needed to verify benefits and understand the mechanisms behind such interventions.

Research into narratives of motherhood often discusses themes of societal expectations for identifying as a mother and instinctively knowing what to do (Miller, 2005), being "totally in love" with the baby (Kerrick & Henry, 2017), what constitutes being a "good mother" (Austin & Carpenter, 2008). However, a review of the literature indicates that research has not explored the intersections of societal ideas about motherhood and compassion to date.

Aims

This research aims to explore mothers' experiences of compassion to better understand mechanisms and societal narratives that may underlie barriers to compassion. Additionally, this research aims to explore how compassion for mothers and babies may be fostered during such a pivotal time of development.

Research questions

- How are the three flows of compassion experienced by new mothers?
- Do societal narratives inhibit or facilitate compassion?
- How do new mothers understand connections between the three flows of compassion?

Methods

Design

Qualitative interviews were conducted and Interpretative Phenomenological Analysis (IPA) was used to explore participants' experiences and sense-making of compassion, motherhood and societal narratives. IPA focuses on the double hermeneutic whereby the researcher interprets the participant's meaning-making of a particular phenomenon (Smith et al., 2009). The researcher took an epistemological stance of critical realism (Cruickshank, 2012) whereby 'compassion', its three 'flows', 'motherhood' and 'society' were positioned as existing phenomena that are interpreted subjectively by individuals.

Participants

IPA studies use homogenous samples to enable the researcher to discover common themes of a particular experience and explore individual differences richly and contextually. A small sample size is recommended to allow increased depth of analysis and "theoretical transferability rather than empirical generalizability" (Smith et al., 2009, p.52); a sample of eight was used to coincide with recommendations for student projects (3-6 participants) whilst acknowledging the requirements of doctoral research.

Eight new mothers from South-East England were interviewed (Table-1). Grey-matter changes that could affect cognition have been shown to last at least two years post-birth (Hoekzema et al., 2017) and were therefore unavoidable in, and exemplary of, this population. The presence of pregnancy hormones

can vary greatly depending on breast-feeding and individual differences, but the post-partum period is conceptualised to last approximately six months (Romano et al., 2010). Hence, for the mothers, a minimum period of six months post-birth was required. A twelve-month maximum was chosen to minimise heterogeneity of experience but later expanded to eighteen months to aid recruitment. Table-2 includes further exclusion criteria information.

Table 1
Participant demographic frequencies

Age of participant	Age of baby	Gender of baby	Ethnicity*	Religion*
25-30 years – 5	7 months – 2	Male – 4	White British – 8	No religion – 6
31-35 years – 2	11 months – 1	Female – 4		Christian – 2
41-45 years – 1	12 months – 2			
	15 months – 1			
	16 months – 1			
	17 months – 1			
Education	**Marital Status***	**Sexuality***	**Socio-economic status***	
A Level – 3	Married – 7	Heterosexual – 7	Higher managerial and professional occupations – 1	
Diploma – 1	Co-habiting – 1	Gay/Lesbian – 1	Lower managerial, administrative and professional occupations – 5	
Undergraduate Degree – 4			Intermediate occupations (clerical, sales, service) – 1	
			Small employers and own account workers – 1	

Note. *Category options were taken from the most recent UK Census (Office for National Statistics, 2011). See Appendix-4 for demographic sheet.

Ethics

This study was approved by the Salomons Institute Ethics Board (Appendix-1). Pseudonyms have been used to protect anonymity and participants were given the right to withdraw until data analysis. Participants arranged childcare for the duration of the interview. Information on appropriate support was available if participants became distressed, but not required.

Procedure

The research advert (Appendix-2) was shared on social media, and in consenting shops, community venues and parenting groups. Potential participants contacted the researcher and were asked to read the information sheet (Appendix-3) and confirm they met the inclusion criteria before an interview was organised (see Table-2).

Table 2
Participant recruitment details

Total potential participants	Did not meet criteria	Change in circumstances	Ceased responding	Included in the study
18	5*	2	3	8

Note. In light of homogeneity, women who self-reported severe mental health problems at time of recruitment and those with older children were excluded from the study; those who had experienced miscarriage were not excluded.
*One participant completed an interview during which she spoke of her baby and an older child; she was therefore informed of the misunderstanding and excluded from the analysis.

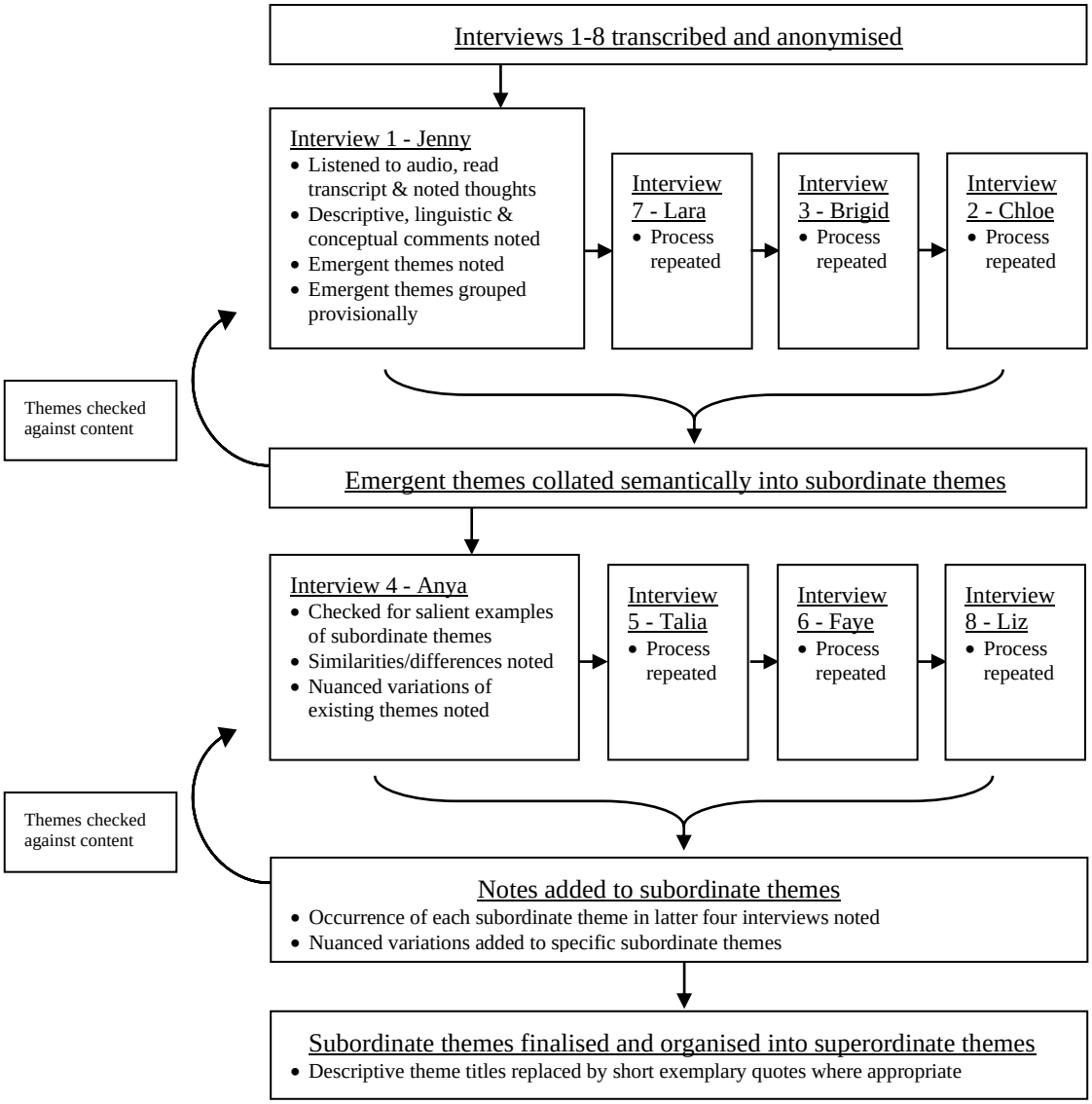
Prior to the interviews, participants re-read the information sheet, asked questions and completed demographic information and consent forms. The semi-structured interviews (Appendix-6) took place at a university campus or via online video, according to participant's availability. Each interview lasted 1-2 hours, totalling 11.8 hours of data.

Data Analysis

Guidance from Smith et al. (2009) was used for the analysis of four randomly chosen interviews (participants 1,7,3,2). The researcher read the first transcript whilst listening to the audio recording and made reflective notes on initial thoughts that emerged and memories from the interview, to enable bracketing for the analysis. Next, the researcher focused line-by-line making descriptive, linguistic and conceptual comments (Appendix-7). After multiple re-readings, emergent themes were noted and collated provisionally according to semantics. This process was repeated for three further interviews and then the emergent themes from each were compared and grouped into subordinate themes (Appendix-8). In an

iterative process, the subordinate themes were compared against the original interview material to ensure they maintained the initial meaning. Focusing initially on four interviews enabled greater depth of analysis, consistent with recommended IPA sample sizes. For larger sample sizes, Smith and Osborn (2008) suggest researchers can "use the themes from the first case to help orient the subsequent analysis" (p.73). See Figure 1 for an illustration of this process.

Figure 1
Diagram demonstrating the analytic process for the eight interviews



The remaining four interviews (participants 4,5,6,8) were studied and salient examples of the subordinate themes were highlighted. No novel themes emerged but more nuance was provided, and some

themes became more prominent. The subordinate themes were finalised accordingly and grouped into superordinate themes. See Table-3 for the recurrence of themes across different participants.

Quality assurance and reflexivity

To improve quality, the researcher considered the context of the participant's environment, wider society, and the interview itself as suggested by Yardley (2000). Additionally, researchers are encouraged to look for higher-order patterns and unique exceptions across individual interviews and the whole sample (Smith et al., 2009).

It is important to ground any claims in the data by checking interpretations against original quotations, and to be aware of how one's own influences and context may be affecting the interpretations (Smith et al., 2009). Therefore, the researcher discussed the interview questions with her own mother and reflected on their assumptions about compassion, motherhood and society.

Inter-rater reliability is not commonly assessed in IPA due to the method's focus on the double hermeneutic: the individual analyst's interpretation of the participant's interpretation of their experience (Smith & Osborn, 2008). Instead, a supervisor experienced in IPA gave comments on one fully analysed transcript and was consulted throughout.

Results

The interview schedule structure resulted in some general themes such as examples of compassionate acts, and themes that recurred throughout individual interviews but were not covered significantly by other participants. Particular frames of reference recurred often such as food, breastfeeding, politics, experiences with pets, economic systems and social media. Such themes and frames provided context for interpretation but will not necessarily be discussed in detail, instead this section will focus on themes that most richly answered the research questions. Table-3 provides a summary of themes.

Superordinate themes

Table 3
Summary of themes of experiences discussed by participants

Superordinate themes	Subordinate themes	Description of experiences within the theme	Participants*
The value of compassion	It's an emotional hug	Examples of what compassion is, how it feels and how its related to love and kindness	All participants
	It was so frustrating and it upset me	How it feels when compassion isn't received, or seeing a lack of compassion to others	Jenny, Lara, Chloe, Anya, Talia, Faye, Liz
	Ad hoc and special compassion	The difference between compassion to loved ones and strangers, one off acts or regular compassion, expected and unexpected compassion	All participants
Immensity and complexity of compassion	It almost makes the world go round	Compassion feeling big, an infinite cycle, flowing between people but sometimes not being obvious or clear. Compassion connecting people.	All participants
	Small acts, big impacts	Small acts of compassion having big impacts.	Jenny, Lara, Brigid, Chloe, Anya, Talia, Liz
	It takes compassion to get you through	Compassion helping people to get through difficult circumstances, feeling necessary and protective	Jenny, Lara, Brigid, Choe, Talia
Compassion is hard to do	You're just not good enough	Self-compassion as more difficult, having high standards for self and being self-critical	All participants
	You have to remember to be compassionate	Compassion taking time and effort, needing to make a conscious decision to be compassionate	All participants
	If I accept that compassion, I'm accepting that I'm failing	Not always wanting compassion, feeling dependent, weak or powerless, reasons not to be compassionate	Lara, Brigid, Chloe, Anya, Talia, Faye, Liz
Needing to focus on needs	It's like they had this sixth sense	People understanding needs, empathising, using own experience to understand, needing more compassion as a mum	All participants
	You've got to set your feelings aside	Conflicting needs with others, putting others first, putting baby's needs first	All participants

What it means to be a mother	They're an extension of you	Becoming and developing as a mum, identity linked with baby, societal narratives of motherhood	All participants
	It's so rewarding, so challenging	Contrasting feelings in motherhood, the stress and guilt of motherhood	All participants
	You grow an extra heart	Endless and intense feelings of love and compassion for baby	Jenny, Lara, Chloe, Anya, Talia, Faye, Liz
	The new mum tribe, it's a bit of a bubble	Connecting with other mums in a safe bubble, cocooning away from others in society, support networks	Jenny, Lara, Brigid, Chloe, Anya, Faye, Liz
Growing a human being	They become like this flower that blossoms	Wanting to help baby develop and grow, physically and emotionally	Jenny, Lara, Chloe, Anya, Talia, Faye, Liz
	If you make the wrong choice your child's going to end up in prison	Worries about doing something wrong, not being a good enough mother	Brigid, Chloe, Faye
	You're turning into a proper human	New awareness of what it is to be human	Lara, Brigid
	It can be kind of character building	Concerns about giving too much compassion, needing to be realistic	Jenny, Lara, Anya
Relating to other parents and partner	You appreciate your mum a bit more, you realise what they went through	Parenting values, influence of own parents, compassionate figures in life	Jenny, Lara, Brigid, Chloe, Anya, Faye
	Having a baby is its own experience	Other parents understanding at a level others cannot. Not knowing before having a baby.	Jenny, Lara, Brigid, Chloe, Anya, Talia, Liz
	Oh here they are, the proper mums	Comparing with other mums, other mums modelling	Jenny, Lara, Brigid, Chloe, Anya, Faye
	He was here, he was great	Partnership with partner, compassion from partner, comparisons with partner	Jenny, Lara, Brigid, Chloe, Talia, Faye, Liz
Venturing into a harsh society	They say that it's a good thing in principle but…	Contradictions between what society says and what it's actually like, judgement, lots of standards to meet	All participants
	Maybe when I get rich then I will start to help others	Capitalism, individualism, political beliefs	Lara, Brigid, Liz, Anya, Faye
	Put out a life when in reality that's not	Social media different compared to real life	Jenny, Lara, Brigid, Anya, Faye

	true		
	An environment where you could ask for as much help as you needed	Experiences with health care, compassionate and uncompassionate	All participants
Miscellaneous	Just offer to bring me some food!	Link between food and compassion	Lara, Talia, Faye
	Diversity	Compassion linking to tolerance of different groups	Jenny, Lara, Chloe
	There should be an emphasis on family	Value of family as most important, context of own upbringing affecting compassion	Lara, Brigid, Chloe, Faye
Noticed during the process	Using humour to discuss difficult topics	Participants using humour to discuss difficult topics	Jenny, Brigid, Chloe
	Caveats so not judged	Participants seeming concerned about being judged	Jenny, Chloe
	Parallel process of how she's speaking	Parallels in what was said and how it was said	Brigid, Chloe

Note. Names have been changed to preserve anonymity

The value of compassion

Participants discussed times they had experienced each of the three flows or noticed a lack of compassion. There was a general sense that compassion can feel good for all involved: giver, receiver or witness. Jenny felt a sense of containment, seemingly paralleling the experience of holding her baby, "You feel validated, it's an emotional hug really, when you need it…[3]it's that warmth, that empathy…it's about being enveloped in an emotion".

Conversely, a lack of compassion caused anger, frustration, sadness and felt unjust and confusing, highlighting the deep values held by participants of the importance of compassion. Jenny seemed to be struck to her core when she received no compassion from a midwife:

> That kind of weird lack of compassion from who you'd expect it most from, kind of strong word but true, *destroyed* my breastfeeding journey with my little one…I lost my confidence to feed her in public so, who you expect it from, and it wasn't there, that was really hard.

Compassion with strangers or loved ones, "ad hoc" or commonplace compassion, were often distinguished. Lara experienced compassion as ingrained and easy in close relationships, but more distinctive with strangers; this highlighted her own compassionate values and suggested similar in her support network:

> Maybe you do need the special compassion with strangers because…if you recognise that somebody needs something then you could potentially help them out whereas with your general network I'd like to think that it's just pre-existing like you're nice to people, you kind of feed off of them and it's just like an ongoing kind of existence of compassion and kindness within the relationship whereas with strangers because it's not pre-existing you

[3] … indicates the researcher has edited the quotation for brevity

> kind of have to go out of your way to think about what it might be…[Special compassion][4] is a one off. It's like ad hoc compassion, an ad hoc act of kindness…you have to think about it a bit more, whether it would be appreciated, and obviously you don't know the person so it's very difficult to judge it whereas with people that you see frequently, it's a lot easier to judge and so you should just try and be that person every day.

Immensity and complexity of compassion

Many participants conveyed a sense that compassion feels far-reaching, immense and almost indescribable. Indeed, throughout the interviews participants seemed to have a strong 'felt sense' (Gendlin, 1991) of having received compassion without necessarily remembering specific examples. Some experienced compassion as flowing between people, keeping the world moving and functioning, and felt that even small acts of compassion could have big impacts, as Chloe explained:

> It almost makes the world go round, it's that kind of um, smiling at someone in a day, or doing a good deed…it doesn't cost anything, it could have such a massive impact on the person that you give compassion to however big or small that is…I see compassion as that that kind of moral compass, that bit that kind of bobs along in society and darts around but…with compassion there is no defined "this is what you have to do to give compassion"…compassion's got a whole different depth to it which is about understanding the scenario, the individual, the environment.

Compassion was felt to facilitate stronger connections between people, with a fluid link between compassion to and from others and a sense of easy reciprocity. Particularly within motherhood, participants used their own experiences of receiving or lacking compassion from others, to guide giving

[4] [ ] indicates an action, non-verbal expression or added context

compassion. Others felt that, although less easily flowing, self-compassion had enabled them to accept more compassion from others and were motivated to share this wisdom to help others. It seemed the women wanted to protect other mothers from experiencing pain.

Relatedly, a lack of compassion from society made Faye feel less worthy of self-compassion and it was perhaps a shared awareness of this influence from society (see final superordinate theme) that made the women feel so protective of others. Many participants had experienced times when compassion itself felt like a protective entity, perhaps in parallel to the role of a mother to a child. Chloe felt that compassion enabled her to persevere:

> I feel for them, if a mother has a child and they don't have people around them, society is hard I think um it takes compassion on a personal level to be able to get you through whatever society on the outside is saying to you to kind of keep you on that track and if you don't have it, well I dread to think.

Compassion is hard to do

All participants experienced themselves as self-critical and found self-compassion harder than the other flows. In fact, some participants only considered self-compassion when times were so difficult, they had realised it was the only way to persevere. Talia made sense of this as a result of competing demands:

> I think you can be too tough on yourself especially when you're a mum or you've got someone else relying on you. I find it hard to be kind to myself sometimes…even if it's taking five minutes a day to sort yourself out. I think when you've got other things, work stresses, family stresses…It's easy to forget about yourself.

Whereas Anya felt that self-compassion could be self-indulgent; it seemed a fear of being selfish was reason to avoid self-compassion:

> There's a big thing about mental health now and looking after yourself and to an extent I think people could be too compassionate towards themselves…We expect to have holidays, clothes, everything and that's pretty self-compassionate because all you care about is yourself at that stage.

Compassion was also experienced as taking effort and time. In contrast to previous themes of compassion flowing easily between people, compassion was sometimes experienced as though it had limited quantities to be apportioned and required a conscious decision. Liz described this with her partner:

> It's sad but you have to put in that effort to do something that should be natural you have to really try out the little things with your partner just giving them a cuddle or it doesn't have to be something massive…Small things that go a long way but you feel like it's an effort and it shouldn't be…and you know it is very difficult sometimes. It's one of those things you have to put effort in and it sounds stupid, you don't always have the energy to be kind.

Other blocks that inhibited compassionate motivations included concerns of seeming patronising or intrusive; risks of interacting with a stranger; not wanting their kindness to be exploited and not wanting to misjudge needs.

Many participants felt uncomfortable requesting or receiving compassion at times. For some this was linked to low self-worth but for many they were grappling to understand changes in independence and increased needs since becoming mothers. There was a distinct sense that asking for help or accepting compassion meant accepting they were dependent on others, there was a problem, they needed more help, or that this was a sign of weakness. Interestingly, this only applied to themselves, not others, indicating the self-critical standards to which the women held themselves. A sense of powerlessness was particularly evident when the women experienced problems with their bodies, often linked to childbirth or child-rearing, that meant their pre-motherhood independence could not continue to the same extent. At times

receiving compassion seemed to be experienced as a representation of this loss. Chloe had also experienced a loss of control:

> I want to feel like maybe I don't need [compassion] so actually it's that defence mechanism that comes into play so if I accept that compassion, I'm accepting that I'm failing and that I need it so sometimes it's easier to almost not accept it…if you accept that compassion you are accepting that you do need compassion, at which point that's opening a weakness and its sometimes not what I want to do. I want to maintain that kind of I'm in control, I know what I'm doing.

Needing to focus on needs

A shared experience for all participants concerned the difficulty in understanding and balancing different people's needs. As discussed above, participants highlighted an increase in their needs, particularly for compassion, since becoming mothers; this was made sense of as hormonal or physical changes, the stresses of motherhood or the influence of society. Many of the participants' experiences were interlaced with mentions of sleep and food, for both baby and parents, highlighting the overwhelming focus on basic needs in the early days of parenting. Chloe described the experience of her friends understanding her needs clearly:

> [Friends] would just seem to appear out of nowhere. It's like they had this sixth sense that I was struggling and it would just suddenly be daa-daa! There they are…I think the reason why their compassion stands out for me is because I didn't have to ask for it. I didn't have to tell them or articulate what I needed or what I wanted. They came in, assessed the situation and just acted.

On the other hand, Faye recalled a time when a nurse appeared to offer compassion but without such understanding. This seemed to make her feel dismissed and misunderstood. There also seemed to be an

element of infantilisation, which may have felt particularly frustrating given the aforementioned loss of independence that some of the women experienced with motherhood:

> She was like “You need to look after yourself, go and go to sleep” and I was like “I'm a big girl, I don’t need to be told when to go to bed” and it felt like she was a classic example of somebody who was going through the motions of this is what compassion is but actually hadn’t stopped and thought about the individual and what the important thing was at that point for them.

Thus, the understanding of specific needs made a distinct difference to how compassion from others was experienced. Participants also experienced conflict when their needs were incongruent with others. Usually participants put others’ needs first, particularly if it was their baby. Talia seemed driven by a sense of responsibility:

> It’s putting your own feelings and thoughts aside and trying to focus on just what the baby needs…being empathetic towards their situation because all they can sometimes tell you is that they're upset and crying and it can be really difficult sometimes to be really compassionate to someone else when you yourself are really tired or emotional or you’ve got to set your feelings aside and show compassion at that moment…I think it's a responsibility as a mother…but it’s a lovely feeling when you can feel that they're less upset.

At other times, the baby’s needs matched well with the mother’s needs; these occasions seemed to be windows of opportunity for the mothers to allow themselves some self-compassion. Lara experienced her happiness as intrinsically linked to her baby’s:

> You feel like they're an extension of you and you feel like if they're happy then you're happy so you just kind of try and give them as much of your energy, your happiness and

like all of these nice things as you can and try and avoid them having to experience any unpleasantness or bad vibes.

Brigid experienced guilt when faced with a dilemma between her baby's immediate needs and what she felt was best for coping with the constraints of her work schedule. She seemed to struggle between her instincts and her concerns for future repercussions, ultimately deciding she needed to be 'cruel to be kind':

> There's a lot of guilt…because I'm not there at night and she has to be without me, if I go in to help deal with her at night now, it's so much worse. So to be compassionate, although it makes me feel crap because she's crying and it's instinct to like pick them up and cuddle, I just can't and [husband] goes instead. But that just makes you feel awful that you make your child feel worse! Even though you're trying to help them.

What it means to be a mother

Participants spoke of a transition through pregnancy to motherhood, developing knowledge and confidence as their babies grew. Throughout the interviews, even if not explicitly, participants discussed how hard motherhood can be and the guilt that often comes with such challenges. Liz experienced intense contrasts of feelings and described them in a way that seemed to represent the chaos and speed of the motherhood experience:

> It's so rewarding, so challenging, you're up, you're down. Your day can be so difficult and you look at him at night when he falls asleep and your heart melts and you forget everything that's happened during the day…I love my husband but you just don't realize what true unconditional love is until you have a baby and suddenly everything changes. You pull your hair out because it's so stressful but at the end of the day you still love them so much.

Many participants spoke of their endless love and compassion for their babies; this was experienced as developing naturally and was incomprehensible before becoming a mother. Lara experienced a stark shift:

> All of your compassion shifts from other people and it's like you blast [the baby] with as much as you can and you just want them to absorb it and then grow into being this really delightful person who models themself on all of the kindness that they've received…people are like "I love my husband so much, they've got all my love, all my heart" and then you have a child and it's like you grow an extra heart and then you've got so much more love, your capacity just increases.

Many participants felt that their identity became inextricably linked with being mother to their baby; Lara felt that her baby was an extension of herself and experienced people's reactions to her baby as reactions to her. Anya navigated a loss of identity:

> It did start to get better but I think for a long time I didn't feel myself, I still don't really feel myself 100%…you sort of lose yourself in the pregnancy stage and in the trying to have a baby phase and then when you have the baby it's like "Oh my God! What's happened to my life?" it's just trying to juggle things and learn how to have him and do me as well…a massive learning curve.

Participant's motherhood identities were linked to their perceptions of societal narratives. There was a sense that mothers are seen as always and instinctively compassionate to everyone, that mothers always put their babies first and that it is motherly instinct to do everything right for one's child. Therefore, when the women did not fit such narratives, they felt guilty and judged. Anya, Faye and Chloe experienced a sense that once they became mothers, society felt more inclined to discuss their lives and pass judgement. Faye felt that people saw mothers as society's property:

> It's societal, it's not an automatic thing to stop and think "how is that going to come across?" You're part of our property now cos you've got this thing. We're all now partly responsible so I can give you this advice.

Anya made sense of this as people wanting to share their knowledge to help the baby develop to its greatest potential but found this quite overwhelming. Many participants felt overwhelmed by society as new mothers. Some experienced a sense of protection in a group atmosphere with other new mothers that felt separate from the harsh nature of wider society with an easy flow of compassion, peace and safety. Jenny experienced this as somewhat idealistic and related it to the human need to belong:

> At the minute this is a bit of a bubble, I live in a bit of a bubble and it's a strange thing, where [in mother-baby groups] you talk a lot about your children and those experiences and you think everything will be lovely…I think throughout our lives, we join different clubs, people belong to groups, we're a social race, we always have that, we need to belong to a tribe, whatever your tribe is, and I suppose this is the new mum tribe…and it's lovely but it's not always particularly realistic [laughs] I think it's a bit of a bubble.

Similarly, some participants also felt an urge to shield away from the harshness of society, and many spoke of feeling isolated, different and separate. Anya experienced an urge to become "a hermit" for privacy and Lara used the analogy of a cocoon to make sense of the way she stayed separate, both conjuring images of protection and envelopment. However, this strategy of separation seemed somewhat fragile, easily slipping into isolation and becoming a barrier to connection with others. Liz shared how motherhood felt when she became disconnected from others:

> It's very lonely. You're by yourself with your baby who doesn't really talk to you. They babble, they scream, but there's no interaction and being lonely…you feel very low. I think doing things with other mums is a lot of help…that interaction with other people is what you need.

Growing a human being

Many participants experienced a desire to help their baby grow, develop skills and wanted to nurture their baby's ability to be compassionate. Having a baby gave some participants a new understanding of what it is to be human. Lara found the experience of observing her baby's development fascinating:

> I could probably record [baby] eating and I could watch it for a really long time because the way they eat, it's just fascinating [both laugh]. It's like working out how to pick things up like new textures or just playing with things and experimenting. It's the way that they do everything and the things that they notice…when they learn something new and sometimes it can take you completely by surprise because a lot of the time they don't seem to be working on something, it just happens…and it's just like wow! Where did that come from?!

Others spoke of their desires to nurture their baby's development as an active process, offering compassion in the hope the baby would grow to be compassionate themselves. Conversely, some of the mothers had concerns that perhaps they should not be compassionate to their babies all the time, as this could result in the child growing up with an unrealistic sense of the world, or a child unable to help themselves. Lara, by making sense of experiences she had learned from in her own childhood, also felt that allowing her daughter to experience difficulty without always being coddled would help her to understand that pain does pass.

Some of the mothers shared underlying concerns that they would do something wrong, wouldn't be good enough and this would cause problems for their baby in the future, using the hyperbolic example that their baby could "end up in prison". This worry seemed to be experienced more by mothers who themselves had had difficult relationships with their parents, perhaps having a stronger sense of what it can feel like to grow up with less compassion and wanting to prevent this for their baby.

Relating to other parents and partner

Most participants made sense of their ideas about compassion, narratives of motherhood and parenting values by connecting with influence from their own parents. Many experienced their mothers or grandmothers as the embodiment of compassion, always putting their children first and offering unconditional love; this seemed to be linked to the deep values the participants held about being compassionate and selfless, suggesting that these ideas may have been passed on through modelling. A number of the women also experienced a new connection with their own and other mothers over the shared experience of motherhood, as Anya described:

> You need someone to understand it's hard and that's why you probably end up having friends that have babies and you end up speaking to your mum, you get closer, like I have with my mum, because we can relate more, that compassion being there, which maybe I don't get from my sisters who haven't had children…I guess having a baby is its own experience and you do find when talking to other mothers, they can understand what you're going through.

This connection may have accounted for some of the ease of compassion that flowed within the aforementioned motherhood bubbles. Indeed, there was a common theme that other parents could understand at a level that non-parents could not, and that this led to more compassion. A number of participants recalled their lack of understanding before becoming parents and used this to make sense of receiving less compassion from non-parents; thus understanding needs seemed to be seen as a prerequisite for compassion.

Participants also made comparisons with other parents and their partners, for example when partners took more time to themselves or had conflicting needs. However generally, participants experienced a sense of partnership and shared responsibility, with both partners learning how to give compassion to meet each other's increased needs. Many of the women, such as Talia, experienced simple acts of

compassion and understanding from their partners which enabled them to continue meeting their babies' needs at times of difficulty. This suggested a sense of compassion flowing from one person to another to another, facilitating the flow of nourishment for mother and baby alike:

> He was great. Sometimes when [breastfeeding] was particularly painful, he would give me a break, five minutes and take the baby and distract the baby and so that I could just have five minutes to collect myself. Must be hard for them as well seeing your partner go through that but he was here, he was great even making me food and bringing me cups of tea when I was feeding [baby]…It was relief.

Venturing into a harsh society

As mentioned previously, society felt harsh and intimidating to venture into as new mothers. This could draw parallels with the physical vulnerability of their new babies, with the women feeling vulnerable in navigating their new identities in relation to the wider world. Nearly all participants experienced society as contradictory, feeling that it seemed to promote compassion in its narratives but gave limited amounts from its wider systems; it seemed that society had an image as an inauthentic, unreliable parent to the mothers. Faye discussed such contradictions:

> The wider society message around compassion I think is: "As a mother, you should be compassionate with yourself and you're doing a great job…but are you doing this? Have you got a baby that's sleeping? Have you got a baby that's thriving? Have you got a baby that's got hair!"…You must be compassionate with yourself but you must always also do all these other things that we are going to tell you to do and so…I feel there's an undertone.

All participants felt overwhelmed by society's information, standards and ideals for mothers and were concerned about judgement for not meeting them. Some of the mothers mentioned judgement from

health professionals as a particular worry, and a barrier to seeking help. Participants also felt pressure to perpetuate the perfect motherhood narrative, even when things were difficult, in order to avoid judgement. Compassion was experienced as the antithesis to such judgement. Indeed, a number of participants recalled birth stories or complications with their baby's health that felt frightening and traumatic but, because they were treated so compassionately by staff, the experiences were not experienced as terrible. Compassion enabled Jenny to experience her emergency caesarean as beautiful:

> I remember being really upset and these lovely people just saying "you have done so well, you've been in pain, you've tried and it's just not going to be this way" and it was beautiful. So for all of that, the difficulty, it was beautiful. Just so nice, so kind, perfect really yeah…they were incredible people…it could have been terrifying and I wasn't scared.

Unfortunately, Jenny had other health care experiences that were not compassionate, as did Anya, Faye and Liz, often surrounding breastfeeding. Anya made sense of this as the societal desire to ensure babies receive the best start in life, services being stretched financially, not having enough time and professionals becoming habituated to suffering, and so unable to connect with her pain. Lara's experience in a birthing centre was particularly compassionate and she felt this was because the environment was well resourced and had a distinct focus on nurture, support and compassion, which more medical environments cannot always offer. Thus it seemed participants were acutely aware of society's resources, a lack of which resulted in a lack of compassion.

Most participants felt society promoted compassion on a philosophical level but highlighted systems and cultural factors that prevented compassion and increased judgement day-to-day. For example, a lack of hospital accommodation for parents to stay with their babies and a shortage of parent-child parking spaces illustrated systems that felt uncompassionate and caused additional stress for mothers. Capitalism, individualism and materialism were felt to push people to focus more on their finances, possessions and

efficiency than connecting with others and offering compassion; as Brigid suggests, “I think we’re expected to work to the bone, and that is supposed to be our lives. And I don’t think that’s being compassionate to yourself”. Lara felt similarly:

> Our focuses in life tend to be more materialistic. A lot of people wouldn't say their goals are “love and, you know, I'd like to live my life with an open heart”, they would say “I'd like to have a big house, I'd like to drive a fancy car and I want to be rich…maybe when I get there then I will start to help others”.

Social media was used by some participants to illustrate their perception of societal ideas. Many experienced people promoting an inauthentic, idealised version of their life which felt like a higher standard to emulate. Participants also mentioned cruel, uncompassionate comments and made sense of their prevalence through the anonymity of social media. However, Brigid had also experienced connections with compassionate ideas through social media:

> You’re able to connect with people that you wouldn’t have been able to connect with before, that allow you to discover things about life, or movements or things that are going on for other people that then allow you to give compassion to yourself.

So, it seemed that social media was experienced as neither purely compassionate nor uncompassionate but perhaps instead was a window into amplified representations of existing societal narratives.

Discussion

Experience of the three flows

In general, compassion was experienced similarly to Strauss et al.’s (2016) definition but with less focus on tolerating uncomfortable feelings. The “immensity and complexity of compassion” theme may

be representative of variance in existing definitions. Whereas Strauss et al. focused on understanding emotions and universality of suffering, participants were explicit about "needing to focus on needs"; the Dalai Lama (1995) and Gilbert's (2009) definitions highlight this more.

Themes of "the value of compassion" and its ability to "get you through" support existing literature on wellbeing, resilience and parental coping (Kogan et al., 2014; Sirois et al., 2019). Likewise, participants' relating with their own parents' expressions of compassion aligns with Farnsworth et al. (2016) and Irons et al. (2006).

Participants felt that compassion "makes the world go round" and highlighted the importance of connections, supporting Gilbert's (2015) evolutionary theory that bonds and compassion underpin social functioning. Likewise, compassion felt easier with loved ones than strangers, corroborating limitations with outgroups (Loewenstein & Small, 2007). The sense of compassion's competition for time, effort and individualistic needs fits with Gilbert's (2015) theory that compassionate social mentalities must compete with others (e.g. resource-focused).

Participants discussed "character building" and the dilemma of not giving their babies so much compassion that they were unprepared for the world; this connects with Winnicott's (1953) concept of a "good enough" mother whereby children benefit from experiencing imperfect parenting to develop tolerance of frustration and unmet needs in an imperfect world.

Participants described putting their babies' needs first, finding them fascinating and "growing an extra heart", supporting Stern's (1995) concept of the 'motherhood constellation'. Stern suggests that mothers' psyches reorganise to focus fully on the tasks of keeping the baby alive, helping the baby develop psychically and transforming their own identities.

Participants' associations between compassion and weakness or failure link with research that shows 'fear of compassion' is related to self-criticism and stress (Gilbert et al., 2011). This is particularly

troubling given participants' experiences of stress and increased need for compassion in motherhood. Indeed, self-compassion was experienced as the hardest of the flows with the most barriers, corresponding with studies highlighting self-compassion as difficult and time consuming (Campion & Glover, 2017). Unlike other studies (Campion & Glover, 2017; Robinson, 2016), few participants voiced an explicit sense that self-compassion was selfish or self-indulgent. However, all discussed a pressure to be perpetually compassionate and "set your feelings aside", suggesting implicitly that prioritising self-compassion felt wrong.

Effects of societal narratives

Campion and Glover's (2017) research mirrored this study's theme of "venturing into a harsh society" in that compassion was experienced as conflicting with society's individualism and capitalism. Likewise, Robinson et al. (2016) discussed society's conflicting narratives whereby compassion is encouraged theoretically but obstructed systemically, similar to this study's sense of society as an unreliable parent.

Existing accounts of motherhood narratives (Austin & Carpenter, 2008; Kerrick & Henry, 2017; Miller, 2005) have been supported and elaborated here to include compassion. However, to contradict or not accomplish "what it means to be a mother" was to risk judgement, appear inadequate and feel unworthy of compassion. Identifying as a mother therefore increased certain pressures and, for some, caused the transformation or loss of past identities.

Stern (1995) outlined that mothers must shift their identities by evaluating their schemas of motherhood from their own childhood, transforming from daughter to mother, corroborating these participants' experiences. Stern puts this in the context of society valuing babies' development, placing responsibility on mothers to raise them optimally, and lacking provisions that could ease this task for mothers; concepts that were discussed throughout this study. Indeed, it is understandable that mothers would feel intimidated by such tasks and society, and thus would seek protection from other mothers in

"bubbles" or separately in "cocoons". Sadly, certain protective spaces that were provided by society in the UK, such as Sure Start centres, have been diminished substantially in recent years (Coughlan, 2019).

Understandings of connections between flows

The flows of compassion to and from others were strongly linked for participants. Compassion from others enabled participants to offer more compassion to their babies and persevere through the challenges of motherhood. The theme of "he was here, he was great" connects with the 'nursing triad' theory (Casement, 2013) based on Winnicott's (1953) assertions that a mother needs a supportive figure, such as the father, to hold and support her while she holds and supports the baby, particularly in times of stress. Conversely, some of the participants who had experienced a lack of compassion from others described using this as motivation to be more compassionate, similar to corrective scripts in systemic theory (Byng-Hall, 1995).

Hermanto and Zuroff (2016) found that self-compassion was associated with the care-seeking social mentality more than care-giving. Indeed, this study's participants offered much compassion to others (care-giving) but this did not flow into self-compassion or accepting compassion from others, perhaps indicating competition with social mentalities of dominance, given participants' aversion to seeming weak.

Limitations

Along with much of the existing literature of parenting, this study focused on mothers only. Although appropriate given IPA's homogeneity requirements, it may have been helpful to further explore the participant's relationships with their partners. However, Berman (2020) highlights that if fathers are discussed in research, it is often regarding their role in supporting mothers. Thus, this study has perpetuated the dearth of literature exploring the father's own experience and may propagate traditional ideas of mothers being mainly responsible for their children's care. Such ideas may add to the

responsibility and standards faced by mothers and perpetuate a lack of support for fathers.

Likewise, the small, homogenous sample of White British women means these findings are not necessarily generalisable to other cultures or groups. However, many of the themes from this study do seem to link with existing research and theory, including other qualitative work, indicating some theoretical transferability (Smith et al., 2009).

A key theme for many participants was feeling judged by society. Particularly for those women who had poor experiences with health professionals, it may be that talking to a researcher elicited some anxiety about seeming "good enough" and may have biased their disclosures. Likewise, the topic of compassion may have encouraged recruitment of women who already had positive views and felt comfortable in their understanding of the concept; although attempts were made to mitigate this, it may have resulted in selection bias overlooking those with a fear of compassion (Gilbert et al., 2011).

Practice implications

Interventions to promote self-compassion seem to be helpful for parents, and potentially for their children, but specific intervention protocols vary and conclusions are limited due to publication bias and methodological quality (Jefferson et al., 2020). Compassion Focused Therapy has been adapted for perinatal populations (Cree, 2010) and, although not empirically evaluated as yet, may help to acknowledge the perceived threats of society, foster self-compassion and encourage compassion to the baby. It seems particularly important to minimise any conflict with the baby's needs given this study's findings.

It also seems important to avoid placing additional responsibilities and standards on the mothers themselves; while encouraging self-compassion could be beneficial, it seems improving society's approach to compassion could have a broader impact, for example by evaluating and improving systems that hinder compassion for all individuals. Likewise, building on existing systems that mothers experience

as compassionate, such as “bubbles” with other mothers, could improve isolation and build protective connections. For health care, services are experienced best when they clearly promote compassion as a priority and are resourced accordingly. As Gilbert states, “building compassion-cultivating contexts will be a collective effort” (2015, p.250).

Future research

Further development and evaluation of compassionate interventions for mothers and wider family members is needed. Participants highlighted “needing to focus on needs” and the frustration they felt when others used their own preconceptions and subsequently offer ill-matched and less impactful compassion. Future research and interventions should be cautious in assuming needs without consulting mothers first. A community psychology approach may help to avoid such top-down dynamics and instead co-create support that matches the needs of specific communities (British Psychological Society, 2020).

As discussed above, the experiences of fathers are particularly under-researched (Berman, 2020). Further exploration into narratives of fatherhood and partners’ experiences of compassion could provide interesting contrasts. Additionally, this study touched briefly on the women’s experiences of healthcare settings but most research into compassion and healthcare is from the perspective of clinicians (Sinclair et al., 2016). Therefore, further research into patient perspectives of compassionate healthcare could give valuable insights into how services could transfer values of compassion (Department of Health, 2013) into meaningful action.

Conclusion

This study has contributed to existing research into maternal experiences and provided mothers’ perspectives to the wealth of developmental literature detailing the importance of care and compassion for babies’ development. Much of this literature has been disseminated into public awareness but society’s desire to use such knowledge to help babies’ development can be experienced as judgemental and

intimidating to new mothers. Compassion on the other hand, even a small act demonstrating an understanding of needs, is usually experienced as protective and allows mothers to persevere through what is already a difficult time of shifting identities and ultimate responsibilities.

Future research could focus on developing compassion-focused interventions that encourage self-compassion but also consider the values mothers hold about putting their babies first. Similarly, bringing partners into interventions and research may help to relieve the responsibility on mothers to be compassionate to everyone and themselves.

Compassion from others, therefore, could be utilised to improve mothers' experiences and support them to focus their compassion on themselves as well as their babies. It is often said that, "it takes a village to raise a child" but society's attempts to do this often just add to standards for mothers. Instead, society could challenge uncompassionate systems and refocus on building connections, offering compassion to mothers with the same strength of value with which mothers support each other. Providing community-led spaces for mothers to connect and find non-judgmental support also seems particularly important.

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Section C – Appendices of supporting material

Appendix 1 – Ethics Approval Letter

Salomons Institute for Applied Psychology

Jodie Allen
Trainee Clinical Psychology
Canterbury Christ Church University

20 May 2019
Direct line 01227 927094
E-mail margie.callanan@canterbury.ac.uk
Our Ref V:\075\Ethics\2018-19

Dear Jodie,

New mothers' experiences of societal narratives around compassion and motherhood.

Outcome: Full Approval

Thank you for addressing the points raised by the Ethics Panel so thoroughly, we are pleased to offer you approval for your proposed study.

We look forward to receiving a short report on progress and outcome on completion of the research, in order to complete our file. The report should be the same one that is provided to your participants. Please note that any changes of substance to the research will need to be notified to us so that we can ensure continued appropriate ethical process.

We wish you well with your study and hope that you enjoy carrying it out.

Yours sincerely,

Professor Margie Callanan
Chair of the Salomons Ethics Panel

Cc Dr L Goodbody

Appendix 2 – Research Advert

Compassion and Motherhood Research

Are you a new mum who would be willing to talk to a researcher about your experiences of compassion and motherhood?

My name is Jodie Allen and I am a Trainee Clinical Psychologist. I am hoping to interview women who have recently become mothers for my doctoral research project.

I am interested in learning more about your experiences of compassion and of being a mum. We will also discuss your ideas about what society says about compassion for mothers.

I am interested in hearing from a wide-range of women from all walks of life, including those with a range of beliefs and perspectives about compassion.

Participants will:

- Have given birth to their first baby between 6-12 months ago
- Be fluent in English
- Be over 18 years old
- Not currently have a severe and enduring mental health diagnosis

You will be eligible to receive travel expenses and be entered into a prize draw to win one of three £25 Mothercare vouchers.

Appendix 3 – Participant Information Sheet

Please read the following information carefully. If you have any questions or concerns, please discuss them with the researcher.

The Researcher and Supervisors

I am the main researcher for this study and my name is Jodie Allen. I am currently doing my doctoral training to become a Clinical Psychologist and this study is part of that training. I am studying at the Salomons Institute for Applied Psychology which is part of Canterbury Christchurch University.

My university supervisor is Dr Louise Goodbody and my external supervisor is Dr Chris Irons. Both supervisors are clinical psychologists and have interests in motherhood and compassion.

Background to this study and why you have been asked to take part

We know that becoming a new mum can be a very exciting and happy time but it can also be stressful and often involves lots of changes in your life. Being compassionate to other people, being compassionate to yourself, and being able to accept compassion from other people, seem to be important for people's wellbeing.

We are interested in finding out more about how new mums experience compassion and whether there is anything that makes this easier or more difficult. We are also interested in new mums' perceptions of what society says about compassion, and whether this influences their beliefs and experiences.

We hope that by understanding this further, we might be able to help more people, particularly new mums, bring more compassion into their lives and improve their wellbeing.

What does taking part in this study involve?

We want to learn about people's different ideas about compassion and motherhood so we will interview you and ask specific questions about what you think compassion means and what you think society and other people say about compassion. We will also discuss your experiences of receiving compassion from others, of compassion towards yourself (self-compassion) and of giving compassion towards other people and towards your baby.

We expect the interviews will take between 1-2 hours. You can have a break whenever you need to, just let the researcher know.

You don't have to answer any questions that you don't want to.

The interviews will be audio-recorded (see below for more information about what we do with the recordings).

What are the potential benefits and risks involved with taking part?

We hope that you may find it helpful to reflect on your experiences of compassion and the interview could be a positive and thoughtful experience for you.

We also hope that the results from this study could guide and improve support that is given to mothers in the future and therefore could make a difference to other people's lives.

We do not expect there to be any serious risks involved with taking part in this study. However, we may discuss potentially upsetting situations or memories of yours if they come to mind during the interview.

If you don't want to discuss a particular topic, please just let the researcher know and they will move on to a different subject. If you become upset during the interview, the researcher will support you and may offer you information on other sources of support if you would like them to (E.g. local wellbeing services).

You will be able to stop the interview whenever you like and you can request to withdraw your data from the study at any point up to the time at which data analysis begins.

Confidentiality and Anonymity

We will ask you to fill in a consent form with your name and signature.

We will ask you to complete a separate form with information about your age, ethnicity etc. but this will be anonymous and will be kept separately from the other form. Your data will be given a code number instead. The recordings will be labelled using your code number.

You will also be asked to choose your own pseudonym that the researcher will use during the write up of the study, if we want to use a specific quote of something you said. If the quote includes information that could identify you to someone else, the identifying information will be omitted for the write-up.

The only time we would break confidentiality would be if we were concerned for your safety, or the safety of another person. If this was the case, we would try to discuss it with you before sharing the information with relevant services.

What will happen to my data and the recording of the interview?

Your written forms will be kept in locked cabinets for 10 years, after which they will be destroyed.

The audio recordings will be transferred to a password protected computer, in a password protected file, within 24 hours of the interview and deleted from the original recording device.

The audio recordings will be transcribed by the researchers, and potentially by a separate transcribing service.

After they have been transcribed, the recordings will be kept for 10 years, and may be used in future research studies by the research team (but only if you give permission for this as well). If they are used in future studies, they may be kept for longer than 10 years in total, as the 10 year time period will start again with the start of the new study.

Do I have to take part?

No, and you are free to leave whenever you like. If you are distressed or upset, please speak to the researcher if you feel able to and they will try to help, before you leave.

What if I change my mind?

If you change your mind during the interview, we will stop the recording and delete it. Your consent form and demographic data sheet will be shredded.

If you change your mind after the interview, up to the point of data analysis, we will also be able to delete the recording and shred your written details.

After the time we begin data analysis, it will unfortunately not be possible to delete it.

Will I be able to read the final research paper?

If you would like to be sent a summary of the findings, please let the researcher know. We also plan to submit the final paper to a peer-reviewed journal to be published.

Do I receive anything for taking part?

We will reimburse your travel expenses up to the value of £10.

You can choose to be entered into a prize draw for a £25 voucher. You can still enter the prize draw, even if you withdraw from the study part-way through.

Next steps

If you would like to participate, please let the researcher know. They will then arrange a convenient time for you to have your interview (which will usually take place at the Salomons Centre, 1 Meadow Road, in central Tunbridge Wells). Before the interview you will be asked to read this information sheet again, and go through a consent form with the researcher before continuing.

Contact Details

If you have any questions or concerns, please do not hesitate to contact the principle researcher:

Jodie Allen (Trainee Clinical Psychologist)
Email: j.allen548@canterbury.ac.uk
Phone: 07999 478 007

If you have a complaint at any time, please contact Jodie Allen (details above) or Salomons Centre for Applied Psychology (Canterbury Christ Church University)
Phone: 0333 011 7101
Contact form: https://www.canterbury.ac.uk/social-and-applied-sciences/salomons-centre-for-applied-psychology/contact-us/contactus.aspx

Appendix 4 - Demographic Sheet

For the purposes of describing the people who have participated in this study, I would like to ask you some general demographic questions. If you would prefer not to answer a certain question, please leave it blank. These categories have mainly been taken from the 2011 UK Census.

Your age:
□ 18-24 □ 25-30 □ 31-35 □ 36-40 □ 41-45 □ 46-50 □ 50+

Age of your baby/babies: _____ months Gender of your baby/babies: _____

Your Ethnicity:
Asian / Asian British:
□ Indian □ Pakistani □ Bangladeshi □ Chinese □ Any other Asian background
Black / African / Caribbean / Black British:
□ African □ Caribbean □ Any other Black / African / Caribbean background
Mixed / Multiple ethnic groups:
□ Mixed White and Black Caribbean □ Mixed White and Black African □ Mixed White and Asian
□ Any other Mixed / Multiple ethnic background, please describe _____
White:
□ English / Welsh / Scottish / Northern Irish / British □ Irish □ Gypsy or Irish Traveller
□ Any other White background, please describe _____
Other ethnic group:
□ Arab □ Any other ethnic group, please describe _____

Your Socio-Economic Status:
If you are on maternity leave, please choose the option that most closely matches your socio-economic status before maternity leave.

□ higher managerial and professional occupations
□ lower managerial, administrative and professional occupations
□ intermediate occupations (clerical, sales, service)
□ small employers and own account workers
□ lower supervisory and technical occupations
□ semi-routine occupations
□ routine occupations
□ never worked or long-term unemployed
□ full-time students

Your education:
Please choose the option that most closely matches the highest level of education you have achieved.
□ GCSE □ AS Level □ A Level □ Diploma
□ Undergraduate Degree □ Masters Degree □ PhD/Doctoral

Your Marital Status:
Please choose the option that most closely matches your marital status.
□ Single (never married) □ Co-habiting □ Married □ Divorced
□ Separated □ Widowed □ Other, please specify _____

Your Sexuality:
□ Heterosexual □ Gay/Lesbian □ Bisexual □ Other, please specify _____
Your Religion:
□ No religion □ Christian □ Muslim □ Hindu □ Sikh □ Jewish
□ Buddhist □ Other, please specify _____

Optional - Please choose two first name options to be used as your pseudonym in the write up of the study if you are quoted directly:

_____ _____

Anonymous Participant Code:

Appendix 5 – Consent Form

Now that you have read the participant information sheet, if you would like to continue and participate in this research study, please sign the consent form below. If you have any questions or concerns, please discuss them with the researcher. Please tick the boxes to indicate you have understood and agree with each section.

Consent for this study

☐ I confirm I have read and fully understood the participant information sheet. I have asked any questions I need to and have received satisfactory answers.

☐ I understand that I can choose to withdraw from the study at any time without giving a reason and that my rights won't be affected.

☐ I understand that I can withdraw my data from the study up until the point that data analysis begins

☐ I understand that my interview will be recorded and the anonymised transcripts may be looked at by the researcher, Jodie Allen, her supervisors and other members of staff at Canterbury Christchurch University.

☐ I understand that my interview recording may be listened to and transcribed by a professional transcribing service.

☐ I understand that the study write-up may include quotations from my interview. I understand the researcher will not use information that could identify me in these quotations and that this write-up may be published in an academic journal.

☐ I understand that I will still receive my travel expenses and can still be entered into the prize draw, even if I choose to withdraw from the study.

☐ I give my consent to participate in this study.

Full Name: _____

Signature: _____ Date: _____

Consent for future studies

☐ I also give my consent for my data to potentially be used in future studies with links to this research team.

Full Name: _____

Signature: _____ Date: _____

Research findings summary

☐ I would like to receive a summary of the research findings and I therefore consent to be contacted at a later date for this purpose

Full Name: _____

Signature: _____ Date: _____

Preferred Contact Details

If you have ticked either of the boxes on this page, please give your email address, phone number and/or written address, whichever way you would prefer to be contacted in future.

Appendix 6 – Interview Schedule

Interview areas: compassion to self, compassion to others, compassion from others, societal ideas about compassion that facilitate and inhibit compassion.
Research questions:
a. In what ways are the three flows of compassion (self to others, others to self and self to self) experienced in new mothers?
b. Are there any wider societal narratives that inhibit the three flows of compassion?
c. Are there any wider societal narratives that facilitate the three flows of compassion?
d. How do participants understand connections between their experiences of the three flows of compassion?

General experiences
What does compassion mean to you?
What have been your experiences of motherhood (both as a mother, and as a child yourself)?
Prompt: can you tell me about your experiences of compassion? How has that/those times affected you? How do you feel about compassion? Compassion to others/compassion from others/compassion to yourself? What was that like?

Society
What do you think society says about compassion?
Prompt: what do you think people in general would say about compassion? What about specifically for mums? Compassion to others/compassion from others/compassion to yourself? How does that idea make you feel?

Linking with your beliefs
Do those ideas from society fit with your own beliefs?
Prompt: how do those messages affect you personally? What impact has that had on you? How do you make sense of that?

Facilitators/inhibitors
Do any of these messages from society make it harder for you to be compassionate to yourself/others/to receive compassion?
Do any of these messages from society make it easier for you to be compassionate to yourself/others/to receive compassion?
Prompt: how? In what ways? Why do you think that is?

Connections
We've spoken about compassion from others, compassion to others and compassion to yourself, do you feel there are any connections between those three things?
Prompt: does how you feel about one affect the others?

Miscellaneous
Is there anything else you wanted to say about these ideas?
Is there anything you think it would be helpful to say that I haven't asked about?

Appendix 7 – Participant Transcript

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Appendix 8 – Emergent themes from all, grouped into subordinate and superordinate themes

Key:

Superordinate Theme

Condensed subordinate theme, exemplary phrase titles

Provisional subordinate themes, using more descriptive titles

Jenny (1) Lara (7) Brigid (3) Chloe (2)

Discussed in the latter four interviews (Anya 4, Talia 5, Faye 6 and Liz 8)

Italics = in more than one theme group

The value of compassion

It's an emotional hug

Examples of what compassion is

Compassion involving being given permission to be human/acceptance of humanity

Was made to feel human during surgery

Compassion involving reminders that it's ok to make mistakes

Compassion involving reminders to not be self critical

Compassion as empathy and kindness

Compassion as having an extra component of understanding people's needs

Wanting to make someone feel cared for

A thoughtful gift as an act of compassion

Wanted to prevent other person feeling bad

Friends making adjustments, understanding their new needs

Compassion as others trying to understand your situation, empathising and then making changes for you.

Giving part of yourself to someone else

Asking how she was was a compassionate act

Supportive space to talk about difficult experiences

Judgement as the opposite to compassion

Compassion is recognising what someone needs

Stepping in to help – an intention, moving towards someone

Compassion being tailored to that individual person, no one size fits all

Practical and emotional examples

Reassurance that she is doing a good job, that her insecurities aren't true

Mum giving support just in her presence

Mum's compassionate act was noticing Chloe's pain

Allowing her space to process that pain and express it

Then gave her reassurance

Again noticing her pain and allowing her space to get it out

Sees compassion as different for everyone

How people give compassion is different

How people want to receive compassion is different

Compassion as understanding the person and their environment

Tough love version of compassion. Less sympathy but telling her she can do it, having faith in her.

Discussed by Anya, Talia, Faye and Liz

Examples of what self compassion is

…lowering expectations

Self compassion as reassurance and praise

Reassurance and praise from staff helped her stop being self critical

Self compassion involves slowing down and taking time, breathing

Self compassion as taking time to herself for hobbies

Being human and making mistakes. Forgives herself.

Self compassion as having balance in life

Some acts of self compassion seem to have other motives, like going to the gym

Personal development as self compassion –

Time for self is self compassionate

Self compassion for her includes taking time off to herself

Discussed by Anya, Talia, Faye and Liz

Link/difference with kindness/love

Helping others

Small acts of kindness feeling compassionate because of a connection between what she needed in that moment

Small platitudes can feel very compassionate if compassion is needed

Love underlies compassion, makes it easier to be compassionate

Compassion and love as underlying always, but sometimes compassion is harder to express

Compassion as a special/particular way of being kind

Difference between politeness and recognising a need and acting upon it

Difficult to distinguish kindness and compassion

Difference between caring and showing compassion is clear in her husband

Discussed by Talia and Liz

Compassion (to others) feels good

Compassion as positive

Emotional hug, containing, connecting,

Calm environment felt more containing

Midwife panicking felt uncontaining

Enjoyment in seeing others be self compassionate
Hearing/seeing compassion can be heart warming
Giving compassion made her feel better as well as the other person
Her compassionate act helped dissolve past negative feelings
Dissolving negative feelings gave space for a more positive view
Compassion cannot be completely pure as you always get some benefit/satisfaction out of it yourself
Inspiration from hearing others be compassionate
Giving compassion feels nice
Feels good to be nice to others
Giving compassion makes her feel like a human being. Connected to others? Good and kind? Warm?
[social media] enables her to question her initial self critical responses to things by seeing other ways of relating
Feels healthy to see people being compassionate to each other
Discussed by Anya, Talia and Liz

Good feelings about receiving compassion
Feels grateful for compassion
Compassion from others makes her feel more positive
Compassion makes her feel included, even when there are differences between people
Feeling warm, losing tension, shoulders relaxing
Compassion feeling like a missing piece of a puzzle. Feeling complete.
Reminds her what it's like to feel good about herself.
Makes her feel good.
Less worn down, more energy?
Compassion from others feels good
Has received a lot of compassion
People swooping in to help
Compassion from others gave her more faith in herself
Then friends helping became a relief
Compassionate acts feeling like a drug. Certainty that she will feel better, relief from stress
Feels lucky to have friends that were so thoughtful, caring and compassionate
Feels amazing to have friends treat her so compassionately
Feels amazing when receiving compassion that you needed, and matched
Discussed by Anya, Talia, Faye and Liz

It was so frustrating and it upset me
Feelings about a lack of compassion to self/others
Lack of compassion is hard to understand
Lack of compassion as unjust
Seeing a lack of compassion causes anger
Far reaching effects of a lack of compassion/understanding, like a domino
Seeing a lack of compassion can feel hurtful
Wanting to help, when someone is experiencing a lack of compassion
Need energy to confront people being uncompassionate
Guilt when not defending others from a lack of compassion
Awareness that anger about lack of compassion, could lead to her being uncompassionate to another person
Midwife's assumptions cut into jenny's insecurities about being a bad mum and so felt more hurtful
Lack of understanding and compassion during one event, changed jenny's ethos on breastfeeding (a key motherhood experience)
Lack of compassion destroyed breastfeeding journey
Anxiety stopped jenny expressing milk properly
Wanting to be careful and compassionate at all times, so needing to not react instinctively
Instinctive reactions not always helpful
Frustrating when people lack compassion or understanding
Making sense of a lack of compassion through priorities
Sadness when reflecting on lack of compassion from others
Lack of compassion/consideration can feel isolating
When accommodations aren't made for baby, she feels unimportant
Feeling ignored as a mother
People intentionally ignoring her
Frustrating and upsetting when people ignore or don't help
Feels degrading to ask for help and be ignored
Easier to remember times of lack of compassion
Lack of compassion when intensity of feeling wasn't acknowledged
Shown care but didn't feel compassionate
Logically feels she was overdramatic as a child but still feels the injustice/dismissal emotionally
Anger at people for judging others
Difference between how people think they act re:compassion and how they actually are
Difficult to see others making uncompassionate choices
Feels angry about a lack of support in the system for others
Brigid believes it's how the person perceives the trauma that is important
Mum dismissing her again
Dismissed by mum again
"she doesn't get it" – doesn't understand the hurt it caused, the feeling of being dismissed
Lack of care and compassion feels heartbreaking
Lack of understanding
Feeling ignored, misunderstood

Dismissal/lack of compassion feels like a tightening in the chest, shaky, tension moving in body
Finds it frustrating not to see compassion or consideration of the struggle
Discussed by Anya, Talia, Faye and Liz

Ad hoc compassion

Compassion with strangers v loved ones. One offs v regular compassion. Expected v unexpected.

Society promotes "special compassion" only at certain times
Easier to offer compassion to those we know than strangers
More opportunities for compassion to people we know, more chances
Harder to give compassion to strangers because it takes more time and thought
Even though she wants to give compassion to strangers more, she doesn't always
Ongoing existence of compassion in her network
Pre-existing relationships and pre-existing compassion provide a framework for offering compassion more easily, less conscious thought needed.
Harder to know what a stranger needs so another barrier to compassion
Worrying about if it's inappropriate to offer help to a stranger again
Ad hoc compassion, special, one off
With strangers have to think more about offering compassion
Harder to judge whether compassion to a stranger will be appreciated
Ease of compassion to loved ones means we should do it more
Not wanting to be annoying or inconvenient by talking to a stranger
Not wanting to offend by making assumptions that someone might need compassion
Societal ideas about what is appropriate to do with strangers
Need to be committed long term to self-compassion to make a difference
Giving to charity seems like not proper compassion because of the distance, impersonal
Giving money not as meaningful as compassion that takes time and thought in person
Donating to charity is easier, packaged
Expectation of compassion from loved ones
Pre-existing relationships seen as giving greater likelihood of compassion
Compassion was expected due to friendship
Very appreciated, even though expected
Difference between being compassionate on a personal level (to friends/family) and to strangers/wider society
Small everyday compassion isn't so noticeable
But sometimes big acts of compassion stand out
Existing relationships make asking for help and receiving compassion easier
Difference in support when no existing relationship
Difference between loved ones, strangers and health professionals
Society is more compassionate when it is tangible
Clear, obvious compassion is more accepted and done
Seems like an underlying regular dose of compassion from husband?
Compassion from obvious people and unexpected people
Motherhood bringing compassion from people she didn't expect it from
Normal world has a mixture of people and levels/expression of compassion
Expected compassion but didn't get it, which felt worse
Expected midwife to be more compassionate and gentle
Easier to accept compassion from loved ones as it's regularly drip fed – Faye
Everyday compassion is easier to forget to do - Talia
Expected/unexpected also discussed by Anya and Liz

Immensity and complexity of compassion

It almost makes the world go round

Compassion as a big thing, far reaching, necessary/infinite/a cycle
Compassion helps people work together and keeps the world moving
Far reaching effects of a lack of compassion/understanding, like a domino
Seeing compassion from others generalises to wider society
Compassion as having a big impact on thoughts, feelings, others
Strong impact that small acts of compassion, or lack of, can have on her
Compassion as infectious, spreads widely
Kindness/compassion as something that keeps things working
Ongoing existence of compassion in her network
Pre-existing relationships and pre-existing compassion provide a framework for offering compassion more easily, less conscious thought needed.
Small gestures that had a big impact
Compassion making the world go round
Compassion making a big impact
Compassion as a moral compass
Bobs along in society – kind of like her mum in the background

"it's there and it exists" – again, in the background but not clear, not obvious
Compassion is all around and common
Compassion moving the world forward, e.g. Charities
Cycle of compassion
Discussed by Talia

Compassion as natural, instinctual

Compassion needing to be fostered, nurtured, to develop and grow
Compassion as natural, instinctual, innate
Discussed by Anya and Liz

Compassion as indescribable/unclear/unsaid

A strong sense of having experienced compassion, without necessarily being able to pinpoint specific examples easily
Difficulty thinking/describing compassion
Difficulty remembering receiving compassion from others
Felt sense rather than specific memory?
Self compassion as hard to describe and understand
Hard to remember specifics from own childhood but has a felt sense
Wants to see compassion as a pure concept, can't have other motives
Compassion cannot be completely pure as you always get some benefit/satisfaction out of it yourself
Hard to think of examples from childhood, maybe tried to block it out
Compassion being able to be expressed without a verbal understanding. Compassion as a commonly understood entity, shared humanity, doesn't need to be described clearly with words?
Not always clear at the time that it is compassion
Compassion as a misty/unclear concept
Not specific or tangible all the time
"nothing more was said" – non-verbal understanding
Hadn't spoken about it, unsaid
Compassion as not a defined concept
Compassion as more than kindness, more complex
"it's there and it exists" – again, in the background but not clear, not obvious
Thinks that when compassionate acts are more complex, they are less accepted by society
Compassion is all around and common
But not simple
Understated, subtle level of compassion from husband
Discussed by Anya

Connections and chances for compassion

Compassion connecting to others
Appreciating others
Appreciating others
Compassion connecting to others, not feeling alone
Relief from connecting with other mums
belonging to groups/tribes as part of human nature, connection
Tribes providing safety, love and compassion
Mum tribe feels like an unrealistic bubble
Everyone in cocoons provides barriers to compassion and connection
Connection and talking as a gateway for compassion
Feels people like to shut themselves off from others (cocoon again) which is a barrier to bonds and compassion
Opportunities and chances for compassion, glimpses
Pre-existing relationships and pre-existing compassion provide a framework for offering compassion more easily, less conscious thought needed.
Talking as a gateway to compassion?
Compassion makes her feel included, even when there are differences between people
Connecting through phone even though far away geographically
"one look from someone else to another" – seems like a connection being made, feel like a compassionate thing
But phone is a big source of social contact
Making connections with people through social media
Social media enabling a sense of connection to other people. Commonality of experiences. Feeling less isolated and less alone by connecting to lots of other people.
Living far away from friends makes compassionate acts harder
So used phone calls and posting things to bridge the gap and still show care and compassion
Giving compassion makes her feel like a human being. Connected to others? Good and kind? Warm?
Discussed by Talia

Links between flows

Link between giving and receiving compassion
Self compassion linked to accepting compassion from others
Being given compassion in the past facilitates giving compassion to another
Reciprocal processes between her and partner
Experience/embodiment of self compassion needed in order to be compassionate to others
Compassion as something that can be passed on
A small amount of self compassion can help people be more compassionate to others
Compassion involving reminders to not be self critical
Feeding off each others compassion in her network

Visualising compassion as circular, interlinked concepts
Quid-pro-quo with compassion, others will be nice to you if you're nice to them, reciprocal
Compassion to and from others are more easily connected than self-compassion
Feels for some people that self compassion is needed to be compassionate to others, but not for her
Refill the tank with self compassion
Differences between people in how the three flows affect each other
After reflections, compassion is more connected than she originally thought
Link between compassion to self and then passing this on to other people
A sense of what worked for herself and then wanting to share this with others
Seeing other people be compassionate can be inspiring to be compassionate to others and to self?
Compassion from others gave her more faith in herself
Cycle of compassion
Using her experiences to think about what others might need
Times when she needed more compassion, she now wants to pass that on to others in the same position
Similar cycle to her friends giving her compassion
Other people being compassionate increasing compassion to others – Anya
Needing to be compassionate to self to give the amount of compassion to others that she wants to give. Giving compassion to others increasing the likelihood they'll give compassion back/to others – Talia
Lack of compassion from society decreased the likelihood she'll feel able to be compassionate to herself – Faye
Needing compassion and help from others so she can give compassion to partner and others - Liz

Small acts, big impacts

Small acts, big impacts
Small acts of kindness feeling compassionate
Small platitudes can feel very compassionate if compassion is needed
Strong impact that small acts of compassion, or lack of, can have on her
A small amount of self compassion can help people be more compassionate to others
Compassion as big or small
Far reaching consequences of supposedly small things in childhood, still affecting her as an adult
"made a huge difference" very important to her, made a difference to her life? Her trajectory?
Far reaching effects of people being unkind.
Small things like spare nappies but this can be really helpful when something's gone wrong.
Small act but a big impact.
Sometimes is compassionate without realising, until after someone has expressed their gratitude
Small act of compassion seems to feel really important to that person, even if the giver of compassion didn't realise at the time
Little gestures/gifts being very thoughtful and compassionate, having a big impact
Small gestures that had a big impact
Small acts of compassion that could have a big impact
"in a couple of seconds" – very quickly the compassion makes the situation feel much better
"a few words" – just something small making a big impact
Discussed by Anya, Talia and Liz

Generalising from one experience to wider experiences
Seeing compassion from others generalises to wider society
Generalising bad experiences to everyone

It takes compassion to get you through

Compassion as necessary, helps to fix, protect and persevere
Lack of self compassion is draining, tiring
Need energy to confront people being uncompassionate
Compassion as necessary for survival
Compassion as vital for keeping people safe and alive
Needing compassion, kindness and communication to get through the difficult times
When exhausted and panicked, needed compassion.
Compassion as protective from danger
Compassion feels like a weight being lifted
Compassion leading to a release of tension
Compassion helps her carry on further when things are hard
Self compassion helps her to persevere through difficult times
Compassion has the ability to keep people persevering through difficulty
Compassion enabling her to keep going on difficult days, when she's feeling near her limit
Needing compassion, kindness and communication to get through the difficult times
Caesarean was lovely despite it being an emergency
Doctors were compassionate and kind when breaking bad news
Compassion from doctors changed the experience into a positive one
Matter of fact but not kind, so was received poorly by jenny

Using compassion improved the situation
Her compassionate act helped dissolve past negative feelings
Dissolving negative feelings gave space for a more positive view
Busy life = harder life = means more need for self-compassion
Self-compassion as a need
Compassion as protective from potential hurt
Perhaps this has come from necessity as has struggled with mental health before
"just necessary for for sanity" has mentioned similar things before. Needs to do certain things for herself in order to stay sane, stay well.
Resulted in a lack of care, lack of compassion for others. Like burn out?
Sometimes really need to be self-compassionate to cope with all the standards and judgements
Gives compassion as doesn't want others to feel bad/be in difficult positions
Compassion helping to cope with difficult aspects of society
Discussed by Talia

Compassion is hard to do

You're just not good enough

Self compassion as more difficult than other forms of compassion
Sees this as common among others
Self compassion is hard
Assumption that she should be more self compassionate
Dismiss own pain and move on
Easier for others to give compassion than be self compassionate
Seeing own struggles with self-compassion in others
Not always able to forgive herself
Easier to be compassionate to others
Easier for others to give compassion than be self compassionate
Compassion being hard/not prioritised in times of difficulty
Not self compassionate often
Self compassion as another "should"
Higher standards than others mean less time to self, less self compassion
Society's movement is evidence that others struggle to be self-compassionate
Time to self is lowest priority
Self compassion as an add-on, less instinctive, less easy
Low self worth makes being self-compassionate harder, feeling undeserving of self-compassion
Need for compassion as hard to recognise
Compassion to others is easier, more natural
Feels that self-compassion is not the default for mothers
Putting compassion to others before self-compassion
Discussed by Anya, Talia, Faye and Liz

Self critical/high standards
Links with self compassion being more difficult
Sense of common experience
Lack of self confidence
Motherhood setting the stage for lots of worries and self-doubt
Sometimes self-critical about mistakes
Self criticism based on things that aren't her fault
Terrifying thoughts that she was killing her baby, ultimate example of being "not good enough"
Very self critical about needing a caesarean
Reassurance and praise from staff helped her stop being self critical
Own insecurities can influence what she thinks others think about her
Own insecurities feeding into ideas about what she thinks others think
Feels default position for her and others is self critical
Midwife's assumptions cut into jenny's insecurities about being a bad mum and so felt more hurtful
Putting pressure on herself, high standards, time pressures to do everything
Awareness that too high standards makes her feel worse
Tries not to overthink her worries
Different standards for herself compared to others who are ill
Has a mental voice that can be negative towards her
Trying to make a conscious effort not to allow the negative mental voice to take over
"make that a constant in my life" – so a sense that if she doesn't make an effort, the negative voice will become constant
Seems to be a strong connection between lack of self compassion and issues around weight/body image?
Cycle of self-criticism when she emotionally eats and puts on weight
Low self worth makes being self-compassionate harder, feeling undeserving of self-compassion
[social media] enables her to question her initial self-critical responses to things by seeing other ways of relating
Being self-critical, thinking she's failing at motherhood
Feels bad for her son to not be compassionate all the time and perfect
Self-critical, blaming herself
Has internalised societal standards/judgements?
Sometimes feels that she doesn't deserve the self-compassion. Self critique takes over.
Discussed by Anya, Talia, Faye and Liz

Weight loss/body image
Kinder to herself with food compared to breastfeeding
Seems to be a strong connection between lack of self compassion and issues around weight/body image?
"because, life" – a sense that weight gain was inevitable with the stresses of life?
"you need to eat to function" – again seems to have come to a decision to focus on what she needs for herself and this is for baby's sake to an extent
Cycle of self-criticism when she emotionally eats and puts on weight
Focus has shifted from losing weight to being healthier for daughter
Worries about appearance
Discussed by Liz

You have to remember to be compassionate

Conscious effort/choice to be compassionate
When finding it difficult to be compassionate, thinks about partner's suffering and needs
Harder to pause and be compassionate when emotions are high
Stopping, pausing, taking a breath
Stopping and being consciously compassionate
Sometimes needing a reminder to not dwell, to move on
Sometimes is able to ignore the shoulds and give herself a break, let it go
Pauses and reflects on her needs
Conscious effort to improve self
Conscious decision to be more compassionate, to show care
Compassion as a conscious process
Compassion as a conscious process feels less natural when others do it on a larger scale
Compassion as a conscious choice
Compassion needing to be thought about to get people to do it
Feels that compassion should be brought in to every day life, implicitly, instead of a conscious thought process every time
Self compassion as an add-on, less instinctive, less easy
Sense of practice makes perfect
Compassion is the harder option
Makes sense of lack of kindness as people prioritising their own needs first above others
Compassion is harder, requires more thought
Consciously remembering to be compassionate when daughter is frustrating her
Conscious decision to be kind to herself and take time for what she needs
"make that a constant in my life" – so a sense that if she doesn't make an effort, the negative voice will become constant
Another conscious effort to be more self-compassionate, less critical, less harsh on herself
So seeing compassion as linked to choice
Needs to think consciously to not judge and then not act on it.
Other people not wanting to put in the effort and prioritise someone else's needs over their own
lack of time – discussed by Liz and Talia

Limit before having to be (self) compassionate/journey towards self compassion
Reaching a limit when she then needs to be self compassionate
Reaching a limit where she's been too self-critical
Reaches a limit where it's too much worrying and has to stop
Seems that in the past she wasn't so aware of the need for self-compassion
Had a really difficult year with [family tragedy]
"found herself" – so less of a conscious decision?
"had to" "the only way" – necessity of self compassion
Self-compassion as the only way to get through something really really hard
Discussed by Talia and Liz

Needing to protect own mental health
Distracts self, focuses on other things to distract from negative thoughts
Practical strategies to help herself
Tries lots of things to prevent her mental health declining
Seems to have worked most of the time by focusing on her needs and preventative strategies
Discussed by Faye

Limited amount of compassion
Limited amount of compassion to give?
Compassion as having limited amounts
People only being willing to help others when their own needs are met.
Compassion as finite again?
Worries about rejecting help in case it's not offered again
Sense of finite amount of help/compassion again?
Compassion as a finite resource, set amount to strangers
Empty tank – limited amounts of compassion
Limited capacity for compassion to others.
When she had her baby, all her compassion allowance was shifted towards baby.
Needing to reduce self-compassion to be able to fill everyone's expectations of compassion to others
Limited amount of compassion

Compassion taking/giving time
Timing – not being self-compassionate is quicker
Some other people are not accepting of difference in pace (linked to timing/rush?)

Lack of time so each moment feels more important
Giving someone time to speak/listening is a compassionate act
Giving space and time
Self compassion involves slowing down and taking time, breathing
Giving someone time to speak/listening is a compassionate act
Stopping, pausing, taking time to be compassionate
Stopping and pausing to remember to give compassion
Pauses and reflects on her needs
Lack of time so each moment feels more important
Putting pressure on herself, high standards, time pressures to do everything
Time for self is self compassionate
Higher standards than others mean less time to self, less self compassion
People pleasing leads to lots of demands on time
Balancing time, not enough time to herself
Compassion as giving time and space
Grandma putting in time, giving time
Listening and time as compassion
Self compassion for her includes taking time off to herself
Conscious decision to be kind to herself and take time for what she needs
Time moving very quickly
Discussed by Talia and Liz

If I accept that compassion, I'm accepting that I'm failing

Not wanting compassion sometimes

Worries about rejecting help in case it's not offered again
If she knows she's the priority she can accept the compassion more easily than if she feels the other person has conflicts
Low self worth makes being self-compassionate harder, feeling undeserving of self-compassion
Even though compassion feels good, still pushes it away sometimes
Feels easier to push compassion away sometimes
Not wanting compassion sometimes due to potential risks from strangers and not wanting to put own needs above someone else's - Liz
Self-criticism getting in the way of wanting to receive compassion – Faye

Independence/powerlessness/control

Having bad/ignored experience for the first time.
Feeling stuck/trapped/dependant for the first time.
Feels degrading to ask for help and be ignored
Difficult to feel reliant on others, powerless
Feeling restricted, trapped, powerless
Powerless to prevent suffering, despite wanting to
"sucked into the routine of life" – seems like a powerless feeling to be sucked in and unable to control where you're going
Wanted independence at first, perhaps worried about critique, different opinions, judgement?
Seems to be empathising with how powerless this might make people feel, when they can't fulfil a basic need because of the barriers/lack of help in the system
Feeling reliant on others for knowledge
Was upset about not having a natural birth
"your body decides for you" – powerless to own body? Not in control of the decision.
Feels independent, in control
Likes to be in control of herself and her career
So made it harder giving birth, being out of control
Used to have everything planned in her day before becoming a mum, feeling organised and in control.
Used to be stronger, more self-reliant – again links into beliefs about compassion meaning you're weaker
Needing more compassion since becoming a mum, feeling less independent – Talia
Lack of choice/control over body in labour – Faye
Wanting to be independent to save other people the trouble - Liz

Compassion and weakness/dependence

Finds it hard to accept help from others, see this as a potential weakness
Doesn't want to show weakness
Accepting help is like showing weakness
Different standards for herself compared to others who are ill
Doesn't like to accept compassion from others
Too much help makes her feel like her independence is being taken away
Doesn't like to be offered help if she doesn't need it
Contrast between feeling inadequate but also wanting their help and support
Eventually realising that her friends helping was not a sign of her weakness
Sometimes accepting compassion feels like admitting she's failing, she's not in control
Would rather she didn't need compassion because that would mean she was doing well?
Accepting compassion feels like accepting a weakness
Pre-motherhood felt very in control of career, competent, skilled, able to manage if things went wrong
Now with motherhood, feels out of her control and less skilled, completely new, so cannot manage on her own if things go wrong
Feels that some people don't want to receive compassion because it's then saying they need compassion.

Strong v. Weak, needing support, needing armour/protection = compassion giver v. Receiver
Thinks other people and groups see receiving compassion as a sign of not being capable, needing armour, dependent on others
People might not want their supposed weakness to be on display
At a group/societal level the supposed weakness is more exposed
Having to accept compassion when she was so weak physically and dependent on others - Liz

Reasons not to be compassionate
Makes sense of lack of kindness as people prioritising their own needs first above others
Risk to safety of connecting with strangers
Risk of offending/bothering someone by offering help
Materialistic nature of society means people focus more on their own financial needs
People only being willing to help others when their own needs are met.
Barrier to compassion is not knowing how to help new mums
Thinks lack of compassion to new mums could be about people not feeling comfortable with babies
Not understanding babies' needs leads to less compassion from others
Harder to give compassion to strangers because it takes more time and thought
Harder to know what a stranger needs so another barrier to compassion
Worrying about if it's inappropriate to offer help to a stranger again
Not wanting to be annoying or inconvenient by talking to a stranger
Not wanting to offend by making assumptions that someone might need compassion
Yoga/mindfulness as fads that people can give up
Things that are too simple seem silly
Sometimes hard to be compassionate when she doesn't understand why daughter is upset
Being beaten down by society in other ways makes people more selfish and less compassionate
Resulted in a lack of care, lack of compassion for others. Like burn out?
Different opinions on who deserves compassion?
When you intersect compassion with different groups of people in society, it becomes more complex, and people might not be so pro-compassion
People using their existing judgements of some groups of people, to deem whether compassion is necessary or not
Compassion seen as interfering
Feels that some people in society think others don't deserve compassion
Feels people think she shouldn't need compassion because she chose to have a baby
Chloe thinks it's harder for men to give compassion to babies before they've got to know them?
Fear of being exploited, self-compassion seen as selfish/self-indulgent – Anya
Compassionate compliments seen as patronising or embarrassing - Faye

Needing to focus on needs

It's like they had this sixth sense

Needing more compassion as a mum
Needs compassion now she is a mother
Got to a point where it's too hard without compassion and support. A limit?
Intensity of the pain in labour meant husband had to offer compassion to a level he'd never had to before
Getting to such a limit where you need compassion? Something about circumstances becoming so difficult that compassion becomes no longer optional
Chloe has needed more compassion since being in labour and having son
Husband having to adapt to chloe's new level of need for compassion
Feeling less independent so needing more compassion – Talia
Need more compassion because it's a difficult time and there are so many shoulds and standards - Faye

Basic needs

Basic needs of food and sleep important for giving (and needing) compassion
Harder to pause and be compassionate when emotions are high
Difficult to be compassionate in times of pain and low energy
When exhausted and panicked, needed compassion.
Basic needs become a big focus
Sometimes the compassion just makes her glad her basic needs are met, no more complex than that
Highlighting her basic needs of sleep again
Needing to prioritise her sleep
"you need to eat to function" – again seems to have come to a decision to focus on what she needs for herself and this is for baby's sake to an extent
Reiterating how important sleep is for her mental health
Mil helped with basic needs – food, drink, cleaning
Mil's help gave them time to think about being new parents
"real moment of need" – needed a lot of support at such a difficult time
But having someone attend to basic needs made everything else go more smoothly

Seeing systems as not fulfilling basic needs, not just being uncompassionate
Seems to be empathising with how powerless this might make people feel, when they can't fulfil a basic need because of the barriers/lack of help in the system
Systems making basic needs very difficult
Too much work and demands feels exhausting, unhealthy.
Needed to have people to ask questions/get reassurance from
Sometimes can think more logically about the stress she's under and her hormones, lack of sleep
Basic needs not being met mean that she can't be as compassionate to baby as she would like
Discussed by Talia and Liz

Need for flexibility

Sister seeming unsympathetic and inflexible
Exclusion of her baby from wedding feeling harsh and inflexible
Compassion being tailored to that individual person, no one size fits all

(others) noticing/understanding needs

Waits for those close to her to notice what she needs and give it to her. Less aware of needs herself.
Partner noticing her needs and helping with the baby
Using each other's strengths to split parenting responsibilities, understanding each other's needs as well as baby's
Emotionally aware
Aware of her needs and steps to take to make herself feel better.
Maternity nurse came and sat without being asked and helped feed and hold baby
Compassion is recognising what someone needs
Having to recognise needs and articulate needs "takes learning" – so perhaps takes experience and time to recognise the need for compassion?
Biological difficulties in understanding needs as well
Age and experience helping to understand self and needs
Needs changing
Not knowing her needs so not able to articulate them
People understanding her needs without her having to say
Particularly as she was finding it hard to articulate her needs at that time
Friends used their experience to know what she needed
People understanding her needs before she knew them herself
Mum was always available, for any of her needs
Her mum recognising something was wrong before chloe did
Her mum thought of her, and understood how she would be feeling in that moment
Husband doesn't identify a need for compassion, opposite of her mum in this way
Midwife not understanding her needs so compassion didn't help – Faye
Mum noticing what she needed and pushing her to take the help - Liz

Asking for help/expressing needs

Different to ask for practical than emotional support
Existing relationships make asking for help and receiving compassion easier
Feels degrading to ask for help and be ignored
Positive, non-judgemental environment, normalising support, enabled her to ask for help when she wouldn't normally
Sometimes even asking for help wasn't enough
Asked mother in law to stay for husband's benefit.
Saw husband was struggling and needed someone else to help as well
Age and experience helping to develop expression of needs more
Barrier to asking for help is fear of judgement
Asking for help is admitting inability to do something
Fear of being seen as not a good enough mother
Worrying about asking about basic things
Needed to have people to ask questions/get reassurance from
Needing someone non-judgemental to ask questions
Not wanting to bother someone by asking for help, not wanting to disrupt others' plans - Talia
Really hard when asked for help but didn't receive it – Faye
Having to ask for help from partner because he hasn't noticed, frustrating - Liz

Understanding and empathy

Compassion is acknowledging hard work
Compassion as feeling understood
Compassion as feeling understood
Compassion is validating
Compassion as validating
Understanding (from self and others) helps self compassion
Match between needs and specific compassion given, results in more memorable experiences
Small acts of kindness feeling compassionate because of a connection between what she needed in that moment
Small platitudes can feel very compassionate if compassion is needed
Some suggestions [from midwives] seemed to not understand jenny's capabilities so were dismissed
Midwife didn't seem to understand jenny's needs, so it felt like there was no compassion

Lack of understanding and compassion during one event, changed jenny's ethos on breastfeeding (a key motherhood experience)
Expected compassion but didn't get it, which felt worse
Compassion as having an extra component of understanding people's needs
Understanding makes her feel welcome with baby
Compassion as others trying to understand your situation, empathising and then making changes for you.
Lack of empathy/understanding towards baby feels the same towards her
Very difficult stage, made worse when people don't understand
Sister seeming unsympathetic and inflexible
Lack of understanding of her and baby's needs
Frustration at not being understood and not understanding other person's thinking
Lack of understanding feeling awkward, uncomfortable
Wanting others to understand and empathise with the struggles
Not understanding babies' needs leads to less compassion from others
Others wanting to help but not understanding what is needed
People forgetting what it's like to be a new parent
Compassion as understanding
"knowing look"- something about understanding what someone else is going through
"how awful it is sometimes" understanding the suffering, shared suffering
Now knows what her mum went through, understanding
Asking how she felt was being seen, being understood
Dismissed by mum again
"she doesn't get it" – doesn't understand the hurt it caused, the feeling of being dismissed
Lack of understanding
Feeling ignored, misunderstood
Grandma didn't always understand but listened
Understanding wasn't necessary to feel her compassion
Sometimes hard to be compassionate when she doesn't understand why daughter is upset
Sometimes understands what daughter is feeling, but is still frustrated
Feeling guilty when wasn't understanding/compassionate enough to keep daughter happy
People in power with privilege not aware of other people's difficulties so it's not thought about in the systems
Other parents understanding what it's like
Understanding what someone might need because they've been through it too
People understanding her needs without her having to say
Needing to have gone through something to fully understand it for someone else
"that kind of look" – non-verbal understanding
Mum as calming, grounding
Compassion as understanding the person and their environment
Couldn't appreciate the need for compassion towards mums until she'd had her own baby
Discussed by Anya, Talia, Faye and Liz

Using own experience as motivation for compassion/understanding others/empathy
Using own negative experience as motivation for compassion
Own struggles helping to empathise with others in a new way e.g. People with disabilities
Discussed by Anya, Talia and Liz

You've got to set your feelings aside
Match/mismatch of needs, conflicting needs
Match between needs and specific compassion given, results in more memorable experiences
Small acts of kindness feeling compassionate because of a connection between what she needed in that moment
Small platitudes can feel very compassionate if compassion is needed
Some suggestions [from midwives] seemed to not understand jenny's capabilities so were dismissed
Midwife didn't seem to understand jenny's needs, so it felt like there was no compassion
Expected compassion but didn't get it, which felt worse
Expected midwife to be more compassionate and gentle
Already found midwife to be dismissive of her needs
Timing of compassion having an impact
Sometimes not compassionate to partner but this is resolved soon after
Happy equilibrium of relationship with partner
Jenny and partner communicating together and understanding their needs, being compassionate to themselves
Compromise, balance, with minor separation allowing for small self-care opportunity
Compromise enables balance between guilt and self-compassion
Friends making adjustments, understanding their new needs
Seems easier for people to not think about others needs
Her and baby's needs are very similar
Concern that others might think she's being purposely awkward with her needs
Lack of understanding of her and baby's needs
Frustration at not being understood and not understanding other person's thinking

Only considering herself now that daughters needs can be met alongside
Missing out in order to put time with baby first
People only being willing to help others when their own needs are met.
Can't always put others first
Dilemma of wanting to help others but not wanting to cause herself extra stress
Weighing up the suffering/inconvenience against wanting to help another
Doesn't like to be offered help if she doesn't need it
Mismatch between needs and what is offered (works both ways)
Putting others' needs/expectations before her own
Baby is a part of her, so making baby happy makes her happy
Her and baby's happiness are intrinsically linked
Invest in baby's happiness for baby's sake and for her own sake
Difference between logical and emotional reaction to different priorities
In order to be self compassionate, need to change the balance of current life
Self compassion as having balance in life
Competing demands
Balance between work, social and time to self
Time to self is often ignored or lowest priority
Conflicting needs, daughter trying to communicate by throwing food, but this conflicts with brigid's needs
Conflict between her needs as a person, family's needs and baby's immediate needs.
Had to make a decision about following a system or being compassionate, getting into trouble, consequences for her
Weighing up whether its worth it or not?
Competing demands as wanting to be compassionate to those she was caring for but needing to be self compassionate as well.
Conflicting needs
Mismatch when someone is trying to be compassionate but it doesn't fit with what she needs, or the compassion she wants
Difficult when there is a mismatch between you giving compassion and the other person not receiving it well
Feels amazing when receiving compassion that you needed, and matched
Baby not giving anything back to parents at first, but still needing compassion
Hard to relate to different ways of mothering and giving compassion if it's not what you do or like
If being given compassion in a way that you don't want, it loses its benefit – Anya as well
Importance of compassion being linked to what is actually needed by the individual
Discussed by Anya, Talia, Liz

Putting others first

Putting others first
Competing needs of hers and others.
Putting others first for a long time
Putting others first is easy
Resenting partner for taking time to himself when she does not
Putting others first as her mum does
Putting others first all the time as saintly, ideal
Can't always put others first
People pleasing leads to lots of demands on time
Putting others' needs/expectations before her own time to self is lowest priority
Struggle to meet people's expectations of how much time to spend with them
She thinks we should always been compassionate
Awareness of needing to meet her own needs, perhaps more than other mums i've spoken to?
Compassion as non-discriminatory, for anyone
Brigid would rather people thought about the greater good, which for her would mean helping others with less privilege
Puts other people's needs (what she thinks they want) above her own by leaving
Putting compassion to others before self-compassion
Needing to reduce self-compassion to be able to fill everyone's expectations of compassion to others
Putting other's needs [to give compassion in their way] before her own need for compassion
People helping when they haven't even been asked – good thing
Chloe's view is that everyone deserves compassion, everyone has a right to compassion
Putting others first at the expense of time/energy for self-compassion – Anya
Only being able to be self-compassionate after sorting everyone else's needs - Talia

Baby coming first

Putting daughter's needs above her own
Sees daughter's enjoyment as more important than her own
Tension between thinking it's good to take time and be self compassionate, and thinking it means not putting baby first so not being a good mum
Own mother putting children first always
Own mother never taking breaks for herself
A sense that being a good mum means putting your children first at all times
Taking a break feels good but also causes guilt, contrasting feelings
Adapting/evolving interests to include daughter
Has adapted what other mums have done
Compromise, balance, with minor separation allowing for small self-care opportunity
Compromise enables balance between guilt and self-compassion

Benefitting consequently from putting baby first
Daughter's happiness gives jenny pleasure and therefore the activity still feels like self-compassion to her
Stops worrying for her baby's sake
Doesn't want to feel stressed in case baby gets stressed
Would like to be less self critical for her and daughter's sake
Her and baby's needs are very similar
Needing to prioritise baby's needs because baby is so small and young
Sometimes not having a choice, prioritising baby is only option
Guilt at being away from baby for her own needs
Wanting to be present for baby always
Always putting baby first
Parenting as something to fully commit to, all the time
Putting baby first is natural and also a conscious decision based on values
Mother equals being there all the time
Happy to put baby first until compares with partner
Missing out in order to put time with baby first
Then when baby comes, others see them as separate and give more attention to baby
When she had her baby, all her compassion allowance was shifted towards baby.
Focusing love and compassion from wider to narrower focus to just baby
Focusing less on partner because he needs her less than baby
Giving baby more care than she does herself
Baby is the main focus of life, routine revolves around her
Life on hold, everything becomes about the baby
Everyone focused on baby when she was born
Only dad asked how she was
Feeling forgotten now that she's a parent
Daughter always coming first
Daughter needs more compassion than other people
Daughter shows her needs more than other people
Focus has shifted from losing weight to being healthier for daughter
Son became priority
Focusing everything on baby
Jokes about being ignored in place of son
Focus is on baby not her
Chloe did what felt right for her, but then was critical towards herself, not self compassionate.
If slight is only against her, then she won't put her needs first
Putting son first more than she would have put herself first.
Now prioritises her son more than she used to prioritise her personal life before
Baby needs more compassion so has to come first – Talia
Baby brings new priorities, has to come first which brings new perspective on looking after self for baby's sake – Faye
Looking after baby all day so can forget to allow room for compassion to self - Liz

Long terms needs outweighing immediate needs
Being cruel to be kind?
Going against compassionate instinct in order to prepare baby for the long term, greater good?
Trying to help and prepare baby, but makes them feel worse in the short term.
Daughter doesn't understand the dilemma as too young
Again conflict between knowing what is best for daughter, but knowing that daughter is upset in the moment and not wanting to cause her pain.
Contrast between as an adult/parent knowing daughter will be ok, knowing this is best for long term, but daughter not understand longer term as living in the moment.
Extreme guilt.
Comes from the conflict? Needing to upset her child for a good reason? No win scenario?
Seems to have worked in the long term. Again, brigid trying to work out what will be best long term for both of them, even if it hurts baby short term.
Again, weighing up pros and cons of different parenting decisions. Thinking about future consequences.
Discussed by Anya

What it means to be a mother

They're an extension of you

Pregnancy/becoming a mum
Always wanted to be a mum
Previously was worrying that she might not be able to be a mum, very difficult feeling
Motherhood beginning at pregnancy
aspirations and beliefs about what motherhood would be like
intuition about body
Previous experiences with dog used as a framework to predict compassion to baby in future
now managing to have a child after the worry, feels very emotional
Motherhood as an indescribable, positive and vast feeling
Motherhood as an indescribable, positive and vast feeling
Felt more compassion when pregnant than when baby came
Using experience of pre-motherhood to make sense of how others see her

Early motherhood needed to block people out, like cocoon again
Felt like pregnancy was a time of optimism, looking forward
Pregnancy as a oneness with baby
Then when baby comes, others see them as separate and give more attention to baby
Felt the early health care experiences set her up with a positive outlook for motherhood
Motherhood as opening a door to new friendships, supportive friendships
Motherhood making her more likely to cry at things, more emotional?
Contrast of being excited and happy but hating pregnancy
Sick, uncomfortable, long labour
Remembering not feeling ready when she gave birth
Biological difficulties in understanding needs as well
"i never knew" – not knowing the experience of being a mum until she was in it
Big changes to self, becoming a different person – sort of moving the goal posts
Need to gain a new understanding of self
No past experience of raising a baby
Feeling reliant on others for knowledge
Although you change as a mother, you're still the same person, may not be compassionate
Motherhood being life changing, has changed her as a person to an extent, but also how she is perceived by others even more so
A sense of not being able to fully understand something from motherhood until experiencing it personally - discussed by Anya, Talia and Liz
Becoming a mum taking over life and identity – Anya
Needing more compassion when becoming a mum and being able to accept it more from pregnancy onwards - Talia

Development as a mum
Feeling more confident as time went on.
Learning about baby as time went on.
Time of lots of changes over and over again
Changing as a person
Needs changing
Perspective from no longer being in that stressful time
Can look back and see it with some distance, not so bad
Has developed her understanding of her sons needs as he has grown, and needs become less intense
Has taken many months for her to feel like she is functioning normally again
Not knowing/learning curve/learning about baby - discussed by Anya, Faye and Liz

Identity linked with baby/motherhood
People embracing and welcoming baby feels good to lara
Baby as an extension of her own self
Lack of empathy/understanding towards baby feels the same towards her
Her and baby's needs are very similar
Exclusion of baby feeling personal to her
When accommodations aren't made for baby, she feels unimportant
When baby is unwelcome she feels unwelcome
Pregnancy as a oneness with baby
Feels that others now see her solely as a mum
Whole identity has become "mother" in other's eyes
Loves being a mother but doesn't like people seeing it as her whole identity
Mentally hard work to work out who you are as a new person – identity
Becoming a mother meaning you become a mother figure to all of society. Identity becomes "mother".
Embodying motherhood for everyone else, not just own baby.
Motherhood role spreads out to all children, not just her own
Only feels like she is given the mother role if her son is with her, as she is visibly a mother
Time to reconnect with her old identity, feeling like an adult
Losing identity - discussed by Anya
Things going well with baby become positive aspects of own motherhood identity - Faye

Narratives of motherhood
Narrative of mothers being instinctive, knowing things naturally
Worry that if you don't know the instinctive things then are you not a proper mother?
Again natural thing of being a mum. If something hasn't come naturally, feel a failure as a mum.
Expectation/narrative that birth is meant to be beautiful but in contrast in real life it's not at all
Assumptions of mothers
Feels there is a narrative in society that mothers are very compassionate
Maternal instinct = lots of compassion all the time
Expectation of society that mothers are soft, compassionate, extra compassion
The opposite happened for chloe where she became less warm/compassionate than her normal self [momentarily]
[anger at baby] seems to feel worse because of the added expectation that she should be compassionate and soothing all the time
Compares herself to mothers who do seem to fit society's expectations

Sometimes the narrative about mothers being compassionate is aspirational, something to aim for, keep trying to attain. Encourages compassion.
Views of society might cloud thinking about self as compassionate, even if logically it shouldn't
Societal narratives cause people to strive to be more like the ideal
Everyone perpetuating the idea that new motherhood is amazing and perfect
Feels that even more experienced mums who know the truth, still perpetuate the narrative of perfection
Thinks she will keep the narrative going later as well
Remembering stress differently in hindsight
"sometimes we do need it" – needing an aspiration, a sense that it can be perfect, work towards it
Societal expectation of mothers to be selfless, always compassionate to others
Mothers seen as safe people, helpful people, compassionate people, approachable
Not being true to herself and her beliefs because of the clash with the motherhood narrative
Expectations of her as a mother change how she acts around others
Difference between her view and story of motherhood, and that view that is expected and perpetuated through society
A sense that being a good mum means putting your children first at all times
Feeling like mothers are seen as objects and now belong to society, are therefore more open to judgement by society- discussed by Anya and Faye
Mothers should be doing everything well anyway, so it's only when things go bad that people notice, no praise for being a good mum, mothers should just get on with it – Faye
Mothers acting like mothers to other children - Liz

Biological understanding

Thinks women more naturally know how to be compassionate to a baby's needs, men need to learn more consciously
Is this one of society's narratives that she has taken on board?
Easier for women and makes sense of this with biology
Linking biological part of pregnancy to compassion
Biological difficulties in understanding needs as well
Biological aspects making it even more stressful
Hormones and time of year used to understand intensity of negative feelings soon after birth - Anya

Breastfeeding

Breastfeeding in relation to other people's opinions
Sense of shame re: self and breastfeeding
"breast is best" – anything else is not good enough
Feeding and nutrition (as a source of pressure?)
Breastfeeding as a frame of reference for compassion and motherhood
Feeding and nutrition as a frame of reference for societal narratives and own standards of motherhood
Lack of understanding and compassion during one event, changed jenny's ethos on breastfeeding (a key motherhood experience)
Lack of compassion destroyed breastfeeding journey
Panicking about starving her baby, has stuck with her and is a strong motivator for her decisions about breastfeeding
"breast is best" so anything else is inadequate and will be judged
Worries about other people judging
Worrying about other judgements of her feeding choices
Exhaustion of breastfeeding
Breastfeeding as constant and tiring
Again, feeding as a framework for compassion
Didn't breastfeed so assumed she would be judged a lot for that
Link between breastfeeding and perception of compassion
Bottle feeding seen as less compassionate
All information says you should breast feed so if you don't, feels like you're not doing right by your baby
Friend also didn't like breastfeeding but continued because of pressure from society – chloe sees this as not self-compassionate
Friend tolerated a loss of individual identity, pain, lack of time, because of the pressure to breastfeed. Not compassionate to herself.
Felt guilty, criminal for not breast feeding.
Discussed by Anya, Talia, Faye and Liz

Not feeling ready to separate from baby for very long

Not feeling ready to separate from baby for very long
Acceptance of not being ready. Security in knowing it will happen eventually.
All mums navigating motherhood in different ways and at different paces
Not ready to leave baby yet, even though other mums are
Accepting of herself, other mums and these differences
Discussed by Liz

Going back to work

Feels less jealous of partner now she is working
Work has been supportive and flexible
Generally workplaces feel not supportive for new mums, not flexible, feels not compassionate
Linking compassionate workplaces to gender

Leaving at nursery so she can work - which in turn seems to be something that is good for her well being.
"i'd go mad"
Context of work is different to other parts of life
If people are unkind has to move on more than she would be people in other settings?
Pre-motherhood felt very in control of career, competent, skilled, able to manage if things went wrong
Has worked hard in her career but it's different since having baby and returning
Going back to work provides her with time to herself
Time to reconnect with her old identity, feeling like an adult
Career is different
Priorities with work are now different
Now prioritises her son more than she used to prioritise her personal life before
High hopes for returning to work and being perfectly organised and boundaried - Faye

It's so rewarding, so challenging

Contrasting feelings in motherhood

Motherhood and intense feelings, contrasting feelings
Taking a break feels good but also causes guilt, contrasting feelings
Motherhood as perfect but also difficult
Sometimes feels neurotic but mostly has had a happy experience of motherhood
Discussed by Faye and Liz

Motherhood as hard work, stressful

Motherhood setting the stage for lots of worries and self-doubt
motherhood as tiring and hard
New motherhood being an unrealistic situation in a negative way. Unrealistically emotional.
Early days of motherhood being the most hard
Intense emotions that have come with early parenthood
Feels like society doesn't understand the difficulties of motherhood, practical and/or emotional
Shoulds and standards from all health professionals at start of motherhood
Shoulds and standards feeling like pressure
Has gone through a lot of difficulty and time to express, but others won't see this and will judge
Expectation that parenting should be hard and that she should get on with it, doesn't require compassion?
Sense that she shouldn't be uptight because things have gone very well in general
Very difficult stage, made worse when people don't understand
Learning process of the struggles that come with having a baby
Simple things becoming pressured
Exhaustion of breastfeeding
Breastfeeding as constant and tiring
Difficult event was so horrible it would put others off having children
Difficulty when she is responsible for baby but Cannot help her
Powerless to prevent suffering, despite wanting to
"how awful it is sometimes" understanding the suffering, shared suffering
Motherhood is very hard work
Contrast between loving baby and not wanting the hard work
Very tiring, tearful
Lots of potential worrying long term consequences
Biological aspects making it even more stressful
Lots of worries about baby's safety
Husband was very worried
Sounds confusing, not sure what was happening at the time
Lots of ups and downs in the birthing process
"you've got to keep them alive" - stakes are higher than anything else before
A time where she really needed support
Feeling heavy, intense to be just her and baby
Difficult to get out of the house with a baby
Difficult thoughts in head
Hard work practically to get baby outside
Mentally hard work to work out who you are as a new person – identity
Minimising difficulties
Concern that if she complains she will look like she doesn't love baby enough
Has taken many months for her to feel like she is functioning normally again
Not knowing how to soothe baby
Remembering stress differently in hindsight
Discussed by Anya, Talia, Faye and Liz

Guilt

Guilt when not defending others from a lack of compassion
Taking a break feels good but also causes guilt, contrasting feelings
Compromise enables balance between guilt and self-compassion
Guilt at being away from baby for her own needs
Guilt of being away brings her back
Extreme guilt. Comes from the conflict? Needing to upset her child for a good reason? No win scenario?
Guilt from not understanding daughters needs and not making her feel better
Seems to be blaming herself for her difficult birth and subsequent health problems
[anger at baby] seems to feel worse because of the added expectation that she should be compassionate and soothing all the time

Feels guilty for not being as compassionate as society thinks she should be
Feels bad for her son to not be compassionate all the time and perfect
Made chloe feel guilty for not being able to empathise/be compassionate with her baby
Difficult when baby gets compassion from someone else and she couldn't do the same in that moment
Chloe did what felt right for her, but then was critical towards herself, not self compassionate.
Felt guilty, criminal for not breast feeding.
Realising she hadn't given her friends the same compassion they were now giving to her – context for later where she says she wants to pass on the compassion?
Guilt for not being able to breastfeed properly at the start - Anya

You grow an extra heart

Endless/huge/intense compassion/love for baby/blasting towards baby

Unbreakable love for baby
Endless love for baby, secure and unbreakable
Couldn't fathom the feeling of love before having her baby
Certainty of love and compassion for baby
Motherhood as an indescribable, positive and vast feeling
Blasting baby with strong compassion
Capacity for loving other grew when she had baby
Focusing love and compassion from wider to narrower focus to just baby
Motherhood as generally positive experience
Feeling lucky to have daughter
Motherhood as rewarding
Baby is interesting, fascinating, engaging
Being in awe of baby
Focusing everything on baby
Doing everything to make baby happy comes very naturally – Anya
Baby as wonderful - discussed by Talia and Faye
Unconditional love like no other - Liz

The new mum tribe, it's a bit of a bubble

New motherhood/social bubble

New motherhood as a bubble, protective, caring, unrealistic, different to the rest of the world
Mum tribe feels like an unrealistic bubble world isn't as nice and protective as their current bubble, so needs to prepare her daughter for this
Overall positive experiences of motherhood
Belonging to groups/tribes as part of human nature, connection
Tribes providing safety, love and compassion
Mum tribe feels like an unrealistic bubble
Lots of compassion since becoming a mum
Pockets of compassion
Safe, positive, loving places, small and separate from wider society.
Protective spaces from negativity of society
Social bubble of similar views, values, personalities
Birthing centre as a positive, community, family, togetherness
Family connectedness of centre made her feel connected too
Positive, non-judgemental environment, normalising support, enabled her to ask for help when she wouldn't normally
Motherhood as opening a door to new friendships, supportive friendships
Shared experience of being a new mum
Similar to other's ideas about pockets of compassion/bubbles
Some supportive places and people, but situated within a wider context of non-supportive society
Daunting to go back out into that society as a new mum
Scary to go back into society
Wanting to stay in bubble, safe, protected
Building friends with other mums since becoming a mum
Society is hard to navigate for mums
She used her back up of compassionate support network to help her face society.
Feels that mums who don't have a compassionate network are having to face society on their own.
Feels like her husband has created an entity of unity and compassion for her, a compassionate space
Linking with other mums to understand more and get closer - Anya

Cocoons and barriers/isolation/feeling different

Compassion and understanding makes her feel less isolated
Lack of compassion/consideration can feel isolating
Compassion makes her feel included, even when there are differences between people
Feeling alone and isolated at times
Feeling restricted, trapped, powerless
Cocoon – feeling the need to stay separated off from others to protect self
Everyone in cocoons provides barriers to compassion and connection
Missed opportunities for compassion by having barriers up
Early motherhood needed to block people out, like cocoon again
Feels people like to shut themselves off from others (cocoon again) which is a barrier to bonds and compassion
Feeling alone, feeling isolated
Now isolated from other adults
More time on her own

When people look it can make her feel that they are unwelcome.
Feeling different, standing out.
Living far away from friends makes compassionate acts harder
Distance from closest friends is very hard sometimes
Feelings of isolation when partner went back to work
Feeling heavy, intense to be just her and baby
People coming in is a relief, breaks up the intensity
Most of the time don't feel the same normalising connection with others, feel like a minority
Even though there are lots of other babies/parents, feeling isolated
Not wanting to invade another mum's world
Not wanting to bother people
Usually sociable but in early days of baby was more careful
Normally social so becoming isolated and self conscious was a big contrast
Something about becoming a mum meant she felt very different socially
Worried about judgement? Feeling different?
Staying at home to feel more comfortable e.g. with breastfeeding, being a hermit – Anya
World feeling fragile and needing protection by staying away from others – Faye
Feeling very lonely and isolated as a new mum, only baby around to talk to - Liz

Needing other adults
Another person feeling like a back up. Another adult to help. Reassurance.
Another person to help make sense of things and rationalise.
Needing adult contact, adult conversation
Reminding her of her previous self before she had her baby
Discussed by Liz

Friends/people swooping in to help/support network
People swooping in to help
Then friends helping became a relief
Feels lucky to have friends that were so thoughtful, caring and compassionate
Feels amazing to have friends treat her so compassionately
Friends swooping in
People swooping in to help
Feels lucky to have compassionate friends and family
Feels sorry for mums that don't have a compassionate support network around them
Loving family seen as being lucky

Growing a human being

They become like this flower that blossoms

Helping baby develop and grow
Wanting daughter to grow and develop as a key motivator
Daughter's enjoyment and development are linked
Wanting to help baby learn
Wants to help daughter learn/develop, that includes managing difficult emotions
World isn't as nice and protective as their current bubble, so needs to prepare her daughter for this
Compassion needing to be fostered, nurtured, to develop and grow
Compassion being modelled by her own parents
Would like to be less self critical for her and daughter's sake
Baby is interesting, fascinating, engaging
Baby immersed in new things, learning, experiencing the world
Noticing the baby so noticing the world through her baby's eyes
Seeing baby learn is rewarding for her as a mother
Baby's development is fast and surprising sometimes
Awareness of baby as a small version of an adult, developing/growing
Fast development, growing independence
Consciously tries to help baby learn and develop
Rewarding when work towards development pays off
Awareness of baby as a small version of an adult, developing/growing
Feels like a human instinct to notice and feel proud of baby's development
Linking compassion to baby's development
Helping baby develop into a grown human being
Passing compassion onto baby so she will grow to give compassion to others. Circular nature of compassion.
Purposely helping baby grow and blossom
Son has grown into more of a human
Wanting to help baby grow into a compassionate being – Liz
Wanting to help other young people develop into good compassionate adults - Talia
Discussed by Anya and Faye

If you make the wrong choice your child's going to end up in prison

Worried about doing something wrong for baby/not being good enough
Seems to be an underlying worry for her about traumatising baby, perhaps more so because of her own trauma history
Doubts herself daily
Worries about being a bad parent
Dilemma between needing knowledge but not wanting to look like a bad mum

Perhaps her insecurity is that she isn't a good enough mother
Made to feel unworthy by society and like child will grow up into something bad - Faye

You're turning into like a proper human

New awareness of what it is to be human
Becoming more aware of unique human traits through seeing them in her baby
Feels like a human instinct to notice and feel proud of baby's development
Giving compassion makes her feel like a human being. Connected to others? Good and kind? Warm?

It can be kind of character building

Concerns about too much compassion
A sense that too much compassion is coddling, over protective
A sense that sometimes a lack of compassion is needed to help child develop (realistic? Not coddling?)
Needing experiences without compassion to gain awareness that pain will pass
Too much care/worry felt exhausting
Too much compassion means people won't help themselves - Anya

Relating to other parents and partner

You appreciate your mum a bit more, you realise what they went through

Parenting/influence of own parents
Compassion being modelled by her own parents
Similarities between how her mum offers compassion and how she is self-compassionate
Own mother putting children first always
Own mother never taking breaks for herself
A sense that being a good mum means putting your children first at all times
Taking a break feels good but also causes guilt, contrasting feelings
Modelling herself on her own mother
Only becoming aware of ideas of motherhood since becoming a mother
Distinction between how she sees her mum as a mum and as a person
Putting others first as her mum does
Making sense of her own childhood through seeing how her mum is as a grandmother
Comparing her parenting style to her parents'
Understanding her parent's perspectives since becoming a mum
Sees extremes of parenting as a barrier to good relationship with child
Extremes of parenting creating distance, alienating
Consciously deciding on what type of parent she wants to be
Wanting to be balanced in parenting
Perspective that comes from being older on teenage years
Becoming a mother changing relationship with mum
Strained relationship until baby came
Appreciates mum more now
Now knows what her mum went through, understanding
Different attitudes towards parenting than own parents
Questioning how she was brought up
Talking about parenting styles is very personal
Thinking and talking about mum's parenting was painful
Wanting to raise baby differently to how she was raised
Seeing mum less means cherishing her more
Lots of respect for her mum and her mum's parenting
Pregnancy reconnected her and her mum
Shared experience of being a mum with her own mum
Connection of being pregnant
Looking to her mum for lots of support and guidance
Wanting to repeat what her mum did?
Her mum didn't give too much advice, not overwhelming
Her mum facilitated chloe feeling supported so she could work things out on her own
The extra layer of relationship with her mum compared to friends, no matter what is needed
Mum always present in the background
"that kind of look" – non-verbal understanding
Mum as calming, grounding
Mum knows her so well that her faith in her is even more reassuring
Her mum recognising something was wrong before chloe did
Mum's compassionate act was noticing chloe's pain
Allowing her space to process that pain and express it
Then gave her reassurance
"nothing more was said" – non-verbal understanding
Again noticing her pain and allowing her space to get it out
Becoming closer with own mum because of shared understanding – Anya
Comparing own dad's parenting to younger siblings to her own parenting from him - Faye

Mothers/grandmothers as embodiments of compassion
Grandma was such a strong influence in her life, such a strong embodiment of compassion that no one else can make her feel quite the same way
Own mother putting children first always
Own mother never taking breaks for herself

A sense that being a good mum means putting your children first at all times

Having a baby is its own experience

Other parents understanding

Shared understanding with other mums

Lack of judgement from other new mums

Connection over common experiences

Some other people are accepting

People forgetting what it's like to be a new parent

Her and sister have also reconnected over parenting. Like she has with her mother.

Something about becoming a parent being universal, connecting over shared experience that isn't like any other?

Sharing experience of being awake at the same time, feeling connected to someone even at a lonely time

Other parents being compassionate

Other parents understanding what it's like

"one look from someone else to another" – seems like a connection being made, feel like a compassionate thing

Understanding what someone might need because they've been through it too

Shared experience of being a new mum

Friends sharing their experiences was reassuring

Friends used their experience to know what she needed

People understanding her needs before she knew them herself

Needing to have gone through something to fully understand it for someone else

"that kind of look" – non-verbal understanding

Mum as calming, grounding

Difference between how parents and non-parents treat mothers

Other parents understand and give compassion

Non-parents don't understand and don't give compassion

Feels that non-parents in general don't understand why a mum would need compassion

Using her experience from before becoming a mum to understand how non-parents might feel towards mums

Couldn't appreciate the need for compassion towards mums until she'd had her own baby

Helping distract baby or normalising the crying

Other people relating, normalising, understanding how she was feeling

Parenthood as its own experience, that others cannot understand – Anya

Other parents being more compassionate because they understand the struggle – Talia

Needing connection with other parents to stay emotionally well. Showing more compassion to other mums now she understands - Liz

Oh here they are, the proper mums

Comparisons with others

Contrast with what partner does with time

Comparison to others makes her feel more annoyed at lack of time to self

Comparing to partner

Instinct is to judge partner for taking time to himself

Makes sense of difference with partner by thinking in terms of priorities/values?

Feels less jealous of partner now she is working

Resenting partner for taking time to himself when she does not

Comparing life to others'

Her life seems less exciting compared to others

Lots of expectations by comparing self to others

Seems that when she thinks logically she knows it's unrealistic but perhaps her instinct is to compare and feel inadequate? Her critical mind?

Comparing herself to others

Feeling inadequate compared to experienced mums

Compares herself to mothers who do seem to fit society's expectations

[when frustrated at son] other mums were thinking with more compassionate explanations

In that moment, feels like more compassionate mothers could be better mothers than her

Felt like she couldn't meet baby's needs as well as other mums could

Other mums modelling

Other mums modelling self compassion

People using inspirational quotes about loving self/self compassion

Peers encourage to be self-compassionate more than society

Others modelling self compassion is more motivating

Seeing other mothers as compassionate can be a learning opportunity, a different way of looking at the situation in future.

Not seeing self compassion from own mum so not seeing it modelled - Faye

Differences between mums and their values

Awareness of differences with other mums (e.g. Independence and self compassion)

Sees decisions as based in values and experiences of other mums

Has been partly influenced by other mums but not fully

All mums navigating motherhood in different ways and at different paces

Not ready to leave baby yet, even though other mums are

Accepting of herself, other mums and these differences

Feeling grouped in with other mums, treated the same

Surrounds herself with friends who have similar beliefs

Fear of having clashing views
Feeling different from everyone else, different views
Feels society groups mothers, splits into groups
When meeting other mums, have baby in common, but otherwise from completely different walks of life and this was quite daunting for her
Noticing differences in mothering between different ages, different friends
Hard to relate to different ways of mothering and giving compassion if it's not what you do or like
Difference between her and a close friend in their ways of giving and receiving compassion
Mums having different experiences of motherhood that enable them to share some experiences with others but not all – Anya
Different ideas about what is best for baby, can result in judgement - Faye

He was here, he was great

Partner/partnership/dads

Using each other's strengths to split parenting responsibilities, understanding each other's needs as well as baby's
Taking it in turns (roughly) to take responsibility at difficult times, step in and help the other person
Never been a burden – sharing the load, enabling both to carrying on
Partner noticing her needs and helping with the baby
Happy equilibrium of relationship with partner
Jenny and partner communicating together and understanding their needs, being compassionate to themselves
Reciprocal processes between her and partner
Past experiences with partner can cloud ability to be compassionate
Sees husband as a parenting partner
He wants to parent as much as she does. Similar effort put into parenting. Similar values?
Asked mother in law to stay for husband's benefit. Saw husband was struggling and needed someone else to help as well
Husband doesn't identify a need for compassion, opposite of her mum in this way
Feels that society is less compassionate to dads
Less resources for dads
Less acknowledgement of dads
Dads in a similar position to mums
Both parents learning at the same time
Both parents needing compassion from others and compassion to themselves
Feels her husband has had to learn how to give compassion to a baby
Has seen her husband grow in his ability to give compassion
Husband learning to give compassion to baby and to her
Understated, subtle level of compassion from husband
Seems like an underlying regular dose of compassion from husband?
Working in partnership becomes compassionate for her when she's struggling
Intensity of the pain in labour meant husband had to offer compassion to a level he'd never had to before
Seems to see [giving extra compassion to new mum] as hard work for dads which isn't often acknowledged
"especially as a mother" – highlight that gender makes this even more stark?
Feels especially grateful that he puts in equal effort because it wasn't planned
A sense that as a man this might not have happened?
Partner giving small breaks – Talia
Partner giving compassion when she doesn't feel worthy – Faye
Partner contributing but not equally – Liz

Venturing into a harsh society

They *say* that it's a good thing in principle but…

What society says vs. What it's actually like – contradictions
Feels like society doesn't understand the difficulties of motherhood, practical and/or emotional
High standards/pressure from society for mums e.g. With work, weight
Media as a framework for spreading uncompassionate ideas/narratives
Locations set up difficultly for mothers
Feeling ignored as a mother
People intentionally ignoring her
Sometimes even asking for help wasn't enough
Societal idea that compassion is good
Contrast with what society says and what people actually do
Making sense of a lack of compassion through priorities
Lack of compassion in our culture feeling fixed
Society as having a negative entity that feeds into people, uncontrollably
Contrast between people acknowledging the struggle but not then helping
People liking the idea of compassion but not necessarily doing it
Recent movement in society of encouraging self-compassion
Society's movement is evidence that others struggle to be self-compassionate
Society says we should always be compassionate
Doesn't feel that society is always compassionate.
Society promotes "special compassion" only at certain times
Society values charities and promotes giving, more than promoting everyday kindness to loved ones

Less emphasis in society on everyday functional kindness
Hard to make sense of people voting in a non-compassionate way as she generally thinks people want to be compassionate
Sees a looks based society as in contrast to a compassionate one
Attractiveness is more valued in society than compassion
People in society value exciting things
Self-compassion is not exciting
Self-compassion as a need
Needs are not exciting
Doesn't feel like society is very compassionate in general
Individuals acting compassionately but not as a collective
Understands this by seeing people as in denial about suffering of others
Thinks people don't know or don't care about other people
"they're just not kind" – so sees the public in general as unkind
Society in general not seen as compassionate
Understands the lack of compassion in society as a sign of privilege of the people who have more power over the systems
People in power with privilege not aware of other people's difficulties so it's not thought about in the systems
Society is more compassionate when it is tangible
Clear, obvious compassion is more accepted and done
Thinks people prefer it when compassion is clear and easy to understand
Thinks that when compassionate acts are more complex, they are less accepted by society
Different opinions on who deserves compassion?
When you intersect compassion with different groups of people in society, it becomes more complex, and people might not be so pro-compassion
Feels that generally society thinks compassion is important
Compassion not always viewed as good depending on who it's for
Compassion at a high level (general level?) Seen as a good thing but not always on a more distinct level.
Makes sense of this discrepancy as it's because of different groups of people, different pots, different settings?
Feels that society wants to be compassionate to mums
Sometimes how compassion is executed/given is not as good as the intention
Feels that society is less compassionate to dads
Less resources for dads
Less acknowledgement of dads
Feels that society in general doesn't show compassion to anyone, not just mothers
Daunting to go back out into that society as a new mum
Scary to go back into society
Views of society might cloud thinking about self as compassionate, even if logically it shouldn't
Feels that mothers suffer at the expense of judgements from other people and society
Society is hard to navigate for mums
Difference between her view and story of motherhood, and that view that is expected and perpetuated through society
Hadn't previously thought about impact of society
Feels society is compassionate and promotes compassion for mums – Anya
Society showing compassion when big events have occurred – Talia
Society says mum's should be self-compassionate but then gives them impossible standards to live up to. Society wanting to protect mums but then judging if they do something wrong. Doesn't feel society promotes compassion to mums very much. Society saying mums should reach out for support but then judges for their shortcomings – Faye
Society says people should be kind and we teach our children to be kind but then people aren't. Should breastfeed for baby's own good, but then its taboo. Should be a perfect mother but then conflicting advice. - Liz

Feeling judged/judgmental

Judgement from more experienced parents occasionally
Some other people are not accepting of difference in pace (linked to timing/rush?)
Generational attitudes influencing compassion
Mobile phone eliciting judgement from other people
People looking and judging
Fear of being judged stops her using her phone
Not as worried about being judged for things her daughter might do as she is for things she is doing.
People looking, she perceives this as judging her for what is happening in that moment
Judges other people herself without consciously wanting to.
Tries to reason with herself not to judge others. But it is her initial reaction.
Makes sense of this as to do with her upbringing, has been conditioned by different things to judge others.
Needs to think consciously to not judge and then not act on it.
Accepting of her judgements of others as long as they are not expressed.
Dilemma between needing knowledge but not wanting to look like a bad mum
Ticking boxes, evaluating
Seems like she sees the box ticking as arbitrary

Wanting confirmation that she is good enough
worry that admitting there's an issue will mean they won't approve her
Wanting information but not always asking because of fear of judgement.
Feels that people are also judged for giving compassion, if the person doesn't feel the compassion is warranted
People's opinions on what mothers do, opinions can then feel like judgements?
Feels that people have opinions on general topics of mothering, instead of seeing the person as an individual and offering compassion
Worried about bothering people that don't like children
More aware/worrying about what others think of her/baby
Feels that mothers suffer at the expense of judgements from other people and society
Sometimes really need to be self-compassionate to cope with all the standards and judgements
Feeling like mothers are seen as objects and now belong to society, are therefore more open to judgement by society- discussed by Anya and Faye
Makes sense of judgement as people having knowledge and wanting what's best for baby. – Anya
Assuming she'd be judged for wanting drugs in labour. Feeling judged/attacked for parenting choices – Faye

Compassion as a lack of judgement

Compassion is a lack of judgement
Compassion involving reminders to not be self critical
Compassion involving reminders that it's ok to make mistakes
Unconditional love and lack of judgement from own mother – Anya
Trying to hide judgements of others so not hurtful - Faye

Shoulds and standards

Shoulds and standards from all health professionals at start of motherhood
"breast is best" so anything else is inadequate and will be judged
Possibility of judgement from society makes her worry and feel inadequate, even though she is doing what's "best"
Worrying about other people's assumptions and judgements
A sense that appearing to take the easy option is wrong
Doesn't feel like society acknowledges the struggle it can be
Information given feels overwhelming, even if kind and helpful
More shoulds, too many to be able to do
Would like less pressure/standards
Underlying value that she should be compassionate all/most of the time
Self compassion as another "should"
Lots of shoulds and obligations
Competing demands
"should be common sense"
Very high expectations for being a mum
Seems like a high expectation of mothers again
Lots of information, too much to be able to meet expectations – Anya
Shoulds about working and contributing to society can get in the way of compassion. Expectations of self – Talia
Self-compassion as another should. Too many shoulds. As a mother being open to critique and shoulds from society – Faye
Should breastfeed, pressure, but taboo - Liz

Worrying about what others think/judgement

Crying seen as a problem/potential reason for exclusion
Talking about ones own acts of compassion can look smug
People in society value exciting things
Friends being a contrast to health professionals where their judgement could have consequences
Worrying about baby crying
Worrying about bothering other people
Embarrassed – worrying what others think of you and how you're handling your baby
Worried about judgement? Feeling different?
Didn't breastfeed so assumed she would be judged a lot for that
Lied to people to avoid judgement.
Worried about being judged for breastfeeding, daunting – Anya, Talia
Worried about being judged for child making noise - Talia

Deception to protect self

Sees it as having to lie about who she is
Lying is exhausting
Pressure of having to lie whilst also having the stress of keeping baby alive
Acts differently according to how she thinks people are perceiving her
Feels more whole when acting in a way that is true to herself
Feels better when not acting like how a mother should act just because of expectations
Seeming like things are fine when they're not – mentioned by Anya and Liz

Maybe when I get rich then I will start to help others.

Capitalism/individualism/politics

Linking capitalism to priorities to compassion
Seeing individualism as clashing with compassion.

Sees collectivism as a more natural frame for compassion, easier.
Uses ideas about other types of society to contrast with ours and make sense of compassion in our society
Materialistic nature of society means people focus more on their own financial needs
Society focusing on material things at the expense of love, openness, sharing
Busy life = harder life = means more need for self-compassion
Linking political views to compassion, kindness, sense of humanity
Hard to make sense of people voting in a non-compassionate way as she generally thinks people want to be compassionate
Sees a looks based society as in contrast to a compassionate one
Attractiveness is more valued in society than compassion
Self-compassion as less tangible than material goods
Easier to value tangible things – particularly in a materialistic society?
Concepts that have become popular suddenly (e.g. Mindfulness) now seem contrived
Marketing/computerising of mindfulness makes it seem less meaningful/attractive
Questioning whether learning/development/targets can be self-compassionate
Politics as a frame of reference for compassion
Seeing people make uncompassionate choices about what they do or what they vote for
Feels that society focuses on hard work
Work as the main focus of life.
Long hours, giving too much to work, doesn't feel compassionate.
She wonders whether others have different ideas about what the greater good is
Systems in place in society can facilitate uncompassionate acts
Seeing systems as not fulfilling basic needs, not just Had to make a decision about following a system or being compassionate, getting into trouble, consequences for her
System/societal designs hurting others. Being compassionate by going against the system.
being uncompassionate
Feels angry about a lack of support in the system for others
Systems making basic needs very difficult
Seems to be empathising with how powerless this might make people feel, when they can't fulfil a basic need because of the barriers/lack of help in the system
Societal systems set up in a way that is not compassionate (e.g. hospital accommodation for parents, MH service provision, parking spaces)– discussed by Faye and Liz
Systems that are compassionate (e.g. mother baby groups). – Anya
Companies highlighting issues/insecurities to make money. – Anya and Liz
Go back to work to make money and be more valued by society – Faye
Self-compassion as a trend. Priorities of money and possessions getting in the way of self-compassion - Liz

Put out a life when in reality that's not true

Social media v real life

Social media as a frame of reference for societal ideas
Social media as a cruel place
Distance/anonymity of social media as the reason for lack of compassion/cruelty
Distance/anonymity of social media as the reason for lack of compassion/cruelty
People projecting ideas that they don't seem to live by
Difference between social media and "real life"
Real life society is kinder than social media
Social media changing people's actions and standards
Society feels judgemental, shoulds, standards
Shoulds and standards feeling like pressure
People using inspirational quotes about loving self/self compassion
Social media as a window into people's lives
Social media increasing pressure to do the same as others and what people will find worthy/impressive
Comparing life to others'
Her life seems less exciting compared to others
Social media as a window for people's views
Social media going outwards.
Feeling she has to "put out a life".
Display that everything is good when it's not necessarily
Makes sense of this as a coping mechanism for her friends who do it
Seems to feel bombarded by constant images of people pretending everything is good. Difficult to compare your own life to?
Feels this is a message to then work harder to achieve what other people seem to have.
Social media as a window for compassion too
Making connections with people through social media
Discovering new ways of thinking, including more compassionate ideas
Enables her to question her initial self critical responses to things by seeing other ways of relating
Birth trauma organisations on social media were very helpful
Social media enabling a sense of connection to other people. Commonality of experiences. Feeling

less isolated and less alone by connecting to lots of other people.
Seeing examples of other people giving compassion and receiving compassion
"people building each other up" – something about putting pieces together, to empower someone
Feels healthy to see people being compassionate to each other
So social media can feel unhealthy at other times
Dilemma between safe spaces and echo chambers with no other opinions
Facebook/social media as a gateway for people being able to say hurtful things as well
Less of a barrier that face to face interaction might have because of the threat to the person for saying something hurtful, social media is a protective barrier which enables people to say more hurtful things without repercussions?
Discussed by Anya and Faye

An environment where you could ask for as much help as you needed

Experiences with health care

Poor experiences of health care for other people but not her
Birthing centre as a positive, community, family, togetherness
Unexpected praise and positivity from birthing staff
Family connectedness of centre made her feel connected too
Positive, non-judgemental environment, normalising support, enabled her to ask for help when she wouldn't normally
Has heard that busier hospitals feel less supportive, have less time to give
Felt the early health care experiences set her up with a positive outlook for motherhood
Staff had plenty of time for her so she didn't feel bad taking up their time
Staff priority was on wellbeing so didn't feel bad for her to focus on her wellbeing
Set up by staff at her own pace, similar to how she supports baby to learn?
Despite the trauma and bad circumstances, was treated well by staff
All staff were lovely, compassionate, caring
Maternity nurse came and sat without being asked and helped feed and hold baby
Heard complaints of staff/treatment from other mums
Was made to feel human during surgery
Expected major surgery to be dramatic and scary
Expected midwife to be more knowledgeable
Wanted a more experienced midwife but her experience didn't help
Midwives gave different levels of encouragement
Prior experiences with midwife made the uncompassionate experience feel even worse?
Worry that admitting there's an issue will mean they won't approve her
Once feeling confident, wanted space from professionals.
Too much advice, confusing information
Early on wanting to be told what to do, wanting lots of information.
Later not wanting to have lots of information.
Lack of compassion around miscarriage led to wider mistrust of staff. Thinks they are too stretched and habituated to bad situations. – Anya
Wanting more earlier/lighter intervention for people. Some experiences of compassionate environments – Faye
Experiences of compassion with breastfeeding – Talia
Lack of compassion with breastfeeding, matter of fact, tactless - Liz

Miscellaneous

Just offer to bring me some food!

Food and compassion

Food/nourishment as a frame of reference for motherhood and care
Food as an act of kindness
Food as an act of kindness
Food as sign of love and care
Discussed by Talia and Faye

Diversity

Tolerance of diversity

Link between lack of tolerance/understanding and lack of compassion
Lack of compassion due to sexuality/difference
Wider community has grown to be more compassionate
When you intersect compassion with different groups of people in society, it becomes more complex, and people might not be so pro-compassion
People using their existing judgements of some groups of people, to deem whether compassion is necessary or not
Hard to relate to people from different social groups

Coming out journey

In the past the gay community was a more compassionate place for jenny
Shared experience of coming out journey
Coming out involving self-compassion
Pub community helping her accept herself and be true to herself

There should be an emphasis on family

Value of family as (most) important

Family as very important, should be prioritised

Hard when others are not meeting your strong value
Value of the importance of family
Parenting as something to fully commit to, all the time
Putting baby first is natural and also a conscious decision based on values
Instinct is to judge partner for taking time to himself
Prioritising her family's suffering over her boss's
Prioritising family again in what she focused on in new life
Family support as more important than she had realised before having baby
Not just mothers who can be the source of compassion [grandmother]
Sees husband as a parenting partner
He wants to parent as much as she does. Similar effort put into parenting. Similar values?

Context of family upbringing
Thinking and talking about mum's parenting was painful
Lack of compassion from dad growing up
Dad couldn't give compassion before working through his own issues
Intergeneration transmission of trauma
Mum had traumatic childhood, passed this on
Mum unknowingly caused trauma
Discrepancy between what her and mum see as trauma
In some ways her mum was supportive and compassionate, other ways abusive, other ways dismissive/absent
Absence of compassion from mum not being around
Not wanting to go to dads because of violence, volatility
Being rejected by mum, pushed away towards grandma
Mum choosing someone else over her daughter, very hard, hurtful
Ran away to see mum's reaction, seeking care
When reunited, still didn't get the care or compassion she was seeking
Compassion and love from her grandma enabled her to focus less on being rejected by her mum
Makes sense of husband's differences in compassion as being from his family background
Discussed by Faye

Noticed during the process

Using humour to discuss difficult topics
Using humour to discuss difficult topics
Dismissing difficulty and pain during the interview bringing humour into difficulty
Using humour to talk about something painful?
Using humour to joke about a big worry
Jokes about being ignored in place of son

Caveats so not judged
Doesn't want to complain too much during the interview
Not wanting to complain too much
Counteracting a negative story with a positive

Parallel process of how she's speaking
Whole account is very rushed, lots of details, back and forth between topics and time points, very confusing, scary and hectic time
The way she's talking sort of represents how chaotic these times might feel for someone
Making sense of societal patterns using similar ideas to her own

Appendix 9 – Research Diary

My reflections that I noted throughout the research process are written in black.
Comments added towards the end of the process, looking back over my thoughts are in blue italics.

Initial thoughts before starting interviews:

My experience of parents, one compassionate, one not so, may mean I make assumptions about mothers being compassionate and fathers(/partners) not being

My attitude towards mothers is generally compassionate, but I assume society is not

Breastfeeding as a quintessential original example of compassion from mother to other. How might society's lack/level of compassion impact the process from mother to child?

Discussions with my mum made me think about how I haven't been taught the formal definition of compassion, could be linked to having non-academic parents? Could be a misconception that it's just being kind?

My mum also kept talking about gender differences with compassion and in general society. Some of which are now outdated, but were her experience and her frame of reference for compassion. Therefore were also my experience in early life.

While organising interviews:

Mums feeling aware of what they are saying. Mentioned it might be different with baby or partner around. Evidence that doing the interviews at uni, without baby is better. Although this may have been a barrier to some women coming forward, if they were single mums for example.

Mums mentioning being aware of what they're saying in front of partner or child (and so being happy to do interviews separately), perhaps links with the theme of judgement

Beginning interviews:

Thought body image might come up more.

I thought people would be more negative about society's views against compassion, but they thought society at least said it was a good thing (even if this didn't result in compassion). Does this show my own attitude to society/paternal figures as uncompassionate? My own family's ideas about compassion.

I think my dad's attitude to emotions and empathy/compassion has skewed what I think society says about compassion so I was a bit surprised about some women being so positive about what society says about compassion

Interesting that the theme still emerged that society was uncompassionate (which is what I had assumed) but I thought that everyone thought that, and that society was quite clear that compassion wasn't the thing to do. So I experienced society as authentically uncompassionate whereas the theme came up about society being inauthentic – not being compassionate but saying it is.

What do I think are the right ways to parent? Very influenced by psychological teaching eg. containment, not leaving a baby to cry, not hitting a child. What feelings does this bring up for me at certain moments

in interviews. Felt uncomfortable when Brigid spoke about "cry it out" but could understand her reasons, although I thought it was the wrong choice.

These same feelings came up whenever I went back to Brigid's transcript. I noticed that I didn't want to spend much time focusing on this section. However, it felt important to bracket this and include it, and so I did use some of it in one of the quotes.

Also my beliefs that we should always try to be compassionate, and you can never be too compassionate to others. Clashed with some participants, how did that change the questions I asked?

Was this my own "corrective script" from my own childhood?

I think I was surprised to hear some of the women saying you shouldn't be too compassionate. I think therefore some of my follow up questions weren't so thoughtful as they had caught me off guard.

Me talking about compassion has made me more aware of trying to be self compassionate

Also made me more sad for people who aren't being self compassionate possibly?

I have been particularly self-compassionate towards the end of the write up process, it has been really stressful but the self-compassion has felt like it has been helpful to get me through. Parallels with themes that came up.

Starting analysis:

Skimming over certain bits, fewer comments, is this when they don't fit with my beliefs? Is it when it's less IPA/internal experience? Less rich or less interesting? Make sure I go back over these sections enough.

Mums who are less self compassionate seemed to maybe had a harder time describing things? Describing their emotions? Are these linked?

This is how it felt after the interviews with Brigid and Anya, I thought it might be their experiences of less compassion as a child. However, Faye was also particularly not self-compassionate and yet she was quite introspective (perhaps because of past therapy?). Liz had lots of compassion as a child but was still not self-compassionate or particularly able to describe her inner world.

After first 15 mins of analysing the first transcript, supervisor told me to not focus too much on just tiny details. Broaden it out a bit as well.

This felt scary. Wanting to get enough detail, not wanting to miss important things participants have said. But it did feel necessary to be able to move on with the interview process.

Those who feel society has more negative views of compassion seem to be the ones who have struggled more with mood?

I was struck by the range in size of compassionate acts. I.e. A small gesture to a big gesture.

Some comments about things that are judged most by society (or subtle comments that seem to show this)

made me think about women that have less choice in what they can do, and have to regularly take a non-perfect option. Particularly women with lower SES (how does this compare to my sample?) or on their own, less support, etc. How must that feel for those women when it's bad enough for the women I interviewed who do have more choice? Could this have biased who volunteered to take part in my research?

I have at times assumed they are referring to compassion, because of the question I have asked, when actually they may be describing love or kindness

I think this was necessary given the language people used to talk about compassion. The acts they were describing did usually still seem to fit general existing definitions of compassion.

There were occasions where e.g. Anya called something compassion when in fact I didn't agree. But I wanted to include this as it was her experience of what compassion is (e.g. self indulgence)

This is where my critical realist position came out, as I needed to be flexible with my own concept of what compassion is in order to analyse the participants' concepts of what compassion is.

Sometimes got stuck on certain sections at each different stage of the analysis (e.g. midwife story) - perhaps because it stood out from the rest of the interview, didn't fit with research questions? I think the trouble is partly that I wasn't moving on in initial comments, so then I wrote some just for the sake of it, and then when I had to get themes from them, they didn't make sense because the comments themselves weren't helpful.

Used colours when grouping themes and it was interesting to see which rough sections linked in with lots of others in the interview, and which were more separate (not much overlap)

Awareness that I come from a position where often I feel that wider systems should be used to explain difficulty, and therefore I may be more likely to see societal narratives in what people say (e.g. self criticism about caesarean, probably comes from societal standards)

This is probably why I wanted to analyse mothers experiences of compassion ***in the context of society and societal narratives*** *in the first place. It is what I am interested in and feel passionate about. However, I do think from what the women said that my implications for research are not just because of my own preconceptions, they are based on women finding self-compassion harder, and wanting society to be more compassionate. So why should we keep trying to get women to be more self-compassionate when societal interventions would feel more meaningful to them?*

Although, I myself have found self-compassion interventions really helpful, so I would like women to have the chance to access this kind of support, if they are inclined

Also political narratives, given that many interviews happened around a general election with very split political views. And that this seems less relevant/important in the context of analysing during coronavirus pandemic.

Additionally, some themes that were occurring I could relate to myself and had been particularly brought to the fore during the pandemic, eg. going into a helper role as that is more familiar to me, and wanting to make others feel better if I have experienced something negative that I think they might be going through.

Interesting that as I was going through the transcript and commenting, often I would comment a question or thought that I then asked in the interview a minute later. So my thought processes were very similar during the interview and analysis without being completely conscious of this.

Awareness of culture, ideas about society are situated in the dominant majority, white, christian roots.

Themes that seemed to be coming out after all interviews were done as I was midway through analysing Jenny's transcript:

other new mums, both helpful and unhelpful, feeling like a minority, the partner, the importance of understanding the need not just trying to help, connection with your own mum, shoulds in the information given to new mums, limits of compassion, limits of own understanding and experiences that then limit compassion but not necessarily kindness, expected compassion noticed more when you don't get it, compassion keeping the world moving and functioning and being necessary (is this more of a theme now that they are mums? would it have been the same opinions before motherhood?), compassion as far reaching?, compassion influencing how similar events are experienced like a colour filter

Themes that seemed to be coming out in Jenny's transcript analysis:

Theme of being in a bubble

Stopping and pausing - Having to make a conscious effort to be self compassionate or compassionate to others when stressed

Compassion as far reaching, positive and negative

Breastfeeding as frame of reference, particularly to do with others and society?

Interface between self critique and what she thinks other people think.

Quite a few qualifying comments/caveats which clarify she doesn't do "bad" things often - seems to be worried about me judging her.

Reaching a limit and then stopping worrying/self critique

Nutrition and food as a source of worry/judgement

Parallels between how she was shown compassion as a child and how she responds best to compassion now

putting baby first but still gaining a benefit (groups, swimming, destressing)

Felt sense of compassion. Compassion as a murky concept, tied in with love and kindness.

Links between experience of compassion from others, and to others, and to self. Parallels. e.g. acknowledgement of stress

007 Lara

Bubble/cocoon/pockets of compassion. Safe places in a largely not compassionate world.

Family as a priority

Harsher standards for herself than Jenny

The wonder of having a child and growing a human being

Lots of similarities with Jenny

Experiences of compassionate birthing centre

At first I felt that bubbles and cocoons were definitely the same, but on closer analysis I realised that Lara's idea of a cocoon served a similar purpose but had a very different outcome to Jenny's bubble.

Probably expected self compassion to be harder for most people as this was my experience and also I think what I see in societal narratives

Unexpected that my p's descriptions of their mums also rang so true for me. Some of their stories were almost exactly like my own mum.

A theme about different things that can feel compassionate?

Medical experiences?

Different frames of reference? E.g. Religious holidays, different cultures, economic systems, food, breast feeding, time of year, politics, pets

003 Brigid

Experience of mother in law coming in to help around the house made me think of stuff I've read about other cultures where birthing practices are different and women from the rest of the village (including younger girls) come in and do all the cooking and cleaning while mum looks after her new baby.

I have focused on mothers but she talks about her grandma and dad. Made me realise I had a bias in my questions.

Throughout transcripts I have been making assumptions that they are talking about compassion based on the question I have asked, even if they don't use the word compassion.

Chloe

Spoke a bit more about her partner, made me realise that I could have asked more specific questions throughout the interview about partners, as I did about babies. Is this because of my preconceptions about men being less compassionate than women? Could be due to my own relationship status.

Particularly during Chloe's interview analysis I could feel how my previous analyses were influencing my thoughts about what she said. Tried to bracket these off an be objective but it was a definite feeling of recognition and excitement when I noticed themes coming through in different ways.

After these four interviews, before trying to collate them, I felt the main themes were:

Describing compassion? Different types (stranger/loved one?)

Small/big? expected/unexpected?

Bubbles and cocoons + isolation and struggles of motherhood

Conflicting and compatible needs
Growing a baby
Connecting with parents
Society's ideals and reality
Compassion as a necessity
Self compassion is hard

Felt sense of compassion - Gendlin 1991

However when I actually started to collate all the themes from the first four interviews I realised that they were a lot more that I'd been holding in mind somewhere, but weren't seeming so obvious. The ones that seemed more obvious were those that were coming out more in the most recent interviews I had analysed so when I went back through Jenny's and Lara's emergent themes I realised there were a lot more.

Started to have thoughts for implications and the write up:

Self compassion interventions
CFT helps to acknowledge the struggle?
Linking with babies needs so not competing
Make use of the motherhood bubble
Support for Cree intervention?
Improve isolation
How to make others/society more compassionate? Reduce conflicting demands and facilitate people using their own experiences to appreciate the struggle of someone else
My research can inform theories of compassion? How do my findings fit with Paul Gilbert? Or social mentality theory?
Health care should make compassion a priority and make that obvious to the women
Fatherhood and compassion

Want to include all the intricacies but can't
Don't want to dismiss or ignore the struggles of motherhood but they are not the main focus on the research question so do I talk about this theme a lot when I come to the discussion?

Before analysing the next four transcripts, I had discussions with supervisor about:
Mothers and babies as co-terminus, like baby in the womb, as one.
She wondered about separation, this wasn't something I've thought about much in the interviews. Maybe because some mothers hadn't gone back to work yet? Others had but I didn't elaborate on that.

We spoke about some of the instances where the mums had discussed needing to think about long term outcomes for baby. Supervisor said it sounded like "For your own good" whereas I had been thinking of

"cruel to be kind"

Food is primary at that stage. She said it's the transfer of self (breastfeeding) to give life to another

Discussed image of mother with arms around baby and then father/other with arms around mother. Winnicott holding environment maybe?

When doing some research into this I realised it was a common concept that had infact been discussed by different people using different terms. E.g. container/contained Bion, motherhood constellation Stern, Nursing Triad (attributed to Winnicott but actually coined by someone else), Solihull approach.

Supervisor said to be transparent about my process for focusing on particular themes in the write up and not others.

Focus on themes that best address the research questions?

Remember to think about how their meaning making was influenced by societal narratives

Discussed how I was regretting covering so many different areas in each interview. Needed to discuss some for the context of others. But ended up with so many different avenues and thus so many themes. But wouldn't have known before doing the interviews that this would be the case. Hindsight.

Finishing collating the themes in order to use them for the last four interviews:

There were so many more than I had realised. I didn't realise I'd been holding so many different nuances in my mind, e.g. nearly a hundred themes. Although some of these were very similar and I had just been thinking about them differently depending on the context of the interview in which they first emerged.

Decided to analyse the next four with these in mind and then condense further later if needed.

Analysis the last four interviews:

Themes that started to emerge but were linked to existing themes. Provided more nuance.

I never knew

Loss of identity

Learning curve, not knowing, learning about baby

Seeming like things are fine/deception

Baby coming first/needing more compassion/new priorities and perspective

Belonging to society (object) linked to judgement

Time/effort of compassion - include other people focusing on their own needs for time/effort before helping others

Societal systems set up in a way that is not compassionate - library 003, hospital staying over 006, parking spaces 008

Themes may have seemed separate in most interviews but then one participant would link them together (eg. Faye with society, flows and worrying about doing something wrong for baby)

Some of the themes are discussed separately but were often/on occasion linked in nuanced ways by one or two participants. However, for the purposes of the write up, they are discussed mainly separately.

Thought some themes were more major and then when I went to look for quotes they weren't so common or explicit as I thought. I think they had simply resonated with me a lot. I felt a dilemma about whether to include them with as much emphasis because there seemed to be an implicit sense of them which had resonated with me, but I wanted to be true to the material.

At particular times throughout the process I reflected on me not being a mum myself. I particularly thought about this when analysing the motherhood identity theme and in the last four interviews when the theme of "I never knew" came more to the fore. Women saying they just couldn't have known what it was like to be a mother before having the baby. This is a narrative I have heard many times before, but it really struck home for me during the analysis and I do wonder whether I will feel differently about my research when/if I have children in the future.

But in some ways perhaps it was helpful for me not to be a mother as otherwise my own experiences of early parenting may have been hard to bracket off.

Discussion with supervisor about finalising themes

Still felt there were too many themes so I needed to narrow them down more.

Again I was worried about losing richness of data.

I therefore kept my more descriptive titles in the emergent theme document but added in quotes that summarised more general groupings within the superordinate themes. This also helped to bring the themes into a more IPA focus, I had to try to think of what the essence of the descriptive groupings was showing, instead of just being descriptive.

Finishing writing up and implications:

Very aware of not wanting to add to the judgement/standards for mothers, but also holding knowledge of the implications of compassion and parenting for young babies. Trying to find balance between falling into the trap of society judging mums and offering lots of knowledge about everything that could go wrong, and wanting to offer that knowledge to help people.

Appendix 10 - End of Study Letter for Salomons Institute Ethics Panel

Thank you for providing ethical approval for this study in May, 2019. Please find below the summary that will be sent to my participants:

"They say it's a good thing in principle but…"
New mothers' experiences of compassion in society

Background to the study:

Compassion seems to be associated with better emotional and physical wellbeing. Some theories suggest that compassion first evolved in mothers offering care to their babies, and later began to occur with other close family members and social groups, resulting in benefits for the whole community. Previous research has shown that compassion can help parents persevere when things are difficult but that people find it hard to be self-compassionate and feel that society has different ideas about it.

Aims of the study:

To find out what new mothers think about self-compassion and compassion to and from other people.

To explore new mothers' experiences of the different flows of compassion and whether they are linked.

To find out what new mothers think about society's ideas about compassion and whether these help or hinder compassion.

Method and Analysis:

The researcher interviewed eight women with babies aged 6-18 months. The researcher then analysed the interviews focusing on how the women made sense of their different experiences of

compassion, motherhood and society. Lots of different themes arose and these were then grouped into subordinate and superordinate themes.

Results:

The women experienced compassion as valuable, immense and complex. Compassion seemed easier with their babies, friends and family but with strangers or at times of stress, it felt like more effort and needed conscious thought. Similarly, self-compassion was particularly hard for the women, and sometimes they found it hard to accept compassion as it felt like admitting they needed more help, were weak or less independent. The women emphasised the importance of understanding their specific needs and always feeling the need to prioritise their babies. Society felt harsh, judgmental and contradictory towards mothers, but acts of compassion helped participants to persevere and could feel protective. The women also highlighted connections with other parents, including their own, as important.

Implications:

This study suggests that interventions to help mothers to be more self-compassionate could be helpful, but these should be co-created with mothers so that their specific needs are taken into account. Interventions will probably be more engaging if they don't cause conflict with the babies' needs and are adapted according to individual communities.

It will also be important not to put more pressure on mothers with additional "shoulds" and standards. Society has a responsibility to evaluate its systems to see whether they are causing unnecessary stress or barriers to compassion for mothers.

Likewise, societal systems, such as health care services should try to offer more compassionate spaces for mothers to connect with each other and find non-judgmental support. It seems to be easier for mothers to accept compassion when it's seen as normal, authentic and expected.

Future research should focus on developing the above ideas and exploring fathers' and other care givers' perspectives on compassion and support.

Appendix 11 - British Journal of Developmental Psychology: Author Guidelines

Sections

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/bjdp

Click here for more details on how to use **Editorial Manager**.

All papers published in the *British Journal of Developmental Psychology* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

Preprint policy:

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The *British Journal of Developmental Psychology* publishes full-length, empirical, conceptual, review and discussion papers, as well as brief reports, and **Registered Reports**, in all of the following areas:

- motor, perceptual, cognitive, social and emotional development in infancy;
- social, emotional and personality development in childhood, adolescence and adulthood;

- cognitive and socio-cognitive development in childhood, adolescence and adulthood, including the development of language, mathematics, theory of mind, drawings, spatial cognition, biological and societal understanding;
- atypical development, including developmental disorders, learning difficulties/disabilities and sensory impairments;
- the impact of genetic, biological, familial, interpersonal, educational, societal and cultural factors upon human psychological development;
- comparative approaches to behavioural development that help to elucidate developmental processes in humans;
- theoretical approaches to development, including neo-Piagetian, information processing, naïve theory, dynamic systems, ecological and sociocultural approaches.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

The following types of paper are invited:

- papers reporting original empirical investigations;
- theoretical papers which may be analyses of, or commentaries on, established theories in developmental psychology, or presentations of theoretical innovations, extensions or integrations;
- methodological papers dealing with any methodological issues of particular relevance to developmental psychologists;
- review papers, which should aim to provide systematic overviews, analyses, evaluations or interpretations of research in a given field of developmental psychology, and identify issues requiring further research. All systematic reviews must be pre-registered.

In those cases deemed appropriate, peer commentaries on key papers/reviews will be solicited from other researchers in the relevant field. These peer commentaries will be published immediately after the target article, with the authors(s) of the article being invited to write a response to the commentaries.

- Articles should be no more than 5000 words (excluding the abstract, reference list, tables and figures). In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.
- Brief reports are limited to a maximum 2000 words (including the abstract, reference list, tables and figures) and have no more than 15 references. Brief reports will be treated as a priority during the review process and published in the next available issue once they are accepted.
- Please refer to the separate guidelines for Registered Reports.

4. PREPARING THE SUBMISSION

Free Format Submission

British Journal of Developmental Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript,

including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://www.editorialmanager.com/bjdp/default.aspx** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; statement of contribution; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Authorship

Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the

role that each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

Abstract

Please provide an abstract of between 100 and 150 words, giving a concise statement of the intention, results or conclusions of the article and brief information regarding the ages and background and distinctive characteristics of any sample. The abstract should not include any sub-headings.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Statement of Contribution

Authors are required to provide a Statement of Contribution that identifies existing knowledge in the area and summarises the new knowledge added by the submitted paper. It should include two subheadings with 2 or 3 bullet points of no more than 100 characters under each, outlining (i) what is already known on this subject, and (ii) what the present study adds. The Statement of Contribution is submitted as a separate file.

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each

issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the **APA FAQ**.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, *159*, 483–486. doi:**10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Colour figures. Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

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Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **Sample:** Empirical reports must give details of the ages and other key characteristics (e.g., gender, ethnicity, socioeconomic status) of any sample.

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