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RESEARCH ARTICLE

'It's like they're learning what it is for the very first time': Clinician's accounts of self-compassion in clients whose parents experience mental illness

Addy J. Dunkley-Smith[1] | **Andrea E. Reupert**[2] | **Jade A. Sheen**[1]

[1]Deakin University, Burwood, Victoria, Australia

[2]Monash University, Clayton, Victoria, Australia

Correspondence
Addy J. Dunkley-Smith, Deakin University, Melbourne Burwood Campus, 221 Burwood Hwy, Burwood, Vic. 3125, Australia.
Email: addyjds@gmail.com

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Abstract

Objectives: Individuals who have a parent with mental illness are more likely to experience mental illness than their contemporaries. As such, it is valuable to examine potential psychological resources, which might assist these individuals to experience good mental health throughout their lifespan. We aimed to learn how clinicians perceive self-compassion, and how it can be incorporated into therapy with clients who have parents with mental illness.

Design: A qualitative interview design was employed to explore clinicians' perspectives and experiences.

Methods: Eight mental health clinicians experienced in working with clients who have parents with mental illness were interviewed. Interpretative phenomenological analysis was used to establish themes representing the clinicians' perspectives and experiences of incorporating self-compassion into their work.

Results: This study found that clinicians were generally positive about incorporating self-compassion into interventions with clients who are children of parents with mental illness. The participants noted barriers to self-compassion for these clients, namely a poor sense of self and divided loyalty between self and family. Participants recommended

taking time and care, building rapport and involving others when cultivating self-compassion with those who have parents with mental illness.

Conclusions: This group of clinicians viewed self-compassion as relevant to clients whose parents have mental illness and believe it can be introduced therapeutically in various ways. Suggestions are made for tailoring self-compassion training to the needs and experiences of this group.

KEYWORDS

children of parents with mental illness, intervention, parental mental illness, psychotherapy, qualitative, self-compassion

Practitioner points

- Clients who have parents with mental illness may have difficulty enacting self-compassion, particularly in the context of a poor parent–child relationship(s).
- When developing self-compassion with this client group, it may be beneficial to explore beliefs about loyalty and self-worth which may present barriers.
- Clinicians recommend developing a foundation of therapeutic trust, gradually introducing self-compassion, allowing generous time to cultivate self-compassion, and considering involvement of peers or family when cultivating self-compassion.

INTRODUCTION

As many as one in four children grow up with a parent who experiences a mental illness (Abel et al., 2019; Maybery et al., 2009). These children face an increased risk of experiencing their own mental health challenges compared with those whose parents do not have a mental illness (van Santvoort et al., 2015). Consequently, experts have long advocated for targeted preventative interventions for this group (Reupert et al., 2021). Existing interventions commonly seek to increase children's mental health knowledge (Riebschleger et al., 2017), develop their peer connections (Pitman & Matthey, 2004) and foster adaptive coping strategies (Riebschleger et al., 2009). Relatively less exploration has concerned the nature and consequence of how these children feel about and respond to themselves during the challenging times associated with having a parent with a mental illness.

Self-compassion

Compassion can be defined as 'sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it' (Gilbert, 2014, p. 19), as a motivation or attitude towards others, from others and inward towards oneself. However, in response to recognising the considerable difficulty many individuals face when trying to elicit compassion for themselves, Kristen Neff pioneered a definition of self-compassion (Neff, 2003). Neff theorised that self-compassion involves using mindfulness to engage

with suffering, 'being touched by and open to one's own suffering, not avoiding or disconnecting from it', as opposed to over-identifying with suffering; a sense of common humanity, that one's experience is part of the human experience, as opposed to feeling isolated by suffering; and self-kindness rather than self-judgement and criticism (Neff, 2003, p.87; Neff, 2019). Since that time, self-compassion has been found to promote resilience amongst individuals faced with stressful life events, including those exposed to potentially traumatic events (Tanaka et al., 2011; Zeller et al., 2015), living with a significant physical (Zhu et al., 2019) or mental illness (Donald, et al., 2019), or caring for a family member with a significant physical (Köhle et al., 2017) or mental illness (Hanson et al., 2021). With the field of clinical psychology turning increasingly to 'third wave' approaches, literature exploring implications for self-compassion as a therapeutic resource is mounting.

Indeed, self-compassion has been described as 'an important mechanism of change in psychotherapy' (Baer, 2010; Germer & Neff, 2015, p.55). A prominent exponent of this idea is Paul Gilbert, whose work on shame and self-criticism (Gilbert, 2000) contributed to the development of compassionate mind training (Gilbert & Proctor, 2006) and compassion-focused therapy (CFT; Gilbert, 2009). Self-compassion is identified within various psychotherapeutic approaches (Kirby, 2017; Germer & Neff, 2013) and forms the basis of several interventions, which show promising efficacy for alleviating symptoms of psychopathology and increasing feelings of well-being (Athanasakou et al., 2020; Baer, 2010; Wilson et al., 2018), including amongst family members of people with mental illness (Hansen et al., 2021). Accordingly, it has been proposed that children and adult children of parents who experience mental illness could benefit from interventions to enhance their engagement in self-compassion (Dunkley-Smith, Reupert et al., 2021; Dunkley-Smith, Sheen et al., 2021). However, whilst empirical evidence for the benefits of cultivating self-compassion is increasing (Javidi et al., 2021), research involving children whose parents have mental illness is in its infancy.

Recent findings highlight the relevance of self-compassion to the experiences of those whose parents experience a mental illness. A scoping review of qualitative research found that, in direct contrast to self-compassion, children and adult children of parents with mental illness often felt isolated from others, criticised themselves when they struggled to cope and ignored their emotional needs (Dunkley-Smith, Sheen et al., 2021). Furthermore, a group of ten young adults whose parents experienced mental illness identified self-compassion as difficult to engage in (Dunkley-Smith, Reupert et al., 2021). Some of the youth did not feel worthy of self-compassion, and it had not been modelled for them by parents nor their society. Nonetheless, some participants highlighted the role psychologists and counsellors had played in providing them with 'permission' and support to be more self-compassionate (Dunkley-Smith, Reupert et al., 2021, p.187). These findings point to the role of self-compassion in the lives of those who have parents who experience a mental illness, and further research is needed to understand perceptions and applications of self-compassion in therapy involving therapy clients who have parents with mental illness.

The present study

To our knowledge, research has not examined clinicians' perspectives and experiences of promoting self-compassion in clients who have parents who experience a mental illness. To better understand the acceptability and applications (if appropriate) of self-compassion as a therapeutic focus for clients who have parents with mental illness, we need to understand the views of mental health clinicians who already work with this group. Consequently, in this study, we aimed to understand clinicians' experiences (if any) and perspectives regarding self-compassion in therapeutic work with clients who have parents with mental illness. Furthermore, we aimed to draw insights regarding current clinical practice and identify any recommendations and/or reservations about self-compassion held by clinicians who currently work with this cohort.

METHOD

Interpretative phenomenological analysis (IPA) was the guiding methodology for this study, given its focus on examining participants' experiences and perspectives of a given phenomenon (Smith, 2004). By combining tenets of ideography, phenomenology and hermeneutics, IPA is a qualitative research method, which allows the researcher to describe and interpret the meaning of a particular situation or circumstance by paying close attention to each individuals' experience (Pietkiewicz & Smith, 2014). IPA calls for a commitment to intersubjective reflexivity, meaning that the IPA researcher actively engages with making meaningful sense of the meaning participants' draw from their experience (Eatough & Smith, 2008). Accordingly, authors are compelled to clarify their position relative to the research and how this influences their conduct.

Reflexivity statement

The first author has lived experience growing up with a parent suffering from a significant mental illness, has facilitated peer-support groups for young people who have parents with mental illness and practised as a Provisional Psychologist in a clinical psychology doctoral programme in Australia. In these contexts, she has introduced the concept of self-compassion to colleagues, clients and programme participants. The author drew on these identities to best understand the interview data. Nonetheless, in keeping with IPA practices of intersubjective reflexivity (Eatough & Smith, 2008), she regularly checked her understanding of participants' meanings throughout the interviews and engaged in interrogative self-reflection, taking notes of thoughts, emotions and circumstances, which might have influenced the research process.

Meanwhile, the second author is a qualified psychologist and academic professor with specialist research experience in families where parents experience mental illness. The final author is a clinical and health psychologist and qualified family therapist with extensive experience offering psychological therapy to children and adult children of parents experiencing mental illness and an associate professor. These positions assisted the research team in engaging in the etic interpretation of the data.

Participants

Research employing IPA generally involves small samples—ranging from one participant, up to 15—this is because analysis is conducted on a case-by-case basis and a decision to conclude sampling is based on the richness of individual case content and capacity for close idiographic analysis and reporting (Pietkiewicz & Smith, 2014). Purposive sampling was conducted in this study, whereby all participants were qualified mental health professionals living in Australia with over 5-year experience (ranging from 5 to 20+ years) working with children, including adult children, who have parents who have mental illness. We intentionally did not limit our sample to clinicians who had already adopted self-compassion as a focus for therapy with these clients. In this study, we wanted to elicit experiences and perceptions regarding self-compassion that was somewhat reflective of the current workforce, including any reservations, recommendations or indifferent positions clinicians may have towards self-compassion. Clinicians who have adopted self-compassion are likely to have done so because they already hold favourable views of the concept. Therefore, this application of purposive sampling varies from some applications of purposive sampling in IPA (Smith, 2004).

Procedure

After obtaining university ethics approval, recruitment took place between November 2020 and May 2021 using flyers distributed through social media platforms and relevant organisations (e.g. Australian Psychological Society and Australian Institute of Family Therapy). Those who viewed the flyer were also invited to share it amongst their networks. Participants provided written informed consent, completed a brief online demographic survey and provided suitable times for 1:1 semi-structured interviews. The first author conducted interviews via telephone, video conferencing software or in person, based on participant preference and COVID-19 health guidelines, with each interview lasting between 49 and 71 minutes (M = 59.5). Interviews were semi-structured, the schedule was developed by the research team informed by the research question and current research, and example questions were provided to participants before the interview. We offered participants a voucher for participation (20AUD), and three requested to donate this to charity. Interviews were recorded, transcribed verbatim and sent to participants for member check procedures (Goldblatt et al. 2011). During this time, participants were also sent a link to three follow-up questions to elicit reflections that arose after the interview. One participant chose to complete these follow-up questions; one participant provided an additional reflection via email, and one made changes directly to their transcript to protect the identity of a specific client population.

Data analysis

The analysis process was adapted from the IPA stages proposed by Pietkiewicz and Smith (2014). The first author conducted the analysis. Immersion in the data began with conducting and transcribing the interviews, then repeatedly reading transcripts. During this time, the first author made reflective memos and notes to summarise and interpret the data. Next, the author reviewed and collated the notes along with highlighted excerpts of data to identify themes. The first author reviewed the themes to produce superordinate themes and their related subordinate themes. This analysis was conducted with each transcript/case in turn, before themes from all transcripts were reviewed and revised. Only themes pertinent to the research aims are reported.

IPA involves both description and interpretation of concepts and meanings reported by participants and understood by the researcher. Whilst the authors followed the stages of IPA to conduct case-by-case analysis and flowed between description and interpretation, some themes presented in the results emphasised description to convey the most meaningful data. The research team met regularly to discuss the construction of themes, during which time each theme was reviewed and challenged to examine its contribution towards achieving the research aims. Members of the research team also broached various questions to ensure ideas in the data were not overlooked or overemphasised. After several discussions and revisions, the final set of superordinate and subordinate themes was viewed as a credible and parsimonious representation of the eight participants' rich, diverse and valuable insights.

RESULTS

We interviewed eight mental health clinicians, including one mental health social worker and qualified family therapist, two occupational therapists and five psychologists, including three clinical, one general psychologist and family therapist, and one educational and developmental psychologist. Five participants identified as white Australian, and three had migrated to Australia, two of which identified as white European and one as Asian. One participant identified as having a parent who experienced mental illness, and three reported having experienced mental health challenges (See Table 1 for participant demographics).

TABLE 1 Participant characteristics

Pseudonym	Age	Gender/ sex	Mental health qualification	Predominant therapeutic framework	Years of work experience with population
Jennifer	36–45	Woman/ Female	Clinical psychologist	CBT, Attachment-based	5–10 years
Lauren	26–35	Woman/ Female	Clinical psychologist	CBT, ACT	5–10 years
Amy	36–45	Woman/ Female	Clinical psychologist	ACT	20+ years
Susan	66–75	Woman/ Female	Psychologist & family therapist	Narrative, Systemic	20+ years
Michael	26–35	Man/Male	Educational & developmental psychologist	CBT	5–10 years
Nicole	46–55	Woman/ Female	Occupational therapist	Solution focused	5–10 years
Julie	56–65	Woman/ Female	Occupational therapist	Systemic, Solution focused	20+ years
Eric	46–55	Man/Male	Mental health social worker & family therapist	IFS, EMDR, Polyvagal theory	5–10 years

Abbreviations: ACT, acceptance and commitment therapy; CBT, cognitive behavioural therapy; EMDR, eye movement desensitisation and reprocessing; IFS, internal family systems.

TABLE 2 Superordinate and subordinate themes

Superordinate themes	Subordinate themes	Minor themes
Self-compassion as a contradiction	Lasting sense of 'something's wrong with me'.	
	Divided loyalty: Self or other	
Self (compassion) as therapist	Self-practice of self-compassion	
	Willingness to engage with suffering	
Developing self-compassion in therapy	Considerations for clients whose parents experience mental illness	Go gently Rapport building Using a group or family approach
	Understanding one's conditioning	

The analysis resulted in three superordinate themes encompassing six subordinate themes. The superordinate theme *Self-Compassion as a Contradiction* encompasses how self-compassion may positively contradict the experiences, habits and beliefs common amongst clients who have a parent with a mental illness. Meanwhile, the theme *Self (Compassion) as Therapist* conveys how the cornerstones of self-compassion were important in participants' personal and professional lives. Finally, the theme *Self-Compassion in Therapy* covers participants' recommendations for supporting these clients to cultivate self-compassion. All themes are outlined in Table 2. Herein, we outline how participants conceptualised self-compassion, before reporting each of the identified themes.

Participants described self-compassion as a construct made of multiple components, including 'staying in the present' and regulating difficult emotions that arise, developing 'understanding' one's strengths and limitations, and how these were conditioned by experiences, generating positive regard for the self and a sense of connection to others. Nonetheless, clinicians adopted alternative language to talk about this concept with clients. Thus, although most participants had explicitly

addressed self-compassion in therapy, they had all explored concepts similar to self-compassion with clients (e.g. 'self-love', 'self-care' and 'feeling good about self'). Furthermore, all participants agreed that self-compassion was a worthwhile consideration when working with clients who have parents with mental illness yet did not see this reflected in clinical teaching nor practice. Julie acknowledged an expanding focus on 'self-care' in the Australian mental health sector, although she distinguished this from self-compassion.

> You know, these concepts of self-care tend to focus on quite external, practical things… which are also very important. But if we think about what might be potentially transformative… how do we talk about self-compassion and self-love? These are concepts that are highly nuanced, but they, they touch a deeper level of a person and (these) children would benefit from that enormously.
>
> (Julie, occupational therapist)

Self-compassion as a contradiction

Participants discussed their experience of self-compassion being contrary to belief systems of some clients whose parents have mental illness. These systems were said to both impede and necessitate self-compassion. Firstly, participants reported these clients present with a sense of the self as 'worthless', shameful and inherently flawed, making self-compassion 'unfathomable' and 'alien'. Secondly, participants noted that in service of loyalty and responsibility to family, these clients learn to forego expression of, let alone compassion for, their own emotional needs.

Lasting sense of 'Something's Wrong with Me'

Participants reported that clients who had a parent with a mental illness often presented with a troubled sense of self. This ranged from '[struggling] to understand who they are and how they fit into the world' to a 'sense of shame' or 'worthlessness'. Jennifer, a clinical psychologist who worked from 'an attachment-based lens', described this as a 'disrupted intrapersonal relationship', impairing clients' ability to relate to themselves compassionately. Participants described how clients' interactions with their parents had influenced this troubled sense of self.

For instance, participants observed that when a parent's distress impaired their capacity to attend to a child's distress, that child could come to see themselves as 'someone who can't be coped with'. This rendered self-compassion unimaginable, as Jennifer said 'There are ingrained beliefs about themselves… that idea of like "How could I have these warm or even accepting feelings towards myself because something's wrong with me?".' (Clinical psychologist).

Participants witnessed how challenging and hurtful parent–child relationships damaged these clients' sense of self, thwarting their ability to be self-compassionate. Eric summarised this notion when he said, 'It's difficult to be compassionate towards the self when for quite a long period of your life you have heard that you're not good enough, that you're bad, that you're worthless'.

Participants observed that some clients learnt to cope by presenting a 'false self' to the world (Jennifer, Amy; clinical psychologists), whilst others, owing to parental criticism and a lack of safety, developed core beliefs of 'no one loves me' and 'what's the point…I'm always going to fail' (Michael). Moreover, Eric warned that following particularly painful parent–child experiences, some clients will 'keep re-shaming themselves to emotionally regulate'.

Additionally, the sense of self could become limited and defined by the labels others applied to them. Susan shared that 'often the adults will say … "you're just like him and he's as mad as a cut snake, and your anger and your distress or your grief or violence or silence or your self-harming is all the same as

your dad. So here you are, you're going to grow up the same as your dad".' Susan's statement captures a powerful story, wherein a client was labelled as 'just like' a person whose emotions they fear, their future was deemed inevitable, and their experience of pain was invalidated, dismissed and engulfed by that of their unwell parent.

Divided loyalty: Self or other

All participants had worked with clients who displayed a strong sense of 'loyalty', 'overinflated responsibility' or 'obligation' towards their parent with a mental illness. Whilst participants did not see this as inherently harmful, they were aware of an often-unspoken trade-off that occurred—the client's trade-off between loyalty to self and others. Consequently, participants described self-compassion as 'alien' to this client group, who often denied their own needs for the sake of loyalty to others.

Responsibility here includes feelings of blame and of duty. Participants recognised that 'kids really do tend to think that they have somehow created or exacerbated their mum or dad's mental health issues' and 'feel responsible for their mum or dad's well-being' (Nicole, occupational therapist). Furthermore, participants described how this 'overinflated sense of responsibility' persisted into adulthood, such that some adult children felt a 'sense of obligation to stay close to [the parent], even if they're damaging' (Jennifer, clinical psychologist). Julie articulated how this divided loyalty directly impacted self-compassion: 'So many are focussed so much on their parent, on caring for their parents…they don't understand the need to be compassionate to themselves' (Occupational therapist).

Lauren hypothesised that attuning to others might have 'been adaptive' or 'protective' for children as it helped them 'manage their context'. Although she noted this could come 'at a cost to themselves' if 'they tend to focus on other people's needs and not enough on their own'. She predicted that increasing their self-compassion would assist with this 'tendency toward "I've got to look after them".', by bringing the notion of care 'back to themselves as well'.

Ultimately, participants believed that of the few children who considered self-compassion, many would face the consequences from their families. Eric described a client's concern 'about the consequences' if she chose to leave home to pursue her ambitions, how her mother would likely use 'an emotional manipulation' to retain the status quo. He said it would be 'something like "well, you don't love me, you don't want me, you don't want to help me, after all I've done for you, I feel like you're abandoning me…".' (mental health social worker and family therapist). Julie had also seen how self-compassion could 'be twisted into a very negative thing' in some families. 'If a young person is thinking about self-compassion and being compassionate towards themselves, that can be misinterpreted as being selfish and uncaring and not being loyal'. (Julie, occupational therapist).

According to Susan, such patterns caused a sort of disenfranchised grief. She described this when saying: 'My experience is that the space had not been allowed for them to express distress and to express their need for security and love because of their loyalty and love for that parent'. (Susan, psychologist & family therapist).

Self (compassion) as therapist

The participants' acceptance and embodiment of the central tenets of self-compassion were believed to influence their introduction of self-compassion to all clients, not only those with parents experiencing mental illness. Reflections on self-practice of self-compassion and participants' willingness to engage client suffering are presented below. Whilst it did not constitute a subtheme in this study, most participants admitted that their clinical practice was influenced by their personal experiences, and in this way,

they carried a sense of common humanity into their work, 'there but for the grace of God go I' (Lauren, clinical psychologist).

Self-practice of self-compassion

There were two reasons why participants advocated for clinician self-practice of self-compassion. Firstly, personal practice of self-compassion was believed to improve one's understanding of the concept, enhancing one's ability to support others to practice self-compassion. Nicole explained, 'It's easy to tell someone else. But if you're not actually practising the principles yourself, then perhaps it doesn't quite feel as…real' (Occupational therapist). Likewise, Julie believed that 'If we, as helpers, don't understand it, then how can we possibly provide that kind of guidance and those ideas to children and young people in ways they can understand?' (Occupational therapist).

Secondly, participants believed that self-compassion was necessary for their emotional well-being. Self-compassion motivated Amy to set boundaries. She shared that working with 'self-compassion doesn't necessarily, I think, mean [taking on] all the person's experiences…sometimes it's about saying no and taking care of yourself too, knowing your limits'. Susan extended this idea by stressing that self-compassion is 'pivotal to preventing burnout'. However, she voiced concern about a creeping culture of self-care, whereby onus is on mental health clinicians to help themselves instead of being supported by systems in the workplace.

Willingness to engage with suffering

Several participants discussed the emotional nature of their work with children who have parents with mental illness. Coupled with this, using self-compassion in therapy was understood to welcome negative affect, which could be challenging to face for client and clinician. Drawing primarily from Acceptance and Commitment Therapy, Amy conceptualised that a 'large element of being able to work with self-compassion' is the clinician's own willingness to 'sit with emotions regardless of how painful they are'. Amy reflected on barriers to her willingness:

> When I'm extremely happy… you kind of want to protect that emotional state…If I'm feeling my own emotional pain, it can be then quite difficult to adopt or make space for another person's emotional pain, you know, if you tend to feel like you've reached a certain threshold.
>
> (Amy, clinical psychologist)

Indeed, many participants demonstrated this kind of reflective practice. Jennifer believed that a clinician's discomfort and avoidance of emotion could limit the client's opportunities to heal from some of their most difficult experiences in therapy. To guide clients through painful emotional memories, clinical psychologist Jennifer felt she would needed to learn 'not to be frightened of them not being okay…Because it's actually a really useful process – letting clients emotionally re-experience what's happened to them'. Jennifer called this 'trust in the process', which built over time, informed by personal experience, scientific evidence and witnessing the benefits to her clients.

Developing self-compassion in therapy

Participants showed that many common approaches for developing self-compassion could be applied to best support clients whose parents have mental illness. Moreover, self-compassion was conceptualised as relevant to various therapeutic orientations. Generally, clinicians discussed modelling the client's

worthiness of compassion in the therapeutic relationship and explicitly introducing self-compassion to clients by sharing observations of client self-criticism, providing education on self-compassion, reframing self-critical thoughts and encouraging clients to schedule time to be kind and caring towards themselves. Furthermore, clinicians suggested using cartoons, illustrations, play, creativity, analogies and metaphors when introducing self-compassion to child and adolescent clients. However, participants shared considerations made when tailoring self-compassion to these clients.

Considerations for clients whose parents experience mental illness

Participants described specific considerations and adjustments when developing self-compassion in clients who have parents who experience a mental illness.

Go gently

Firstly, participants stressed that adequate time should be allocated to the teaching and practising self-compassion for this client group given the noted barriers or 'sticking points'. Amy recommended:

> …when we do talk about self-compassion, it's usually really delicately presented … it's gradually presented over several sessions. There's a lot more exploration about what that means and what it might look like and a lot of trial and error, and… how do I describe this? It's like they are learning what it is for the very first time.
>
> (Amy, clinical psychologist)

Michael similarly noted that for clients whose parents experience mental illness, a lack of self-compassion 'is a problem that has been years in the development, and we can't just undo it in a few months'. (Educational & developmental psychologist).

Gradual guided introduction to self-compassion was also considered necessary when clients interpreted emotions as frightening or overwhelming. Jennifer proposed that in supporting self-compassion *in vivo*, clinicians demonstrate that the client is worthy of compassion. This also assists clients to build emotional self-efficacy.

> So out of session, they know that they could re-regulate. It wasn't this big, you know, empty hole that they fell into forever. You know, we dip into the hole and come back out, and every time we dip in, it closes a little bit.
>
> (Jennifer, clinical psychologist)

Rapport building

Given the newness of self-compassion to many of these clients, participants believed it essential to take time to build a trusting and safe therapeutic relationship 'to have them feeling comfortable enough to be uncomfortable, try different things and experience different things' (Susan, psychologist & family therapist). However, two clinicians had sensed 'something missing' in the therapeutic relationship with clients who had a parent with mental illness, a sort of 'gap' or 'chasm' (Jennifer, clinical psychologist). In Amy's experience, focussing on developing self-compassion was an effective bridge to deeper therapeutic engagement with these clients because 'it's really hard to be experientially avoidant when you are talking about self-compassion'.

Using a group or family approach

Many participants also recommended the involvement of parents or peers when enhancing client self-compassion. Most participants who supported child clients endorsed the involvement of primary carers. Lauren noted the 'reciprocal' nature of parent and child distress, suggesting that shared self-compassion

practice could benefit both parties. Occupational therapist Nicole hoped that increasing parental self-compassion would lessen the 'tension at home' and create a model of self-compassion for children. Although Eric, a qualified mental health social worker and family therapist, believed family involvement to be beneficial, he honoured adolescent clients' preferences when involving parents.

Furthermore, two participants believed a self-compassion peer-support group could benefit clients from families where a parent experiences mental illness. Nicole thought that compared with one-on-one therapy, encouraging self-compassion could be 'more powerful and more meaningful if it comes from someone who has a similar or shared lived experience…' as this 'makes it seem more real and a little bit more achievable'. (Occupational therapist).

Understanding One's conditioning

Despite varied therapeutic orientations, many participants observed that exploring key memories of parent–child interactions allowed clients to access more compassionate insights about themselves and their experiences. Understanding means a client recognises 'It's okay for [them] to feel like this, and actually, it makes sense'. (Jennifer, clinical psychologist). Fostering this understanding helped clients to regard themselves with greater compassion and less criticism.

> Being able to acknowledge that her parent had their own difficulty… for her, it was "Well… this is not just me, you know, it could be due to a combination of things and people from my past, rather than just me".
>
> (Amy, clinical psychologist)

Using storytelling and art and the relationship that you have with them to have them thinking more creatively about what their experience has been and move away from the self-definition of madness or self-definition of hopelessness…to be able to get in touch with compassion. (Susan, psychologist & family therapist)

Informed by Internal Family Systems, Eric (Mental health social worker & family therapist) suggested that revisiting memories facilitates self-understanding, which helps shift the client's sense of self from shaming to compassionate. Eric described revisiting memories to 'unpack and restore that sense of self that has been affected' by 'bringing awareness' to the limits of their responsibility and the origins and protective intentions of previously rejected aspects of oneself. He proposed, 'this is when the unburdening, the mending, and the healing occurs'. Eric considered an experiential process essential to change. Jennifer also noted a difference 'between the head and the heart of knowing'. To restore, self-compassion was said to require a change in heart, not only mind.

Several participants, including Susan who often drew from Narrative Therapy, noted that clients whose parents experience mental illness 'often haven't had the opportunity to tell their stories properly'. Moreover, telling their story was not easy. Julie spoke of a young woman who 'worried if she talked too much about her childhood' she could be 're-traumatised'. Nonetheless, many participants experienced that exploring the past to promote self-understanding was helpful for clients who had a parent with a mental illness.

DISCUSSION

The purpose of this study was to describe and interpret the experiences and perspectives of mental health clinicians regarding self-compassion in their work with clients with a parent who experiences mental illness. We hoped to gauge the familiarity and openness of these clinicians to this concept. Furthermore, we sought to learn from them about incorporating self-compassion into this field of work. Three superordinate themes were presented. Firstly, participants viewed self-compassion as relevant to this client group, mainly to improve their sense of self and offset a strong sense of responsibility to

others with consideration for the self. Secondly, clinician self-compassion and willingness to engage clients' emotional pain were considered pertinent to their ability to facilitate client self-compassion. Thirdly, the participants described therapeutic approaches and considerations when promoting self-compassion in clients whose parents have a mental illness. This study found that self-compassion might assist with specific challenges clients face when their parent experiences mental illness. This study supports previous findings that the children of parents with mental illness often feel a complex sense of responsibility and loyalty towards their unwell parents, and may experience considerable feelings of shame and a poor sense of self in the context of parental mental illness (Dunkley-Smith, Sheen et al., 2021; Gladstone et al., 2011). These experiences may impede their capacity to engage in self-compassion. Uniquely, self-compassion was positioned as beneficial for improving self-worth, reducing self-criticism and balancing a strong sense of responsibility to others, namely parents, by promoting a greater degree of kindness towards the self. Conversely, divided loyalty, shame or a troubled sense of self may present as barriers to self-compassion and thus need to be addressed as part of self-compassion interventions with this client group.

The findings suggest that where self-compassion is concerned, the needs of children and adult children may vary based on the nature of their parent–child relationship(s). Specifically, we surmise that self-compassion may be particularly difficult, and yet especially valuable, for these clients when their parent is or was rejecting, emotionally manipulative or otherwise maltreating. This finding is supported by established theory that the development of self-compassion is heavily influenced by early experiences with primary caregivers (Gilbert, 2020), and cross-sectional and longitudinal data indicate self-compassion is lower amongst those exposed to emotional maltreatment by caregivers (Mackintosh et al., 2017; Ross et al., 2019; Tanaka et al., 2011). Thus, clients whose parents experience mental illness may require more support to establish warm and soothing ways of relating to their suffering if their early experiences of caregiving lacked these same qualities.

Participants discussed how self-compassion requires a degree of attention to negative affect, which may initially be frightening or overwhelming for some clients whose parents have a mental illness. These findings suggest that self-compassion may relate to distress tolerance and emotion regulation and are supported by existing definitions of compassion (Strauss et al., 2016) and findings that emotional regulation may mediate the relationship between self-compassion and psychopathology (Inwood & Ferrari, 2018).

Clinician self-practice of self-compassion: Self as therapist

These findings extend the literature regarding self-practice of self-compassion amongst mental health professionals. Specifically, participants perceived that clinician self-practice influenced efficacy in delivering self-compassion interventions and reduced vulnerability to burnout. Germer and Neff (2013) recommend clinicians have personal experience with self-compassion before teaching the practice. Presently, cross-sectional and intervention studies provide preliminary evidence that health care professionals with greater self-compassion are more engaged with their work, report greater professional life satisfaction (Babenko et al., 2019), personal well-being (Beaumont et al., 2016) and are less prone to burnout (Delaney, 2018), emotion regulation difficulties (Finlay-Jones et al. 2015) and compassion fatigue (Conversano et al., 2020). Taken together, these findings support the notion of self-compassion as a potentially adaptive resource for clinicians, not only their clients.

Clinical implications

Considering the present findings in light of existing literature, it can be deduced that some clients whose parents have a mental illness would benefit from a therapeutic focus on cultivating self-compassion. This study can inform tailored self-compassion training for clients whose parents have

mental illness. Whilst these findings suggest that many therapeutic approaches may be employed with this goal in mind, some specific considerations are recommended. When introduced to this cohort, self-compassion may take considerable time to develop and may bring up strong emotions. Thus, participants recommended gradually introducing self-compassion to clients whose parents experience mental illness, taking time to build a foundation of rapport, facilitating opportunities to practice self-compassion in session and supporting development of skills to tolerate and regulate distress and discomfort. This strategy echoes recommendations for clinicians engaged in psychotherapy with trauma survivors (Germer & Neff, 2015).

A strong therapeutic relationship is likely to facilitate self-compassion by supporting emotional co-regulation and demonstrating that the client is worthy of compassion. Participants also proposed that exploring memories of parental mental illness allowed clients to foster self-compassion by building understanding of how they had been influenced, or conditioned, by circumstances beyond their control. Discussion of parental mental health, parent–child relationship and related memories may assist these clients to understand barriers to self-compassion, including shame, poor sense of self and notions about mutual exclusivity of care for self and care for others. To that end, clinicians might support these individuals to manage when there is a conflict between their needs and those of the parent.

Some of the needs and experiences of dependent children whose parents have a mental illness will differ from those of adult children who may be parents themselves (Patrick et al., 2019). Indeed, mental health clinicians are trained to adapt their practice to each client's context, including age, culture and risk factors (Välimäki & Lantta 2019). Similarly, we recommend that the promotion of self-compassion assumes a developmental approach, for example using creative approaches to teaching self-compassion, involving art, music or storytelling, especially when promoting self-compassion with children and youth. Additionally, consideration of the client's unique family structure is needed including the mental health of key caregivers other than biological parents.

Various settings may be suitable for the engagement in self-compassion training depending on the client, including peer support, one-on-one or family-based interventions. Peer support may promote a sense of common humanity. Meanwhile, individual therapy might be suitable for revisiting childhood memories involving sensitive content, including parental mistreatment. Family-based approaches might promote shared practice of self-compassion and correct any misinterpretations about self-compassion. Finally, mental health clinicians might consider the professional and personal value of self-compassion practice for themselves.

Future research

Future research could evaluate the effectiveness of self-compassion-based interventions for improving outcomes for clients with parents experiencing mental illness. This could reasonably take the form of a case series, a pilot trial of a structured self-compassion intervention or an evaluation of self-compassion training added to existing interventions for this cohort. In addition, cross-sectional studies could measure participant self-compassion to identify whether this is related to outcomes for children and adult children who have parents with mental illness. Such studies could also examine the intersection of self-compassion, parental mental illness and exposure to childhood maltreatment or trauma. Finally, future studies might investigate the further nuances of the types of applications to different subgroups in this population (i.e. dependent children and adult children).

Strengths AND limitations

In this study, participants described their experiences working with a subset of the population who have parents with mental illness, namely those who had presented for mental health support. Additionally, participants regularly reflected on clients who had been exposed to potentially traumatic events in

the context of a parent's mental illness. Therefore, these findings may be most transferable to similar populations. The study was conducted in Australia, with Australian mental health clinicians. Thus, some of the findings may be contextually specific. In this study, we did not require that participants had experience using self-compassion in therapy, only that they had experience working therapeutically with clients whose parents have mental illness. Thus, the findings are not necessarily based on extensive experiences of applying self-compassion in therapy.

CONCLUSIONS

The present study represents these clinicians' perceptions and experiences of self-compassion in their therapeutic work with therapy clients whose parents experience mental illness. These clinicians supported including self-compassion in work with this population and shared recommendations for this. The participants indicated factors that thwart self-compassion for this group and how these could be navigated in therapy. These findings frame self-compassion as a resource that may benefit clients whose parents experience a mental illness and the clinicians who work with them.

AUTHOR CONTRIBUTIONS

Addy Jean Dunkley-Smith: Conceptualization; Data curation; Formal analysis; investigation; methodology; Project administration; Writing–original draft; Writing–review&editing. **Andrea Reupert:** Conceptualization; methodology; supervision; Writing–review&editing. **Jade Sheen:** Conceptualization; Funding acquisition; methodology; supervision; Writing–review&editing.

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CONFLICT OF INTEREST

The authors have no potential conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

Research data are not shared due to privacy or ethical restrictions.

ORCID

Addy J. Dunkley-Smith https://orcid.org/0000-0003-3823-2029
Andrea E. Reupert https://orcid.org/0000-0003-2885-2814
Jade A. Sheen https://orcid.org/0000-0001-8327-5314

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