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Women's experiences of group intervention with schema therapy techniques: A qualitative process analysis

Sevda Sarı[1] | **Faruk Gençöz**[2]

[1]Department of Psychology, İstanbul Medeniyet University, İstanbul, Turkey

[2]Department of Psychology, Middle East Technical University, Ankara, Turkey

Correspondence
Sevda Sarı, İstanbul Medeniyet University, İstanbul, Turkey.
Email: sevda.ksm@gmail.com

Abstract

Aims: Our study focused on a self-soothing system and analysed how women feeling shame experienced compassion-focused group intervention with schema therapy techniques. Group schema therapy, which is process-oriented and person-oriented (Farrell & Shaw, 2012), inspired us to combine schema therapy techniques with Compassionate Mind Training in the interventions for this study.

Methods: Data were collected through the programme that comprised 2-hr sessions over a period of 10 weeks and self-compassion and self-criticism diaries of women.

Analysis: Data analysis was conducted according to the phases of thematic analysis (Braun & Clarke, 2006). Twenty hours of group sessions (2 hr per session) and follow-up sessions were audio recorded and transcribed. Thematic analysis was conducted to analyse 26 hr of group intervention and follow-up sessions and also women's self-compassion and self-criticism diaries, to understand how shame-prone women experienced change process.

Findings: Thematic analysis of the group sessions yielded two superordinate themes: overcoming the threat of compassion and the process of change. Overcoming the threat of compassion was divided into three subthemes; fear of self-compassion, the difficulty of accessing the vulnerable child side, and feeling anger at others and self. The process of change involved two subthemes; the feeling of acceptance, and recognising self-compassion and its sources in the self. When the women could access their self-soothing system, they could better understand the needs of their vulnerable child side and address these needs by transferring the emotions of compassion to their vulnerable child side.

KEYWORDS

group intervention, qualitative study, schema therapy, self-compassion, thematic analysis

1 | INTRODUCTION

Self-compassion is described as being kind towards oneself when experiencing pain and/or failure (self-kindness), perceiving one's faults and suffering as part of the common human experience (common humanity), and holding painful feelings and thoughts in mindful awareness instead of over-identifying with them (mindfulness) (Neff, 2003a,b). Self-compassion has many therapeutic benefits (Hoffmann, Grossman, & Hinton, 2011), including for people with severe mental health difficulties (Braehler et al., 2013). After short-term psychodynamic treatment, higher levels of self-compassion were associated with decreases in anxiety, shame and guilt, as well as increase in willingness to experience sadness and anger (Schanche, Stiles, McCullough, Svartberg, & Nielsen, 2011). Practising self-compassion

early in treatment may promote better treatment outcomes (Kelly, Carter, & Borairi, 2014), especially for clients with borderline personality disorder (BPD); the ability to self-soothe is key when the critical parent mode is activated (Young, Klosko, & Weishaar, 2003). For that reason, teaching self-compassion skills to combat severe chronic self-loathing is highly effective (Krawitz, 2012).

Various therapeutic interventions have been used to teach self-compassion skills. Cognitive behavioural interventions of acceptance and commitment therapy (ACT; Hayes et al., 2004; Hayes, Luoma, Bond, Masuda, & Lillis, 2006), dialectical behavior therapy (DBT; Linehan, 1993; Linehan et al., 1999) and compassionate mind training (CMT; Gilbert & Irons, 2005; Gilbert & Procter, 2006) focus on enhancing mindfulness, acceptance and self-compassion. DBT aims at teaching emotional regulation skills, interpersonal skills and distress tolerance (Linehan, 1993; Linehan et al., 1999). In a study of DBT, it was found that clients with BPD reported mindfulness, distress tolerance and self-soothing exercises to be amongst the most helpful interventions (Lindenboim, Comtois, & Linehan, 2007).

Acceptance and commitment therapy focuses on mindfulness and acceptance (embracing and being aware of one's experiences) as interventions (Hayes et al., 2004). The main aim of ACT is to create a non-judgemental attitude towards self (Hayes et al., 2004). CMT is practised to combat emotions of shame, guilt, and self-blame, and can be used for clients with high self-criticism to teach self-soothing and self-reassuring thoughts (Gilbert & Irons, 2005; Gilbert & Procter, 2006). In one study, six clients completed 12 two-hour sessions of CMT for their chronic difficulties. Six clients attending a cognitive–behavioural-based day centre for chronic difficulties experienced a significant decrease in depression, self-criticism, shame, inferiority and submissive behaviour. Further, they experienced increases in self-soothing and in feelings of self-related warmth and reassurance (Gilbert & Procter, 2006). A comparative outcome study was conducted using CBT and CMT (Lee, 2005). The participants in the CMT-with-CBT group developed significantly higher self-compassion scores than the CBT-only group. The study also found that high levels of self-compassion were linked to decreases in anxiety, depression and trauma-related symptoms. Lee (2005) suggested that CMT can be a supplementary therapy to CBT.

As CMT is useful for teaching self-soothing skills to self-critical adult women with traumatic backgrounds (Gilbert & Irons, 2005), and as self-kindness is a buffer against shame (Gilbert, 2017), we decided to conduct a group intervention with CMT for high shame-prone adult women. In addition, we aimed at combining CMT with schema therapy techniques, because negative emotions such as anger and self-hatred have been found to block self-compassion (Gilbert & Procter, 2006). The experiential techniques of Young Schema Therapy (Young et al., 2003) have facilitated overcoming such blocks (Farrell, Reiss, & Shaw, 2014). We aimed to conduct a qualitative psychotherapy process research to uncover the experiences of high shame-prone women through these interventions and to understand the process of change.

2 | METHODS

2.1 | Participants

The participants were four adult women in Turkey who were involved in a previous study of phenomenological analysis of shame (Sarı & Gençöz, 2015). For the previous study, a purposive sampling process consistent with interpretative phenomenological analysis guidelines (Smith & Osborn, 2008) was used, and a homogeneous sample was formed based on six factors; a diagnosis of depression, level of shame, age range, marital status, treatment history and socioeconomic status. The participants met the criteria for depression according to the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV; American Psychiatric Association, 1994), and high shame proneness was measured with the Test of Self-Conscious Affect–3 shame proneness sub-scale (Motan, 2007; Tangney & Dearing, 2002; Tangney, Dearing, Wagner, & Gramzow, 2000). All participants had experienced cognitive behavioural psychotherapy for at least 6 months. The four women from the first study volunteered to participate in the second study and formed the final sample for the group intervention. The first inclusion criterion was having a low level of self-compassion, assessed by the self-compassion scale (Neff, 2003a). Not being involved in psychotherapy or medical treatment for psychological problems at the time of the group intervention was another inclusion criterion. The last inclusion criterion was being able to attend weekly sessions of group interventions. These four women had experienced emotional neglect during childhood and had long-term relational problems. See Table 1.

Ethical approval for the study was secured from the Sarıyer municipality, where the Women's Health Centre is located and where the study was conducted. It was also gained from Middle East Technical University's ethics committee. Consent and information forms were administered. The participants were informed that they could withdraw from the group intervention at any time by informing the researcher. They were also informed that their confidentiality would be respected, and that regular attendance to group sessions was important. They were asked not to discuss anything shared in group with others outside.

TABLE 1 Participant characteristics

Anonymised name	Age	Education	Mostly blamed herself for
Naz	39	High School	Being an over-controlling mother
Suzan	40	High School	Being unattractive and an inadequate mother
Oya	40	High School	Being aggressive
Seda	38	High School	Being not worth unconditional love

2.2 | Materials

2.2.1 | Diary of self-compassion and self-criticism

Gilbert and Procter (2006) developed a diary for self-compassion and self-criticism for participants who attended the self-compassion training. The authors requested participants to include self-soothing and self-critical thoughts in the diary on a weekly basis. The content of the diaries was used in the data analysis.

2.3 | Procedure

The first researcher conducted group interventions on Tuesdays for 10 weeks between 12:00 and 14:00 at the Women's Health Centre, Sarıyer. Follow-up meetings were conducted 3 months, 6 months and 1 year after the group interventions ended. Participants completed self-compassion and self-criticism diaries every week.

2.3.1 | Compassionate mind training

Compassionate mind training has been found to be useful for teaching self-soothing skills and self-reassuring thoughts to people with high self-criticism, guilt and shame (Gilbert & Irons, 2005; Gilbert & Procter, 2006). This approach involves learning about the concept of *self-compassion*, understanding the fear of positive affect and defences against being kind to oneself, as well as learning mindfulness exercises, breathing exercises and compassionate-image exercises. It also uses a compassionate mind diary to help people understand their compassionate and critical sides, as well as compassionate letter writing, exploring anger compassionately and understanding the functions of anger (Gilbert & Procter, 2006).

2.3.2 | Why we combined schema therapy techniques with CMT

Women in our study had experienced emotional deprivation, defectiveness and mistrust-abuse schemas, and so feeling self-compassion was difficult. According to schema therapy (Farrell et al., 2014), participants' vulnerable child side—that is, the suffering inner child experiencing fear, sadness and helplessness—is in need of protection, acceptance, soothing and nurturing. Therefore, we used schema therapy's experiential techniques to help the women move into the vulnerable child side and experience the needs of their child side. We could then address the child side's needs by transferring the emotions of compassion, acceptance and kindness to her through imagination. CMT (Gilbert & Irons, 2005; Gilbert & Procter, 2006), combined with schema therapy interventions (Young et al., 2003) (mode work, limited reparenting, imagining the vulnerable child, empty-chair technique), was part of the intervention programme.

Schema therapy techniques were involved in the group intervention by the third week, in terms of learning about schema therapy modes; critical parent mode, lonely child mode, angry child mode and healthy adult mode. The aim was to help participants understand their child mode and dysfunctional adult modes. We asked them to observe their critical parent mode and angry child mode through that week. During the fourth week, schema therapy imagery technique was used for imagination of the vulnerable child. The therapist helped the women imagine their child side and understand her needs. On the fifth week, imagery technique was used to understand the vulnerable child's needs and to help the child feel safe and calm in a compassionate way, with the help of the therapist. During weeks six and seven, mode work of schema therapy was conducted by an empty-chair exercise, to facilitate the women engaging in dialogue between critical parent and compassionate sides. The aim was to confront the critical parent mode using healthy adult mode (compassionate side). The programme, goals and homework exercises are shown in Table 2 by session.

2.4 | Analysis

Thematic analysis is the basis of qualitative analysis (Braun & Clarke, 2006; Clarke & Braun, 2017), and is used for analysing and interpreting patterns (themes) within data (Boyatzis, 1998). In the literature exploring thematic material in group psychotherapy sessions and understanding group dynamics and therapeutic processes, thematic analysis has been used as an analytic framework (Liu et al., 2013; May, Strauss, Coyle, & Hayward, 2014; Van Rooij, Zinn, Schoenmakers, & van de Mheen, 2012). We used inductive thematic analysis (Boyatzis, 1998) without a pre-existing coding frame. Data analysis was conducted according to its six phases of thematic analysis (Braun & Clarke, 2006; Clarke & Braun, 2017). The aim was to understand the experiences of women across group data. According to the first phase of thematic analysis, we transcribed 20 hr of group sessions (2 hr per session). Then we reread the transcriptions of the group sessions and self-compassion, and self-criticism diaries of women several times to familiarise ourselves with the data. Following the second phase of thematic analysis, we coded the group session transcripts and women's diaries. At the third phase of the analysis, we collated the codes within the group sessions and diaries of women to form themes. At the fourth and fifth phase, we checked the themes and defined them, and formed superordinate and subordinate themes. At the last phase, we formed the report of data and selected example extracts for the themes. The qualitative data analysis program Maxqda was used to analyse data according to these six phases of thematic analysis.

2.5 | Trustworthiness of the study

To contribute to the trustworthiness of the study (Elliott, Fischer, & Rennie, 1999), we formed a research team consisting of the researcher, the researcher's supervisor, a clinical psychologist and an expert in qualitative analysis. The research team monitored the group process and checked the transcripts. All themes were audited by the research team, which made the research process transparent, and the direct quotations for the themes enhanced credibility.

TABLE 2 Compassionate mind training with schema therapy techniques

Sessions	Applied techniques per session	Aim of the session
Week 1	Introduction and getting acquainted, introducing the concept of *self-compassion* and self-criticism	To understand defences against self-compassion and increase awareness of the need for self-compassion
	Talking about the fears around self-compassion	To enhance participation and group interaction
	Participants stated that they got angry easily and talked about what made them angry	To let participants express their anger
Week 2	Mindful breathing exercise, discussing advantages and disadvantages of defences against self-compassion and self-kindness	To make participants explore the advantages and disadvantages of self-compassion
	Exploring the emotions underlying anger	To understand the emotions underlying anger
	Homework: Practice mindful breathing	
	Homework: Write in diary of self-compassion and self-criticism	
Week 3	Learning about schema therapy modes: healthy adult, critical parent, lonely child and angry child	To help participants understand their different modes
	Talking about anger	
	Homework: Observe their critical parent and angry child modes. Write in diary of self-compassion and self-criticism	To conceptualise anger for lonely child not getting her needs met
		To observe participants' modes
Week 4	Safe-place and compassionate-image exercises. Disclosure of the therapist. Imagination of vulnerable child, asking her needs. The therapist helped participants soothe child, to make child feel safe with limited reparenting. At the end, participants returned to their safe place	To experience self-compassion
		To understand vulnerable child and her needs
	Homework: Write in diary of self-compassion and self-criticism	
Week 5	Imagining vulnerable child and trying to understand her needs and help her feel safe and calm in a compassionate way with the help of therapist	To experience self-compassion by understanding child mode's needs and giving her compassion, warmth and kindness
	Return to safe place	
	Homework: Write in diary of self-compassion and self-criticism	
Week 6	Using empty-chair exercise to engage in dialogue between critical and compassionate sides	To confront critical side using compassionate side
		To empower compassionate side
	Homework: Write in diary of self-compassion and self-criticism	
Week 7	Through empty-chair exercise, conducting dialogue between critical and compassionate sides	To confront critical side using compassionate side
	Homework: Write in diary of self-compassion and self-criticism	
	Write compassionate letter to self	
Week 8	Each group member read her letter to self out loud. The group tried to understand each member's emotions while sharing their letters	To enhance approval of emotions by group members
	Homework: Write in diary of self-compassion and self-criticism	
Week 9	Talking about the feelings that emerged during group training	To understand each other and treat each other's emotions in a compassionate way
Week 10	Closure: Sharing feelings and evaluation of the group process and treatment goals. Setting date to meet 3 and 6 months later	

Furthermore, we discussed the themes of the analysis with the participants at follow-up meetings and got their feedback.

Etherington stated (2017) that a reflexive researcher does not report facts, but co-constructs meanings and interpretations. Therefore, to be transparent and to understand how these interpretations come about, the researcher must uncover his/her story. As a clinical psychologist, I (first researcher) conducted therapy at the Women's Health Centre for 2 years before the doctorate study. My interest as a schema therapist is in women with long-term interpersonal problems. The second researcher who conducts analytic psychotherapy is interested in emotions in psychopathology. Because of our interest in emotions and women's psychopathology, conducting such a psychotherapeutic intervention for this group of women became crucial.

During the interventions, I disclosed how I, as a Turkish woman, experienced shame related to sexuality and my body. Since I was a little girl, I have felt shame, and it was difficult for me to cope with that feeling. I think that is related to the patriarchy and culture we

were exposed to. Women in our culture are expected to control their sexual desires, be obedient to men and protect their sexual purity. Being ashamed of sexuality is a good characteristic of women and represents family honour. As a Turkish woman, I usually felt I was under control of these moral rules.

3 | FINDINGS

The thematic analysis yielded two main themes; *overcoming the threat of compassion* and *the process of change*. *Overcoming the threat of compassion* was divided into three subthemes; fear of self-compassion, difficulty accessing the vulnerable child side, and anger at others and self. *The process of change* involved two subthemes; the feeling of acceptance, and recognising self-compassion and its sources in the self. The superordinate themes and their subordinate themes are shown in Table 3.

TABLE 3 Themes of compassion-focused group intervention with schema therapy techniques

Superordinate Theme 1: Overcoming the Threat of Compassion
Subordinate Themes
1.1 Fear of self-compassion
1.2 Difficulty of accessing the vulnerable child mode
1.3 Feeling anger at others and self
Superordinate Theme 2: The Process of Change: Beginning to feel self-compassion
Subordinate Themes
2.1 Feeling of acceptance
2.1.1 Feeling acceptance by the group and the therapist
2.1.2 Accepting and understanding vulnerable child side's needs and emotions
2.2 Recognising self-compassion and its sources in self

3.1 | Overcoming the threat of self-compassion

3.1.1 | Fear of self-compassion

The participants stated they felt a sense of threat when they encountered compassion from others. They refused or avoided it. Oya stated in session 1:

> When someone behaves compassionately towards me, I feel bad. I feel there must be an underlying reason for behaving like that. I feel uneasy. I think it is because compassion is an unknown emotion for me. On the contrary, I feel better when there is a problem, an issue; I feel like a fighter. You know that is a familiar emotion.

Similarly, to Oya, Naz also felt a sense of threat:

> I also think that compassion from others is a threat. Because of my past adverse experiences at work, I begin to think the person treating me with compassion will expect something in return from me. I begin to wonder what underlies the compassionate behavior. Maybe he is doing that because of his love but… since I have not experienced this emotion from others before, I believe that compassion from others is based on self-interest and I refuse it. (Week 1, Naz)

3.1.2 | The difficulty of accessing the vulnerable child mode

The imagery technique of Young Schema Therapy was used to access the women's lonely child side. As an imagery technique, the therapist requested the women to turn the flow of compassion from self to a caring and compassionate image, and then back to self by replacing their lonely child side with that compassionate image. The aim was to feel compassion for their vulnerable, lonely child mode by using a compassionate image, while experiencing limited reparenting. This exercise was very difficult for the women and they felt tense. Their vulnerable, lonely child mode did not believe she was worthy of love or compassion. During imagination, Seda described her lonely child as follows:

> She is smiling reluctantly, uncheerfully, keeping feelings to herself, betraying no emotion. An introverted child…believes that no one will love her. The child has a rebellion inside since nobody notices her. The adult wants to hug her but she does not trust that someone can love her. The child is confused, does not believe the adult. (Week 4)

Oya also did not want to go into vulnerable child mode; she did not even want to imagine her (Week 4):

> When I met my child side, I wanted to get away from her. I had a feeling of not accepting her. That (self-compassion) is an unknown thing, a feeling I can't understand and haven't experienced before. There is something…how can I say it…uncertainty…the thing I can't understand.

3.1.3 | Feeling anger at others and self

The participants stated that they usually ignored their own needs and gave priority to others' needs. Ultimately, this made them be angry at others and self.

> Oya I do everything before people ask me to. I do a lot of others although I do not want

to. I am angry at them, but the anger is directed at myself. I think I do not have a right to get angry at them since they are not asking me to do these things.

Therapist Doing a lot for others, is it something about us?

Oya Yes, it belongs to us. I do something for you that I do not want to do. I do it so that you won't feel disappointed in me. But in fact, I do not really want to do it. If I were to express my real emotions, I would not get angry and feel frustrated. (Week 3)

These women became aware of their need for self-compassion when they understood that giving too much is a defence. In focusing on giving to others, they do not have time to think about their own needs—and therefore, whether those needs can even be fulfilled in their current situation. During the sessions, the women began to be aware of each other's need for compassion and understanding. Below Oya shares what she realised about Naz:

> You are a woman always giving everything to others, but deep inside, you need love and understanding from others. In fact, you need compassion more. You have given so much, and you have created distance between you and the people who can take care of you.
>
> Naz: You are describing me very well now. (Week 3)

3.2 | The process of change

The process of change began with the feeling of acceptance, and proceeded by *recognising self-compassion and its sources in self*.

3.2.1 | The feeling of acceptance

Feeling acceptance has two subordinate themes; feeling acceptance by the group and the therapist, and accepting and understanding child side's needs and emotions. Oya described her sense of feeling acceptance in her diary as follows:

> This week I did not criticise myself; what I felt this week was a sense of acceptance. (Week 8)

Feeling acceptance by the group and the therapist

Limited reparenting is a mechanism of change used in Schema Therapy and involves trying to compensate the client's core emotional needs within an appropriate professional boundary (Young et al., 2003). Therapists may self-disclose and use experiential or emotion-focused techniques to meet these needs. In our group intervention, the therapist disclosed herself as a model of self-accepting adult mode and was transparent to the group members about her own feelings of shame, as a limited reparenting intervention used in group schema therapy (Farrell & Shaw, 2012). The therapist shared the feeling of shame and her dysfunctional critical parent mode and how she dealt with that mode in the group. That facilitated the women, by enabling them to disclose their own vulnerable feelings in the group. The women began to disclose within the group how they felt accepted by the group members. Feeling acceptance was a core emotional need of the women, and the group process and interaction was valuable tool to meet that need. According to Group Schema Therapy, limited reparenting can also be provided by group members (Farrell & Shaw, 2012). Accepting the feelings of other group members was a limited reparenting provided by the women in our group. They expressed that they felt they were not alone in the group. They felt close to each other because they experienced similar emotions.

> At first, I was concerned about what others (group members) would think of me. Then, I thought that others must accept me as I am. In this group, I felt that I can be myself and others can accept me. (Naz, Week 9)

The therapist's accepting manner modelled a compassionate attitude for the women in the group.

> Last week I thought about what you (therapist) said to me here. I felt you would listen to me, would not criticise anyone. And now you have not criticised any of us. You have accepted everyone in this group as they are. I feel that way…and I remembered your attitude. (Suzan, Week 7)

> The people around me are usually critical. I realised by your (therapist's) attitude what it means not to be criticised. No one behaves towards me like you do; they always criticise me. I feel such understanding from you. (Oya, Week 7)

Accepting and understanding vulnerable child side's needs and emotions

The women in our group had difficulty accessing their lonely child side, and anger was a defence against feeling self-compassion. According to schema therapy, that was a detached protector mode, and the process of change proceeded by being aware of that mode, with the imaginary technique of schema therapy conducted in weeks four and five.

The women began to understand their own needs after imagination of their vulnerable child mode in different sessions of the group interventions. With the help of the therapist, they worked to calm

the child, be with her and share her grief. Naz stated feeling compassion for little Naz during imagination.

Naz	She is so innocent that I want to hug her to relieve her pain.
Therapist	Be your accepting, affectionate adult side and ask Little Naz what she needs…

At the beginning of the imagination, Oya imagined herself as a child in the room. However, she did not want to be with Little Oya in the same room.

Therapist	What does little Oya feel?
Oya	She does not feel anything…I (little Oya) want to go out of the room.

Oya's detached protector mode was activated not to face with painful emotions of Little Oya.

Therapist	What does Little Oya feel?
Oya	Loneliness.
Therapist	Can you imagine me at that room?
Oya	uh huh
Therapist	May I open the door and go near Little Oya?
Oya	uh huh
Therapist	Can I talk to her?
Oya	uh huh
Therapist	How do you feel?
Little Oya	Like crying

Therapist (to Little Oya in imagery): Oya, you can do what you want. I came here to be with you. I will be with you… If you want to cry, you can cry… I will stay with you if you want.

Little Oya	Okay.
Therapist (asked to Little Oya)	Do you want anything from me?
Little Oya	No, just stay with me.
Therapist	I am with you… I am ready to do anything you want here (Week 4).

An extract below is from imagination of Suzan's child side. (Week 4)

Therapist	What does Little Suzan need now?
Suzan	She needs to be understood, to feel valuable, important…. I want to hug her and tell her that her being is valuable…. I want to hug her (cries)

The following extract illustrates how Suzan tried to understand her emotions and her needs in a later session of group intervention.

Therapist	What did you realise?
Suzan	There, in imagination, Suzan needed to understand herself, accept her negative emotions. She realised that she had a right to understand her negative emotions. She had a right to get angry…because these are her emotions, they belong to her. She doesn't need to ignore them. In past I blamed myself: Why I am like that? Now, with this compassion, feeling that compassion…the most important thing is feeling that compassion. The emotion Little Suzan feels makes me very comfortable and peaceful. (Week 10)

The process of change began by feeling acceptance and continued by being aware of their self-punitive sides. Mode work was used to confront their punitive parent side. We defined the punitive parent side's tone of voice and whom the tone of voice sounds like. They named their punitive parent side.

Therapist	Whose tone of voice involved in these criticisms?
Oya	My father's tone of voice
Therapist	Listen to that voice, what does that voice make you feel?
Oya	makes me feel inadequate…

Then healthy adult side responded to punitive adult side (by empathy chair technique: weeks 6 and 7), with the help of the therapist and the group.

3.2.2 | Recognising self-compassion and its sources in self

Imagery techniques of Young Schema Therapy (Young et al., 2003) were used, and when the women in our group encountered their vulnerable child side during imagery, they came to understand their child side's need for understanding, acceptance, attention and love. They realised that self-compassion is a kind of emotion that their vulnerable child side needed. Working to take care of their child side invoked feelings of self-compassion.

In the next extract, Naz explains when she began to feel self-compassion:

> During our group sessions I could not feel compassion till I met Little Naz. When I met her, I felt that we were both alone. She was standing alone there; I was alone here. You helped us (vulnerable child side and adult side) to come together through imagery. Now, when I meet little Naz (in imagery), we hug, we feel each other. As Seda said, the feeling of loneliness disappears. Like the recovery of a wound (crying)…. I was alone, struggling against life alone. I have a daughter, a husband, but I was alone. I could not get rid of that emotion. Meeting Little Naz, feeling close to her, unlocked the door.
>
> Therapist What did Little Naz feel when you met her?
>
> Naz What did she feel? She needs love, attention, needs to feel that she is alive. She is alive…she is worthy, she is waiting for someone to hug her. Since I discovered this, we both became happy (Week 10).

3.3 | Follow-up meetings

In the last session of the interventions, the therapist asked the women to practise their self-compassion skills, self-soothing and breathing exercises as needed, until the next meeting. We met 3 months, 6 months and 1 year after the last group intervention session. These meetings lasted 2 hr, and we evaluated whether the women had used the skills they had learned. After 3 and 6 months, all four women stated that they could feel self-compassion and use it in confronting their self-critical mode during events that triggered moderate self-criticism. After 1 year, Oya, Suzan and Naz were still using the skills and could access their compassionate side. However, Seda had difficulty activating and feeling self-compassion. Her critical side was activated by problems she had with her husband, and her critical parent mode made it difficult to move into her self-compassionate mode. She was referred to the Women's Health Centre's clinical psychologist for further counselling.

4 | DISCUSSION

This study focused on women's experiences of compassion-focused group intervention with schema therapy techniques. In our group intervention, fear of self-compassion was one of the blocks against self-compassion. In order to better conceptualise fear of compassion, feelings of emotional neglect must be understood. The women in our group were criticised, not acknowledged for their accomplishments or abilities and had not experienced unconditional acceptance by their parents during childhood. Moreover, their parents were harshly humiliating and did not treat them compassionately. In parallel with our findings, Liotti (2010) stated that individuals who have experienced neglect and abuse can experience compassion as threatening. During the self-compassion exercises in our study, the women resisted self-compassion, because it reminded them of the lack of affection and compassion in their childhood. Supporting our finding, Gilbert (2010) found that fears of affiliative emotions may be related to past experiences of neglect and abuse. Therefore, those unfamiliar to self-compassion may experience it as overwhelming and dissociate from it (Gilbert, 2010). In our study, participants stated that receiving compassion from others made them drop their guard and feel prone to threat; that self-compassion was not appropriate for their "fighter" role in life. Correspondingly, Gilbert and Procter (2006) found that the first reaction of mental health patients to self-compassion was doubt, fear and resistance, and that resistance was related to perceiving self-compassion as a weakness.

Another sub-theme of blocks against self-compassion was difficulty accessing child mode. When people are in abandoned and abused child mode, they may feel shame, inferiority, pain and fear of abandonment (Farrell et al., 2014). As a maladaptive coping mode, the detached protector mode may be activated to protect people from the pain of being vulnerable (Arntz, Bernstein, & Jacob, 2013). In our group, the participants also had difficulty accessing vulnerable child mode, feeling an emotional disconnection with their child side. Detached protector mode (Jakob, 2012) was a block against self-compassion because it prevented the women in our group from being aware of their own needs and feelings. However, when detached protector mode is bypassed, healthy adult mode can soothe the self and be kind and compassionate towards the feelings of vulnerable child.

The process of change began by *feeling acceptance by the therapist*. This theme supports Greenberg, Watson, and Goldman (1998), who found that clients' feeling of acceptance by the therapist enhanced their feelings of self-compassion and allowed them to disclose their vulnerabilities. Therefore, for the development of warmth, compassion and forgiveness, a supportive therapeutic relationship is crucial (Lee, 2005). Moreover, Germer and Neff (2013) stated that during the psychotherapeutic process, self-compassion should be modelled by therapists through accepting their own faults and emotions in a kind, compassionate manner. In our group, the women also stated that the belonging and connection that developed among them facilitated feeling compassion for each other and for themselves. Being in a group may catalyse schema therapy interventions (Farrell & Shaw, 2012). In our group, the soothing statements of the women for each other, the bond

between group members, getting feedback from each other catalysed the group interventions and were helpful for instillation of hope. Correspondingly, in a support group for adult males with high shame, a sense of feeling connected to group members with similar experiences enabled the men to decrease their feelings of shame and develop a sense of belonging (Dorahy & Clearwater, 2012).

The significance of this group intervention for women can be better conceptualised taking into account cultural issues. Turkey is a culture of honour, and shame is usually attributed to women, and is important for protecting family honour in honour cultures (Sakallı-Uğurlu & Akbaş, 2013). Honour defines and controls women's behaviours, and Turkish women are expected to be obedient to family-centred gender roles (Erden-İmamoğlu, 2013). In a study of women's shame, it was found that Turkish women ignored their need for individuation to fulfil these gender roles (to be a chaste wife and a good mother) (Sarı & Gençöz, 2015). Moreover, they felt shame for their own body and their sexual acts (Sarı & Gençöz, 2015). This intervention may be significant for women living in cultures of honour, since these women need self-kindness and self-understanding to confront feeling of shame.

5 | CONCLUSION

Compassionate mind training is a successful psycho-educational programme aimed at skill empowerment through structured sessions (Gilbert & Irons, 2005; Gilbert & Procter, 2006). CMT does not focus on group dynamics or group processes but places emphasis on skill development. Group schema therapy, which is process-oriented and person-oriented (Farrell & Shaw, 2012), motivated us to combine it with CMT in the interventions for this study, and we formed a new group intervention for depressive women feeling high levels of shame. At the beginning, the women perceived self-compassion as a threat, they felt fear and anger. These reactions were conceptualised as detached protector mode according to the schema therapy (Young et al., 2003). During interventions, when detached protector mode of the women was bypassed by emotion-focused experiential techniques (imagination of vulnerable child, reparenting, disclosure of therapist), the women could soothe and be compassionate to their vulnerable child mode. Hence, one of the strengths of this study is that it added experiential techniques into a skills training programme (CMT). Another strength of this study is its focus on affiliative emotions. It supported that when the self-soothing affect system is accessed, the threat-focused affect system is regulated (Gilbert, 2014) through emotional resilience. Lastly, feeling acceptance by the therapist and the group facilitated the interventions. Therefore, focusing on the group dynamics and group interaction were another clinical significance of the study. Besides the clinical significance we were able to understand the change process of women by qualitative analysis of group sessions.

ORCID

Sevda Sarı https://orcid.org/0000-0003-0117-8380

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BIOGRAPHIES

Sevda Sarı is Assistant Professor at İstanbul Medeniyet University. This study is based on her doctoral thesis. She is a certified schema therapist, and her clinical interest focus on emotional difficulties of adult women and their early maladaptive schemas. She is giving qualitative research courses. Psychotherapy process research and qualitative analysis of women's emotions are her research interests.

Faruk Gençöz is Professor at Middle East Technical University. He is the director of Ayna Psychotherapy Center at METU. His clinical work focuses on Lacanian psychoanalysis. His research interests involve qualitative study and psychotherapy interventions.