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Self-compassion in family carers of older adults: a qualitative investigation

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Regular Article

Self-compassion in family carers of older adults: A qualitative investigation

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ABSTRACT

Objectives: Little is known about the nature and role of self-compassion in family carers of older adults. The study aimed to explore carers' understanding and experiences of self-compassion within their everyday lives.
Methods: This study involved thematic analysis of semi-structured qualitative interviews with 17 British carers of older adults.
Results: Six themes were identified: In *Self-compassion means connected self is prioritised*, carers identified self-compassion to involve self-kindness, common humanity, and the self as priority; *Compromise and conflict* reflected stressors within the caring context and surrounding relationships; *Resource depletion* described how stressors increased physical or psychological strain, highlighting the need for self-compassion; *Connection with others* described how carers experienced self-compassion when they felt connected, but aloneness was experienced more often than not; *Coping mindset* involved reframing and acceptance of challenges to foster self-compassion, and in *Setting boundaries* participants described maintaining a separate identity or role.
Conclusions: This study described key aspects of self-compassion experiences of carers in their everyday lives. It also identified facilitators and barriers to self-compassion which may inform possible interventions. Overall, self-compassion depended on mindset, clarity and understanding of the situation, and ability to maintain separation between 'self' and 'carer'. These qualities were offset against barriers such as demands and compromises between lived experience and ideal recipient relationship, that made achieving self-compassion in these ways difficult.

1. Introduction

Family caregiving refers to care provided due to necessity or concern for an individual, such as caring for a relative or friend. Family caregiving may offer rewards, particularly where a positive relationship exists between the carer and recipient (Pendergrass et al., 2019). However, caregiving can also be physically and mentally demanding (Eifert et al., 2015; Schulz & Sherwood, 2008), and demands can be high on time and space for personal activities, such as for socialising with others (Andréasson et al., 2018). Shifting relationship roles could create additional challenges. For example, carers may experience reversal of roles when caring for a parent, and spouses can shift from an equal to imbalanced dynamic (Egilstrod et al., 2019; Eifert et al., 2015). A family caregiving relationship may then increase responsibilities for the carer, not only in supporting the well-being of the recipient, but also in maintaining a positive relationship with the recipient while managing demands of the situation. These aspects of caregiving can undermine mental and physical health of carers, but certain characteristics or mindsets of carers may make them resilient to these challenges (Aggar et al., 2011; Lloyd et al., 2019). A self-compassionate mindset may be one important form of resilience because it helps to reaffirm the self in an otherwise demanding and self-depleting situation (Neff, 2023). This study was designed to explore the nature and context for this promising protective factor – the role of self-compassion – in carers' well-being and ability to respond with resilience to the stressors of caregiving.

To examine self-compassion in carers one needs to have a working definition of it. Multiple approaches have been used to define and apply self-compassion outside of the caregiving context; two prominent perspectives informed our research questions at the outset.

A first model by Gilbert et al. (2017), takes a holistic approach to compassion and identifies *Action* and *Engagement* in overall compassion. Taking an evolutionary perspective, Gilbert et al. (2017) noted that compassion encompassed 'sensitivity to suffering' (engagement) and 'action to alleviate it' (action). These two characteristics of compassion are thought to be an evolutionary drive to protect the well-being of others and self, such as a parent providing food for a hungry child. From this work, Gilbert et al. (2017) identified three flows of compassion: 1. *Compassion for others*; 2. *Compassion from others*; 3. *Compassion for self*.

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One should note all flows of compassion support emotion regulation since interactions observed between self and others, or thoughts and feelings within self, can elicit a response (Gilbert, 2014). However, self-compassion is particularly important for coping with stress (Ewert et al., 2021). Indeed, there is some evidence to support better coping and reduced burden in carers of older adults with interventions which include a self-compassion component (Murfield, Moyle, Jones, & O'Donovan, 2020). The nature of the care relationship can also pose challenges for compassion between others, particularly when the recipient exhibits challenging behaviours (Allen et al., 2020).

From research focused on fears of compassion, it was noted that fears of compassion from others and for self had the strongest impact on poor mental outcomes including self-criticism and depression (Gilbert et al., 2011). Drawing on the 'engagement' element of compassion proposed by Gilbert et al. (2017), if one learns to be open and accepting of one's suffering, they can have better understanding of what actions to take. However, potential challenges that arise within the care relationship can hinder or 'block' these actions (Gilbert et al., 2011). We propose that self-compassion is the most accessible and controllable component within the three flows of compassion for carers. For these reasons, we focused on self-compassion specifically in carers of older adults.

Taking an approach focused specifically on self-compassion, a prominent view (Neff, 2003a) suggests the construct includes three positive components, each with opposing negative poles. These include: 1) *Self-kindness* in which individuals treat themselves with gentleness and understanding when faced with difficulties or failures versus *self-criticism*; 2) *Common humanity* where human experience is recognised as shared, and the individual does not feel they are the only one experiencing challenges or struggles versus *isolation*; 3) *Mindfulness* where awareness of difficult thoughts and feelings is achieved with acceptance rather than engagement versus *over-identification* with thoughts and feelings.

1.1. The role of self-compassion in caregiving

Caregiving may confer challenges including a sense of imbalance in the contribution to the relationship, feeling entrapped in the role, and shame related to perceived inadequacies in meeting expectations (Martin et al., 2006; Reid et al., 2005). Furthermore, with increasing dependency of the recipient, 'engulfment' in the caregiving role may threaten identity as time for activities important to the individual may decline (Eifert et al., 2015; Miller et al., 2008).

Self-compassion may offer a way of reframing carers' experiences. For example, carers may engage in self-compassion at difficult times and focus on a more positive outlook. Indeed psychological distress was found to be lower when self-compassion was greater from a cross-sectional survey of family carers of older adults (Murfield, Moyle, O'Donovan, & Ware, 2020). Furthermore, self-compassion can provide a healthy way to relate to oneself when faced with challenges and stress (Neff, 2023). From the standpoint of Neff (2003a), a self-compassionate mindset in caring would include adopting greater tolerance of one's own limitations whilst being gentle and non-judgmental towards oneself when unable to fulfil caring demands.

Looking to self-compassion experiences in different carer populations, young family carers are challenged to carve out their own enjoyment time and, while they are compassionate for their loved one, they can lack self-compassion (Berardini et al., 2021). For example, mothers of children with Autism spectrum disorder recognised benefits of self-compassion, including self-care and self-kindness, but also identified barriers, including self-judgement and lack of time (Bohadana et al., 2021).

1.1.1. Current research

There is insufficient research exploring the role of self-compassion in family carers of older adults (Murfield, Moyle, Jones, & O'Donovan, 2020). Yet there is reason to believe it is an important and potentially beneficial resource in this population because carers tend to focus heavily on providing compassion for the recipient, but as a result opportunities for self-focus and self-compassion are likely to be challenged. The current study was designed to address this gap in our knowledge to explore carer understanding and experience of self-compassion. We approached this question using a qualitative approach to allow in-depth exploration of individual experiences informed by, but not restricted to, existing researcher reviews on what self-compassion entails.

Two approaches informed the interviews conducted. First, for Gilbert et al. (2017), self-compassion operated in conjunction with compassion for others and from others. This model provided a useful representation of compassion exchanges within a family caregiving relationship. The self-compassion components proposed by Neff (2003a) also guided the study. Self-compassion in carers was explored within the context of the family care relationship by drawing on these two models.

This approach balanced existing models with receptiveness to new information provided by the carers themselves, allowing us to explore two research questions:

1. How do carers understand self-compassion and its role in their lives?
2. What challenges do carers face with engaging in self-compassion within the caregiving context?
3. What facilitates self-compassion for caregivers in their everyday lives?

2. Methods

2.1. Participants

The study gained ethical approval from the University Research Ethics Committee. Participants were recruited through relevant organisations/charities, email contacts, snowballing through study participants, and researcher contacts.

Inclusion criteria for the study were that participants: 1. Were aged over 18 years; 2. Provided emotional and/or physical care for an older adult recipient who relied on them at least once weekly; 3. Cared for someone over 65 years; 5. Spoke English fluently (for communication). Flexibility was allowed where a care recipient was close to age 65 or had moved recently into residential care. In these latter cases, recipients had moved to residential care from 3 weeks to 19 months before interview.

All interviewed participants were retained, with none choosing to withdraw from the study. One person expressed interest in participating but was later unable to take part due to passing of the care recipient.

One non-binary, five men, and eleven women participants were interviewed for the study (Table 1). Participants' age ranged from 27 to 87 years ($M = 54.71$ years, $SD = 14.38$), with recipients ranging from 59 to 90 years ($M = 82.01$ years, $SD = 8.95$). Time spent caring ranged from one year to over 26 years ($M = 6.71$ years, $SD = 6.56$).

Individuals received a £10 voucher following participation. Debriefing information was forwarded to participants to ensure they were aware of how their information may be used.

2.2. Data collection

Informed consent was obtained, and interviews were conducted by FW between May 2021 and January 2022. All participants were previously unknown to the researcher, apart from two who were previous acquaintances.

Participants were initially asked about their caregiving context to determine suitability for the study. This involved discussion to gain understanding of the participant's situation, for example exploring the relationship between carer and recipient and the nature of care provided.

A semi-structured interview schedule was used. The interview schedule (Appendix A) was designed based on previous research (Pauley & McPherson, 2010), including the Neff (2003a) components of

Table 1
Participant characteristics and caregiving conditions.

Characteristic	Participant
Age (%)	–
27–40	2 (11.76)
41–53	9 (52.94)
54–69	4 (23.53)
80–89	2 (11.76)
Gender (%)	–
Non-binary	1 (5.88)
Men	5 (29.41)
Women	11 (64.71)
Ethnicity (%)	–
White	15 (88.24)
Mixed	1 (5.88)
Other	1 (5.88)
Recipient relationship (%)	–
Father	3 (17.65)
Mother	7 (41.17)
Father and mother	1 (5.88)
Spouse	3 (17.76)
Grandfather	1 (5.88)
Mother-in-law	1 (5.88)
Friend	1 (5.88)
Caring time/living arrangement (%)	–
1–2 years	4 (23.53)
3–5 years	7 (41.17)
7–12 years	4 (23.53)
16 years+	2 (11.76)
Lived with recipient	5 (29.41)
Care provided/diagnosis (%)	
Emotional	3 (17.76)
Companionship	6 (35.29)
Mental health	1 (5.88)
Everyday living	13 (76.47)
Mobility	3 (17.76)
Vision or sight	3 (17.76)
Chronic health condition	7 (41.17)
Stroke	1 (5.88)
Memory	5 (29.41)
Dementia	8 (47.06)
Alzheimer's	3 (17.76)
Parkinson's	1 (5.88)
Multiple Sclerosis	1 (5.88)
Additional work demands (%)	–
Employed or self-employed	11 (64.71)
Retired	4 (23.53)
Student	1 (5.88)

Notes: N = 17.

self-compassion, and the self-compassion component of the Compassionate Engagement and Action Scale (CEAS) (Gilbert et al., 2017). To gain understanding of self-compassion from the carers' perspectives, we did not provide participants with a definition but instead asked them to define what self-compassion meant to them. After each question, prompts were used to encourage participants to describe experiences in greater depth.

Interview duration ranged from 37 min to 1 h 34 min (M = 58.71 min, SD = 17.00). Two participants requested telephone interviews because of internet connectivity issues and all other interviews were conducted online using Microsoft Teams. Automatically generated initial transcripts recorded using Microsoft Teams were then promptly corrected by the researcher and pseudonyms were created to replace real names. Microsoft Teams was used to record all interviews, regardless of whether interviews were by telephone. All other identifiable data was also removed.

2.3. Data analysis

Thematic analysis (TA) was used to analyse the data. We used this approach to allow in depth exploration using an existing framework of self-compassion whilst maintaining flexibility to identify patterns of experiences specific to a carer population. To build an illustration of self-compassion based on experiences of carers within this sample, an inductive approach was applied with a focus on latent assumptions within the data (Braun & Clarke, 2006). This meant we were able to consider all aspects of carers' reported experiences which became apparent throughout the interview process. Deductive methods, drawing on existing theories, informed the interviews and analysis.

The researcher recorded their own thoughts experienced during interviews to consider during analysis. This reflexive approach is important in TA since themes derived from interviews include meanings based on the researcher's subjective experience of the process (Braun & Clarke, 2019). Reporting on potential influences of past experiences, the first author had spent time living with older relatives. This deepened understanding of the importance of keeping a loved one at home for the well-being of both individuals.

For the current project, Nvivo Pro 12 (QSR International Pty Ltd, released 2018) was used to code the data; codes were then sorted into themes. Codes included quotes related to self-compassion; themes represented overall descriptions of codes based on shared underlying meanings. The researcher identified the codes with a focus on participants' experiences and beliefs about self-compassion, with some codes being applied across participants. Where participants supplied information which did not fit with previous comments, a new code was added.

The TA method suggested by Braun and Clarke (2006) guided the process of transcription, coding, and analysis, where patterns are identified within the data (Braun & Clarke, 2006). The first author repeatedly read interviews following transcription before coding quotes. After completing this process for the first five interviews, findings were discussed between authors, and it was noted that meaningful patterns were not evident at this stage. After seventeen interviews authors were satisfied that saturation had been reached. At this point, codes with shared meanings were merged and those identified as irrelevant were eliminated. Through discussion, final revisions were made.

For rigor, reliability within themes was tested by two researchers external to the study. Whilst this positivist approach has not been advocated for use with TA (Braun & Clarke, 2019, 2021), we tested reliability to check alignment of themes against existing theories drawn upon in this research and for greater generalisability. This was important for since an aim of the study was to inform future interventions.

Each researcher testing reliability coded 25% of the data at theme level using the theme descriptions (Table 2). From this process, three themes showed less reliability (Theme 1: 31.08%; Theme 5: 47.62%; Theme 6: 53.33%). These themes were discussed with the external researchers to clarify differences in understanding. The external researchers coded further data for these themes. Two of these themes showed increased reliability (Theme 5: 74.19%; Theme 6: 80.65%). Theme 1 increased slightly (41.46%). However, from discussion between contributing authors, it was noted this theme was broad with less defined boundaries to separate information within it. Remaining themes had reliability of >60% (Theme 2: 63.27; Theme 3: 60.71%; Theme 4: 74.58%). There has been no universally agreed threshold for reliability for qualitative data (O'Connor & Joffe, 2020). Therefore, after reviewing how independent coding decisions were made, the team selected to accept themes as sufficiently reliable as they could be.

3. Results

3.1. Overview

Six themes were generated through analysis (Table 2). Theme 1 represented carers' overall experiences including beliefs, actions, and facilitators for self-compassion; Themes 2 and 3 represented barriers for self-compassion; Themes 4, 5, and 6 included facilitators for self-compassion described by carers in the sample.

There was an even spread of codes across themes, with a maximum of four codes. Theme 1 included one code because this was a broader

Table 2
Themes and theme descriptions representing carers' experiences of self-compassion.

Theme	Description
Theme 1: Self-compassion means connected self is prioritised	*Beliefs around what self-compassion means. Ways in which carers do or could achieve self-compassion. Carers described ways they could or were able to make the caring role easier. Connection with one's needs and prioritising them facilitated engagement in self-compassion.*
Theme 2: Compromise and conflict	*Tolerating challenges of caring and associated difficulties. Challenges included external demands including those within the care role and demands of others. Conflict was also identified in self where carers were critical or judgemental of themselves or their ability to care.*
Theme 3: Resource depletion	*Emotional and physical strains of being a carer are a barrier to self-compassion. Carers often described lack of time or resources to prevent them becoming physically or emotionally overwhelmed. They also described restrictions on time for self.*
Theme 4: Connection with others	*Self-compassion is facilitated through connection with others. This theme represents the common humanity component of self-compassion, where connection and recognition of similar experiences and shared understanding with others helps prevent sense of aloneness. Where the opposite of this experience occurred, caregivers described feelings of isolation and disconnection from others.*
Theme 5: Coping mindset	*Recognising and understanding the challenges of the situation. Mindfulness is demonstrated in this theme, where carers demonstrated openness to observing challenges and emotions tied to the situation without becoming overwhelmed. For some carers this allowed clarity and acceptance. Carers were also able to reflect on the extent of their difficulties, recognising that the situation could be worse.*
Theme 6: Setting boundaries	*Setting boundaries to preserve well-being and needs. Carers actively expressed needs and limits to what they could provide. They also preserved their interests and separate roles from caring for the recipient.*

theme. Participants contributed to all themes, with the minimum of eleven participants contributing to one of the themes. Together these themes described beliefs, actions, barriers, and facilitators for self-compassion in the context of participants' everyday experiences.

Themes are described in detail below. Additional example quotes can also be found in Appendix B.

3.2. Self-compassion means connected self is prioritised

This theme provided an overarching description of what self-compassion involved and how it was achieved. Furthermore, participants demonstrated 'connection' with their needs through understanding of what these were and how to meet them. Needs included activities, thoughts, and actions which carers perceived as self-compassion.

In this theme, carers described activities and conditions which allowed them to achieve self-compassion within the caregiving context. This was demonstrated by Anna, who sometimes lived with her mother aged 80, but often care was by distance since her mother lived abroad. Anna's mother experienced a number of health conditions, including osteoporosis and heart problems. She required help remembering to take medications and to keep up with medical appointments. Anna spoke regularly with her mother and kept on top of care arrangements in her absence. Anna also worked full-time and met demands of a busy job. She identified when she needed self-compassion and how spa visits provided relaxation. However, these visits were only possible for her when she was able to find time:

> *"I do go to the spa as often as I can, when I can get the time and that's always lovely and relaxing."*

In this quote, Anna identified self-nurture as her self-compassion, where she prioritised time for herself when she was able.

Carers described how they utilised available time for enjoyable activities. For example, Julie no longer worked but instead cared for her father, aged 85, who had vascular dementia, hypertension, deafness, and was blind. She described how writing poetry was outlet and form of enjoyment. Julie additionally cared for her brother who had learning disabilities. Julie's other brother helped sometimes but was often unavailable. Although Julie had considered larger writing assignments, poetry seemed more manageable with less demand on her time:

> *"And that feels like something that I could try and fit in. Because it's writing poetry, it's not it's not studying. I don't have to research and read books."*

Julie also identified engagement in chosen over obligatory activities as self-compassionate:

> *"They're not have to things, they're nice to things."*

Self-kindness, involving being gentle with yourself when facing difficulties, was described by Grace who was retired and cared for her husband, aged 90. Grace struggled with the situation as she was unaware of her husband's dementia diagnosis until he moved into residential care. Grace was also challenged with her own health, such as high blood pressure and physical pain. Throughout her interview, she described worries that she was less kind because of her emotional struggles. She identified kindness towards yourself as self-compassion:

> *"Self-compassion is loving yourself, forgiving yourself because you know you're not perfect."*

Self-compassion in caregiving also involved thinking of oneself as a priority, with needs independent of the recipient. Anna recognised the importance of self-care and how this could impact her ability to care:

> *"Making sure you look after yourself er and keep yourself in as good, both mental and physical health so that you can help the others. So not not forgetting yourself in the process basically."*

Lauren shared caring responsibilities for her grandfather, aged 90, with her mother. Lauren was a student and worked part-time. Her grandfather had diabetes and dementia requiring daily support. She recognised the importance of providing the care she wanted without compromising her own health:

> *"Not doing something too strenuous just because you need to or just because you want to help the person you're caring for."*

In summary, 'connected self' within this theme was demonstrated through self-focus and awareness of one's needs. This awareness allowed carers to engage in activities, thoughts, or actions which they identified as self-compassionate.

3.3. Compromise and conflict

This theme included conflict within self, such as self-criticism and emotional challenges. It described challenges blocking self-compassion, including managing demands of others such as family members and the care recipient. Carers described barriers to self-compassion including role conflicts, demands of others (such as other family members), and self-judgement. In this theme carers described compromising their own needs to meet the needs or expectations of the recipient.

Role conflict was illustrated in Mark's experience in caring for his wife, aged 71, who had been diagnosed with Multiple Sclerosis and needed ongoing physical and practical assistance. He cherished his relationship with his wife, but this had changed due to the need for constant monitoring and care. He described a sense of loss for the

relationship they once had. Mark was retired but engaged in activities he enjoyed, such as volunteering, but this was sometimes interrupted by problems at home. Despite these challenges, Mark commented his love for her remained strong:

"I still love my wife as much as I ever did. It's just very very different. She's so much now more my patient rather than my wife, but I try and ignore that."

Role conflict was experienced by Alex who worked and cared for their mother, aged 84, who was diagnosed with dementia. She was also unaware of Alex's non-binary identity, which Alex described as the "*challenges of actually being me,"* and commented *"it's almost like I'm living two separate lives."* This meant Alex was unable to be their true self or focus on their own needs in meeting their mother's expectations.

Another challenge to self-compassion was perceived obligation to tolerate or please others, including the care recipient and other family members. Sophie, who also worked described challenges she faced with her father's (aged 89) behaviour and mood when she visited. Sophie's father had vascular dementia and Parkinson's and she described how she often experienced a display of emotions from her father because of his difficulties. Sophie put her feelings aside and tolerated these behaviours since she knew her father needed her:

"A lot of the time you know his erm, you know his erm he can fly off the handle, he seems quite childish."

Grace illustrated her struggle to treat herself with compassion and kindness and perceived her actions in a negative light:

"I hate what I'm doing at times when I get angry, and that that will take a long time to go after. I feel I totally let him down when he needed me the most, I was the most horrible."

Grace's quote illustrates conflict between care she wanted to provide and sense of failure to contain difficult emotions. This meant that rather than noticing her struggles, she focused on the impact of her actions on her husband. Grace also illustrated how her struggles prevented self-compassion:

"Every morning I would get up and say, "please God, just make me nice, that's all," and every day I wasn't. And how can you feel compassionate for yourself? You can't, I can't."

These quotes highlighted difficulties carers faced with self-focus and ability to meet their own needs. Sometimes these difficulties were in the form of self-judgement and conflict between meeting their own needs and those of the recipient. In the last quote from Grace for example, it was evident that she was torn between the care she wanted to provide and the care she was able to provide. Conflict of roles for Mark, Alex, and Sophie meant these participants often needed to put their own needs on hold in meeting the needs of their relative.

3.4. Resource depletion

Self-compassion was impacted by the volume of demands encountered leaving little time for self, emotionally and physically. Carers sometimes felt overwhelmed and, where other people were unable to assist, carers often appeared frustrated.

Ability to balance individual demands was challenging for carers. Individual demands, such as caring for children and work, meant time was often split between roles. Lily described the necessity to plan work and family time around caring:

"Then something else would go, you know something would happen in the week. You you trying to fit that in with everything else, that that's when it was hard."

Lily received assistance in caring for her mother, age 83, but not consistently. Lily's mother used a wheelchair and struggled with mobility and hearing. Lily noted that she had two brothers who did not help which left her feeling let down. She also had children and needed to include them in planning; combining their needs with trips to her mother's home put a strain on her time.

Emotional depletion was demonstrated in Sophie's experience of meeting caring needs:

"It doesn't matter how much time you give to someone in their sort of end-of-life period, it's never enough. You can never meet their needs because it it's it's like a great big hole."

Time for self-compassion was a challenge for Ted, who was retired, described difficulties in planning time away for himself due to demands for care of his mother, aged 89, who needed help with mobility and his father, aged 87, who had dementia, heart, and sight problems. It was evident that if he went away, he would need to remain available for his parents in an emergency:

"Just thinking of going away on holiday for that week. You know I've put things in place but (pause) will I be able to detach myself from what's going on at home? No because I'll still be expecting a call."

Being the only person able to provide certain care was a challenge for self-compassion. Anna described how her presence was essential at appointments to interpret conversation into another language:

"If my mum doesn't understand something, there is nobody there who can interpret it for her, and then it's going to be just a waste of everybody's time, so we rescheduled the appointment for early October."

Greater demand was then placed on Anna's time as she was unable to depend on others for this type of support.

In summary, demands on time and space as well as emotional strains of caring left carers depleted of these resources. Self-compassion was impacted by attention being directed towards demands and away from the carers' own needs.

3.5. Connection with others

Carers described self-compassion as facilitated through connecting with others in this theme. Carers who felt connected were able to recognise and understand their experiences as similar to those of other carers. This was evident if carers shared their experiences with others or if care responsibilities were shared with other family members. In contrast, carers sometimes demonstrated aloneness and disconnection, for example when they felt like the only person in their position or were unsure how to help the recipient.

Anna demonstrated a sense of release in connecting with others:

"Sometimes a shoulder to cry on erm and kind of gets all the frus … sort of the tension out of you."

Connectedness was demonstrated by Grace through recognition of potential struggles of other carers, but without seeing or hearing of these struggles she felt uncertain whether these struggles occurred:

"If you saw other carers getting cross and angry then you wouldn't be so hard on yourself, but you don't, and they're probably all feeling resentful and hard at times."

Connectedness was challenged for Rachael who moved away from work and home to provide care for her mother, aged 89, who was diagnosed with dementia and needed physical help for some time due to a broken arm. Although Rachael attempted to counter this disconnection through support groups, she still felt alone in her experience:

"I did feel like I was the only person, and I was really the only person I knew who was had cared in the same way as I'm caring, you know, living at home and it all being on me."

Julie recognised others experienced similar, but felt very alone:

"I absolutely think there are other people out there. But I'm also aware that sometimes, I feel extremely alone. Actually, a lot of the time I feel extremely alone. I feel like I've been left with the burden of this."

This sense of acknowledging common humanity but still feeling alone was echoed in Ted's interview:

"Even though I know it's not a fact, I do feel that I'm the only person at times, yes."

Connecting with others provided comfort where carers felt able to express their struggles and feel understood. In this way, they were able to accept compassion from others. Challenges arose when carers experienced difficulty in sharing their experiences or when they were unable to identify similar experiences in others. It was evident that feeling burdened with challenges of caring created a barrier to connectedness.

3.6. Coping mindset

This theme involved recognition and understanding of challenges with acceptance and clarity. Carers demonstrated openness to face challenges and difficult feelings in this theme. Tendency to not dwell on difficulties prevented carers from becoming overwhelmed, allowing reflection. Openness also allowed carers to recognise their emotional and physical limits within the situation. They were then able to maintain perspective of challenges they faced.

One example of coping mindset was demonstrated by Eva. Eva worked and cared for her mother, aged 59, who needed emotional support and had experienced ongoing conditions, including fibromyalgia. Eva recognised and accepted that she did not always have control in situations and that worrying was unhelpful:

"There's no point dwelling, 'cause it's not it's not going to change anything, it's not going to make me feel any better, and there's no point in worrying because I can't I have literally zero control."

Lauren demonstrated understanding and acceptance of herself as a carer for her grandfather. However, she also had professional experience of caring which required her to reflect on her actions and experiences. She brought these skills to the informal care setting, allowing her to recognise and accept her feelings and responses to situations:

"*I don't judge myself or anyone for acting or feeling a certain way if they're in a time of distress, difficulty or emergency."*

A non-judgemental mindset was echoed by Anna:

"I'm not judging myself thinking or, you know, I should be stronger, I should be this, I should be this should be that whatever. Erm, yeah, I think I'm quite OK, with myself."

Incorporating a self-kindness mindset was then helpful for both Lauren and Anna.

Participants reminded themselves of the extent of their challenges by taking note of difficulties faced by others. For example, William, who was looking for work, cared for his father, aged 81, who had Alzheimer's and vascular dementia but reflected on his situation with a positive perspective in noting that the challenges could have been greater:

"By looking at other people's situations that are a lot worse than mine erm and his own health could be a lot worse erm, so we take, we take that as a positive and that's why."

A coping mindset allowed participants to reflect on and maintain perspective of their situation. Self-compassion was facilitated by stepping back and looking at the bigger picture. In this way, carers were able to recognise the extent of their abilities and to understand the level of control they had in the situation.

3.7. Setting boundaries

Setting boundaries facilitated self-compassion through carers' recognition and expression of their limits. In this theme, carers were able to maintain other roles and priorities outside of the care relationship. By setting boundaries, carers were able to maintain separate interests and needs. Boundaries between caregiving and time away allowed carers to preserve an individual identity. It also allowed them time for self-focus and time to focus on others who were important to them, such as other family members.

This theme was demonstrated when caregivers described times when they asserted their need for space. One example was from Mel whose mother-in-law, aged 85 and diagnosed with Alzheimer's, was dependent on her making it difficult to focus on her own needs. She described how she asserted her need for space to her husband when she became overwhelmed:

"At the time, all I would do is I would just say to James, I would just go that's it, you're on duty, I just need to, you know erm, take myself away from it."

There were times when carers asserted their need for time alone directly to the recipient. Julie described how she spent more time at her father's home than her own because he was dependent on her care. She managed this problem by scheduling time for zoom classes to set boundaries around her time. Scheduled times provided her with a reason to be away:

"*He's not always happy, but I can say to him I'm going upstairs for an hour, so you need to tell me now if you want anything because I'm not available for an hour."*

Eva described the natural boundary between caring for her mother and her own mothering role. She also noted that being a mother was a role which was naturally separated from caring because they both resided in different homes:

"So, when I come back to my my own home, I'm not the informal unpaid carer that I am there."

Mel also recognised how her job provided natural boundaries to caregiving:

"I think erm (pause) I think I almost would have felt worse if I didn't have a job and something else to fill to give me another identity."

Taken together, boundary setting was achieved through actions of the carer but sometimes occurred naturally due to caregiver circumstances. Maintaining some form of separation facilitated fulfilment of individual needs.

4. Discussion

This study investigated understanding and experiences of self-compassion in the everyday lives of family carers of older adults. Another aim was to understand challenges carers faced engaging in self-compassion within the caregiving context. Facilitators for self-compassion as they were identified by carers. We were informed by the Gilbert et al. (2017) focus on action and engagement in compassion for self, others, and from others and Neff's (2003a) conceptualisation of self-compassion. Other than an eye towards these models, we started with the knowledge that conceptualisation of self-compassion had varied within the literature and indeed explored the very definition of the construct in this study. We assumed, stemming from previous research, that self-compassion may play an important role in well-being of family carers. With this assumption in mind, we observed how carers felt they could practice self-compassion and kindness towards themselves and what conditions made this possible.

All six themes identified from our interviews aligned with self-compassion as defined in previous research and models of self-

compassion (Gilbert et al., 2017; Neff, 2003a), demonstrating that self-compassion is indeed relevant in a family caregiving context and can be broadly understood through these models.

Across interviews, participants described what self-compassion involved for them, and how they were able to achieve self-compassion (if at all). This overarching theme included activities for enjoyment, but also activities for coping and allowing space for oneself. The essence of this theme was self-connection and recognition of one's needs and how to fulfil them. Sometimes this involved actions, such as engagement in self-care behaviours, and sometimes this involved being gentle with oneself at times of difficulty. This theme aligned with the *self-kindness* component of self-compassion (Neff, 2003a), but some element of the *mindfulness* component was evident, since connection with one's needs was necessary to meet them. In the model of Gilbert et al. (2017), action and engagement in self-compassion was then facilitated through self-connection.

The perception of engagement in self-care behaviours to fulfil carers needs somewhat aligns with loving-kindness meditation. This practice includes a self-care approach where feelings of kindness are directed towards oneself (Reilly & Stuyvenberg, 2023). Furthermore, a meta-analysis has shown a loving-kindness approach can increase overall self-compassion (Reilly & Stuyvenberg, 2023). These findings highlight the importance of engagement in self-focused activities identified by carers in the current study.

Recognising barriers to self-compassion also provides valuable insight into supporting engagement in self-compassion within the caregiving context. Furthermore, Gilbert et al. (2011) noted we need more than to recognise facilitators for self-compassion, such as openness to difficulties and identifying one's needs. One should also understand the barriers and how to tackle these to access a self-compassionate mindset.

In two themes, participants described barriers to self-compassion, largely from conflicts, stresses, and compromises they made during caregiving. These barriers interfered with self-compassion by shifting participants into a caring role, often involuntarily. Furthermore, they made compromises by holding back on activities important or enjoyable to them, instead prioritising the care recipient's needs. Sometimes conflicts occurred in the form of participants' harsh judgement towards themselves when they felt they had not provided the best care. Additionally, demands on time for caring and other responsibilities (such as work or family) combined with inability to take time away from the situation meant that carers were often required to manage multiple demands leaving little time for themselves.

The barriers experienced by carers in the current sample are not dissimilar to those experienced by young carers, who struggled to find time for themselves and instead prioritised the care recipient (Berardini et al., 2021). Or the lack of time which was highlighted by mothers of children with Autism spectrum disorder (Bohadana et al., 2021).

'Connection' demonstrated how the *common humanity* aspect of carers' understanding of self-compassion facilitated but sometimes hindered a self-compassionate mindset (Gilbert et al., 2011; Neff, 2003a). Participants who were able to share their experiences with others, or recognise similar experiences in others, were able to find comfort and maintain a sense of social connection with other people and carers. Through connection, carers also may be in a position to receive compassion from others; another important facet in the flows of compassion (Gilbert et al., 2017). However, carers could feel alone in their experiences when connection was absent. Aloneness was amplified by reflecting on one's own actions in comparison with actions observed in others. Although there was recognition that opportunity to observe other carers' experiences may have facilitated sense of connection.

Although mindfulness was not directly discussed by carers, it may have been reflected, in a somewhat different form, in discussions of viewing the caring situation without becoming overwhelmed. This was observed as a 'coping mindset', in which carers demonstrated understanding and acceptance of their situation.

Participants recognised limits that facilitated boundaries around what they could provide. From the perspective of Gilbert et al. (2017), acceptance was evident where participants engaged with difficult emotions arising from challenges demonstrating ability to reflect, reason, and act to remain within these limits (Gilbert et al., 2017).

4.1. Broader context within caregiving

The current study highlighted the intense strain that carers experienced, both physically and emotionally. Looking to the care relationship, a prominent finding was the emotional demands of adapting to a changing relationship, which was particularly noticeable when the recipient was experiencing dementia symptoms. When faced with these demands, it was evident that carers often felt overwhelmed. What helped in these situations was ability of carers to maintain perspective of the situation and their role in it. This can be described within the context of *mindfulness,* which Neff (Neff, 2003a) defined as a precondition for other self-compassion components.

It should be noted that benefits of mindfulness could depend on mindset. Influence of mindset may be explained through research focused on self-reported burden in carers of people with dementia (Lloyd et al., 2019). Burden can be defined as perceived physical or psychological stresses, consequent of caregiving. In reference to psychological stress, measured burden was lower when emotion-focused strategies (such as acceptance or humour) were applied (Lloyd et al., 2019).

In the context of the current research, mindset was a strategy which carers utilised to reduce negative perceptions of their situation. From a negative standpoint in the study of Lloyd et al. (2019), carer burden and dysfunctional coping strategies (such as disengagement or denial) were most often reported by carers with lower self-compassion. The findings from Lloyd et al. (2019) and the current study suggest self-compassion may be facilitated through a mindset in which carers could notice difficulties they faced with greater tolerance and understanding of their own limitations.

Looking to research demonstrating relationship context, carer burden was reported to be lower where reciprocity within the care relationship was greater (Reid et al., 2005). Additionally, role engulfment has been identified as occurring in care relationships where the carer lost their individual identity as time for activities once important to them started to diminish (Eifert et al., 2015; Miller et al., 2008). Carer perception of identity preservation has also been linked with burden in carers. For example, perceived change in identity was linked with greater burden in dementia carers (Enright et al., 2020).

Focusing on the current study, carers managed challenges of caring and maintaining an individual identity by separating their different roles. Some achieved this by building physical distance from their caregiving relationship, for example when the carer lived at a different location, whereas sometimes this occurred through their assertion of need for time or space.

Although connection with others facilitated self-compassion, loneliness was also described in discussions of aloneness and isolation. Loneliness has been defined in various ways (Fakoya et al., 2020), but here it was discussed as a 'perception' of being alone or disconnected from others whereas 'social isolation' included lack of social connection with others, including friends, family, or wider social network (Fakoya et al., 2020). Perception of aloneness therefore created a barrier to self-compassion for participants who felt disconnected, whereas self-compassion was facilitated for those who experienced sense of connection.

Overall, carers defined self-compassion in terms of enjoyed activities and conditions which made these possible. Carers were also aware of strategies to lighten demands where possible. However, it was apparent that awareness of what self-compassion involved was not sufficient for its application in everyday life without a coping mindset and carers struggled when faced with self-judgement, conflicts, and strains such as lack of time. Whilst connecting with others allowed carers to share

experiences or reduce feelings of isolation, there were carers who described sense of aloneness and disconnection from others. This study demonstrated that self-compassion in family carers was reliant on the framing of experiences but understood in terms of conditions and activities. Despite the presence of barriers to self-compassion, this was achievable with clarity of the situation and through setting boundaries to separate roles.

4.2. Strengths and limitations

By focusing on how participants understood self-compassion in their own lives, this research highlighted carers' needs within the context of the care relationship. Furthermore, we were able to develop understanding of a mindset which facilitated self-compassion for these carers which could inform future interventions.

A limitation of the study was that we only explored diagnoses of care recipients. Although some participants did describe problems with their own health, we did not explore this further or ask if carers had received medical or psychological diagnoses themselves. It would have been informative to gain understanding of health challenges these carers may have been experiencing and how they managed these within the caregiving context.

We also recognise that experiences of females make up much of the sample included in this study. It would have been insightful to have accessed a more gender balanced sample.

Despite the knowledge gained through this research, we acknowledge that qualitative approaches inevitably involve interpretation by the researcher. However, the findings provide valuable insight which may not be easily accessed through quantitative methods, including caregiver definitions and their understanding of self-compassion.

4.3. Future directions and conclusions

It would be fascinating to explore carers' views on self-compassion interventions that would be useful and accessible to carers within their schedules. This would likely involve discussion of self-compassion and how this might be applied in caregiving. Carers may consider their own barriers to self-compassion and what might help them overcome these. Methods of delivery should be discussed, for example carers may not be able to travel to sessions whereas others may prefer to meet away from the care setting. An approach which is adaptable to a range of scenarios would be most beneficial and perhaps more appealing to carers.

The study focused on self-compassion in family carers of older adults, informed by models outlined in Neff (2003a) and Gilbert et al. (2017), but receptive to the lived experiences of our carer participants. Carers described self-kindness to be a particularly important quality of self-compassion, but a difficult one: they found it difficult to prioritise themselves over their roles, to avoid self-judgment, and to create the space for self-care. The caregiving relationship itself contributed to these difficulties, leaving many feeling isolated and lonely, depleted and drained. Yet carers identified strategies that helped them, including creating physical distance where possible, having a broader, receptive perspective, and recognising others also experience similar challenges. Overall, self-compassion was intensely important, but also very difficult, in this population.

Data availability

The raw data are not publicly available to protect participant privacy.

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CRediT authorship contribution statement

Farah Wiita: Writing – review & editing, Writing – original draft, Visualization, Validation, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Netta Weinstein:** Writing – review & editing, Visualization, Supervision, Formal analysis, Conceptualization. **Aileen K. Ho:** Writing – review & editing, Visualization, Supervision, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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