The Experience of Self-Compassion in Individuals Suffering from Long COVID

by

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A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Education

in

Counselling Psychology

Department of Educational Psychology

University of Alberta

Abstract

Long COVID is a chronic health condition that persists following recovery from COVID-19 infection and is linked to a staggering range of mental health difficulties. Self-compassion has been found to protect against psychological distress in those with other chronic health conditions. However, research on self-compassion for people with Long COVID is scarce. Furthermore, little is known about the experience of self-compassion from the perspective of those suffering from this challenging health condition. This study aimed to develop an in-depth understanding of the lived experiences and perspectives of self-compassion in adults with Long COVID. An interpretative phenomenological analysis (IPA) approach was implemented to explore, describe, and interpret participants' lived experiences. Data were collected by conducting one-on-one semi-structured interviews with six participants, ranging between the ages of 22 and 60. Data analysis was based on Smith et al.'s (2022) seven-step approach for IPA studies. Five group experiential themes were produced based on participants' experiences of self-compassion during their time with Long COVID: accepting Long COVID, turning down the dial, directing attention to the positive, compassion from others, and validation of the Long COVID experience. These findings provide a nuanced understanding of how self-compassion may play a role in the coping and recovery processes of those with Long COVID. Clinical implications, limitations, and avenues for future research are also discussed.

Keywords: self-compassion, Long COVID, post COVID syndrome, COVID-19, chronic illness, interpretative phenomenological analysis

Preface

This thesis is an original work by Brandon Kyle Krebs. The research project, which this thesis is apart of, received research ethics approval from the University of Alberta Research Ethics Board, "The Experience of Self-Compassion in Individuals Suffering from Long COVID", Pro#00130920, May 29th, 2023.

Acknowledgments

My completion of this thesis project would not have been possible without the kindness, compassion, and support of so many truly wonderful individuals. First, I want to thank my thesis supervisor, Dr. Jessica Van Vliet. You have always been caring, patient, and compassionate as you guided me through this thesis project and, more broadly, through my master's degree in counselling psychology. The current thesis project only came to fruition because of the countless hours you dedicated to guiding me throughout the design, implementation, analysis, and write-up processes. I am incredibly grateful for your mentorship. Additionally, I want to thank the other members of my thesis committee, Dr. Veronica Smith and Dr. Maxi Miciak. I am appreciative of the time you have volunteered out of your busy schedules to be a part of this process. Thank you also to Dr. Doug Gross and all the members of the Rehabilitation Research Centre; you have taught me so much about conducting research and helped me progress as an academic.

Thank you so much to my incredible parents for always being there to support me, offer me guidance, and keep me grounded throughout my academic journey. You have always provided me with the opportunities I needed to reach my goals. For your support, I am forever grateful. I would also like to thank my loving girlfriend, Victoria, for always supporting and being patient with me throughout my academic journey. Although there were many long days and late nights dedicated to completing this thesis project, getting to spend even a minute with you helped recharge my batteries and allowed me to continue to push forward. Finally, I would like to thank all my friends, both in and outside of academia, who offered me support and company throughout this process. Having all of you as part of my support system helped me to remember to enjoy the journey and not just focus on the destination.

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Chapter 1: Introduction

Background

Following COVID-19 infection, roughly 10–35% of individuals in the general population and up to 85% of individuals hospitalized due to COVID-19 report related long-term health complications, classified as Long COVID (Pavli et al., 2021). Long COVID, also referred to as post-COVID syndrome or post-acute COVID-19 syndrome, is a chronic health condition that encompasses a range of symptoms including, but not limited to, fatigue, joint and chest pain, cognitive impairment (Aiyegbusi et al., 2021), cardiac abnormalities, muscle pain, and impaired lung function that persists for more than twelve weeks after COVID-19 infection (World Health Organization, 2023). The symptoms of Long COVID are also highly persistent over time, as evident in a study by Davis and colleagues (2021) indicating that 91% of individuals diagnosed with Long COVID still reported symptoms 35 weeks after the initial COVID-19 infection. Based on the current literature, Long COVID appears to be a prevalent and long-lasting chronic health condition with many adverse symptoms.

Although COVID-19, and subsequently Long COVID, may be thought of as primarily a physical health ailment, researchers have found that there is a wide range of mental health sequelae experienced by individuals with this condition (Burton et al., 2022; Lyons et al., 2020; Thye et al., 2022; Vindegaard & Benros, 2020). Specifically, Long COVID can lead to several psychological difficulties, including feelings of depression and anxiety (Ismael et al., 2021; Shanbehzadeh et al., 2021), as well as insomnia (Badinlou et al., 2022) and reduced quality of life (Burton et al., 2022; Malik et al., 2022). Exemplifying some of the psychological consequences of Long COVID, Houben-Wilke and colleagues (2022) examined the prevalence of mental health symptoms in 239 individuals (82.8% women) six months following the onset of

Long COVID symptoms and found that 26.8%, 34.7%, and 40.6% of participants endorsed clinically elevated symptoms of posttraumatic stress, anxiety, and depression, respectively (Houben-Wilke et al., 2022). Collectively, the current literature strongly suggests that Long COVID can contribute to various adverse psychological outcomes.

In response to the array of mental health complications associated with Long COVID, recent research has focused on examining mechanisms that may help explain this relationship. One factor that may have a critical role in explaining the development and maintenance of mental health problems in this population is the body's inflammatory stress response (Penninx, 2021; Pierce et al., 2022). The inflammatory stress response occurs when a stressful event or trigger causes the activation of the sympathetic nervous system and the subsequent release of the corresponding hormones, neurotransmitters, and neurochemicals (Liu et al., 2017). Chronic activation of this inflammatory stress system is prevalent in most chronic diseases (Liu et al., 2017) and is linked to symptoms of depression, anxiety, bipolar disorder (Najjar et al., 2013), and posttraumatic stress disorder (PTSD; Michopoulos et al., 2017).

Numerous psychological factors may also be associated with the mental health symptoms commonly experienced by individuals with Long COVID (Becker et al., 2021; Dai et al., 2022; Voruz et al., 2022). One factor in particular that may be involved in the mental health symptoms of individuals with Long COVID is disruptions in the emotion regulation system (Voruz et al., 2022). Indeed, difficulties with emotion regulation are commonly associated with mental health concerns, such as symptoms of depression, anxiety and posttraumatic stress (Berking & Whitley, 2014; Sheppes et al., 2015), which are also commonly reported in individuals with Long COVID (Ismael et al., 2021; Shanbehzadeh et al., 2021). Numerous protective factors also play a role in mitigating the severity of the mental health complications observed in people with Long COVID.

Specifically, psychological resilience (Becker et al., 2021), mindfulness (Dai et al., 2022), and tolerance of uncertainty (Burton et al., 2022) are all believed to be related to the quantity and severity of mental health difficulties experienced by individuals in this population.

One psychological construct that has only just begun to be examined in individuals suffering from Long COVID and that may have a significant role in people's experience is self-compassion. Self-compassion can be defined as exhibiting understanding and kindness to oneself during times of suffering, fear, or failure (Neff, 2003a, 2011). Gilbert (2009a, 2009b), one of the leading thinkers in self-compassion research, proposed that dysregulation between three emotion regulation systems often contribute to the occurrence of mental health difficulties. These systems include (a) the threat detection and protection system, which is the alarm center of the brain and activates defensive responses such as the fight or flight response; (b) the soothing and social safety system, which elicits feelings of comfort, contentment, and social connection; and (c) the drive and excitement system, which motivates humans to seek resources necessary for survival and thriving. An imbalance between these three emotion regulation systems can produce feelings of shame and guilt and self-critical patterns of thinking. According to Gilbert (2009a), compassion and self-compassion are healthy ways in which individuals can foster their soothing and social safety system to help regulate emotions and alleviate feelings of shame, inadequacy, guilt, and failure. Gilbert's conceptualization of self-compassion seems particularly relevant in the context of Long COVID, as individuals with Long COVID are commonly left unable to perform daily life tasks that they were previously able and expected to perform. This functional impairment and loss of autonomy may negatively impact social relationships and an individual's sense of identity. Negative changes brought on by Long COVID may be accompanied by activation of the threat detection and protection system, resulting in feelings of shame and guilt as well as self-critical patterns of thinking. In support of this argument, feelings of shame and self-critical thought patterns are commonly reported in individuals with other chronic illnesses (Martensson & Liedberg, 2015; Nicola et al., 2019). Self-compassion may pose a potential antidote to feelings of shame, self-criticism, and guilt seen in those with Long COVID due to self-compassion's ability to foster the soothing and social safety system and improve the regulation of emotions.

Researchers have also found that self-compassion is an essential source of resilience and strength for individuals facing various life stressors, including chronic illnesses (Bluth & Neff, 2018). Moreover, self-compassion may help promote more positive coping strategies in those experiencing hardships due to their chronic illness (Purdie & Morley, 2016). Sirois and colleagues (2015) demonstrated the benefits of self-compassion in individuals suffering from chronic illness by examining two populations of women, one with inflammatory bowel disease and another with arthritis. They found that higher levels of self-compassion were associated with more adaptive coping styles, higher coping efficiency, and lower stress levels (Sirois et al., 2015). Additionally, a longitudinal study by Carvalho and colleagues (2020) examined the depressive symptoms of chronic pain patients and found that self-compassion acted as a protective factor that reduced the risk of depression. Judging by the encouraging research pointing to a connection between self-compassion and positive mental health outcomes in individuals with other chronic illnesses, it seems plausible that self-compassion could also meaningfully contribute to the psychological well-being of those with Long COVID.

Further supporting the notion that self-compassion may be critical in the experience of those with Long COVID, previous research has linked self-compassion with constructs found to influence mental health outcomes in individuals with Long COVID. For example, self-compassion is negatively correlated with emotion dysregulation (Arch et al., 2018; Bakker et al., 2019; Diedrich et al., 2014) and has been found to protect against stress-induced inflammation and inflammation-related mental illness (Breines et al., 2014). In addition to this, self-compassion is association with psychological resilience (Nery-Hurwit et al., 2018), tolerance of uncertainty (Poluch et al., 2022), mindfulness (Bluth & Neff, 2018), and reduced shame (Johnson & O'Brien, 2013). Moreover, all the factors above have been linked to the mental health outcomes of those with Long COVID (Becker et al., 2021; Burton et al., 2022; Dai et al., 2022; Penninx, 2021; Pierce et al., 2022; Voruz et al., 2022). Based on these connections, there is reason to believe that self-compassion may be crucial in how individuals experience and cope with Long COVID.

Purpose and Research Questions

Despite the evidence indicating that self-compassion may play a critical role in the illness experience of those suffering from Long COVID, limited research has focused on explicitly examining self-compassion in this population. Additionally, most of the research on mental health and coping with Long COVID has been quantitative, focusing on identifying a relationship between Long COVID and various indicators of psychological health and well-being. The lack of qualitative research in this area results in a limited understanding of the lived experiences of individuals with Long COVID. Moreover, to my knowledge, there are no published studies on the subjective perspectives of the meaning and significance of self-compassion for individuals with this chronic illness. These individuals' subjective accounts are needed to understand better how people with Long COVID make sense of their lived experiences of self-compassion in the context of their personal and social worlds.

The current study addressed these gaps by employing a qualitative research methodology to explore self-compassion as experienced and perceived by adults suffering from Long COVID. The study's aims were centred on the following research questions:

1. What are the lived experiences of self-compassion in adults suffering from Long COVID?
    a. From participants' perspectives, what facilitates or hinders the practice of self-compassion in individuals with Long COVID?
2. What meaning do adults with Long COVID attribute to their experiences of self-compassion?
    a. From participants' perspectives, what impact does self-compassion have on their ability to cope with Long COVID?

An interpretative phenomenological analysis (IPA) approach was implemented to gain a nuanced, contextualized understanding of how individuals suffering from Long COVID experience and attribute meaning to self-compassion and how self-compassion impacts their ability to cope with Long COVID. The insights provided by this study could be applied to help design and shape prevention and treatment programs. Findings may also inform counsellors and other mental health care providers in their efforts to support and treat individuals suffering from Long COVID. Moreover, by gaining a contextualized understanding of participant experiences, findings from this study illuminate potential ways in which individuals suffering from Long COVID can relate to themselves in a healthy manner.

Overview of Remaining Chapters

The remainder of this thesis is comprised of four main chapters: Literature Review, Methodology, Findings, and Discussion. In Chapter Two, I review the literature on the COVID-

19 pandemic, Long COVID, chronic illness treatment, and self-compassion; and I contextualize the study within the field of counselling psychology. In the third chapter, I describe and justify the interpretative phenomenological approach (IPA) utilized in the study and discuss the recruitment, data collection, and data analysis processes. I also talk through ways the current study has considered methodological integrity. Within the fourth chapter, I introduce the study's findings and summarize the themes that arose within and across participant accounts. Finally, in Chapter Five, I discuss the study's findings, strengths, and limitations, provide clinical implications of the findings, and offer suggestions for future research.

Chapter 2: Literature Review

In this chapter, I provide a brief overview of the COVID-19 pandemic and its impact on physical and psychological well-being, followed by a more in-depth literature review of the background, physical and mental health difficulties, and psychosocial consequences of Long COVID. I also explore the risk and resiliency factors associated with mental health difficulties in individuals with Long COVID, as well as the psychological interventions that are commonly implemented to improve the well-being of individuals with chronic health conditions. Subsequently, I discuss multiple conceptualizations of self-compassion before focusing more directly on the mental health benefits associated with self-compassion. Finally, I review existing research on the mental health benefits of self-compassion in individuals suffering from chronic illness, as well as the mental health benefits of self-compassion in the specific context of the COVID-19 pandemic.

The COVID-19 Pandemic and Its Impact

COVID-19 Infection

COVID-19 is a highly contagious disease caused by the infection of the severe acute respiratory syndrome coronavirus-2 virus (SARS-CoV-2; Yuki et al., 2020). Initially surfacing in December 2019, COVID-19 has spread worldwide (Ciotti et al., 2020) and, at the time of writing, has infected over 775 million individuals and caused over seven million fatalities across the world (World Health Organization, n.d.). The SARS-CoV-2 virus impacts major organ systems, including the respiratory (Yuki et al., 2020), cardiothoracic, gastrointestinal, neurologic, and vascular systems (Capaccione et al., 2021). This results in a wide range of symptoms, including coughing, sore throat, runny nose, fever, sneezing, chest pain, dyspnea, nausea, vomiting, diarrhea, abdominal pain, stroke, confusion, aphasia, lethargy, headaches, dizziness, fatigue, changes in skin colour, and generalized weakness (Capaccione et al., 2021; Yuki et al., 2020). Symptom severity and course of infection largely vary based on the individual; however, 80- 90% of cases are classified as not severe (Pascarella et al., 2020), and individuals typically recover within 7-10 days (Raveendran et al., 2021).

Impact of the COVID-19 Pandemic on Psychological Well-being

Apart from the range of physical symptoms and health consequences of acute COVID-19, the COVID-19 pandemic has also impacted the psychosocial health and well-being of many individuals (Fiorillo & Gorwood, 2020; Vindegaard & Benros, 2020). One of the factors that appeared to contribute to the mental health difficulties amidst the COVID-19 pandemic was the COVID-related lockdowns (Ding et al., 2021; Fiorillo et al., 2020; Olson et al., 2023; Panchal et al., 2023; Pieh et al., 2021). A thematic analysis study examining the impact of the COVID-19 lockdowns on a sample of 20 adult participants from the United Kingdom reported that the lockdowns disrupted participants' sense of self, created difficulties in social relationships, and caused interpersonal conflict due to polarizing social and political views (Schneiders et al., 2022). Other studies have pointed to the emergence and, in some cases, worsening of emotional and mental health difficulties due to the COVID-19 lockdowns (Le & Nguyen, 2021; Panchal et al., 2023l; Pieh et al., 2021). For instance, Le and Nguyen (2021) used the differential timing of the lockdowns within the United States to examine and compare the prevalence of mental health difficulties across states in and out of lockdown. The researchers found COVID-19-related lockdowns to be associated with increased feelings of worry, worse perceptions of general health, disinterest in daily life tasks, and feelings of depression and anxiety.

Another possible cause of mental health difficulties amidst the COVID-19 pandemic is COVID-19-related fears. Amongst these fears include fear of exposure to the virus, fear of death, and an altruistic fear for others, such as family, friends, and healthcare professionals (Slaon et al., 2021). These COVID-19-related fears appear common worldwide (Luo et al., 2021). COVID-related fears have also been linked to numerous adverse mental health consequences (Alimoradi et al., 2022; Şimsir et al., 2021). For example, a cross-sectional study by Sakib and colleagues (2023) examined the impact that fear of COVID-19 had on depression in a sample consisting of 2554 individuals from the general population and 834 healthcare providers in Bangladesh. In both groups, fear of COVID-19 was associated with depression, indicating that COVID-related fears may significantly impact psychological well-being (Sakib et al., 2023). Similarly, a meta-analysis of 33 studies, encompassing samples of participants from countries across the world, found the fear of COVID-19 to be associated with mental health difficulties, including anxiety, depression, posttraumatic stress, and insomnia (Şimsir et al., 2022).

Despite an apparent decrease in lockdown protocols, restrictions, and news coverage concerning the COVID-19 pandemic in 2023, millions of cases and tens of thousands of deaths have been reported worldwide (World Health Organization, n.d.). Although the spread of new COVID-19 infections is relatively under control, there is concern that a wide range of long-term consequences associated with the COVID-19 pandemic will remain prevalent (Appleby et al., 2022; Charney et al., 2021). One concern that is garnering a large amount of empirical attention is the long-term health implications associated with COVID-19 infection (del Corral et al., 2022; Serviente et al., 2022; Zarei et al., 2021; Zeng et al., 2023). Broadly, the long-term effects of COVID-19 are labelled Long COVID (Pavli et al., 2021). Although there is a growing body of literature examining the implications of the COVID-19 pandemic on mental health and well-being, the impact of the chronic health condition, Long COVID, on mental health does not appear to have received the same amount of empirical attention, creating numerous novel avenues for future inquiry.

Long COVID

Background on Long COVID

In most cases of COVID-19 infection, an individual is typically able to recover within 7-10 days, while recovery from more severe cases can take up to 6 weeks (Raveendran et al., 2021). However, in some cases, recovery from COVID-19 can take upwards of 12 weeks; such cases are commonly referred to as Long COVID (World Health Organization, 2023). Long COVID, also known as post-COVID syndrome or post-acute COVID-19 syndrome, is a chronic health condition that is characterized by the persistence of COVID-19 symptoms for more than 12 weeks following recovery from the initial COVID-19 infection (World Health Organization, 2023). Other conditions with similar symptom profiles must also be ruled out before a Long COVID diagnosis can be made (World Health Organization, 2023). It has been suggested that the symptoms of Long COVID may arise due to complications in crucial body systems, including cardiovascular, neurological, musculoskeletal, endocrine, respiratory, gastrointestinal, renal, pulmonary, hematological and dermatological systems (Desai et al., 2021). The mechanisms by which the COVID-19 virus causes damage to these organ systems are not entirely known. However, it is believed that maturation of the COVID-19 virus may cause the immune system to activate an inflammatory response in some patients, which could explain the damage to organ systems (Crook et al., 2021).

It is also important to emphasize that Long COVID is not a rare condition. On the contrary, numerous researchers have found that Long COVID is prevalent worldwide and extremely common in the general population (Chen et al., 2022; O'Mahoney et al., 2023; Pavli et al., 2021). In support of this assertion, a recent systematic review and meta-analysis examined the recovery time of over 735,000 individuals diagnosed with COVID-19 across 194 individual studies (O'Mahoney et al., 2023). O'Mahoney and colleagues found that regardless of whether the person was hospitalized due to COVID-19, around 45% of individuals reported at least one unresolved Long COVID symptom four months after the initial COVID-19 infection. In addition to high prevalence rates, the symptoms of Long COVID often persist over time, with some reports suggesting that roughly 91% of people diagnosed with Long COVID still report symptoms 35 weeks after the initial COVID-19 infection (Davis et al., 2021). Future research will be needed to determine the long-term consequences of Long COVID accurately; however, based on the available evidence, it is likely that the symptoms of Long COVID will persist, at least for some individuals, for the foreseeable future (Davis et al., 2021; Wu et al., 2021; Zhao et al., 2021). Qualitative research focusing on the illness experience of individuals with Long COVID could be critical in learning more about how various circumstances influence the illness trajectory and progression of Long COVID over time.

Consequences of Long COVID Infection

Physical Health. A range of symptoms and health complications are associated with Long COVID. The physical symptoms of Long COVID include fatigue, joint and chest pain, headaches (Aiyegbusi et al., 2021), heart palpitations, damaged blood vessels (Crook et al., 2021), nausea, diarrhea (Desai et al., 2021), loss of smell or taste, fever, muscle aches, persistent cough, and shortness of breath (World Health Organization, 2023). In addition to these symptoms, researchers have linked Long COVID to various enduring health complications (Yende & Parikh, 2021). For example, COVID-19 can cause inflammation in the kidneys and the cardiovascular system, leading to chronic kidney disease and hypertension, respectively

(Mamlakat & Kamola, 2022; Yende & Parikh, 2021). Moreover, preliminary evidence suggests that individuals with long COVID are at an increased risk of new-onset diabetes (Khunti et al., 2021).

Psychological and Mental Health. Beyond the physical symptoms and potential health complications, many individuals with Long COVID experience adverse cognitive symptoms and mental health challenges (Nouraeinejad, 2022). Cognitive symptoms may include brain fog, disrupted sleep, impaired attention, memory loss, and frequent headaches (Nouraeinejad, 2022). Furthermore, symptoms of posttraumatic stress, depression, and anxiety are also very prominent in this population (Taquet et al., 2021). In fact, one meta-analysis reported that over 32% of individuals with Long COVID presented with PTSD, while 14.9% and 14.8% had depression and anxiety disorders, respectively (Rogers et al., 2020). Although less common, phobias, avoidant patterns of behaviour, and obsessive and compulsive behaviours may be additional consequences of Long COVID (Walia et al., 2021).

Mood and emotional well-being may also be impacted in individuals suffering from Long COVID (Carter et al., 2022; Ranieri et al., 2023; Samper-Pardo et al., 2023). For instance, Gorelik et al. (2023) examined subjective well-being (i.e., a component of well-being comprising measures of emotional and cognitive experiences) in those with Long COVID. The subjective well-being of 390 individuals with post-COVID-19 symptoms were compared to 1719 individuals who had never been infected with COVID-19, as well as 186 individuals who had previously had COVID-19 but reported no long-term symptoms. Gorelik and colleagues found that subjective well-being ratings were significantly lower in individuals with post-COVID-19 symptoms than in the other groups. Further supporting this finding, Samper-Pardo and colleagues (2023) recently conducted a qualitative study in which they interviewed 35 adults in

Northern Spain about their experiences of Long COVID. Using thematic content analysis to identify central themes in the data, the researchers found that Long COVID negatively impacted several aspects of participants' emotional well-being. In particular, participants experienced frustration due to the persistence of Long COVID symptoms, uncertainty about the development of Long COVID, and fear of reinfection. The researchers also reported that individuals with Long COVID commonly described feeling like they lost control of their bodies and were missing an essential aspect of their previous life (Samper-Pardo et al., 2023). Based on these results, many of the challenges and fears resulting from Long-COVID appear to bring about feelings of frustration and uncertainty, consequently diminishing psychological well-being.

Losses that Long COVID brings with regard to one's previous functioning may also be considered a threat to an individual's entire sense of self (Fang et al., 2023). The possible impact of Long COVID on a person's self-concept and identity is supported by sociomedical research examining other chronic health conditions (Lively & Smith, 2011). For example, Lively and Smith (2011) suggest that a shift in the sense of identity occurs in many individuals with chronic illnesses because the illness often dramatically alters the roles an individual assumes within their life (Lively & Smith, 2011). For example, individuals with long-term illnesses such as chronic fatigue syndrome or chronic pain may no longer be able to assume their previously maintained occupational and social roles (Bailly et al., 2015; Bartlett et al., 2022; Strub et al., 2022). Applied more specifically to Long COVID, individuals commonly experience both a significant amount of distress as well as physical and psychological limitations (Burton et al., 2022). These limitations can subsequently affect a person's sense of purpose and threaten their sense of identity (Burton et al., 2022). Researchers suggest that a disrupted self-concept and a damaged sense of identity are highly interconnected with feelings of shame (Van Vliet, 2008), which are linked to an array of mental health problems (Kim et al., 2011; López-Castro et al., 2019; Szentágotai-Tătar et al., 2020).

To gain a more in-depth and holistic understanding of the role that Long COVID has on identity, Fang et al. (2023) conducted a narrative interview study on the experiences of 80 individuals living in the United Kingdom who self-identified as suffering from Long COVID. Using semi-structured interviews, the researchers adopted an existential focus in exploring participants' major life events and daily life struggles related to their illnesses. Findings were organized into a framework with three key dimensions: circumstances leading to loss of identity, experiences of loss of identity, and responses used to retain self-identity. Fang and colleagues' findings indicate that the symptoms and consequences of Long COVID could negatively impact resilience and make it difficult for individuals with Long COVID to maintain their sense of purpose and identity. Although insightful, the study did not investigate the role of various psychological constructs on the relationship between Long COVID and self-identity; nor did the researchers identify personal areas of strength or weakness that could help protect against psychological distress and diminished emotional well-being in this population. Based on the preliminary evidence suggesting that Long COVID influences an individual's sense of identity, further qualitative research examining the illness experience of individuals with Long COVID is needed. Such research may help provide a more nuanced understanding of how specific psychological factors that are integral in self-identity—including self-compassion—could influence the post-illness identity of individuals suffering from Long COVID.

Quality of Life. Individuals with Long COVID face physical impairments and commonly have difficulties engaging in recreational and leisure activities (Lambert et al., 2022). Likely related to these tribulations, another key consequence of Long COVID is social impairment (i.e., a negative impact on the quality of one’s social relationships; Lambert et al., 2022). Long COVID also negatively impacts an individual's capability to engage in a healthy level of physical activity, which leads to the deterioration of physical capabilities, a reduced capacity to perform daily life tasks, and an increased dependency on the help of others (Delbressine et al., 2021). Considering these difficulties, it is unsurprising that health-related quality-of-life ratings are low in individuals with Long COVID (Lemhofer et al., 2023). For instance, one meta-analysis found that in a sample of over 4800 individuals with Long COVID across 12 independent studies representing samples from Europe, the United States, Iran, and China, 59% of individuals responded with scores indicative of poor health-related quality of life (Malik et al., 2022).

Occupational Functioning. Another area of life that Long COVID symptoms may drastically impact is an individual's occupational life (Delgado-Alonso et al., 2022; Magnavita et al., 2023). In the workplace, Long COVID may cause increased fatigue, reduced productivity, and decreased ability to participate in work (Magnavita et al., 2023). Additionally, the fatigue and cognitive symptoms commonly reported in those with Long COVID are associated with extended sick leaves and time off (Delgado-Alonso et al., 2022). For instance, Delgado-Alonso and colleagues (2022) found that roughly 50% of their sample of individuals with Long COVID were on extended sick leave, with an average duration of 12 months long (Delgado-Alonso et al., 2022). Time off work due to illness is concerning, as it may be a key factor contributing to the economic distress caused by the COVID-19 pandemic (Kinman & Grant, 2021). Additionally, extended time off work may be detrimental to workers' psychological health, given that unemployment has been linked to feelings of shame, personal failure, and worthlessness (Peterie et al., 2019). In contrast, steady work often helps build self-esteem, provides structure, and acts as an area for social interaction (Kinman & Grant, 2021).

Overall, the literature shows that Long COVID's negative implications are vast and multifaceted. To mitigate these adverse outcomes, it is critical for future research to employ methodologies that allow for insight into the illness experience of those with Long COVID, as this will allow researchers to identify healthier ways for these individuals to cope and relate with themselves.

Risk and Resiliency Factors for Long COVID-Related Mental Health Difficulties

Risk Factors. Several factors are believed to increase the risk that an individual will develop mental health complications due to Long COVID. One mechanism suggested to have a role in developing and maintaining many of the symptoms seen in those with Long COVID is the body's inflammatory stress response (Oronsky et al., 2021). This response is an innate autoimmune reaction activated by various illnesses, including COVID-19 (Doykov et al., 2021; Lage et al., 2021), as well as exposure to high-stress situations (Penninx, 2021; Pierce et al., 2022). Research has found that following COVID-19 infection, the immune system releases an increased number of inflammatory cytokines and chemokines to protect from invading viruses (Mishra et al., 2020).

Although beneficial in fighting the virus, the body’s autoimmune response contributes to the hyperinflammation commonly reported in people with Long COVID (Mishra et al., 2020). Researchers suspect that hyperinflammation results in neuropsychological changes, which may contribute to the mental health difficulties commonly reported in this population (Cothran et al., 2020; Penninx, 2021). In support of this theory, hyperinflammation has been previously linked to symptoms of depression, anxiety, bipolar (Najjar et al., 2013), and posttraumatic stress disorder (Michopoulos et al., 2017), all of which have been reported in individuals with Long COVID. Li and colleagues (2021) demonstrated the connection between mental health and hyperinflammation in individuals with Long COVID by utilizing a cross-sectional approach to examine the correlation between levels of inflammatory biomarkers and the psychological symptom severity of 66 adults with a confirmed COVID-19 diagnosis. Psychological symptoms were measured using the Self-Rating Depression Scale and the Self-Rating Anxiety Scale, while inflammatory markers were collected through blood test results accessible through the participants' medical records. Li et al. found that biomarkers indicative of inflammation were positively correlated with higher rates of mental health concerns and difficulties sleeping.

Disruptions in the emotion regulation system are another factor that may contribute to the mental health problems experienced by individuals with Long COVID (Voruz et al., 2022). Emotion regulation is a critical capability that helps prepare individuals to respond to situational demands, process the stimuli in their environment, and regulate their emotions, moods, and feelings (Gross, 1999). However, the emotion regulation system can become dysregulated when demands overwhelm the coping resources available to the individual (Gross, 1999). Emotion dysregulation is observable when emotional responses exceed what is typically seen as standard in the context of the situation (Ramsook et al., 2020). Emotion dysregulation is also evident when emotional states fluctuate very abruptly or when emotional states persist despite the use of strategies to alleviate them (Ramsook et al., 2020).

In support of the belief that emotion dysregulation may contribute to the mental health difficulties seen in individuals with Long COVID, many similarities exist between the mental health consequences linked to emotion dysregulation and those reported in individuals with Long COVID, such as symptoms of depression, anxiety and posttraumatic stress disorder (Berking & Whitley, 2014; Ismael et al., 2021; Shanbehzadeh et al., 2021; Sheppes et al., 2015). Moreover, emotion dysregulation is associated with feelings of shame (Puhalla et al., 2022) and aggressive behaviour (Mclaughlin et al., 2011), as well as reduced quality of life and well-being (Henry et al., 2016; Kraiss et al., 2020). Linking emotion dysregulation and Long COVID, a preliminary study using positron emission tomography (PET) scans on individuals roughly eight weeks following COVID-19 infection found abnormalities in the amygdala, cingulate cortex, right pre-/post-central gyrus, and other key limbic system structures (Guedj et al., 2021). Importantly, many of these neurological structures have been found to play crucial roles in the emotion regulation system (Voruz et al., 2022). Thus, based on the existing literature, it appears that emotion dysregulation may partly explain why mental health concerns are commonly seen in those suffering from Long COVID. However, there is currently a shortage of studies on how people with Long COVID can reduce the emotional dysregulation that commonly accompanies their illness. Research examining psychological phenomena that help reduce risk factors and foster resilience will be critical in cultivating positive coping in this population.

Protective Factors. A range of psychological factors may help protect against the mental health difficulties commonly experienced by people with Long COVID (Becker et al., 2021; Dai et al., 2022). One such factor that has helped populations with other chronic illnesses is psychological resiliency (Hu et al., 2015; Mesman et al., 2021; van der Meulen et al., 2018). Psychological resiliency broadly refers to a process in which individuals apply personal and environmental resources to help persevere toward their goals and overcome difficult situations (Sisto et al., 2019; Stainton et al., 2018). Previous research indicates that psychological resiliency is negatively associated with mental health issues, such as depression and anxiety (Hu et al., 2015); is predictive of psychological well-being (Mayordomo et al., 2016); and is negatively correlated with burnout (Atay et al., 2021). Additionally, resiliency has been linked to higher quality-of-life ratings and reduced somatization in populations with various chronic health illnesses (Cal et al., 2015).

Individuals living with Long COVID are exposed to a very high degree of adversity due to the physical and psychological symptoms they experience (Anaya et al., 2021). Therefore, resilience is essential in the context of Long COVID, as it may play a prominent role in adapting to and overcoming these adversities (VanMeter & Cicchetti, 2020). Demonstrating the role of psychological resiliency in Long COVID, Becker et al. (2021) conducted a small-scale study on 90 adults hospitalized in two Swiss hospitals due to COVID-19, with 63 of the participants having a confirmed Long COVID diagnosis. Levels of psychological distress were found to be inversely correlated with resiliency, suggesting that in adults with Long COVID, being more psychologically resilient helps protect against mental health difficulties. Thus, examining experiences involving resilience could help identify strategies to reduce the mental health challenges individuals with Long COVID face.

Another psychological factor that may be critical in helping protect individuals with Long COVID from mental health problems is tolerance of uncertainty. In their meta-analysis and synthesis of the literature, Hillen and colleagues (2017) defined tolerance of uncertainty as “the set of negative and positive psychological responses—cognitive, emotional, and behavioural—provoked by the conscious awareness of ignorance about particular aspects of the world” (p.70). Accordingly, individuals who are tolerant of uncertainty have more positive cognitive, emotional, and behavioural responses to situations and stimuli that cause feelings of ambiguity and uncertainty (Hillen et al., 2017). This trait is vital in the context of Long COVID because a high tolerance of uncertainty is positively related to numerous advantageous outcomes, especially in healthcare settings (Strout et al., 2018). For example, a systematic review by Strout and colleagues (2018), including the findings of 67 studies originating from various countries around the world, examined the association between uncertainty tolerance and health outcomes of patients with a range of illnesses. Higher tolerance of uncertainty was associated with more favourable cognitive, emotional, and behavioural outcomes (Strout et al., 2018). Specifically, patients with a high uncertainty tolerance were more likely to perceive the benefits of health screening tests, have greater reported emotional well-being, be less likely to experience emotional distress, and have better disease-specific symptom profiles (Strout et al., 2018).

Applied to the COVID-19 pandemic, Korkmaz and Guloglu (2021) reported that one of the largest predictors of anxiety and depressive symptoms in adults during the COVID-19 pandemic is being intolerant of uncertainty. Additionally, a recent qualitative reflexive thematic analysis study explored factors that influenced the mental health and well-being of 21 individuals suffering from Long COVID (Burton et al., 2022). Based on their analysis of interview data, the researchers found that the uncertainty of the illness trajectory adversely impacted participants. More specifically, participants expressed feelings of helplessness and anxiety due to the uncertainty and ambiguity surrounding the progression of their Long COVID symptoms. Given the above studies, it appears that uncertainty may be prominent in the lives of many individuals amid the COVID-19 pandemic, especially in individuals living with Long COVID. For that reason, it is fair to speculate that the ability to adapt to and tolerate the ambiguity associated with Long COVID could play a critical role in the ensuing mental health consequences seen within this population. However, research has not yet focused on identifying ways individuals with Long COVID can improve their tolerance to the uncertainty they face. Examining psychological factors associated with better tolerance of uncertainty may help identify ways in which those with Long COVID can relate to themselves better and cope with the uncertainty that Long

COVID presents. Self-compassion, which has been linked to a higher tolerance of uncertainty within other populations (Pickard et al., 2023; Poluch et al., 2022), may be one such factor.

Also of considerable interest when discussing the mental health of individuals with Long COVID is mindfulness, which, according to Neff (2003a), is considered a key component of self-compassion. The psychological practice of mindfulness is a central aspect of Buddhist psychology and refers to the ability to be intentionally conscious and aware of the present moment (Siegel et al., 2009). This practice is widely applied across various cultural groups and has a range of potential benefits for psychological health and well-being (Kirmayer, 2015). Some of the mental health benefits associated with mindfulness include reduced prevalence of depression (Heath et al., 2016), anxiety (Jaiswal et al., 2019), psychological distress (Carmody et al., 2008), posttraumatic stress, and feelings of shame (Goldsmith et al., 2014) and guilt (Hafenbrack et al., 2022). Moreover, mindfulness is believed to help reduce negative affect by allowing individuals to pay attention to their experiences, including their negative thoughts and feelings, in a non-judgemental manner (Carpenter et al., 2019; Kabat-Zinn, 2003). In addition, researchers have found that mindfulness may benefit people suffering from various chronic health ailments (Poulin et al., 2016; van Son et al., 2015). For example, in a sample of individuals with diabetes, those who scored high in a measure of mindfulness were found to have fewer symptoms of anxiety and depression (van Son et al., 2015). Moreover, Poulin and colleagues (2016) utilized a cross-sectional survey to examine the relationship between mindfulness and pain in a sample of 76 cancer survivors experiencing chronic neuropathic pain. Mindfulness was found to be a key mitigating factor of pain intensity, pain interference, pain catastrophizing, and depression and was correlated with increased health-related quality of life ratings.

Finally, mindfulness may also impact the mental health outcomes of individuals following infection with the COVID-19 virus (Dai et al., 2022). For instance, Dai and colleagues (2022) conducted a cross-sectional study on 1541 adults who were from Wuhan, China, and had recovered from COVID-19 infection. The authors reported that higher levels of mindfulness were related to participants' ability to attend to their immediate thoughts, feelings, and body sensations in a non-judgemental fashion, subsequently reducing ratings of anxiety and depression.

Psychotherapeutic Interventions for Treating Chronic Illnesses

It is relatively common for mental health complications to arise in individuals diagnosed with chronic health conditions (Delamater et al., 2017; Gosling et al., 2018; Hooten, 2016; Ireys et al., 1994). Therefore, research has examined a range of psychotherapeutic interventions for these populations. The primary interventions that I will discuss in relation to their ability to treat those with chronic illnesses are traditional cognitive behavioural therapy (CBT), as well as mindfulness- and compassion-based therapies. A CBT orientation is important to consider when treating individuals with chronic illnesses due to the breadth of literature indicating CBT's effectiveness in treating persons from this population (Altieri et al., 2023; Ecker et al., 2019; Morey & Loades, 2021). Although a more limited amount of research has focused on examining the use of mindfulness- and compassion-based interventions for counselling individuals with chronic health conditions, the relevance of these therapeutic orientations to the concept of self-compassion makes them critical to discuss in the context of the present study.

First, CBT has been widely applied to individuals suffering from various conditions, including diabetes, chronic pain, chronic headaches, inflammatory bowel disease, and chronic fatigue syndrome (Morey & Loades, 2021). CBT for treating chronic illness does not have a standardized procedure; however, there are commonalities that CBT approaches may follow when treating individuals in these populations (Morey & Loades, 2020). In line with a traditional CBT approach, if problematic behavioural patterns are identified, altering these patterns is a vital component of treatment (Sturgeon, 2014). This may involve promoting enjoyable activities through behavioural activation or developing coping strategies that can help mitigate mental health issues (Morey & Loades, 2020). Further, CBT typically involves identifying, challenging, and restructuring unhelpful thought patterns. Applied to the treatment of clients with chronic health ailments, this could involve restructuring illness-related thoughts and beliefs (Morey & Loades, 2020), such as catastrophizing pain and pain-related disability (Sturgeon, 2014). In addition, a clinician using a CBT approach may also employ psychoeducation to inform clients about their chronic illness and educate them on the link between their mental and physical health (Morey & Loades, 2020).

The use of CBT for treating individuals with a wide range of chronic illnesses has demonstrated positive mental health outcomes, such as decreases in suicidal ideation (Ecker et al., 2019), depression, anxiety, and sleep disturbances, as well as improved quality of life (Altieri et al., 2023). Beyond the potential mental health benefits for individuals with chronic illnesses, CBT interventions can also lead to increased physical functioning (Bloot et al., 2015) and reduced pain intensity and fatigue (Knoop et al., 2007). Overall, the effectiveness of CBT in treating mental and physical health complications in individuals with various chronic illnesses supports the idea that mental health interventions could play a vital role in treating clients struggling specifically with Long COVID.

Although CBT-based treatment approaches may help reduce physical and psychological symptom severity in individuals suffering from chronic ailments, such as chronic pain, alternative psychotherapeutic treatment approaches have also been explored. Amongst the alternative approaches gaining popularity are mindfulness-based interventions (MBIs; Kohut et al., 2017; Majeed et al., 2018; Veehof et al., 2016). MBIs, considered part of third-wave behaviour therapies, typically focus on relieving distress by attuning to one's body sensations, perceptions, cognitions, and emotions and adopting an accepting and nonjudgemental attitude toward present experiences (Baer, 2003; Shapero et al., 2018). This is commonly achieved through mindfulness exercises like guided breathing, yoga, body scans, and meditation (Shapero et al., 2018). MBIs for chronic illness typically try to improve tolerance of physical symptoms and manage coinciding emotional distress (Kohut et al., 2017).

Mindfulness-based approaches have been shown to positively impact physical and mental health and well-being as well as quality of life in populations suffering from chronic health ailments (Kohut et al., 2017). A meta-analysis conducted by Niazi and Niazi (2011), comprising the results from 18 studies, investigated the effectiveness of mindfulness-based stress reduction therapy for populations with a range of chronic illnesses, including cancer, diabetes, hypertension, chronic pain, and immune system disorders. The researchers found that mindfulness-based stress reduction was associated with decreased psychological distress, reduced feelings of anxiety and depression, decreased somatization, healthier blood pressure and body weight, and increased quality of life. Notably, the health benefits of MBIs encompassed a reduction in physical, somatic, and psychological symptoms. Due to the positive impact of MBIs on both the physical and psychological difficulties of those with chronic health conditions, these interventions appear to be a promising approach for treating individuals in this population (Kohut et al., 2017).

In addition to MBIs, another form of third-wave behaviour therapies, compassion-based interventions, also shows promise in helping individuals with chronic health conditions (Austin et al., 2021; Malpus et al., 2022; Mistretta & Davis, 2022; Mofrad et al., 2022). Although research on the use of compassion-based interventions for treating those with chronic illnesses is in its infancy, compassion-focused therapy (CFT) has been gaining popularity in this population (Mistretta & Davis, 2022). CFT is rooted in evolutionary psychology, neuropsychology, and social psychology and draws heavily from Buddhist traditions and practices (Gilbert, 2009b). It is a multimodal therapy that is largely grounded in Gilbert's (2009a) emotion regulation theory, which suggests that imbalances between three emotion regulation systems (i.e., the threat detection and protection system, the soothing and social safety system, and the drive and excitement system) can result in mental health difficulties (Gilbert, 2009a, 2009b). CFT focuses on not avoiding painful experiences, thoughts, and memories but rather engaging with them while stimulating the soothing system that underlies many positive emotions (Gilbert, 2009b). The goal of this practice is to have individuals relate to their painful experiences, thoughts, feelings, and memories with self-kindness and acceptance (Gilbert, 2009a; 2009b).

A CFT approach to treating chronic health conditions typically aims to have clients apply compassion to their illness experience and frame their view of the experience in a more positive light (Gooding et al., 2020). These goals are achieved by providing psychoeducation on the link between the client's mental health and their illness, teaching the concept of compassion and its importance, and helping the client apply compassion to their illness experience (Gooding et al., 2020). When applied to treating chronic illnesses, CFT also focuses on increasing the activation of the soothing and social safety system and fostering acceptance and self-kindness to combat obstacles and fears that prevent the experience of compassion and self-compassion. Finally, a primary goal of CFT is to address feelings of shame and guilt and reduce self-critical thought patterns (Gooding et al., 2020). Individuals experiencing difficulties functioning due to their chronic illness commonly report high degrees of shame and self-criticism, making CFT a good fit for treating individuals belonging to this population (Gooding et al., 2020).

Researchers have found that CFT and other compassion-focused interventions help improve self-efficacy and psychological well-being (Mofrad et al., 2022) while reducing psychological and somatic symptom severity in populations with chronic health conditions (Malpus et al., 2022). For instance, Parry and Malpus (2017) employed a mixed methods design to assess the effectiveness of an eight-week group therapy program based on the principles of CFT for eight individuals with chronic pain conditions. Quantitative analysis of data confirmed that participants reported improved mental health outcomes characterized by lower ratings of pain-related anxiety and depression following the intervention. The qualitative component of the study employed an Interpretative Phenomenological Analysis (IPA) approach to gain insight into the participants' perspectives of this intervention. From the qualitative analysis, Parry and Malpus found that the intervention resulted in greater self-reflection, increased feelings of self-acceptance, and facilitated the development of new coping skills.

Furthermore, Austin et al. (2021) performed a synthesis of qualitative research findings on the use of various compassion-focused interventions, including CFT, for treating individuals with various chronic illnesses. The researchers found that these interventions promoted psychological well-being by cultivating an individual's acceptance of their condition, improving their emotion regulation, and helping reduce their feelings of isolation. Despite these findings, there is limited research on the lived experiences of self-compassion in individuals with chronic health conditions. Due to this deficit, scholars such as Kılıç and colleagues (2021) have called for future research to identify more ways that self-compassion can be fostered in individuals with chronic illnesses and to understand better the mechanisms through which self-compassion makes its impact. Moreover, to my knowledge, no research has explicitly explored the lived experiences of self-compassion in those suffering specifically from Long COVID. Focusing on the lived experiences of self-compassion in people with Long COVID will be critical in addressing gaps in the literature and informing future self-compassion-related interventions for individuals with Long COVID and other chronic illnesses.

Psychotherapeutic Treatments for Long COVID

Due to the relatively recent emergence of Long COVID, a limited array of research has been conducted on the effectiveness of mental health interventions for treating the psychological consequences of this illness. However, the use of popular psychotherapeutic approaches, such as CBT, for populations suffering from Long COVID has been narrowly examined. For instance, a recent case study examined the effectiveness of a patient-led CBT approach in treating a 36-year-old male suffering from Long COVID symptoms (Skilbeck, 2022). This individual had contracted COVID-19 eight months prior and presented with symptoms of depression and anxiety, a persistent cough, and chronic headaches. Due to his symptoms, he was hospitalized and unable to engage in daily tasks such as work. As a part of his treatment, he attended twelve 60-minute online CBT-based therapy sessions over five months. These therapy sessions included psychoeducation on Long COVID and its overlap with mental health symptoms, normalization of his condition, goal setting, behavioural experiments, physical and psychological symptom monitoring, graduated activity, challenging negative thoughts, and progress tracking (Skilbeck, 2022). Following the intervention, the participant reported that psychotherapy helped him normalize and manage his symptoms, improve his quality of life, set more realistic goals, and instill hope in his recovery. Further, he displayed improvements post-treatment and at a 3-month follow-up period on measures of quality of life, somatic symptoms, depression, and anxiety.

In addition, Kuut and colleagues (2023) utilized a randomized control trial study to compare a CBT approach to treatment as usual for 114 adults from the Netherlands suffering from Long COVID. Participants in the CBT condition received 17 weeks of CBT treatment and were assessed across a range of measures at post-treatment and 6-month follow-up periods. Kuut and colleagues found that participants assigned to the CBT condition had significantly lower scores on measures of fatigue and somatic symptoms and scored higher on measures of physical and social functioning at post-treatment and 6-month follow-up periods. Although these results are promising, the amount of research looking at psychotherapeutic treatments in cases of Long COVID is extremely scarce. Additionally, the research on therapeutic interventions for individuals with Long COVID has primarily focused on approaches like CBT and has not explored alternative options that may offer additional benefits. For example, approaches like CFT, which have demonstrated effectiveness with other chronic illnesses (Mistretta & Davis, 2022), have yet to be applied to populations with Long COVID. For that reason, research aiming to gain a nuanced and in-depth perspective of the experiences of individuals suffering from Long COVID is needed to provide valuable insight into understanding how self-compassion is experienced in this population. These findings could be applied to help inform CFT-based interventions for people in this population.

Self-Compassion

One psychological construct that has yet to be extensively examined in individuals suffering from Long COVID is self-compassion. Before exploring self-compassion, it is crucial to first discuss the concept of compassion more broadly. Compassion can be conceptualized as acknowledging and being sensitive to the adversity, pain, and suffering of others and wishing for their relief from that suffering (Feldman & Kuyken, 2011). Furthermore, compassion is commonly demonstrated through acts of kindness, empathy, tolerance, and acceptance (Feldman & Kuyken, 2011). Self-compassion is the same sensitivity and active desire to alleviate suffering; however, it is directed to oneself rather than outwardly (Gilbert, 2009a; Neff, 2003a). Moreover, self-compassion is a construct found across various cultural groups (Brikett, 2013; Toth-Kiraly & Neff, 2021). For instance, using the Self-Compassion Survey (Neff, 2003b), Birkett (2014) quantitatively compared 40 Chinese and 41 American undergraduate students on levels of self-compassion. Although Chinese students displayed higher levels of self-kindness and common humanity, there was no significant difference in overall levels of self-compassion between the groups. Consistent with Birkett's findings, the literature largely suggests that although self-compassion may manifest differently across cultures, it is a universal construct present across various populations (Montero-Marin et al., 2018; Toth-Kiraly & Neff, 2021).

Conceptualizations of Self-Compassion

Neff's (2003a, 2011) conceptualization of self-compassion is derived from Buddhist psychology and is defined as exhibiting understanding and kindness to oneself during times of suffering, pain, or failure. Neff (2003a) described self-compassion as encompassing three main elements: self-kindness, common humanity, and mindfulness. Self-kindness refers to being caring and understanding of one's personal flaws, in contrast to being judgemental and hard on oneself. Common humanity consists of acknowledging the shared human experience and recognizing that failures, inadequacies, and mistakes are a part of this experience. Finally, mindfulness means being aware of the present moment without judgment or avoidance. Although these three components are distinct, they are closely related to one another and interact to encapsulate the experience of self-compassion (Neff, 2003a, 2011). For instance, maintaining mindfulness helps keep an individual's view of an experience balanced and unbiased, allowing them to see the situation for what it is, a shared experience that occurs to many people. Understanding that this experience is common and shared helps normalize feelings of failure, subsequently making it easier to display care and kindness to oneself.

In contrast to Neff's (2003a, 2011) view of self-compassion, Gilbert's (2009a) theory of compassion and self-compassion is heavily rooted in evolutionary theory, social psychology, developmental psychology, neuroscience, and Buddhist psychology (Gilbert, 2009a). Gilbert has conceptualized compassion as a way of relating with oneself and others, ultimately helping humans survive and function in a complex world (Gilbert, 2009a). According to Gilbert (2009a, 2009b), compassion is comprised of six key attributes: caring for well-being (i.e., wanting to alleviate distress and promote positive development in others), sensitivity (i.e., being sensitive to feelings such as distress as well as the needs of another being), sympathy (i.e., feeling an emotional response due to feelings of distress in another), distress tolerance (i.e., being able to tolerate and not avoid intense levels of emotion), empathy (i.e., attempting to understand another's thoughts and feelings), and non-judgment (i.e., not shaming, criticizing, or being judgemental toward others). When applied inwardly, these attributes comprise self-compassion. Gilbert's (2009a) emotion regulation theory provides one way of understanding why self-compassion is a critical component of psychological health and well-being, especially in the context of individuals with chronic illnesses.

Emotion Regulation Theory. Gilbert (2009a) asserted that three emotion regulation systems, including the threat detection and protection system, the soothing and social safety system, and the drive and excitement system, interact and can produce psychological difficulties when they become dysregulated. First, according to Gilbert, humans evolved to have an innate threat detection and protection system that alerts us to impending threats through feelings such as anxiety, fear, anger, shame, or disgust. These feelings notify individuals to take action and protect themselves from threatening situations and can involve reactions such as flight, fight, or submission (Gilbert, 2009a, 2009b). Second, the contentment and soothing system may be active when danger and threats are not imminent and when sufficient resources are present. This system is believed to trigger a soothing effect by releasing the neurohormone oxytocin, which facilitates feelings of safeness, social connectedness, and well-being and manages feelings of distress (Gilbert, 2009a, 2009b). Finally, the drive and excitement system operates under the assumption that all animals have a motivation system that compels them to pursue essential resources, such as food, social connections, sexual opportunities, and territory. When a desired resource, such as food or a date with a potential partner, is obtained, this system stimulates feelings of excitement and pleasure, driving further pursuit of these desires (Gilbert, 2009a, 2009b).

These three emotion regulation systems are closely interrelated, and psychological distress is believed to arise when these systems become dysregulated or out of balance (Gilbert, 2009a, 2009b). For example, an overactive threat and protection system and an underactive soothing and social safety system may result in feelings of inadequacy, shame, and guilt (Gilbert, 2009a). These feelings commonly result in self-critical and self-damaging patterns of thinking, which negatively impact psychological well-being (Gilbert, 2009a). Gilbert (2009a, 2009b) suggested that a balance between the three interrelated systems is needed to combat emotional dysregulation, promote healthy social relationships, and improve psychological well-being. To bring these systems into balance, compassion may be key; in Gilbert’s theory (2009a), compassion is a mechanism that can help facilitate the activation of the soothing and social safety system, reduce overactivation in the other two systems, and create a balance between the three emotion regulation systems. Relating this to the current study, one of the suspected causes of the mental health difficulties seen in populations with Long COVID is emotion dysregulation (Voruz et al., 2022). Applying Gilbert's theory to the mental health difficulties of individuals with Long COVID, it is possible that compassion and self-compassion may be critical components in facilitating emotion regulation and subsequently improving the mental health outcomes of individuals in this population. Therefore, research examining how individuals with Long COVID apply self-compassion could be critical in identifying practices that may improve the mental health outcomes of individuals in this population.

Self-Compassion, Mental Health, and Well-Being

Cultivating self-compassion has been found to have mental health benefits for people from a diverse range of cultural backgrounds (Arimitsu, 2023). Some of the benefits of high levels of self-compassion include greater life satisfaction, quality of life (Kim & Ko, 2018), emotional intelligence, happiness, curiosity, positive affect (Neff, 2011), mindfulness, optimism, self-efficacy (Smeets et al., 2014), and psychological well-being (Zessin et al., 2015). Moreover, self-compassion is negatively correlated to the development of various mental health difficulties, including depression (Lopez et al., 2018; Pullmer et al., 2019), anxiety (Hoge et al., 2013; Werner et al., 2012), and posttraumatic stress (Macbeth & Grumley, 2012; Winders et al., 2020).

Self-compassion is also linked with many other psychological constructs that benefit mental well-being. For example, researchers have found that self-compassion is negatively associated with self-criticism (Vidal et al., 2023). Self-criticism is predictive of various mental health concerns, including depression, eating, anxiety, and personality disorders, as well as increased interpersonal problems (McIntyre et al., 2018; Werner et al., 2019). Moreover, self-criticism is characterized by feelings of guilt, inferiority, failure, and worthlessness, all of which can harm psychological health and well-being (Warren et al., 2016). Of particular importance to the current study, researchers have found that in populations with chronic health conditions, high levels of self-criticism predict more mental health difficulties (Lerman et al., 2012), increased illness-related shame (Trindade et al., 2018), and worse treatment outcomes (Kempke et al., 2013). Therefore, self-compassion and other factors that have been found to combat self-criticism may help reduce the risk of mental health difficulties in those with chronic conditions such as Long COVID.

Furthermore, self-compassion has been linked to increased activity in the self-soothing and stress response system (Kirschner et al., 2019). The increased activity in this response system is believed to cause the release of the hypothalamic nonapeptide oxytocin (Uvnäs-Moberg et al., 2015), which consequently promotes the downregulation of the threat and safety system (Johnson & O'Brien, 2013; Kirschner et al., 2019). According to Gilbert's (2009a) theory, downregulation of the threat and safety system is critical in minimizing negative emotional responses such as anger, disgust, guilt, anxiety, and related mental health difficulties. To investigate the link between self-compassion and self-soothing, Kirschner and colleagues (2019) randomly assigned 135 participants to five groups, including three control conditions and two brief self-compassion intervention groups designed to build self-compassion. The two intervention conditions included self-compassion-based meditation and compassionate body scan conditions. In contrast, the three control groups included self-critical rumination, positive-excitement, and neutral control conditions. Participants in the self-compassion and the positive-excitement conditions reported higher state self-compassion and reduced self-criticism. Furthermore, participants in the self-compassion conditions also demonstrated increased parasympathetic nervous system activation and physiological response patterns consistent with reduced arousal compared to all the control conditions (Kirschner et al., 2019). These results suggest that improved control over the stress response system can be acquired by facilitating increased self-compassion.

In addition to its relationship with the self-soothing and stress response system, self-compassion is also related to self-esteem (Hwang et al., 2016; Souza et al., 2016), which refers to the positive or negative perceptions, opinions, and beliefs an individual holds about themselves (Rosenberg, 1979). In populations of individuals with chronic health conditions, self-esteem has been linked to positive mental health benefits such as increased optimism (Symister & Friend, 2003), decreased depression and anxiety, use of a more active coping style (Soares & Grossi, 2000), improved health-related quality of life (Mikkelsen et al., 2021), and improved psychological well-being (Timkova et al., 2021). Furthermore, given its potential role in protecting against challenges to one's identity (Luyckx et al., 2013), self-esteem is a notable trait to consider when discussing populations that face a threat to their previous way of life and sense of self, such as those with Long COVID.

Although self-esteem and self-compassion are sometimes incorrectly thought to be synonymous, fundamental differences exist between the two constructs. Self-esteem typically involves comparing oneself to others and identifying positive traits that make oneself feel better than others (Neff, 2011). In contrast, self-compassion does not rely upon self-other comparisons and instead focuses on relating to oneself (Neff, 2011). That is, self-compassion involves less self-evaluation, self-enhancement, and defensiveness than self-esteem (Neff, 2011). However, these distinct constructs are positively correlated with one another (Holas et al., 2021; Pandey et al., 2019). Despite the association between the two, some researchers assert that self-compassion is more robust and, in many cases, more beneficial than self-esteem for fostering resilience and psychological well-being (Leary et al., 2007; Neff, 2011). Supporting this claim, researchers have indicated that many of the positive mental health benefits of high self-esteem are due to the mediating effect of self-compassion (Holas et al., 2021; Pandey et al., 2019). For example, Pandey and colleagues (2019) implemented a correlational design measuring self-esteem, self-compassion, and well-being in 272 university students and found that self-compassion acted as a mediating variable explaining a significant proportion of the relationship between self-esteem and well-being (Pandey et al., 2019). The positive mental health benefits associated with self-esteem for individuals with chronic health conditions and the association between self-esteem and self-compassion reinforce the idea that self-compassion could be a critical contributor to the mental health outcomes of individuals with chronic illnesses such as Long COVID.

Self-Compassion in Populations with Chronic Illnesses

The benefits of self-compassion have been demonstrated in individuals with chronic health ailments, including chronic fatigue syndrome (Rimes & Wingrove, 2013), respiratory illness, and chronic pain conditions (Ziemer et al., 2015), many of which share similarities to Long COVID. In these populations, self-compassion is linked to various components of mental and physical well-being (Edwards et al., 2019; Trindade & Sirois, 2021; Wren et al., 2012). For instance, in those with chronic health conditions, self-compassion is related to lower pain-related disability, pain catastrophizing, and pain-related fear, as well as higher pain acceptance (Edwards et al., 2019; Wren et al., 2012). High levels of self-compassion also predict fewer symptoms of anxiety, depression, and posttraumatic stress and high quality of life ratings in individuals with chronic health illnesses (Pinto-Gouveia et al., 2014; Trindade & Sirois, 2021). The limited research on self-compassion in individuals with chronic health conditions has primarily used quantitative methodologies to draw an association between self-compassion and mental health outcomes. Despite the value of this research, additional research focused on the perspectives of people who suffer from chronic conditions is needed in order to learn more about the relationship between self-compassion and positive mental health and well-being.

Benefits of Self-Compassion During the COVID-19 Pandemic

Recent research has begun to examine the impact of self-compassion on components of mental health during the COVID-19 pandemic in numerous countries, such as Canada, Spain, Vietnam, Portugal, France, and the United States (Beato et al., 2021; Beshai et al., 2022; Garcia et al., 2022; Gutiérrez-Hernández et al., 2022; Nguyen & Le, 2021; Paucsik et al., 2022; Tran et al., 2022). For instance, researchers have found that higher levels of self-compassion can reduce feelings of COVID-19-related stress, isolation, and loneliness, as well as improve mental health outcomes amid the COVID-19 pandemic (Andel et al., 2021; Kotera et al., 2023; Nguyen & Le, 2021). Demonstrating this, Gutiérrez-Hernández and colleagues (2022) implemented a cross-sectional design with 855 participants from Spain during the COVID-19 pandemic to examine the impact of self-compassion on mental health. Particular emphasis was on how each of the three main components of self-compassion, as defined by Neff (2003; i.e., self-kindness, mindfulness, and common humanity), affected perceived vulnerability to COVID-19 infection and emotional distress. Each component of self-compassion was negatively related to emotional distress, suggesting that self-compassion may have a significant protective role against mental health problems derived from the COVID-19 pandemic (Gutiérrez-Hernández et al., 2022). Furthermore, a recent narrative review found that amid the COVID-19 pandemic, self-compassion had mental health benefits, such as improved motivation, well-being, and life satisfaction for individuals in non-Western countries (Kotera et al., 2023). Importantly, these findings were consistent with findings from samples comprised of individuals from Western countries, suggesting that self-compassion has similar mental health benefits during the COVID-19 pandemic regardless of cultural background (Kotera et al., 2023).

Another benefit of self-compassion is that it promotes resiliency, which can help individuals cope with adversity and be less susceptible to mental health problems (Gerace, 2022). For instance, an interpretative phenomenological analysis study on a sample of eight teachers in the United States during the COVID-19 pandemic demonstrated that self-compassion promotes stress resilience (Chen, 2022). In particular, Chen found that shifting from self-judgement and emotional rumination to more self-compassionate states of self-kindness, connectedness, and mindfulness promoted resilience and allowed participants to handle stressful situations and COVID-19-related stress better. Based on the findings from the studies above, self-compassion appears to be a vital protective factor for psychological health and well-being during the COVID-19 pandemic. That being said, a minimal amount of research explores the impact of self-compassion on individuals with COVID-19, let alone individuals with Long COVID. Therefore, qualitative research that provides insight into the lived experiences of self-compassion in those with Long COVID is critical in developing a fundamental understanding of how self-compassion may benefit individuals in this population.

Self-Compassion and Long COVID

Supporting the notion that self-compassion may be critical in the experience of those with Long COVID, previous research has pointed to significant associations between self-compassion and several factors related to the development and severity of Long COVID. For example, Self-compassion is negatively associated with emotional dysregulation (Arch et al., 2018; Bakker et al., 2019; Diedrich et al., 2014) and has been found to protect against stress-induced inflammation and inflammation-related mental illness (Breines et al., 2014). In addition to this, self-compassion is positively correlated to psychological factors such as resilience (Nery-Hurwit et al., 2018), tolerance of uncertainty (Poluch et al., 2022), and mindfulness (Bluth & Neff, 2018). The links between self-compassion and resilience, tolerance of uncertainty, mindfulness, stress-induced inflation, and emotion regulation are important, as each of these factors has been connected to the development, maintenance, or prevention of mental health symptoms seen in individuals with Long COVID (Becker et al., 2021; Burton et al., 2022; Dai et al., 2022; Mondelli & Pariante, 2021; Oronsky et al., 2021; Voruz et al., 2022).

In addition to empirical studies, a strong theoretical argument also suggests a link between self-compassion and psychological well-being in those with Long COVID. As previously mentioned, the reduced functioning brought on by chronic illnesses can greatly impact a person’s ability to assume key life roles they once held, resulting in a damaged self-identity (Charmaz, 1983; Lively & Smith, 2011). In keeping with Gilbert's (2009a, 2014) theory of compassion, these challenges to an individual's sense of identity may result in shame and guilt, activating the threat detection and protection system. The increased activation of this system and the coinciding emotional dysregulation caused by the imbalance of the three emotion regulation systems may explain the occurrence of the mental health difficulties commonly reported in individuals with Long COVID. If this is the case, compassion and self-compassion could be important in addressing these mental health difficulties due to their ability to reduce emotional dysregulation by increasing the activation of a biological system orientated towards safety and soothing (Gilbert, 2014).

Supporting the idea that there is a relationship between self-compassion and the experiences of those with Long COVID, preliminary research has suggested that numerous factors, including self-compassion, are essential to the post-COVID-19 recovery process (Wang et al., 2022). Recently, Wang and colleagues (2022) implemented a grounded theory approach to examine people's experiences with Long COVID in China. The study utilized narrative responses from an online question-and-answer forum, similar to Reddit, that was not created by the researcher or initially intended for research purposes. This "COVID-19 Pandemic" thread detailed individuals' experiences adapting to and recovering from Long COVID. The researchers identified numerous themes present in the illness experience of individuals with Long COVID, such as the endorsement of a sick role, a reported lack of body control, and self-stigmatization. Finally, Wang and colleagues identified self-compassion as a practice that helped reduce negative emotions and motivated participants to rebuild their life post-COVID.

Although Wang et al.'s (2022) qualitative study showed promising results in terms of the potential benefits of self-compassion for aiding people in their Long COVID recovery process, the study had several limitations. First, by extracting narratives from a question-and-answer forum that was not created by the researchers or initially intended for research use, there was no interaction between the researcher and the participant. This also means that the researchers could not verify the accuracy or credibility of the narrative accounts produced by participants. The use of more interactive qualitative methodologies, such as those employing rigorous semi-structured interviews and member checks, may help build a more credible, in-depth, and nuanced understanding of the experiences and meaning of self-compassion for individuals struggling with Long COVID. Further, Wang et al.'s study only included participants from one country, China. Research in other areas of the world is also needed to provide a more comprehensive view of the perspectives and lived experiences of self-compassion in adults suffering from Long COVID (Wang et al., 2022). Finally, despite identifying self-compassion as a theme involved in the Long

COVID recovery process, Wang et al. (2022) did not specifically focus on identifying the experiences of self-compassion in individuals with Long COVID. Therefore, the study did not identify the meaning that individuals with Long COVID attribute to experiences of self-compassion or nuanced ways in which this population demonstrates self-compassion (Wang et al., 2022). For these reasons, a qualitative study implementing a more rigorous methodology allowing for an in-depth perspective of the experiences of self-compassion in individuals suffering from Long COVID is needed.

Moreover, most of the existing research on Long COVID and mental health has focused on establishing correlations between Long COVID and various mental health problems (Ismael et al., 2021; Shanbehzadeh et al., 2021). Although these correlational studies have been valuable for establishing associations between Long COVID and various mental health outcomes, there is a shortage of research on the lived experiences and perspectives of individuals suffering from Long COVID. Research examining the experiences and perspectives of individuals with Long COVID is needed to gain a more nuanced understanding of how individuals suffering from Long COVID relate to and attribute meaning to self-compassion. Such an understanding is critical, as it can help inform mental health care providers on how to best support and treat individuals with this condition.

Summary

The mental health benefits of several psychological factors, such as resilience, mindfulness, and tolerance of uncertainty, have all been examined in the context of people suffering from Long COVID. Although self-compassion is closely related to some of these factors, research examining the role of self-compassion in individuals with Long COVID is limited. Furthermore, few studies have focused on qualitatively examining the more general lived experiences of individuals within this population. Thus, there is a lack of research on the perceptions of people with Long COVID. To help address the gaps in the current literature, the present study aims to gain an in-depth and nuanced understanding of how individuals experience and attribute meaning to self-compassion in the context of their struggles with Long COVID. The findings from this study may provide insight into how self-compassion can be applied to help those with this condition cope with their symptoms. Additionally, the findings of this study could inform the practices of counsellors to help ensure they best support clients suffering from Long COVID.

Chapter 3: Methodology

The current study used a qualitative research approach to examine the lived experiences of self-compassion in individuals who suffered from Long COVID. Qualitative research offers a flexible method to explore participants' perspectives, experiences, social realities, attitudes, and beliefs (Creswell, 2013). A benefit of qualitative research is that it allows researchers to understand the context surrounding a participant's experience, which is critical for informing real-world interventions. Additionally, by attending to the perspectives and experiences of participants, qualitative research studies allow researchers to gain a more nuanced understanding of the meaning that participants attribute to experiences of a phenomenon of interest (Creswell, 2013; Smith, 2008).

For the purposes of this qualitative study, I employed an interpretative phenomenological analysis (IPA) approach. IPA is a qualitative methodology that explores, describes, and interprets participants' lived experiences in the context of their social and personal worldviews (Smith et al., 2022). With its foundations in phenomenology, ideography, and hermeneutics, IPA is orientated toward gaining an in-depth understanding of how a small number of participants experience a phenomenon, the meaning that participants attribute to that experience, and how they make sense of it (Smith et al., 2022; 2011). In the current study, the phenomenon of interest was the lived experience of self-compassion of individuals with Long COVID. IPA has been widely used in health psychology research and has been extensively applied to research examining the experiences of individuals with various chronic health ailments, such as chronic pain, chronic fatigue syndrome, and heart disease (Smith, 2011). Due to the similarities between these other chronic health conditions and Long COVID, IPA is a fitting approach to examine the experiences of self-compassion in individuals suffering from Long COVID.

Theoretical Underpinnings

The following section will discuss the philosophical underpinnings of IPA to provide the reader with an in-depth understanding of this qualitative methodology. Moreover, this section will focus on discussing phenomenology, ideography, and hermeneutics and how they have contributed to IPA.

Phenomenology

Phenomenology is a philosophical approach broadly concerned with examining and comprehending lived experiences (Smith, 2003; Smith et al., 2009). As a research methodology, phenomenology concerns itself with uncovering the meaning behind a specific phenomenon of interest that is experienced by the participant while also considering the context surrounding the experience and the assumptions and biases held by the researcher (Creswell & Poth, 2017; Smith, 2008). Modern phenomenology can be divided into two broad traditions: descriptive phenomenology and interpretive phenomenology.

Descriptive Phenomenology. Commonly referred to as the father of phenomenology, Edmund Husserl contributed immensely to the philosophical underpinnings of descriptive phenomenology (Creswell, 2013). Husserl’s descriptive phenomenology focused on how, in describing the meaning of a phenomenon of interest, it is essential to take a reflective stance on one's perceptions of a phenomenon rather than examining the phenomenon of interest as it exists in the world (Smith et al., 2009). In line with this, Husserl (2012) believed that the individual's experiences prescribe meaning to a phenomenon. Due to the introspective nature of descriptive phenomenology, Husserl asserted that consciousness, or an awareness of one's experiences, is a required component of this approach; without conscious awareness, the phenomenon of interest could not be seen, discussed or interpreted (Husserl, 2012). Phenomenological reduction has been adapted in various phenomenological methods and is another key property of descriptive phenomenology, (Husserl, 2012). Phenomenological reduction, from a Husserlian perspective, means attempting to remove one’s motives, biases, and preconceived assumptions and suspending them, allowing the researcher to view the phenomenon in its purest form, free from bias that might taint their perspective (Husserl, 2012). This is commonly referred to as bracketing in modern phenomenological research and is used to reduce the influence that a researcher's assumptions and preconceptions have on the data collection and analysis process (Hamill & Sinclair, 2010).

Interpretive Phenomenology. In contrast to descriptive phenomenology, IPA is an interpretive phenomenological method. Interpretive phenomenology largely originates from the work of Martin Heidegger, a student of Edmund Husserl (Dowling, 2004). Heidegger contended that understanding of experience is achieved through interpretation, not description (Heidegger, 1927/2011). Accordingly, Heidegger proposed two critical components of interpretation: the "structure," which is the interpretation of an entity, and the "fore-structure," which refers to the prior knowledge held about an entity world (Heidegger, 1927/2011). As opposed to Husserl, Heidegger argued that the fore-structure of a researcher could not be truly bracketed or disconnected from the experience they are trying to examine (Heidegger, 1927/2011). Thus, a significant component of Heidegger's phenomenology is acknowledging that prior understanding influences a researcher's interpretation of participant experiences; and the researcher’s biases and assumptions can never be fully removed.

Another key figure in interpretive phenomenology is Merleau-Ponty, who primarily focused on the role of the body in experience (Smith et al., 2022). Merleau-Ponty (1962) regarded the body as the means through which humans communicate and gain an understanding of the world around them. Further, knowledge and experiences of the world are gained from the particular point of view of the body, which is determined by the world in which the individual is situated (Merleau-Ponty, 1962). The body-in-world relationship is critical for IPA, as it asserts that the body shapes an individual's knowledge and preconceived notions of the world (Smith et al., 2022). Similar to Heidegger's concept of fore-structure, this is another way of saying that previous experiences help shape future interpretations. Taken together, the work of philosophers such as Heidegger and Merleau-Ponty introduced the idea that the individual and their experiences result from the language, culture, relationships, and the overall world within which they are embedded (Smith et al., 2022). This view contributed to the movement away from strictly descriptive approaches and placed attention on interpretation as a mechanism to understand involvement in the world (Smith et al., 2022).

Hermeneutics

Smith (2009) described hermeneutics as “the theory of interpretation” of language (Smith et al., 2022, p. 17). Much of interpretive phenomenology is built on the basis of hermeneutics; however, hermeneutics also stands as its own discipline that predates phenomenology (Smith et al., 2022). In fact, the term hermeneutics was initially used to refer to the interpretation of biblical passages before it was expanded to refer to the interpretation of a broader range of literary texts (Dowling, 2004; Smith et al., 2022). One of the primary purposes of hermeneutics is to uncover the meaning ascribed to a text by its author (Smith et al., 2022). This requires the interpreter to consider the context surrounding the creation of a text, including the year it was written, where it was written, the language it was originally written in, and the intended audience (Smith et al., 2009). Moreover, consideration of how the text's historical context interacts with the personal views and life factors influencing the interpreter's view of the text is also needed (Smith et al., 2009).

Schleiermacher was one of the first philosophers to write about hermeneutics (Smith et al., 2022). He held a holistic perspective of interpretation and saw interpretation as being composed of two major components: the grammatical and the psychological (Smith et al., 2022). The grammatical refers to the objective meaning of the text exactly as it was written. In contrast, the psychological refers to how the specific techniques, intentions, and language the author uses shape the meaning of the text they produce (Smith et al., 2022). As previously discussed, Heidegger is also a key figure in hermeneutics, especially in hermeneutic phenomenology (Smith et al., 2022). Heidegger's outlook on the influence of the fore-structure in the interpretive process was critical in moving away from the perspective that the researcher can be completely isolated from the research toward the more reflexive viewpoint endorsed in IPA, which emphasizes the role of the researcher (Smith et al., 2022).

Another influential figure in hermeneutics was Gadamer. Gadamer expanded upon many of Heidegger's ideas and emphasized the relationship between the fore-structure and the text being interpreted (Smith et al., 2009). In particular, Gadamer held the perspective that although preconceptions could negatively influence the interpretive process, they are an inevitable part of the human condition that cannot be merely cast aside (Gadamer, 2004). Regarding the construction of knowledge, Gadamer (2004) stated:

> All that is asked is that we remain open to the meaning of the other person or text. But this openness always includes our situating the other meaning in relation to the whole of our own meanings or ourselves in relation to it (p. 271).

Overall, Gadamer viewed the pre-existing fore-structure and the interpretation of the text being examined as mutually influencing each other, working to shape and define understanding (Gadamer, 2004).

Similarly, a critical component of modern interpretive phenomenology is the acknowledgement that the researcher and participant contribute to the interpretation of the phenomenon of interest (Tuohy et al., 2013). The researcher's and participant's importance in the data collection and analysis process is represented in IPA through a *double hermeneutic* process (Smith & Osborn, 2008). The double hermeneutic process refers to the idea that the research participants are trying to provide an interpretation of their experience while the researcher is also trying to provide their interpretation of the participant's account (Smith & Osborn, 2008). Arising from this process, one of the primary aspects of IPA as a research methodology is that both the researcher and the participant play an active role in the data collection process (Smith & Osborn, 2008). Finally, it is also crucial to touch upon the concept of the *hermeneutic circle* when considering hermeneutics and the IPA approach. The hermeneutic circle is an interpretive process where the interpreter moves between the parts of a text and the text as a whole, with the idea that understanding the parts requires examining the whole, while to understand the whole text, the parts must be individually examined and understood as well (Smith et al., 2022). This is reflected in IPA through the iterative process that IPA adopts, which allows researchers to move back and forth between steps rather than moving in a linear pattern (Smith et al., 2022).

Ideography

The final major theoretical influence involved in IPA is ideography (Pietkiewicz & Smith, 2014). The ideographic and nomothetic perspectives of knowledge construction were introduced in the work of Wilhelm Windelband, a German philosopher (Salvatore & Valsiner, 2010). The ideographic perspective emphasizes the particular, proposing the idea that experiences are only *experienced once* and that all experiences are unique cases (Salvatore & Valsiner, 2010). In contrast to the ideographic perspective, the nomothetic perspective focuses more on the universal and provides generalizations of the population being studied, as commonly seen in most quantitative research studies (Salvatore & Valsiner, 2010). Applied to IPA, ideography refers to focusing on a particular by performing a detailed exploration of every single case (Pietkiewicz & Smith, 2014). In IPA, the ideographic approach allows researchers to study every individual in-depth and establish themes by comparing the experiences of several individuals (Pietkiewicz & Smith, 2014). Due to the ideographic nature of IPA studies, they typically have a relatively small and homogenous sample (Pietkiewicz & Smith, 2014).

Epistemological Assumptions

The IPA approach acknowledges that the researcher cannot objectively measure and quantify participants' lived experiences (Smith et al., 2022). Instead, IPA recognizes that data collection and analysis involve researchers co-constructing the data by interpreting the participant's experience (Smith et al., 2022). Moreover, in an IPA approach, previous experiences are acknowledged as shaping an individual’s subjective perspective and, thus, the meaning they attribute to present experiences (Smith et al., 2022). Similarly, the social constructionist outlook emphasizes that an individual’s perspectives are socially and historically informed (Creswell, 2017). That is, the subjective meaning of an individual’s experience is informed by their interactions with others and the historical and sociocultural norms within which they operate (Creswell, 2017). Furthermore, social constructionism maintains that reality is created from the interaction between the researcher and the participant, with the experiences of each shaping the data (Cresswell, 2017). A social constructionist perspective guides the current study due to its alignment with my views and its consistency with an IPA methodology. Endorsing this approach, I recognize that my findings are just one possible interpretation of the data. Therefore, the knowledge generated from this research is constructed from my interpretation of a shared social reality, influenced by my experiences and perspectives and the historical and cultural norms within which I operate.

Background of Researcher

Consistent with the social constructionist perspective guiding this study, I acknowledge that research data are co-constructed and inevitably influenced by the researcher and participant (Creswell, 2013). Under this framework, the researcher's perspectives cannot be fully bracketed out and removed; however, they can still be reflected upon to help reduce the amount the researcher's biases interject into the participant's account of their lived experiences. Creswell (2013) advised researchers to do this reflection by describing their experiences with the phenomenon of interest. In accordance with this, I brought awareness to my experiences regarding chronic illness and self-compassion by writing detailed accounts of my exposure to these phenomena (Smith et al., 2021). In the coming paragraphs, I describe and reflect on my experiences involving chronic illness and self-compassion.

Before university, I was involved in combat sports such as wrestling, which resulted in my sustaining an injury to the nerves in my shoulder, causing radiating pain up my neck and down my lower back. The chronic pain caused by this injury was severe for over five years, limiting my upper body's mobility and preventing me from working laborious jobs and participating in sports I had once enjoyed. I experienced feelings of shame and guilt while I suffered from chronic pain because, despite being young, I could not engage in activities in the ways I did prior to my injury. The limitations I faced due to my chronic pain condition took a tremendous toll on my mental health. Seeing my physical health's impact on my psychological health, I became highly interested in psychology, specifically psychological research examining the interrelation between physical health conditions and mental health and well-being.

Pursuing this interest in psychology, I began my Master's degree in Counselling Psychology at the University of Alberta, where I became educated in Gilbert’s CFT (2009) and Neff's (2003) literature on self-compassion. The work of these pioneers in self-compassion theory and research taught me about the utility that compassion and self-compassion can have in relieving feelings of shame and guilt and overcoming self-critical patterns of thought. Due to my experience with chronic pain, where I personally experienced these adverse emotions, I became fascinated with how compassion and self-compassion could be implemented in therapeutic practice. As such, I have applied techniques and practices from CFT in my own life as well as in practice as a therapist in training to help clients experiencing self-critical thoughts and feelings of shame and guilt. Coinciding with my interest in the use of compassion-focused interventions in practice, my research interests have centred around the role of self-compassion in the psychological health and well-being of individuals with various chronic illnesses.

Based on my personal experience with chronic pain and my research interest in self-compassion, throughout the data collection and analysis process, I focused on being reflexive about my own experiences, preconceptions, and biases regarding these topics. Additionally, because I have lived experiences with a related phenomenon to the one of interest in this study, I deployed a degree of bracketing to ensure that I approached interviews with an open mind because I wanted to ensure that I was open to the participants' perspectives. Moreover, during the data collection and analysis process, I also frequently created memos of my thoughts and interpretations, which helped me interpret the participants' experiences and perspectives more accurately. Despite these steps to limit my bias, I acknowledge that interview data is co-constructed, and completely removing my perspective from the data collection and analysis process is neither feasible nor desirable.

Methods

Participants

Prior to participant recruitment, I attained ethical approval from the Health Research Ethics Board (HREB) at the University of Alberta and operational approval from Alberta Health Services (AHS). I also had my study protocol approved by AHS and completed an AHS data disclosure agreement before receiving contact information for potential participants. Following ethics approval from the HREB and AHS, the co-director of the Long COVID clinic operating out of the Kaye Edmonton Clinic provided me with an email list of individuals who had been diagnosed with Long COVID and had previously consented to be contacted for research opportunities. The email list contained over 700 names, and no demographic data on Clinic patients were provided. In order to make for a manageable recruitment process, and to avoid making assumptions about gender and cultural background, I randomly selected a subset of names from the list through (a) assigning an integer to each potential participant based on the row they appeared on the Clinic list; and then (b) using a random number generator to select participants. I contacted potential participants using a recruitment email (see Appendix A) that contained an explanation of the current study, a study consent and information form (see Appendix B), and an invitation to participate in the current study. I sent 80 initial recruitment emails, and 15 participants responded. I sent recruitment emails in batches of 10 to 20 until I had six participants return the signed consent form who met the study's recruitment criteria. The recruitment criteria included participants being over the age of 18, speaking fluent English, and having or having had at least one Long COVID symptom for twelve weeks or more following a confirmed or reasonably presumed COVID-19 infection.

IPA methodologies typically focus on gaining an in-depth analysis of a small number of homogeneous participants (Pietkiewicz & Smith, 2014). Therefore, I recruited a small sample of six adult participants. Demographic and health information was collected through a participant information form (see Appendix C). Participants were all adults who ranged in age from 22 to 60. One participant had been hospitalized in the past due to COVID-19-related complications. Of the six participants, one self-identified as male, and five self-identified as female. Two participants were employed full-time, one was employed part-time, one was retired, and two were unemployed at the time of the interview. All six participants were diagnosed with Long COVID by a medical professional. Participants presented with between nine and 18 Long COVID symptoms. Long COVID symptoms experienced by participants included fatigue, headaches, chest pain, shortness of breath, persistent cough, fever, heart palpitations, increased blood pressure, changes in taste or smell, swollen feet, skin rashes, muscle aches, dizziness, worsened memory, impaired balance, tinnitus, difficulties concentrating, joint or muscle pain, chest pain, abdominal pain, stomach pain, reduced appetite, low oxygen levels, brain fog, vision difficulties, nausea, sinus congestion, vertigo, sleeping difficulties, depression, and anxiety. The length of time that individuals experienced Long COVID symptoms ranged from roughly eight to 36 months. Further, two participants indicated that they had health conditions before contracting Long COVID; these conditions included asthma, depression, and anxiety.

Data Collection

After I received an email response from participants indicating that they wished to participate in the study, I sent interviewees a participant information form (See Appendix C) to complete prior to the first interview. Subsequently, I scheduled a semi-structured interview between me and each participant at a time convenient to them. I also provided individuals with a choice of participating in the interview online through a web-based video calling service (i.e., Google Meets) or in person at the University of Alberta. Before the interview, I confirmed the participants' eligibility by reviewing their participant information form. Moreover, preceding the interview all participants provided written consent, and I ensured that they understood their rights as research participants. Finally, participants were invited to ask me any questions they had about the interview and research processes.

Individual semi-structured interviews lasted between 45 and 63 minutes, which allowed for an in-depth exploration of each participant's experiences and perspectives of self-compassion. I selected the semi-structured interview format, as it is a flexible approach that permits the researcher to formulate follow-up questions and probes based on participant's responses, providing the opportunity for richer dialogue (Smith & Osborn, 2008). The interview schedule focused on the following topics: a description of the participant's experiences of self-compassion in coping with Long COVID, the impact that self-compassion had on how the participant coped with Long COVID, how the participant defined self-compassion, and factors that interfered with or helped the participant's ability to experience self-compassion in coping with Long COVID (See Appendix D for the semi-structured interview guide). Probing questions such as, "Can you tell me more about that?", "Can you provide me an example of that?" and "How did you feel about that?" were used to gain greater detail about the participant's experiences. Participants were each given a $25 gift card as compensation for their participation following the initial interview. They were also reimbursed for any travel costs they incurred. At the end of the interview, I discussed booking a brief follow-up interview with the participant approximately four weeks after the initial interview. All interviews were audio-recorded for later transcription and data coding. I personally transcribed interviews verbatim, and I started preliminary coding of the transcripts before the follow-up interviews in order to allow me to identify areas for further clarification with the participant.

Initial interview transcripts were password-protected and sent to participants to review before the follow-up interviews. Once the initial interview transcripts were reviewed and their accuracy was confirmed, I engaged in follow-up interviews with each participant. Follow-up interviews occurred between 49 and 85 days following the initial interview and lasted between 14 and 19 minutes. These follow-up interviews followed an unstructured format, allowing participants to confirm the accuracy of the information gathered in the initial interview. The follow-up interviews also helped me clarify my understanding of the initial interview and gain additional insight into the participant's experiences of self-compassion in the context of Long COVID. Follow-up interviews were also transcribed verbatim and coded for data analysis purposes.

Data Analysis

When taking an IPA approach, uncovering the meaning embedded in ideographic aspects of a participant's lived experiences is a central aspect of the data analysis process (Smith & Osborn, 2008). Moreover, the double hermeneutic nature of data analysis when using an IPA approach means that the result of the data analysis is a representation of how I, as the researcher, "make sense of how the participant makes sense" (p.77) of their experience (Smith et al., 2022). This process required me to reflectively engage in an interpretive relationship with the text and utilize a hermeneutic approach of moving between the text as a whole and the individual parts of the text (Smith & Osborn, 2008). Overall, I conducted an interpretive analysis of interview transcripts to understand the content and complexities of individual participants' experiences of self-compassion and identify commonalities present across participants (Smith & Osborn, 2008). Although IPA does not have a prescriptive method that is universally employed for data analysis, I utilized a process closely aligned with a seven-step process described by Smith and colleagues (2022). Although laid out in a stepwise fashion, data analysis followed an iterative and multi-directional approach that involved moving back and forth between steps as needed (Smith et al., 2022). The process I used for data analysis was as follows:

1. I first immersed myself in the interview data by listening to the audio recording multiple times while transcribing the interviews. Following transcription, I read the interview transcript over several separate instances to become familiar with the data and ensure I centred the participant as the focus of the data analysis.
2. After reading a transcript multiple times, I started the exploratory noting process, which is a form of line-by-line coding done at a low level of abstraction. Exploratory noting consisted of dividing the text into meaning units (i.e., a word, sentence, paragraph, or other segment of data that contains insight about a phenomenon of interest) that captured relevant aspects of the participant's experiences and interpretations. The goal in this initial noting stage was to produce a comprehensive set of notes[1] and comments (also referred to as memos in the qualitative literature and in this thesis) that attended to both the explicit and implicit meanings of the participant. At this exploratory level, notes were created for any quotations of interest but primarily focused on quotations relevant to self-compassion or Long COVID.

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[1] Notes refer to labels given to help organize meaning units, whereas comments refer to a written record of my thoughts and interpretations about the data being analyzed.

Atlas.ti software (Scientific Software, 2013) was used to help organize my notes and comments throughout the data analysis process.

3. I reviewed the transcript several times to refine the exploratory notes into experiential statements. Experiential statements were essentially phrases that were constructed from both the participant's words and my interpretation as the researcher, and that remained close to the data (i.e., at a relatively low level of abstraction).
4. Following the construction of experiential statements, I created a code list containing all the experiential statements in the transcript, with each statement appearing on a separate line. Experiential statements were mapped out based on how they related to one another (i.e., similarities, differences, and interconnections). This process involved placing similar statements into a cluster that cohered at a higher level of abstraction.
5. The next step of my data analysis process involved creating Personal Experiential Themes (PETs; Smith et al., 2022) by appropriately naming the established clusters of experiential statements. Where fitting, clusters of notes contributing to the formation of a theme were also labelled as sub-themes. I then created a table to depict each participant's PETs and subthemes.
6. The first five steps of this process were repeated separately for every individual case. During this process, I also stayed consistent with the ideographic assumptions of IPA by acknowledging and writing about how the PETs that emerged with each new case could be influenced by my own life experiences and perspectives as well as my analysis of the previous cases.

7. After identifying themes from each case, I developed Group Experiential Themes (GETs; Smith et al., 2022), which were patterns across the individual cases. In this stage, I compared similarities and differences in the PETs to arrive at themes commonly shared by participants.

Methodological Integrity

When conducting data collection and analysis of a qualitative research project, it is critical to ensure the study's trustworthiness (i.e., the degree to which readers can be confident that a study captures significant experiences of the topic of interest; Levitt et al., 2017) and rigour (Baillie, 2015; Creswell, 2013). One way to enhance rigour and trustworthiness is by reflexively discussing the biases and assumptions that a researcher brings to the study (Baillie, 2015; Creswell, 2013). This is especially important in a study implementing an IPA approach, as interpretive methods acknowledge that data is co-constructed by the researcher and the participant (Smith et al., 2022). As a contributor to the data, I needed to be reflective of my prior beliefs, experiences, and assumptions about self-compassion and chronic illnesses such as Long COVID. In line with this, I focused on reflexively thinking and writing about my prior assumptions and beliefs so that I could acknowledge their impact on the co-construction and subsequent interpretation of the data. In doing so, I documented my experiences in areas related to the phenomenon of interest before the data collection process began and reflected upon how they could bias my perspective. Additionally, throughout the data analysis process, I attached detailed memos on the interview transcripts to document the thought processes behind my analysis and help make my assumptions and potential biases known. With that being said, I operated under the assumption that data is co-constructed, and completely removing my perspectives is not possible, nor is the goal of data analysis in an IPA study.

My research supervisor provided peer review throughout the data analysis process to further enhance trustworthiness. Peer review included multiple code reviews, where she reviewed my experiential statements and themes. These reviews kept me accountable and helped ensure my experiential statements were clear and grounded in the data. Member checking was also completed to increase the study's rigour. This involved sending participants the interview transcript and conducting a follow-up interview. In follow-up interviews, I asked participants to confirm the accuracy of the information gathered and additional questions to help clarify my understanding of their experiences. In addition to member checks and peer review, I kept an audit trail containing all the information on the study, ranging from the initial proposal to the final write-up. The audit trail included documents outlining preliminary research questions, interview protocols, sample procedures, methodological decisions, consent forms, and other relevant documentation. Moreover, drafts of interview transcripts containing exploratory notes and experiential statements were saved throughout the research process. Finally, I aimed to maximize the credibility and transferability (i.e., the applicability of the study's findings to other contexts and settings that have not been directly studied; Drisko, 2024) of my research by providing thick and rich descriptions of both ideographic themes and group experiential themes.

Ethical Considerations

This study was approved by the University of Alberta's Health Ethics Research Board (HREB), and Alberta Health Services gave operational approval. Before the interview, all participants were reminded that the study was voluntary, that they could choose not to answer a question if they wished, and that they could withdraw from the study at any time. Participants were also told they were free to take breaks and ask questions throughout the interview process. They were also provided with my and my supervisor's contact information to allow them to ask questions between interviews or after the completion of the study. Participants were asked questions requiring them to recall their experiences of Long COVID, which could have given rise to negative feelings in some individuals. Therefore, during the interview process, I monitored participants for any signs of distress and provided all participants with a list of counselling resources following the initial interview (See Appendix E). No participants withdrew from the study once the interview began, and I observed no signs of significant participant distress throughout any of the interviews.

All identifying or potentially identifying information was removed from the interview transcripts to protect participant anonymity. Participants were also assigned a pseudonym to be associated with their interview transcript and participant information form. Pseudonyms were assigned following the initial interview; then, participants were given the option to select a new pseudonym at the time of the follow-up interview. Raw data were stored separately from deidentified data on a password-protected and encrypted memory drive in a locked filing cabinet. Finally, a secure computer with updated anti-virus and malware protection software was used for all online interviews.

Chapter 4: Findings

The purpose of this study was to investigate the lived experiences of self-compassion in adults suffering from Long COVID. Consistent with the ideographic nature of IPA, I open this section by introducing the study participants through brief vignettes that summarize participants' experiences of self-compassion during their time with Long COVID. Subsequently, I present the descriptions of the five experiential group themes that arose through the data analysis process. Pseudonyms have been used, and all identifying information, such as occupation and specific age have been removed to keep participants' identities confidential.

Participant Vignettes

Clara

Clara self-identified as a Caucasian woman in her early 60s who experienced Long COVID symptoms for approximately one and a half years. She sought the help of medical providers early on in the COVID-19 pandemic when she presented with persistent symptoms such as shortness of breath, brain fog, fatigue, muscle aches, and low oxygen levels. However, due to the novel nature of COVID-19 at the time, the medical community lacked knowledge about the virus. As a result, Clara felt considerable uncertainty about her symptoms. She came to doubt her own experience, leaving her to question "if it was all in [her] head." During this challenging time, Clara showed herself compassion by trying to learn more about her condition through the news, Facebook stories, and medical journals. From Clara's perspective, learning more about her condition was an act of self-compassion in that it helped validate the legitimacy of her condition and reduced feelings of self-doubt about her experience with Long COVID.

Through previous experience dealing with stressful life events, Clara felt as though she had developed resilience to adversity. In the face of Long COVID, resilience meant "tak[ing] charge of what [she] could do" and maintaining a positive mindset. A few of the ways in which Clara demonstrated this mindset were by engaging in positive self-talk, having a hopeful outlook on her future, and reassuring herself that she was going to get better. For Clara, a positive mindset was both a form and facilitator of self-compassion; by adopting positive thinking, Clara was able to shift from feeling anger and self-pity to having increased compassion for herself.

Furthermore, when Clara was confronted with negative emotions, she demonstrated self-compassion by focusing on accepting her feelings and participating in activities that made her happy, such as getting facials, taking baths, and spending time in the sun. Clara also displayed self-compassion by turning to a support system comprised of friends and family who were compassionate towards her. Friends and family provided Clara with a safe space to talk, checking up on her, offering her advice, and speaking to her with compassion. For Clara, compassion from her friends and family helped her have a more positive outlook on her future, and during times that others were "compassionate towards [her]…, it was easier for [her] to be compassionate towards [herself]."

In addition, during Clara's Long COVID experience, there was tension between her wanting to return to a pre-COVID level of functioning while also trying to show self-compassion by allowing herself to rest and do less. At times, this tension resulted in Clara pushing herself too far. However, Clara found that when she was able to extend compassion toward herself, it was a crucial mechanism that helped her lower her self-expectations, take more time to rest, and be accepting of her Long COVID-related limitations.

Sandra

Sandra, a woman in her late 50s, was hospitalized for COVID-19 infection and had been struggling with Long COVID for just under three years. Throughout this time, she experienced a myriad of symptoms, including fatigue, muscle aches, heart palpitations, shortness of breath, dizziness, worsened memory, and difficulties concentrating, which made it difficult for her to maintain her usual level of everyday functioning. Sandra's husband also developed Long COVID. The symptoms and resulting impairment that Sandra and her husband experienced made everyday chores like shopping, cleaning, and cooking difficult for their household. These impairments led Sandra to be frustrated by her limitations and self-critical. In particular, she judged herself as being lazy due to her inability to perform the daily life tasks she had completed prior to getting Long COVID. The criticism and frustration that Sandra directed toward herself appeared to hamper her ability to show self-compassion. However, by giving herself time, Sandra was able to accept her illness and mourn the loss of what her life was like before Long COVID. By accepting her Long COVID symptoms and letting go of the lifestyle she held in the past, Sandra's ability to practice self-compassion also increased.

Another aspect of self-compassion from Sandra's perspective was taking action to look after herself the best that she could. As she stated, "Daily care needs to happen." For Sandra, daily care involved fulfilling her basic needs. For instance, she attempted to sleep more and eat a healthy diet. In addition to showing herself compassion by ensuring her fundamental needs were met, Sandra demonstrated self-compassion by shifting her mindset about her Long COVID illness. More specifically, Sandra endorsed a more understanding mindset, telling herself, "It'll be fine, it'll work out, it'll be what it will be."

For Sandra, having a caring support system was another vital aspect of self-compassion: "It is really hard to have self-compassion if you don't have any support [systems]." Supportive family and friends checked in on her, were emotionally supportive, and sent her positive messages. Despite the support she received from her friends and family, the lack of compassion and empathy that Sandra perceived from the medical community made it difficult for her to show compassion toward herself. In addition, Sandra felt as though medical providers did not have an adequate understanding of her illness and lacked helpful suggestions, which was discouraging for her. From Sandra's perspective, being shown compassion, reassurance, respect, and validation by medical professionals would have helped garner more self-compassion.

Tanya

Tanya was a woman in her early 40s who had suffered from Long COVID for over three years. She had been physically active prior to her Long COVID illness, with dancing and singing being among her hobbies. However, Long COVID brought several symptoms, such as fatigue, joint and muscle pain, shortness of breath, and heart palpitations, which limited her ability to engage in previously enjoyable activities. No longer being able to participate in her hobbies frustrated Tanya and contributed to her experiencing feelings of anger and shame about her illness-related limitations. These feelings of shame and anger seemingly reduced Tanya's capacity for self-compassion. Conversely, by showing herself compassion, Tanya was able to find alternative activities she enjoyed and ways to be happy with her new lifestyle. Some of the ways that Tanya showed herself compassion included "watching one of [her] favourite movies or talking to [her] best friend [or other] tiny things" that she could do to make herself feel happy.

Another component of self-compassion, to Tanya, was allowing herself to rest and adopting a more understanding mindset about her limitations. For instance, when describing how she conceptualized self-compassion, Tanya said, "I guess giving yourself permission, like telling yourself things are okay, it's okay that you did not clean something [to]day." In Tanya's experience, self-compassion also involved planning rest days after she exerted herself. Through accepting her need to rest, Tanya was able to reduce the feelings of shame and anger that she had previously experienced when she was unable to engage in activities because of her condition. Moreover, by accepting her limitations and honouring her physical needs, she felt less obligated to engage in the same activities she did before developing Long COVID. On a related note, medical professionals also played a prominent role in helping Tanya acknowledge her illness and be more understanding of her Long COVID-related limitations. More specifically, medical providers were able to facilitate feelings of self-compassion by reassuring Tanya that there was something medically wrong with her and that Long COVID was a legitimate illness.

In addition to her compassionate conversations with medical professionals, Tanya's interactions with her friends, family, and other people in her life during her struggles with Long COVID had a role in her experiences of self-compassion. From Tanya's perspective, making time to talk with her best friend was an act of self-compassion, as it provided her with a safe place to vent and a sense of camaraderie: "On the days I was trying to tune out [people's negative views about COVID], but it was still making me angry, I would just text my best friend how angry I was, and she would justify it to me." However, Tanya also described negative interactions with friends, family, and co-workers as barriers to self-compassion. Particularly, when people around Tanya pointed out that she was not as social as she was before and she had to explain why she no longer had the same amount of energy as she did prior, Tanya appeared to experience feelings of shame. These feelings of shame and the loss of a key component of her identity made it more difficult for Tanya to show herself compassion.

Rachel

Rachel self-identified as a Caucasian woman in her early 50s who lived a busy life pre-COVID, working full-time while also taking care of her children. She experienced a range of Long COVID symptoms, including fatigue, shortness of breath, worsened memory, and heart palpitations, which resulted in her having to take time off work. Despite Rachel seeking help from her family doctor, she was "pushed back to work and [told] 'this is in your head.'" The perceived lack of compassion demonstrated by her medical provider made Rachel feel like self-compassion was not justified in her situation. Following her negative experience with her family doctor, Rachel found a new doctor who acknowledged her symptoms and referred her to other specialized medical providers at a Long COVID treatment clinic. In her ensuing interactions with medical professionals, Rachel received a Long COVID diagnosis, which provided her with validation that her symptoms were real. The confirmation that she was actually sick was a crucial step in Rachel allowing herself to feel self-compassion.

During her Long COVID experience, Rachel demonstrated self-compassion in a number of ways. One way was by acknowledging her limitations, which was expressed through allowing herself to lower her standards on unimportant tasks, be less perfectionistic, and slow down her pace. Rachel also acknowledged her limitations by permitting herself to "do as little as possible… and take breaks and rest when [she] need[ed] to." Reducing the amount of time spent cooking and cleaning were additional ways that Rachel did less during her struggles with Long COVID. Another way was through altering how she perceived her own mistakes and their potential consequences: "I think that's another kind of piece for this to me is that those consequences [of making mistakes] are not necessarily punitive… and realizing, no one is really coming after me, and nobody's acting in a punitive manner." However, when it came to Rachel's work life, she was not nearly as forgiving about making mistakes. Instead, she considered it an act of self-compassion to implement strategies, such as making lists, to help her prevent her mistakes at work.

From Rachel's perspective, having her Long COVID experience normalized was also crucial in her experiences of self-compassion. Particularly, hearing the anecdotal accounts of other patients at the Long COVID treatment clinic helped Rachel—and recognizing that other Long COVID sufferers shared similar struggles—helped her feel less alone in her experience: "I was so similar to them that it just felt like [a] relief in a way and like this is normal, and this is okay.". In addition to having her experiences normalized, receiving compassion by others was another key contributor to self-compassion from Rachel's perspective. For instance, her manager showing her compassion improved Rachel's morale and helped her feel more comfortable about making mistakes.

Jack

Jack was a Caucasian man in his mid-30s who experienced Long COVID complications for roughly eight months. During his time with Long COVID, he experienced several Long COVID symptoms, including fatigue, worsened memory, difficulty concentrating, depression, and anxiety. These symptoms made it difficult for Jack to uphold his professional responsibilities, resulting in him taking a leave of absence from work. Long COVID was also accompanied by conflict with Jack's extended family due to differing beliefs about the legitimacy of COVID-19 as an illness. Jack's extended family's dismissive views about COVID made Jack question his own beliefs and his own experience with Long COVID. Further, Jack had difficulty trusting in his experience due to the controversy that was present in the public and media around COVID-19 and Long COVID. For Jack, applying self-compassion was critical to navigating the disparate information about the virus and developing trust in his own experience. Jack described applying self-compassion as a means of reconciling the difference between his view and those of his extended family with regard to COVID:

> I reconciled that in my mind [by] saying… yeah, okay, we can have a different opinion and the way I see things is still valid and the way I see things is reasonable and logical despite [them] not thinking that. That was an exercise of self-compassion, for sure.

In addition to having an impact on Jack's interpersonal relationships, Long COVID also hindered Jack's mental health and well-being. More specifically, during his time with Long COVID, Jack experienced feelings of anxiety and depression. He also described feeling broken or weaker than others due to his condition. Together, these mental health difficulties made it more difficult for Jack to have self-compassion. However, during times when Jack was able to view his Long COVID struggles through a compassionate lens, he was able to regulate his emotions better and experienced fewer Long COVID-related mental health difficulties. On a related note, applying self-compassion also aided in improving Jack's self-image and helped him cope with the stigma associated with having Long COVID. For instance, when discussing how self-compassion helped him manage stigma from co-workers, Jack stated, "I think it helped in managing my reaction when somebody said something to me [that was stigmatizing]."

Moreover, Jack described a number of external and internal resources that had key roles in promoting self-compassion throughout his time with Long COVID. One of the main external catalysts of self-compassion for Jack was the understanding shown by several individuals in his life, such as his wife, friends, therapist, and medical professionals. These sources of support provided Jack with a safe space to talk about his Long COVID struggles. Another external source of self-compassion for Jack was exposure to the Long COVID experiences of other individuals through anecdotal accounts and research papers. Learning about the Long COVID-related impairments of others helped foster feelings of self-compassion in Jack as it validated to him that what he was experiencing was real. In addition to these external facilitators of self-compassion, an internal strategy that Jack used to increase his capacity for self-compassion was journaling. Although journaling involved various forms of writing, one approach to journaling for Jack was similar to compassionate letter writing, where Jack would write to himself from a kind and compassionate perspective. Overall, writing provided Jack with a way to introspect on his Long COVID experiences and helped him separate himself from negative feelings such as shame, guilt, and self-judgement.

Finally, the self-compassion that Jack developed throughout his Long COVID journey encouraged him to make multiple changes in his life. For instance, his increased capacity for self-compassion contributed to him making the paradigm-shifting decision to leave his traditional career path and pursue career opportunities that he believed were a better fit for him. Additionally, the propensity for self-compassion that Jack developed throughout his Long COVID experience acted as a gateway for him to apply more compassion within his parenting, his marriage, and his other interpersonal relationships:

> I think that having to employ that self-compassion for survival's sake has made it glaringly obvious to me how important it is, and I think that I am now incorporating that… into my parenting, into my marriage, [and] into my interpersonal relationships.

Sarah

Sarah, a Caucasian Woman in her early 20s, had been suffering from Long COVID for approximately three years. Before contracting Long COVID, she was an avid runner who had multiple jobs. However, chronic symptoms, such as shortness of breath, heart palpitations, chest pain, impaired balance, vertigo, and fatigue, impacted her ability to engage in the same activities that she did before her illness. Arising in part from how early on in the pandemic Sarah developed Long COVID, she experienced a lack of recognition from other people about the validity of COVID-19 and Long COVID. The perceived failure of others to validate her health struggles made it more difficult for Sarah to show self-compassion:

> I don't complain, but the moment I acknowledge a symptom or talk about a symptom and what's going on for me, it's just not heard and brushed under the table and labelled like you're just crazy type stuff. So, yeah, the whole compassion thing is not super easy.

Moreover, when Sarah did try to speak out about her Long COVID struggles, she received backlash from individuals who doubted her experiences. This backlash made Sarah question her own experiences at times:

> People were just so aggressive… Like they were just scary, and so that just made me feel even more small and [like] what I was going through wasn't a thing, and [that] it was in my head.

In addition to backlash from friends, family, and other people, Sarah felt doubted by medical providers when she shared her Long COVID struggles. Early on in Sarah's time with Long COVID, she perceived medical providers as discrediting her symptoms by refusing to examine her and provide her with referrals to specialists. As Sarah explained, the lack of care and compassion she experienced from medical professionals contributed to her having little care and compassion for herself. For instance, while recounting one of her interactions with a medical provider, Sarah stated, "He had no understanding…, he just didn't have any compassion towards me, and so I think from that moment on I just had barely had compassion for myself."

However, Sarah's experience shifted upon attending a long COVID treatment clinic, where she experienced considerable compassion from the medical professionals. From Sarah's perspective, receiving such compassion was a critical mechanism that allowed her to begin having compassion for herself. More precisely, Sarah was "able to accept compassion towards

[her]self because [interacting with] the people [at the Long COVID treatment clinic] was when [she] first experienced compassion from others towards [her]." In addition to receiving compassion from the medical community, validation from the medical community regarding the legitimacy of Long COVID was another essential component of Sarah's Long COVID experience. The self-compassion that emerged from the compassion and validation that Sarah experienced from medical professionals increased Sarah's belief in herself and helped her to be more confident in accepting what she was experiencing. Describing self-compassion, Sarah shared:

> Yeah, I think it's giving yourself the room to just like be who you are and acknowledge, and at least in the context of COVID, to just acknowledge those symptoms and validate the symptoms… rather than denying them or trying to hide from them or push them away.

Furthermore, self-compassion aided Sarah in forgiving herself for contracting Long COVID. Initially, Sarah blamed herself for getting sick because she felt like she did not take the appropriate steps to protect herself from becoming ill: "There was a lot of frustration towards myself because I put myself in the position of contracting COVID, and so it was kind of like me having to lay in the bed that I made." However, by showing compassion toward herself, Sarah was able to take steps towards forgiving herself for contracting the virus.

Common Themes

Five group experiential themes emerged among the participants: accepting Long COVID, turning down the dial, directing attention to the positive, compassion from others, and validation of the Long COVID experience. Table 1 indicates when a group experiential theme was relevant for a particular participant. The following sections provide a detailed description of each group experiential theme and include quotations to accentuate participants' experiences of self-compassion while suffering from Long COVID.

Table 1

Group Experiential Themes

Participant	Accepting Long COVID	Directing Attention to the Positive	Turning Down the Dial	Compassion From Others	Validation of Long COVID Experience
Clara	X	X	X	X	X
Tanya	X	X	X	X	X
Rachel	X		X	X	X
Jack	X	X		X	X
Sandra	X	X	X	X	X
Sarah	X			X	X

Note. X's indicate when a GET was present in the account of a particular participant.

Accepting Long COVID

Across all interviews, there appeared to be a relationship between participants' accepting their Long COVID experiences and self-compassion. For most participants, this relationship manifested itself as an acceptance of their Long COVID diagnosis and corresponding symptoms. In other words, participants demonstrated compassion for themselves by accepting that they were sick and acknowledging that the symptoms they were experiencing were due to Long COVID. For example, Sarah regarded self-compassion as "giving [her]self the room to… sit in those [Long COVID] symptoms rather than denying them or trying to hide from them or push them away." Similarly, in Jack's case, accepting his diagnosis meant acknowledging that what he was experiencing was Long COVID and accepting that he would need time and space to heal:

> There was a period of accepting that this had happened, accepting the diagnosis, accepting the need to take time and to heal, and then after that, what followed was the reality that healing was going to take time.

Along similar lines, participants described how self-compassion meant accepting limitations caused by their Long COVID symptoms. These limitations spanned across life domains and included difficulties performing occupational duties, completing housework, engaging with others socially, and performing physical activity. For Jack, accepting his limitations involved recognizing that Long COVID was causing him impairment in these settings and that to recover, he would need to accept his limitations and reduce the amount he pushed himself. Likewise, Tanya described showing self-compassion by being mindful of her body's limitations and trying to accept the lifestyle changes caused by her Long COVID symptoms: "So I kind of even changed my mindset on that, [I just] told myself, this is my new normal, and I need to adjust, and if it gets better, cool, and if it stays the same then I am not as devastated." As the proceeding quote illustrates, acceptance of limitations went hand-in-hand with reducing self-expectations. Moreover, Tanya's acceptance of her Long COVID limitations appeared to counteract the frustration she experienced when she was not able to engage in her enjoyed activities.

In Rachel's case, this involved lowering her self-expectations by accepting that she did not have to be perfect and that mistakes happen. For instance, Rachel detailed her experience of showing self-compassion by forgiving herself for being more forgetful since getting Long COVID:

> [Self-forgiveness] came with the acceptance that it's not the end of the world if you forget something. I used to feel like I had to be so on top of everything or [everything] would

> crumble, and with enough experience of forgetting things and realizing things don't crumble, it became easier.

In some instances, the acceptance of Long COVID-related limitations was also met with tension caused by the conflicting desire to return to pre-COVID levels of functioning. For example, Clara described showing herself compassion by reducing her expectations and accepting that she could no longer engage in several previous activities. However, Clara also expressed self-compassion by engaging in actions that she hoped would improve her condition; and she celebrated small improvements in her functioning:

> I was very proactive… I tried to do things that I felt good about, and when I did have these incremental achievements, that I could, you know, walk a little further or I could go for little bike rides or sleeping a little bit better, I felt very proud that I had done the right steps to get that far.

This tension sometimes resulted in Clara pushing herself "too far because [she] didn't want to lose to COVID, [she] didn't want COVID to win."

Grieving the losses caused by their illness was another vital component of accepting Long COVID for several participants. More specifically, participants applied self-compassion to help them grieve over the loss of their previous lifestyle and accept the changes that they had to make in their lives due to Long COVID. For example, when describing how she showed self-compassion while grieving her previous lifestyle, Sandra stated: "You mourn what used to be, but you got to let it go. You can't live in the past." From Sandra's perspective, applying self-compassion was an important aspect of coming to accept the loss of her previous way of life.

Directing Attention to the Positive

For most participants, dealing with the struggles of Long COVID was an intensely negative experience marked by impaired functioning, a loss of lifestyle, and feelings of shame and self-blame. An essential component of self-compassion that helped most participants cope with the negativity caused by Long COVID was directing their attention to the positive aspects of life. In some cases, this involved participants trying to generate positivity by engaging in uplifting activities. For example, Tanya showed herself compassion by trying to reclaim control of how she felt emotionally and engaging in activities that made her happy: "I kind of went, okay, well, I am responsible for my own happiness, so I tried to figure out ways… to make me happy each day." Tanya did this by watching comedy shows, listening to happy music, and watching heartwarming TV programs.

Another commonality represented across several participants was showing self-compassion by identifying the positive aspects of an otherwise negative experience. Demonstrating this, Tanya showed self-compassion by finding the positives in her Long COVID experience: "Hey, but I didn't have to be intubated… for the most part, I would try to find the positive in it." Similar to Tanya, Sandra displayed self-compassion by focusing on the positives despite the challenges she was facing due to Long COVID. Specifically, self-compassion amidst Sandra's Long COVID experience involved her reflecting on the positives in her life:

> We are so lucky compared to most… We have a great pension, we have a good life, we have a nice house, you know, we've got it made compared to a lot of other people… We have anything and everything we truly need or want.

In addition to displaying self-compassion by engaging in uplifting activities and identifying positives in one's life, some participants also expressed self-compassion by maintaining a positive and hopeful outlook toward the future. For instance, Clara adopted a positive mindset by being optimistic about her Long COVID condition: "Knowing that it's going to get better, and it's going to pass, that I think it allowed me to have those days where I wasn't feeling very good." Amidst her Long COVID difficulties, Clara prioritized maintaining a hopeful orientation toward the future, as she regarded optimism as a vital aspect of the Long COVID recovery process: "I'm a true believer that being positive and having positive thoughts makes a huge difference to not all diseases or symptoms, but a lot of them." Accordingly, Clara showed herself compassion by engaging in positive self-talk, telling herself, "It's going to be okay. I'll get through it."

For one participant, directing attention to the positives also involved focusing positivity inwardly to help promote a more positive sense of self. One of the negative consequences of Long COVID was that it reduced participants' ability to maintain their previous levels of functioning across multiple settings, including in the workplace, within interpersonal relationships, and in the household. In some cases, this reduced functioning led to participants experiencing a damaged sense of self. For instance, Jack described feeling "different or weaker than, or broken" due to his Long COVID illness. However, in Jack's case, choosing to display self-compassion offset these negative self-perceptions and promoted a more favourable self-image. One of the ways that Jack was able to do this was by compassionately introspecting on his Long COVID experience, which helped him perceive himself in a more positive light and separate himself from negative feelings of shame. Describing the impact that self-compassion had on his ability to think more positively about himself, Jack explained:

> I think that it's important to recognize for anybody [who] wants to change that kind of inner experience that self-compassion is a choice you can make, and making that choice consciously over and over again can change your inner monologue.

Turning Down the Dial

As a third common theme that appeared in the majority of participant accounts, self-compassion meant reducing the intensity and frequency of the activities that participants engaged in. One component of this theme involved giving oneself permission to rest and do less. In Rachel's case, she demonstrated self-compassion by permitting herself to slow down, rest, and do less without feeling guilty. For example, Rachel described her experience of allowing herself to rest by not pushing herself to keep up with her young children:

> What I will do is sometimes send them outside to play, and I don't play with them… I don't think my boys even notice I am not there because they are having so much fun, and so I have dialled back on that without feeling guilt.

Similarly, Clara showed self-compassion by giving up some of her household responsibilities and allowing herself to take breaks, watch TV, and do tasks over a more extended period: "It's okay if we sit and rest. I can sit and rest, I can watch an hour of TV and get up and do a little bit of something else, but that's what it was. It's just breaking it down into smaller pieces."

Like Rachel and Clara, Sandra showed herself compassion by giving herself time and space to rest and do less. For Sandra, resting and doing less involved planning fewer activities throughout the day, taking time to relax, pacing herself, and staying home more often. In addition, it also meant pushing herself less by engaging in non-taxing activities:

> I guess I probably watch a lot more TV than I probably ever have before just because it's easy, I guess. I read a little bit…, but you know, that seems to kind of pass the time; it's entertainment.

For some participants, the exhaustion and fatigue caused by Long COVID made it more difficult for them to demonstrate self-compassion. However, when participants allowed themselves to rest and they felt better as a result, it then became easier for them to extend compassion toward themselves. For example, describing what made it easier for her to experience self-compassion, Rachel recalled:

> To take those breaks and to rest because I have now felt myself improve and I've felt that recovery. So, that makes it even easier moving forward when I start to feel a little tired. I'm like, I've got to stop now because I know if I keep going, things are going to get worse, but if I stop, we're going to be better tomorrow.

Similarly, when discussing facilitators of self-compassion, Tanya detailed how permitting herself the time and space to rest helped make self-compassion bubble up more easily: "It wasn't until… I finally gave myself permission that it was okay to have a day where I had no energy and needed to sleep." Moreover, for several participants, the self-compassion that arose from permitting themselves to rest seemingly diminished the feelings of shame they had about their reduced capacity to engage in meaningful activities.

Compassion From Others

For all the participants, compassionate interactions had a role in the experience of self-compassion. In particular, receiving compassion from others helped make it easier for most participants to extend compassion toward themselves. A majority of these interactions involved close friends and family members. In Clara's experience, people in her support system, comprised of her friends and family, showed her compassion by offering her advice, spending time with her, and providing her with a safe place to talk and grieve. Recalling the impact that receiving compassion from others had on her, Clara stated: "It helped a lot because… they really did care, and that helped… It just makes you feel valuable or worthy or whatever when there [are] people around who care." Receiving this care and compassion from others helped make it easier for Clara to have compassion for herself.

On a related note, participants demonstrated self-compassion by positioning themselves close to supportive and compassionate individuals. For instance, one way of demonstrating self-compassion for Tanya was through making time to talk with her best friend. In part, Tanya's compassionate interactions with her best friend involved venting about her experiences with Long COVID, such as negative exchanges with individuals who did not believe in COVID-19. When describing the impact of being shown compassion by her best friend, Tanya stated: "It made it a bit easier… There were a handful of days [when] she came, and we just stood outside in my garage. Those [were the] days that filled my bucket."

Although there was a relationship between receiving compassion and feelings of self-compassion for a majority of participants, a lack of compassion and caring from other individuals, including friends and family, also acted as a barrier to feelings of self-compassion for multiple participants. As described by Sarah, there were instances when family members and other individuals in her social circle showed a lack of compassion for her Long COVID struggles. The perceived lack of care and compassion from others made it more difficult for Sarah to experience self-compassion at multiple points throughout her Long COVID journey: "I think my perspective would, like my experience of compassion would, be very different if I had received compassion early on in my COVID journey." For Sarah, the backlash and criticism displayed toward her made it difficult to find a safe place to talk about the adversities she went through during her time with Long COVID. Her difficulties speaking about her experiences contributed to Sarah feeling a lack of support from those around her, which made feeling compassion for herself more challenging.

Another aspect of this theme that arose in multiple participant accounts was the influence that compassion from medical providers had on participants' experiences of self-compassion. In cases when medical providers were not seen as understanding, caring, or compassionate, participants found it more difficult to extend compassion toward themselves. For example, the perceived lack of care and compassion from various medical providers made it more difficult for Sarah to have care and compassion for herself:

> It really felt like the medical field wasn't really sure what was going on, or like caring for people with these symptoms,… so it was just a lot of passing the baton… And above all, there was just such little care for what was going on for me. I think that made it worse that people just didn't care, and I think that made me then have little care for myself.

Similar to Sarah's experience, Sandra also had negative interactions with medical providers that made self-compassion more difficult. In particular, a perceived lack of support, understanding, empathy, and compassion were barriers to self-compassion for her. When discussing her interactions with one of her doctors, Sandra explained, "I never actually saw the guy. He didn't even have the compassion to FaceTime [me]." For Sandra, the lack of time and effort that she experienced from medical professionals made her feel unsupported, contributing to her difficulty in having self-compassion.

However, the majority of participants also described having positive interactions with medical providers characterized by caring and compassion. For example, Jack described receiving compassion from numerous individuals in the healthcare profession: "My physiatrist, my general practitioner, and a few members of the health community that I have in my social circle [were] all overwhelmingly understanding and compassionate." In situations where medical providers were perceived as compassionate, it promoted feelings of self-compassion for participants. From Sarah's perspective, being shown compassion by members of the medical community at a Long COVID treatment clinic allowed her to overcome the impact of previous negative experiences with doctors and to be compassionate towards herself:

> It just kind of reversed what was said to me and allowed me to let go of [previous negative experiences with medical professionals]… to then give myself compassion and be compassionate towards myself.

Likewise, Rachel also felt permitted to express self-compassion after having compassionate interactions with her provider. More specifically, being told by a doctor that self-compassion was an appropriate and needed response to her Long COVID struggles made Rachel feel like she then had permission to begin to show herself compassion as well.

Validation of Long COVID Experience

For all participants, validation—and in some cases, invalidation—of their Long COVID struggles played an essential role in their experience of self-compassion. The significance of validation, as a part of participants' process of developing self-compassion, can be understood against the backdrop of participants' experiences of invalidation. Specifically, when participants felt invalidated by others it made experiencing self-compassion more difficult. In part, participants felt that their Long COVID experiences were being invalidated by the controversy surrounding the legitimacy of Long COVID and the backlash they received when they shared about their Long COVID experiences. Additionally, the differing belief systems of friends and family led participants to question the reality of their Long COVID experiences. Moreover, in Sarah’s case, the lack of validation she received from others led her to experience feelings of shame about her condition, which acted as a barrier to her showing self-compassion.

Another reason participants had doubts about the legitimacy of their illness experience was due to conversations they had with professionals in the medical community that participants perceived as invalidating. For example, in Clara's early interactions with medical providers, she felt like she did not receive any clarification or confirmation about her condition:

> I didn't feel like [the doctor] believed I had Long COVID or any symptoms that would have resulted from Long COVID or from COVID. So he gave me an inhaler, and I didn't feel that I had been understood or heard.

The perceived lack of validation from her medical providers made it more difficult for Clara to experience self-compassion because she questioned if her experience was real or "if [she was] being a bit of a hypochondriac." Sandra and Rachel described similar invalidating experiences with medical professionals. Demonstrating this, Rachel described how she felt following an interaction with her doctor, who told Rachel that she was not sick and pushed her to go back to work: "Yeah, it was very deflating, and I felt completely hopeless because I felt there was really something wrong with me, and she's telling me it's in my head."

As opposed to the perceived negative role of invalidation in participants' experiences of self-compassion, when participants felt as though their perceptions and experiences were validated, it was a key catalyst of self-compassion. Although validation arose from multiple sources, in the present theme, validation originating from medical providers and from hearing the accounts of other people with Long COVID was especially salient. In Sarah's case, finally receiving validation from the medical community allowed her to begin to show herself compassion:

> I think that the reason the medical basis was so big for that [self-]compassion component was because prior to that, the medical professionals that I experienced… told me what I was going through wasn't real… So, in a way, it was almost like this apology or like enlightening… It just kind of reversed what was said to me.

One way that receiving validation from medical providers appeared to promote Sarah to feel self-compassion was by allowing her to reject the shame that was pushed on her by others. Similarly, Jack reported that validating conversations with friends, family, and members of the medical community helped him overcome feelings of shame: “There was an element of shame at first, *for sure*… Then, after I had those validating conversations… the experience was calming and positive.”

A particularly important source of validation that participants received from the medical community was in the form of a Long COVID diagnosis. For instance, when Rachel was diagnosed with Long COVID, it "was step one" in allowing herself to show self-compassion. Receiving an official diagnosis and having her symptoms acknowledged by her doctor helped validate the legitimacy of Rachel's Long COVID experience. Similarly, medical professionals reminding Tanya that there was actually something medically wrong with her felt like a form of reassurance:

> I think it was just the reminding me that there was actually something medically wrong with me… So them saying don't push yourself because your heart is telling you, you can't, it was that reassurance of, yes, you are okay, but you can't go that fast yet.

Another source of validation for some participants came through learning about the Long COVID experiences of others. Such learning helped normalize 'participants' experiences and allowed them to recognize that they 'weren't alone in their struggles. For Rachel, exposure to the anecdotal accounts of others with Long COVID "showed [her] that what [she] was feeling and how [she] was experiencing things is completely normal for [individuals with] Long COVID." Congruent with what Rachel described, Jack reported that having his Long COVID experiences validated through hearing and reading about the lived experiences of others helped him foster self-compassion. More specifically, from Jack's perspective, exposure to the experiences of others with Long COVID positively impacted his ability to be compassionate towards himself because it validated the legitimacy of his experience:

> Reading anecdotal accounts on social media and on the internet… some studies, and things like that, I find those things comforting in the sense that it's a bit validating to hear that other people have been going through similar things.

Chapter 5: Discussion

The purpose of the current study was to gain an in-depth and nuanced understanding of the experiences of self-compassion in individuals suffering from Long COVID. The interviews of six adult participants were analyzed using an IPA approach (Smith et al., 2022), resulting in the formation of five group experiential themes: accepting Long COVID, turning down the dial, directing attention to the positive, compassion from others, and validation of the Long COVID experience. To summarize, participants demonstrated self-compassion by coming to accept their Long COVID diagnosis, symptoms, and limitations. Several participants also displayed self-compassion by generating positivity through uplifting activities, having a more positive outlook on the future, and identifying the positives in their lives and in themselves. Furthermore, a majority of participants expressed showing self-compassion by taking a step back and allowing themselves to rest and engage in fewer activities and tasks than they did before developing Long COVID. Participants also emphasized the role that receiving compassion from other people, including friends, family, and doctors, had on their ability to show self-compassion. Lastly, participants discussed how receiving validation about the legitimacy of their Long COVID experience was a key facilitator of self-compassion.

In the following sections, I discuss how each group experiential theme relates to the existing literature and identify several novel findings. I also consider the implications of these findings for counselling settings. Finally, I bring attention to the limitations of the present study and identify directions for future research.

Discussion of Key Findings

Accepting Long COVID

For all participants, self-compassion was perceived as having a key role in promoting acceptance of their Long COVID illness. The relationship between self-compassion and acceptance of Long COVID appeared to be quite nuanced. For instance, multiple participants described self-compassion as a critical contributor to their ability to accept their Long COVID diagnosis. In like fashion, Sirois and Hirsch (2019) suggested that self-compassion may aid in non-judgemental acceptance of one's medical condition in participants with five different chronic illnesses, including CFS, cancer, and fibromyalgia. Further supporting the link between self-compassion and acceptance of one's chronic condition, in a systematic review, Austin and colleagues (2021) investigated 20 studies examining the benefits of compassion-focused interventions (e.g., Compassion-Focused Therapy, Mindful Self-Compassion and Cognitively-Based Compassion Training) for individuals with chronic health conditions. One of the primary findings reported by Austin et al. was that compassion-focused interventions resulted in an increased acceptance of individuals' chronic health conditions. These findings, considered in tandem with what was found in the current study, illustrate that self-compassion may have a considerable role in helping individuals accept their Long COVID diagnoses.

In addition to facilitating acceptance of their Long COVID condition, self-compassion aided several participants in accepting the limitations they experienced due to Long COVID. These limitations made it difficult for participants to maintain their previous roles occupationally, socially, and within the home setting. Consistent with the idea that self-compassion may be critical in accepting Long COVID-related limitations, one of the core facets of self-compassion as conceptualized by Neff (2003) is mindfulness, which includes acceptance of shortcomings and setbacks. Further supporting the relationship between self-compassion and acceptance of limitations, Wren and colleagues (2012) examined the influence of self-compassion on pain and pain-related disability in a sample of 88 adults with chronic pain conditions. Their findings suggest that in the context of individuals with chronic illnesses, self-compassion may increase an individual's capacity to be accepting of day-to-day illness-related limitations. On a related note, a novel finding of the current study, not previously reported in those with Long COVID or chronic health conditions more broadly, was that several participants were compassionate towards themselves by reducing their self-expectations. In particular, participants reduced their expectations for themselves by accepting that they did not need to perform in the same capacity as they did before developing Long COVID.

Another function of self-compassion identified by several participants was its ability to help the participants grieve the loss of their pre-Long COVID lifestyle. Although grief is usually thought of as a typical response to the loss of a loved one (Arizmendi & O'Connor, 2015), previous research suggests that grief can also arise due to the loss of previous capacities (Byrne, 2022; Fennell et al., 2021). For example, Byrne (2022) suggested that in persons with CFS, many of the mental health symptoms that arise may actually be a result of a grief response to the loss of previous capacities. In support of the connection between self-compassion and grief reported in the present study, Szocs et al. (2022) found that high levels of self-compassion were linked to lower levels of prolonged grief in a sample of adults experiencing grief related to bereavement. The findings of the current study provide evidence that self-compassion may have a similar relationship to feelings of grief in those suffering from Long COVID as those experiencing bereavement, meaning that greater self-compassion may help the grieving process in people with Long COVID.

Finally, some participants drew attention to a tension they experienced between, on the one hand, showing self-compassion by accepting their diagnosis and, on the other hand, trying to push themselves to recover from their condition. As a result of this tension, participants commonly pushed themselves too far by doing too much and faced setbacks in their recovery as a consequence. In accordance with this finding, a commonly reported symptom of Long COVID is post-exertional malaise (Twomey et al., 2022; Wurz et al., 2022). Post-exertional malaise presents as severe fatigue and increased symptom severity following a period of brief physical or mental exertion (Fukuda et al., 1994). The current study's findings suggest that promoting acceptance of one's Long COVID condition may encourage individuals not to overextend their capabilities, which could reduce the severity of symptoms such as post-exertional malaise. Overall, given the existing literature as well as the findings of the present study, promoting self-compassion could be a promising strategy to encourage illness acceptance and reduce the risk of overexertion in those with Long COVID.

Directing Attention to the Positive

In the current study, most participants indicated that during their time coping with Long COVID, they expressed self-compassion by directing attention to the positives in their lives. For some individuals, this included trying to manifest positivity by engaging in uplifting activities that made them happy. Consistent with these findings, previous literature has linked self-compassion to various behavioural strategies aimed at facilitating happiness and well-being (Adie et al., 2021; Allen & Leary, 2010; Takagaki & Yokoyama, 2024). For instance, self-compassion has been connected to action-orientated coping, a type of coping that involves actively making behavioural changes to improve a stressful situation (Allen & Leary, 2010). Moreover, higher levels of self-compassion have been found to have a positive impact on promoting behavioural activation (i.e., engagement in activities that generate positive feelings; Adie et al., 2021). Finally, third-wave CBT interventions orientated around building mindfulness and self-compassion in populations with chronic conditions typically include treatment components that promote engagement in important and enjoyed activities, suggesting these activities play a role in recovery (Torrijos-Zarcero et al., 2021). Taken in conjunction with the literature mentioned above, the findings of the current study indicate that there is a relationship between self-compassion and participation in uplifting activities in populations with Long COVID.

Along with positive activities, maintaining a positive outlook on the future was another way that some participants treated themselves with compassion during their Long COVID experience. More specifically, participants showed self-compassion by being optimistic about the progression and future of their Long COVID condition. Congruent with these findings, prior research has found that self-compassion can positively influence one's outlook on the future (Phillips, 2018). The relationship between self-compassion and a positive attitude toward the future has also been demonstrated in populations of individuals with chronic health conditions (Rafiee et al., 2019). For example, in a sample of 20 adults with diabetes, a self-compassion training intervention was found to increase hope for the future (Rafiee et al., 2019). Rafiee et al., 2019 and colleagues suggested that hope and thinking positively about the future are vital in those with chronic illnesses because optimism helps individuals overcome illness-related limitations and reduces the focus placed on failure and illness-related deficiencies. The findings of the current study provide further support for the connection between self-compassion and a more positive outlook for the future while also demonstrating this connection in an understudied population, persons with Long COVID.

Turning Down the Dial

A majority of participants in the current study indicated that showing themselves compassion in the context of Long COVID involved both allowing themselves to rest and reducing the volume and intensity of the activities they engaged in. In some instances, participants' experiences of resting and doing less involved spending more time at home relaxing and less time engaging in daily activities like cooking and cleaning. Participants also gave themselves permission to reduce the amount of physical activity they engaged in. Previous researchers have similarly found a relationship between self-compassion and engagement in health behaviours, such as maintaining healthy levels of physical activity (Ferrari et al., 2017; Semenchuk et al., 2022). An important aspect of turning down the dial for participants was managing their symptom severity by not overexerting themselves. Similar to this finding, Olson and colleagues (2015) qualitatively examined the nature of fatigue in a population with CFS and found that introducing extended periods of rest and avoiding overexertion were ways in which participants managed their fatigue. Considering previous research, alongside the findings of the current study, managing physical activity, particularly by not overexerting oneself, appears to be a way that individuals with chronic conditions, such as Long COVID, may exhibit self-compassion.

In addition to being an expression of self-compassion, resting led to an improvement in participants' symptom severity, which coincided with an increase in self-compassion. This shift to a more compassionate stance towards their Long COVID condition appeared to lead participants to have reduced feelings of shame about their illness-related limitations. Conversely, when participants felt debilitated by their sickness, feelings of shame appeared to be more prominent. Consistent with this, illness-related shame is commonly reported in populations with chronic health conditions (Matos-Pina et al., 2022; Stage, 2022). Similar to the present study, previous research examining experiences of shame in people with various chronic conditions has also found that shame commonly arises due to energetic failures, that is, the tiring of the body that occurs when engaging in various activities (Stage, 2022). In the current study, self-compassion appeared to have a key role in alleviating these feelings of shame. Supporting this findings, Gilbert (2017) proposed compassion and self-compassion as possible solutions to the feelings of shame that can arise in medical contexts. Moreover, researchers have found that self-compassion is negatively related to feelings of shame in populations of individuals with other chronic medical conditions (Finlay-Jones et al., 2023). Overall, my findings add to the literature mentioned above by suggesting that resting may be an act of self-compassion that is particularly beneficial in reducing shame in those with chronic health conditions, such as Long COVID.

Compassion From Others

Receiving compassion from others was a theme that was present in the interviews of all six participants. More specifically, compassion directed towards participants from others was a facilitator of self-compassion. The connection between receiving compassion from other people and self-compassion is a surprisingly understudied area of empirical inquiry. However, a recent study by Chan et al. (2022) found that receiving compassion from others was related to higher levels of self-compassion in a sample of university students. Moreover, there is evidence suggesting that both directions of compassion have many of the same mental and physical health benefits (Steindl et al., 2021). The findings of the current study add to the existing literature, suggesting that receiving compassion from others could be crucial in promoting self-compassion in those with Long COVID.

Compassionate interactions with individuals in the medical profession, such as doctors, nurses, and rehabilitation providers, were perceived by participants as being particularly important in their experience of self-compassion. From the participants' perspectives, medical professionals demonstrated compassion by being understanding of participants' limitations and treating them with care, kindness, and empathy. The empirical literature examining patients' perceptions of receiving compassion from healthcare providers is relatively limited (Malenfant et al., 2022). With that being said, research has investigated the role that compassion from healthcare providers can have in the quality of care and healthcare outcomes of individuals with various illnesses (Watts et al., 2023). A review by Watts and colleagues examined the findings of 22 publications investigating the impact of compassion from medical providers and found that compassion from these individuals can increase adherence to treatment, improve physiological outcomes, and reduce mental health symptoms. However, to my knowledge, no research has examined how self-compassion is influenced by receiving compassion from medical providers in populations with chronic illnesses, let alone Long COVID. In the current study, when medical professionals exhibited compassion, it helped confirm that compassion was a needed and appropriate response to participants' struggles. Conversely, for participants, a lack of compassion from medical professionals was experienced as being a notable barrier to feelings of self-compassion. Given these findings, the present study can guide novel inquiry into the role that compassion from medical providers can have in cultivating feelings of self-compassion in those with Long COVID.

Validation of the Long COVID Experience

For all participants in the present study, receiving validation about the legitimacy of their Long COVID condition promoted their ability to express self-compassion. In some instances, validation paved the way for self-compassion by helping reduce participants' feelings of shame. Limited research appears to link external validation and shame, especially in those with chronic illnesses. However, one study by Shin and colleagues (2022) broadly suggested that receiving validation of one’s life experience can help reduce negative feelings, including shame. The current study builds on this finding by indicating that validation may not only help reduce feelings of shame but that the reduction in feelings of shame may also promote self-compassion.

One of the sources of validation commonly reported by participants was validation by medical providers. Receiving a Long COVID diagnosis was found to be particularly validating for several participants. Consistent with this finding, Ireson and colleagues (2022) conducted a thematic analysis study examining the physical and epistemic challenges of adults living with Long COVID and found that the need for validation was a common theme across participant accounts; furthermore, receiving a COVID diagnosis was an especially salient source of validation. In addition to echoing Ireson et al.'s findings and highlighting the importance that validation from medical providers may have in the experiences of people with Long COVID, the present study extends the literature by illuminating a potential connection between the validation of one's Long COVID condition and the promotion of self-compassion. More specifically, my findings showed that, from participants' perspectives, receiving validation from medical providers helped participants experience a greater flow of compassion toward themselves. In contrast, when participants did not feel validated about their condition by medical providers, it was perceived as a major barrier to self-compassion.

Lastly, several participants indicated that having their Long COVID experiences normalized was another source of validation. Feelings of normalization commonly originated from exposure to the anecdotal accounts of other people with Long COVID and from reading Long COVID literature. As discussed earlier in this thesis, a key component of self-compassion, as defined by Neff (2003), is common humanity. Common humanity involves identifying shared experiences with others and recognizing that failures are part of the shared human experience (Neff, 2003). Therefore, it is not surprising that in the present study, the normalization of participants' experiences contributed to feelings of self-compassion. However, no prior studies on populations with chronic illnesses have explored a relationship between normalization of experience and self-compassion. Thus, the findings of the present study may provide new insights into a potential link between normalization of experiences and self-compassion not only in individuals with Long COVID, but also in people with chronic illnesses more broadly.

Implications for Counselling and Mental Health Care

Individuals suffering from Long COVID are at risk for various mental health difficulties (Burton et al., 2022; Houben-Wilke et al., 2022). However, limited research has examined the lived experiences of adults suffering from Long COVID. Thus, the current study provides unique insight into how Long COVID is experienced, as well as the role that self-compassion may have in Long COVID coping and recovery. Based on the core values of counselling psychology that focus on individual strengths and the role of relationships in the change process (Canadian Psychological Association, 2009), the findings of the current study are especially well-orientated to inform the practices of counselling psychologists. By applying understandings from this study, counselling psychologists may be better prepared to bolster self-compassion and reduce barriers to self-compassion in clients with Long COVID.

One of the primary aspects of participants' experiences of self-compassion in coping with Long COVID was accepting their Long COVID diagnosis, symptoms, and limitations. For participants, acceptance helped them to alter their lifestyles, grieve Long COVID-related losses, view mistakes in a less punitive fashion, and lower self-expectations. Based on the positive benefits of acceptance perceived by participants in the current study, therapeutic approaches aimed at encouraging acceptance may be an appropriate approach for clients with Long COVID. For example, counsellors might consider using Acceptance and Commitment Therapy (ACT), which promotes psychological flexibility and mindfulness by encouraging clients to accept and adapt to life challenges (Dindo et al., 2017). ACT aims to encourage acceptance by introducing experiences such as grief, loss, pain, fear, and illness as inevitable aspects of life that must not be suppressed (Dindo et al., 2017). Applied to clients with Long COVID, an ACT approach could focus on reducing avoidant behaviours and fostering acceptance of the client's medical condition. Mindfulness-based approaches, such as Mindfulness-Based Stress Reduction, which has been found to be beneficial for those with other chronic illnesses (Niazi & Niazi, 2011), may also be valuable for encouraging acceptance for individuals in this population.

In the current study, participants showed self-compassion while coping with Long COVID through positivity. This included engaging in uplifting activities and focusing on the positive aspects of participants' experiences. Based on the importance of positivity in the experiences of participants with Long COVID, mental health professionals aiding this population may find success in implementing techniques from positive psychology to help clients access their positive resources, such as their positive emotions and personal strengths (Rashid, 2020). Moreover, techniques from CBT, such as cognitive restructuring, could also be applied to help target negative illness-related thoughts and reframe them into more positive ways of thinking (Morey & Loades, 2020). For participants, an important component of endorsing a more positive mindset also involved being hopeful about the future. Therefore, hope-based interventions, which aim to enhance optimism for the future by helping clients set goals and plan attainment toward their goals (Lopez et al., 2000), may be an effective approach in treating those with a chronic illness such as Long COVID. Applied to treating individuals with Long COVID, this form of intervention may be able to help clients establish and pursue realistic and appropriate goals.

Another important aspect of participants' Long COVID experiences was receiving compassion and validation from other people. Given the importance participants placed on receiving validation and compassion from external sources, counsellors working with clients from this population should consider employing a client-centred therapeutic approach, emphasizing empathy, genuineness, unconditional positive regard, and understanding (Erekson & Lambert, 2015). Additionally, a notable source of validation for several participants was exposure to the anecdotal accounts of others with Long COVID. Specifically, exposure to the accounts of other individuals with Long COVID allowed participants to feel like they were not alone in their experience. To capitalize on the benefits of positive interpersonal interactions, counsellors working with Long COVID populations could consider offering group therapy options to help create a sense of connectedness among clients with Long COVID.

Normalization and the resulting validation of Long COVID experiences were critical in participants' experiences of self-compassion. Therefore, a therapeutic approach such as Mindful Self-Compassion (MSC; McGehee et al., 2017) training, which uses the recognition of commonalities with others as one means of fostering self-compassion), may be a suitable modality for counselling this population. Moreover, CFT, with its emphasis on helping individuals internalize support, kindness, and compassion from others (Gilbert, 2010), should also be considered when counselling clients with Long COVID. In particular, CFT may be an effective orientation to apply based on the finding that compassion from others promoted self-compassion for all participants in the current study. Additionally, one apparent benefit of self-compassion from participants' perspectives was that it helped reduce feelings of illness-related shame. CFT interventions such as compassionate letter writing, a technique where individuals are instructed to write about their difficulties from a compassionate, non-judgmental, and genuine stance (Swee et al., 2023), could be utilized to cultivate self-compassion and reduce shame in clients with Long COVID. Indeed, one participant (Jack) described applying a process similar to compassionate letter-writing as a way of introspecting on his experience from a caring and compassionate stance, which helped him reduce feelings of shame and self-criticism.

Finally, beyond the current study's applicability to counsellors, compassionate and validating interactions with other medical professionals, such as doctors, were emphasized across participant accounts. Therefore, insights derived from this study's findings could inform the practices of other healthcare providers by highlighting ways they can foster self-compassion in their patients. Particularly, participants felt validated by medical providers when medical providers took the time to acknowledge participants' illness, offer them reassurance, and educate them on their condition. Additionally, when medical professionals were understanding, caring, and compassionate toward participants, it helped participants be more compassionate toward themselves. Overall, by taking a patient-focused approach and emphasizing the display of compassion and validation, medical providers may be able to foster increased self-compassion in their patients, subsequently improving patients' experiences of receiving medical treatment for their Long COVID condition.

Limitations

Several limitations should be considered when interpreting the findings of this research study. First was the cultural and ethnic homogeneity of the sample, which was comprised of individuals who all identified as Caucasian individuals from Western cultural backgrounds. In addition, five of the six participants identified as female. The lack of gender balance may reflect research suggesting that females appear to be at a higher risk of developing Long COVID compared to males (Jensen et al., 2022). Moreover, participants in the current study ranged in age between 22 and 60. However, research indicates that age impacts functional status in those with Long COVID, suggesting that older individuals may have marked differences in their Long COVID experience (Hussein et al., 2021). Overall, a limitation of the present study is that it does not provide insight into the perspectives of individuals from a more diverse range of age, gender, and cultural groups, whose experiences of self-compassion during Long COVID may be fundamentally different from the participants in the current study.

Another potential limitation of the current study concerns the retrospective recall of information. Participants recalled lived experiences of self-compassion during their time with Long COVID; however, some individuals developed Long COVID roughly three years before the onset of the first interview. Previous research suggests that in individuals with CFS, a chronic illness with many similarities to Long COVID, the optimal length of time for accurate recall of retrospective self-report data is six months (Evans et al., 2013). Thus, for individuals reporting aspects of their Long COVID experiences from up to three years prior, there may be inaccuracies due to the nature of retrospective recall over time.

Moreover, participants were recruited from a list provided by the Long COVID Clinic in Edmonton, Alberta. An advantage of this is that all participants had a confirmed Long COVID diagnosis from a medical professional. However, recruitment from this clinic also meant that participants had received varying degrees of treatment for their Long COVID condition. Many participants described interactions with treatment providers at the Long COVID clinic as being a critical component of their experiences of self-compassion. Thus, the lived experiences of self-compassion of those who did not receive treatment for Long COVID may vary in nature from those who did. Lastly, consistent with the IPA approach, data collection and analysis focused in-depth on the perspectives of a small number of participants; the findings are not meant to be representative of all Long COVID experiences nor to be generalized to large populations.

Future Directions

Researchers could expand upon the current study's findings in numerous areas. First, future studies should aim to recruit individuals from a more diverse range of populations. For instance, a better understanding of the role of culture in the experiences of self-compassion in those with Long COVID is needed. Additionally, researchers could also aim to expand the current knowledge base on self-compassion in Long COVID by recruiting individuals from a more diverse range of gender identities and age groups.

The themes that emerged in the current study also provide numerous directions for future research. First, when participants received validation about their Long COVID condition, they found it easier to have compassion for themselves. A particularly notable source of validation was being formally diagnosed with Long COVID. As this was a novel finding in people with Long COVID, future research could expand on these findings by quantitatively examining the relationship between a Long COVID diagnosis and feelings of self-compassion. Additionally, the findings of the current study indicated that receiving compassion from others was a key contributor to participants' experiences of self-compassion. Compassion displayed by medical professionals was especially critical in facilitating self-compassion in participants. Despite this finding, in the literature on Long COVID, there is still limited knowledge on how compassion from medical providers impacts patients. To address this gap, future research could more explicitly examine the influence that receiving compassion from others has on self-compassion in adults struggling with Long COVID.

Finally, the findings of the present study could be expanded upon by researching psychotherapeutic interventions for individuals with Long COVID. At present, an insufficient amount of research has explored the use of psychotherapy on individuals with Long COVID, and the limited literature that exists focuses primarily on CBT-based treatment approaches (Kuut et al., 2023; Skilbeck, 2022). Although CBT-based interventions may be promising for treating individuals in this population, the findings of the current study highlight the importance of capacities such as compassion, self-compassion, a positive mindset, and acceptance. Therefore, it could be beneficial for future research to examine therapeutic interventions, such as CFT and ACT, for counselling people with Long COVID. Moreover, feelings of grief over the loss of a previous way of life were apparent throughout participant accounts; however, the majority of grief-based interventions focus on bereavement. Therefore, research examining the application of grief- and loss-based interventions for individuals with a chronic illness such as Long COVID could also provide critical insights into counselling this population. For instance, a mixed-method study looking at the effectiveness of the above interventions, as well as exploring the experiences of participants receiving these interventions, could be especially beneficial in expanding empirical knowledge regarding the use of psychotherapeutic treatments for individuals with Long COVID.

Conclusion

Although the literature around Long COVID continues to grow, little is known about self-compassion in individuals with this illness. To address this gap in the literature, the current study explored the lived experiences of self-compassion in six adults with Long COVID. An IPA methodological approach was used to allow for an in-depth and nuanced understanding of participants' experiences. For the participants in this study, self-compassion meant being accepting of their Long COVID condition, directing their attention to the positives within their lives, and recognizing rest as a necessity. Additionally, participants discussed how receiving compassion and validation from others around them, including medical professionals, helped facilitate feelings of self-compassion. Findings from the present study lend themselves to the newly emergent evidence base on the potential role of self in promoting the mental health and well-being of adults with Long COVID.

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Appendix A - Recruitment Email

Email subject line: Invitation to Participate in a Research Project

Hello, my name is Brandon Krebs. I am a Master's student in the Counselling Psychology program at the University of Alberta. I am emailing you because you indicated to the Kaye Edmonton Clinic that you might be interested in being contacted about opportunities to volunteer in research studies. For my Master's thesis, I am seeking participants for a research study exploring the experience of self-compassion in people coping with long COVID. This study is being supervised by Dr. Van Vliet, who is the principal investigator for this study. Participants will be interviewed about their experiences of being compassionate toward themselves in coping with long COVID, as well as things that may have helped or gotten in the way of self-compassion. Participation in this study would occur over two interviews. The first interview would take around one hour, and the second interview would occur four weeks later and take roughly 15-30 minutes.

Interviews can be done either in person or online through Google Meet. Please see the attached Study Information and Consent Form for more information on this study.

Please contact me at bkkrebs@ualberta.ca if you are interested in participating in this study.

If you have any questions regarding your rights as a research participant, you may contact the University of Alberta Research Ethics Office at reoffice@ualberta.ca and quote Ethics ID Pro00130920. This office has no affiliation with the study investigators.

Kindly,
Brandon Krebs

Appendix B – Study Information and Participant Consent Form

STUDY INFORMATION and PARTICIPANT CONSENT FORM

Title of Study: The Experiences of Self-Compassion in Individuals Suffering from Long COVID

Principle Investigator:	Jessica Van Vliet, Professor, Educational Psychology
Mailing Address:	6-129, University of Alberta T5G 2G5
Email:	jvanvliet@ualberta.ca
Phone Number:	(780) xxx-xxxx
Student Researcher:	Brandon Krebs, M. Ed. student, Educational Psychology
Mailing Address:	6-129, University of Alberta T5G 2G5
Email:	bkkrebs@ualberta.ca

Why am I being asked to take part in this research study?

You are being asked to participate in this study because you have had at least one long COVID symptom for twelve weeks or more after a COVID-19 infection. The current study is being done to learn more about how self-compassion is experienced in individuals coping with long COVID symptoms.

This form contains information about the study. Before you sign it, a member of the study team will explain the study to you in detail. You are free to ask questions about anything you do not understand. You will be given a copy of this form for your records.

What is the reason for doing the study?

My name is Brandon Krebs. I am a Master's student in the Counselling Psychology program at the University of Alberta. For my Master's thesis research, I am looking at experiences of self-compassion in people coping with long COVID. The aims of this study are to learn about the lived experiences of adults living with long COVID, identify things that benefit or hinder the practice of self-compassion in adults with long COVID, and learn what meaning adults with long COVID attribute to their experiences of self-compassion. The information gained from this study may help inform counsellors and other mental healthcare providers on how to best care for and support individuals with long COVID.

What will I be asked to do?

This study will take place over two separate interviews. The total estimated time commitment to complete this study is roughly 1 hour and 15 minutes to 1 hour and 30 minutes. The first interview will be around 1 hour in length, and the follow-up interview will take around 15-30 minutes. Interviews will take place either in-person or virtually, based on your personal preference. Virtual meetings will occur on Google Meets. If you choose to meet in person, the interview will take place on the University of Alberta campus in the Faculty of Education. Specifically, the interview will take place in Clinical Services or in the principal researcher's laboratory. The option to wear masks during the interview will be provided. The interview will be audio recorded and transcribed word-for-word. For interviewers conducted through Google Meets, you are allowed to turn off your camera if you choose to.

If you agree to participate:

1. You will be asked to take part in an interview with the student researcher, Brandon Krebs. The interview will be a one-on-one discussion where you will be asked to answer questions about your experiences of self-compassion in coping with long COVID. You will also be asked about things that may have helped or gotten in the way of self-compassion in your time coping with long COVID.
2. As a part of the data analysis process, you will be invited for a follow-up interview. This interview will take place either in person or virtually, roughly 4 weeks after the first interview. In this interview, you will be asked to review the transcript from the first interview for accuracy, and you will be given a chance to ask anything that you would like to clarify from the first interview. You will also be asked follow-up questions to clarify my understanding of our initial interview.

How long will I be in this study?

Participation in this study will take place over two interviews. The first interview will require around 1 hour of your time. The second interview will occur around 4 weeks after the first interview and require roughly 15-30 minutes of your time. Participation will take a total of about 1 hour and 15 minutes to one hour and 30 minutes of your time.

What are the risks and discomforts?

As a part of this study, you will be asked questions about your experiences of self-compassion in coping with long COVID. Talking about these experiences may be upsetting for some people. You can ask to pause or stop the interview at any time. If negative feelings arise for you during the interview, we expect them to be temporary and not harmful. However, if you experience distress due to your participation in this study, please contact Brandon Krebs (bkkrebs@ualberta.ca) or his research supervisor Dr. Van Vliet (jvanvliet@ualberta.ca). You will also be provided with a list of counselling resources following the initial interview. Finally, if you choose to participate in the interview online, there may be risks related to online data collection. To reduce this risk, I will ensure that the laboratory computer has up-to-date anti-virus software and the highest security settings. It is not possible to know all of the risks that may happen in a study, but the researchers have taken all reasonable safeguards to minimize any known risks to a study participant.

What are the benefits to me?

There are no direct benefits for participating in this study. However, some people may find it helpful to talk about how they have been compassionate toward themselves during difficult times.

Do I have to take part in the study?

Being in this study is your choice. If you decide to be in the study, you can change your mind and stop being in the study at any time, and it will in no way affect the care or treatment that you are entitled to. While participating in this study, you can opt out of answering specific questions or withdraw from the study at any point without penalty. Furthermore, you can withdraw the interview data at any time up until two weeks after your first interview. After that point, we will not be able to remove the data from the study because the data analysis process will have already begun. If you decide to withdraw from the study, please email Brandon Krebs (bkkrebs@ualbert.ca) to let him know.

Will I be paid to be in the research?

As a small token of appreciation for your participation in this study, you will be able to choose a 25$ gift card following the first interview. The options for the 25$ gift card are Tim Hortons, Walmart, Subway, or Amazon. You will receive a cash reimbursement for parking up to $13.00 per visit if you park at the University of Alberta. This equals 2 hours of paid parking at the Education Carpark on 114 Street 87 Avenue Northwest. If you pay for public transportation, you will receive a cash reimbursement of up to $7.00 per visit. This equals the public transportation fare for one individual to take two trips through the Edmonton Transit System. You must show the researcher proof of expense to receive reimbursements, such as a used transit ticket or a parking receipt. If you leave the interview or ask to be withdrawn from the study, your expenses will still be covered, and compensation will still be provided.

Will my information be kept private?

During the study we will be collecting data about you. We will do everything we can to make sure that this data is kept private. No data relating to this study that includes your name will be released outside of the researcher's office or published by the researchers. Sometimes, by law, we may have to release your information with your name so we cannot guarantee absolute privacy. However, we will make every legal effort to make sure that your information is kept private. During research studies it is important that the data we get is accurate. For this reason your health data, including your name, may be looked at by people from the University of Alberta and/or the Research Ethics Board.

Data for this study will be safely stored on a password-protected and encrypted computer. Audio recordings will be transferred to an encrypted memory stick that will be stored in a locked filing cabinet in the principal researcher's laboratory or the student researcher's place of residence. Physical documents, such as consent forms and interview notes, will also be stored in this locked filing cabinet. Additionally, only the student researcher, Brandon Krebs, and the principal investigator, Dr. Van Vliet, will have access to the data. To further protect your privacy, a pseudonym will be used in place of your real name. Identifying information will also be removed from your data. If any information from this study is published, you will not be identifiable in this work. After the study is done, we will store the audio recordings for 5 years. All other forms of data will be retained for a minimum of 10 years.

How will this data be used?

Research data collected in this study will be used in my Master's thesis research and may appear in academic or public presentations and publications. Data that appears in these works will not contain identifying information. It is also possible that this research data will be used in future research studies. However, separate Research Ethics Board approval will be obtained if this occurs.

What if I have questions?

If you have any questions about the research now or later, please contact Dr. Jessica Van Vliet at (780) xxx-xxxx or through email at jvanvliet@ualberta.ca or Brandon Krebs through email at bkkrebs@ualberta.ca.

If you have any questions regarding your rights as a research participant, you may contact the University of Alberta Research Ethics Office at reoffice@ualberta.ca. This office has no affiliation with the study investigators.

How do I indicate my agreement to be in this study?

By signing below, you understand:

- That you have read the above information and have had anything that you do not understand explained to you to your satisfaction
- That you will be taking part in a research study
- That you may freely leave the research study at any time
- That you do not waive your legal rights by being in the study
- That the legal and professional obligations of the investigators and involved institutions are not changed by your taking part in this study.

SIGNATURE OF STUDY PARTICIPANT

____
Name of Participant

______________________________ ____________________
Signature of Participant Date

SIGNATURE OF PERSON OBTAINING CONSENT

______________________________ ____________________
Name of Person Obtaining Consent Contact Number

______________________________ ____________________
Signature Date

SIGNATURE OF THE WITNESS

____
Name of Witness

______________________________ ____________________
Signature of Witness Date

A copy of this consent form has been given to you to keep for your records and reference.

Appendix C – Participant Information Form

Participant Information Form

Pseudonym: ____________________

Age: ______

Gender: _________________________

Ethnic background: _________________________________

Employment Status (Please check all that apply):

☐ Employed (Full-time)

☐ Employed (Part-time)

☐ Student (Full-time)

☐ Student (Part-time)

☐ Unemployed

☐ Reduced hours in work and/or studies due to long COVID

☐ Unable to work and/or continue studies due to long COVID

☐ Retired

COVID-19 diagnosis:

☐ Suspected (was not confirmed through a positive test)

☐ Confirmed from a positive swab test

☐ Confirmed through a positive antibody test

Have you been diagnosed with long COVID by a medical professional?

☐ Yes ☐ No

Were you hospitalized due to COVID-19-related symptoms?

☐ Yes ☐ No

Roughly how long have you been experiencing long COVID symptoms? (Number of months at the time of the interview) ________________

Before testing positive for COVID-19 had you ever been diagnosed with a chronic physical or psychological health condition (e.g., asthma, diabetes, depression, etc.)?

☐ Yes ☐ No

If yes, please list them:

____

What long COVID symptoms have you experienced? (Check all that apply)

☐ Fatigue
☐ Persistent cough
☐ Muscle aches
☐ Headaches
☐ Shortness of breath
☐ Fever
☐ Heart palpitations (fast-beating/pounding heart)
☐ Chest pain
☐ Abdominal pain
☐ Joint or muscle pain
☐ Decreased or lack of appetite
☐ Stomach pain
☐ Impaired balance
☐ Dizziness
☐ Worsened memory
☐ Sleep difficulties
☐ Skin rashes
☐ Changes in taste or smell
☐ Changes in menstrual cycle
☐ Difficulties concentrating
☐ Depression
☐ Anxiety
☐ Other: ____________________________
☐ Other: ____________________________
☐ Other: ____________________________
☐ Other: ____________________________

Appendix D – Interview Protocol

Interviewer: _______________

Date: ____________________

Time of interview: _________

Place: ___________________

Participant Pseudonym: __________

Interview Protocol – Experience of Self-Compassion in Individuals with Long COVID

Interview Questions:

1. What impact has long COVID had on your everyday life?

   Prompts may include:

   a. Can you provide some examples of how long COVID has impacted your everyday life?

2. In as much detail as possible, could you please describe a time when you treated yourself with compassion in coping with long COVID?

   Prompts may include:

   a. What was going on around you when this experience was occurring?
   b. I'm wondering what self-compassion looked and felt like to you during that experience. What were some of the thoughts, feelings, and actions that were a part of that experience of self-compassion?
   c. What was the impact of self-compassion on your coping with long COVID?
   d. Is there anything more you would like to add about this experience of self-compassion?

3. Can you think of another example of when you treated yourself with compassion in coping with long COVID?

   Prompts may include:

   a. What was going on around you when this experience was occurring?
   b. I'm wondering what self-compassion looked and felt like to you during that experience. What were some of the thoughts, feelings, and actions that were a part of that experience of self-compassion?
   c. What was the impact of self-compassion on your coping with long COVID?
   d. Is there anything more you would like to add about this experience of self-compassion?
4. Is there anything else you would like to add about the impact of self-compassion on how you have coped with long COVID?
5. During your experience of coping with long COVID, what, if anything, has helped make it easier for you to be compassionate toward yourself?
   a. How have these things made it easier for you to show yourself compassion?
   b. Can you provide me with an example of an instance when it was easier for you to be compassionate toward yourself while coping with long COVID?
6. During your experience of coping with long COVID, what, if anything, has made it more difficult for you to be compassionate toward yourself?
   a. How have these things made it more difficult for you to show yourself compassion?
   b. Can you provide me with an example of an instance when it was harder for you to be compassionate toward yourself while coping with long COVID?

7. Having described your experiences of self-compassion while coping with long COVID, I am wondering, more generally, how you would define self-compassion?
8. In conclusion, is there anything else you would like to mention about your experiences of self-compassion in coping with long COVID?

Appendix E – Counselling Resource List

Counselling Resources in Edmonton

University of Alberta Faculty of Education Clinical Services

Address: 11210 87 Ave., 1-135 Education North Building, University of Alberta

Phone: 780-492-3746

https://www.ualberta.ca/educational-psychology/centres-and-institutes/clinical-services

Momentum Walk-In Counselling
Address: Suite 706, 5241 Calgary Trail NW, Edmonton
Phone: 780- 757-0900
https://www.momentumcounselling.org

City of Edmonton Counselling Services
Phone: 780- 496-4777
http://www.edmonton.ca/programs_services/for_family_individuals/counselling-services.aspx

Catholic Social Services

Address: Multiple locations in Edmonton

Phone: 780-432-1137

https://www.cssalberta.ca/

Cornerstone Counselling Centre

Address: 302 – 10140 117 St. NW, Edmonton

Phone: 780-482-6215

http://www.cornerstonecounselling.com

Jewish Family Services (Integrity Counselling Service)
Address: 8702 Meadowlark Rd. NW, Edmonton
Phone: 780-454-1194
https://www.jfse.org/programs-services/

YWCA Counselling Centre

Address: #400 – 10080 Jasper Ave., Edmonton
Phone: 780-423-9922 Ext. 222
http://www.ywcaofedmonton.org/programs/counselling-centre

Distress Line – Canadian Mental Health Association (Edmonton Region)

Phone: 780-482-HELP (4357)

https://edmonton.cmha.ca/programs-services/distress-line/