

Exploring the emotional experiences of young women with chronic pain: The potential role of self-compassion

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Abstract

Chronic pain is multidimensional and includes an emotional dimension in addition to the physical and cognitive dimensions. Self-compassion, being touched by and open to one's own suffering, has been identified as a useful resource during difficult experiences. The purpose of this narrative inquiry was to explore the role of self-compassion in the emotional experiences of women with chronic pain. Seven women participated in focus groups, reflective photo voice and one-on-one interviews. Three collective narratives were generated highlighting the women's sources of emotional pain and suggesting self-compassion as a constructive approach to manage the emotional dimension of chronic pain.

Keywords

coping, narrative, pain, photography, qualitative, self-attitudes

Introduction

Chronic pain is a complex, subjective and multidimensional phenomenon that can negatively impact the daily lives of those living with it (Costa and Pinto-Gouveia, 2011; Lerman et al., 2010). Individuals living with chronic pain often experience physical limitations, concentration difficulties, anxiety, stress and depression. While there are many potential causes and sources of chronic pain, knowledge about the causes and sources and management strategies of unspecified chronic pain is limited and often takes a purely physiological approach (e.g. Costa and Pinto-Gouveia, 2011). The multidimensional aspects of chronic pain include sensory-descriptive (intensity and location of pain), affective-emotional (negative

emotions evoked from pain) and cognitive (thoughts regarding pain) dimensions (Lerman et al., 2010). Although there has been extensive research on chronic pain, particularly the intensity of pain (Robinson-Papp et al., 2015) and the role of physical activity in managing physical pain (e.g. Brittain et al., 2018), there has been limited research focused on pain's affective-emotional dimension separate from or as primary in relation to the physical dimension of pain.

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Pain automatically, with or without conscious awareness, gives rise to unpleasantness or discomfort, and it is the moment-to-moment unpleasantness of pain that is the first component of the affective-emotional dimension of chronic pain (Price, 2000). Affect does not require cognition, awareness or reflection, and provides the moment-to-moment colouring of experiences as positive or negative (Ekkekakis, 2014). Affect is a necessary component of emotions, occurring alone or embedded in emotions (Ekkekakis, 2014). The second component of the affective-emotional dimension consists of the emotions directed towards the long-term implications of chronic pain (Price, 2000). Emotion theorists have identified three key components to the nature of and experience of emotions: (a) emotions require situational attention; (b) emotions are subjective, multifaceted, embodied phenomena and (c) emotions can interrupt and disrupt as they take precedence in our awareness (Gross, 2008). Furthermore, it is the appraisal of a situation that gives rise to emotions.

The emotions that are associated with the affective-emotional dimension of chronic pain can take an enormous toll on individuals, including negative emotions such as fear (Price, 2000), pain catastrophizing, over-identification with pain (Wren et al., 2012), depression (Lerman et al., 2010) and shame (Werner et al., 2004). Coping, the process of adapting to challenges, is the primary way that people manage thoughts, feelings and behaviours associated with their chronic pain (Costa and Pinto-Gouveia, 2013). People with chronic pain may fear and avoid unpleasant events, emotions or bodily sensations in an attempt to cope; however, these tactics can result in the pain becoming more disruptive (Costa and Pinto-Gouveia, 2011). Isolation is one of the several potential consequences of living with chronic pain, specifically, isolation is related to anxiety, stress and depression for those with chronic pain (Costa and Pinto-Gouveia, 2011). Developments in cognitive behavioural therapy highlight the benefits of shifting away from trying to control, change or avoid psychological experiences while adaptively moving towards acceptance

and mindfulness (Costa and Pinto-Gouveia, 2011). Self-compassion may be a useful resource for individuals with chronic pain (Costa and Pinto-Gouveia, 2011, 2013), as it is a strategy where unpleasant emotions are approached with self-kindness, mindfulness and common humanity (Neff et al., 2005).

Self-compassion involves being open to one's suffering rather than avoiding it, and the desire to alleviate the suffering to heal oneself with kindness (Neff, 2003a). Neff (2003a, 2003b) explains that self-compassion consists of three components: self-kindness (i.e. extending understanding to oneself instead of self-criticism and judgement during suffering or pain), mindfulness (i.e. holding one's painful thoughts and feelings in balanced awareness rather than over-identifying or suppressing them) and common humanity (recognizing one's own experiences as part of the larger human experience as opposed to seeing them as isolating). The three components of self-compassion promote a kind, connected and clear-sighted self-attitude that can promote an adaptive perspective when managing challenging and emotionally difficult experiences (Neff, 2003a, 2003b).

Self-compassion has been proposed as a helpful resource in a variety of contexts (Neff, 2003a, 2003b, 2009). Wren et al. (2012) highlighted that self-compassion-enabled persons with chronic pain to better adjust to persistent pain, as individuals with higher levels of self-compassion were found to have lower negative affect, pain catastrophizing and pain disability, as well as higher positive affect. Costa and Pinto-Gouveia (2011) found an association between self-compassion and acceptance of pain, where self-compassion helped individuals with chronic pain continue to engage in daily activities. In another study, Costa and Pinto-Gouveia (2013) found that self-compassion was related to the ability to turn towards one's suffering rather than avoidance and attempted control of suffering. Moreover, self-compassion was related to lower anxiety, stress and depression. Together, these three studies examined how self-compassion may help individuals with chronic pain to adaptively cope to reduce their

pain intensity and psychological distress. However, to date the role of self-compassion specifically in relation to the affective-emotional dimension of chronic pain has not been explored. It is pertinent to identify how individuals can adaptively manage the emotions that accompany their chronic pain.

Self-compassion has been related to adaptive coping in previous research (Neff et al., 2007; Sirois et al., 2015). Sirois et al. (2015) found that self-compassion was associated with adaptive coping and outcomes such as acceptance and less use of maladaptive responses such as self-blame. Specifically, self-compassion was associated with greater use of problem-focused coping, which was linked to coping efficacy and lower stress in women. Researchers suggest that women cope with pain differently than men (Tamres et al., 2002). Specifically, the results of a meta analysis on sex differences and coping behaviour highlights that women were more likely to adopt adaptive coping strategies such as seeking emotional support and positive self-talk than men; however, women are also more likely to engage in maladaptive processes such as ruminating about problems when coping with pain compared to men (Tamres et al., 2002). Furthermore, researchers have highlighted that women with chronic pain have expressed that one way they cope with their chronic pain is by rejecting gendered stereotypes such as chronic pain being caused by weaknesses or attention seeking (Werner et al., 2004). Responding to chronic pain with self-compassion may be a constructive approach to managing women's affective-emotional experiences. Self-compassion has been related to increased positive psychological functioning, as well as lower depression and anxiety (Neff, 2003a, 2003b, 2009) which makes it relevant to individuals with chronic pain who may experience anxiety, stress and depression when managing their pain symptoms. However, the role of self-compassion in women's affective-emotional chronic pain experiences remains unclear. Therefore, the purpose of this study was to explore the role of self-compassion in women's experiences of the affective-emotional dimension of chronic pain.

Table 1. Summary of participant demographics.

Participant pseudonym	Age	Length of time with chronic pain
Amy	31	4 years
Kelly	24	2.5 years
Lisa	20	5 months
Macy	34	7 years
Marie	19	4 years
Rianne	19	7 years
Sarah	23	11 months

Methods

Participants

Seven women who had been experiencing chronic pain for 5 months to 7 years participated in this study. The women were between 19 and 34 years old (see Table 1). The women in this study self-identified as Canadian and white (one also self-identified as indigenous). Furthermore, the women in this study were experiencing chronic pain that was not related to another health condition or related to a diagnosed pain condition such as fibromyalgia.

Strategy of inquiry

To best address the research purpose and research question – what role does self-compassion play in young women's experiences of the affective-emotional dimension of chronic pain? – a narrative inquiry approach was adopted to focus on individuals' experiences through story telling (Creswell, 2014; Creswell and Poth, 2018). Recognizing that the affective-emotional dimension of chronic pain is highly personal, the use of narrative inquiry was deemed valuable to explore these rich and complex experiences (Smith and Sparkes, 2009).

Data generation

After obtaining institutional ethical approval at a mid-Western Canadian university, participant recruitment involved online bulletins, university classroom visits and social media posts.¹ The young women were recruited based on two main

inclusion criteria: that they were at least 18 years of age and been experiencing chronic pain (unrelated to a diagnosed condition) for at least 5 months. The study consisted of three phases (i.e. focus groups, reflective photo voice and one-on-one interviews) that each contributed to the overall research purpose. All participants provided written and verbal consent prior to the first phase of the study.

Phase 1 consisted of focus groups.² Two audio-recorded focus groups took place, with 3 and 4 participants, respectively. The focus groups started with rapport building, which provided a forum for the women to provide initial context about their pain experiences. After all participants spoke about their pain experiences, the affective-emotional dimension of chronic pain was introduced and the women shared their relevant experiences. At the end of the focus groups, participants were provided with instructions for Phase 2.

The women were asked to engage in reflective photo voice for Phase 2. Reflective photo voice is a novel data generation process in which photos are, simultaneously, data and a resource for data generation in following phases. While the application of photo-based data collection methods is less common in general, photos are highly relevant within narrative approaches, as photographs have the potential to add richness to qualitative data through more detailed and precise information than what is generated by word-only interviews, allowing participants to provide additional insight into difficult, emotional or otherwise sensitive issues and experiences (Clark and Morriss, 2015; Frith and Harcourt, 2007). Furthermore, narrative approaches promote the collection of multiple and often creative data types (Creswell and Poth, 2018) and are therefore essential in telling the women's story. The women were invited to take photographs of anything that represented their affective-emotional experiences of chronic pain for 1 week. The women were asked to select a few photographs to focus on during Phase 3 to generate discussion and help explain their unique emotional experiences of chronic pain.³

The women participated in one-on-one semi-structured interviews for Phase 3.⁴ The photographs each woman selected to share were viewed on a tablet during their interview. Each woman described the photographs, shared their meanings and explained how they represented her emotional experiences of chronic pain. Self-compassion was then verbally introduced and a short online video was viewed that further explained the concept (<http://www.self-compassion.org/video-clips/self-compassion.html>). A reference sheet outlining the components of self-compassion was provided to refer to during the interview. These approaches to introduce a novel concept have been effective in previous research (Ferguson et al., 2014; Sutherland et al., 2014). The women then discussed how, if at all, they might use self-compassion to manage their affective-emotional chronic pain experiences, and why and how they might intentionally use self-compassion in the future. Each woman was also invited to reflect on her engagement with the three study phases and to share what she may have gained, liked or disliked about the research process.

Data analysis

The goal of data analysis was to interpret the women's stories and shared experiences. Frith and Harcourt (2007) identify four key issues when combining audio and photograph data. First, discussing participants' photographs is just as important as the photographs themselves. Second, it is important that the photographs are adequately represented in the participants' narratives. Third, participants have control over the images produced and what they share about the photographs. Fourth, recognizing that both the photographs' functions and forms add to the participants' stories. Therefore, participant photographs were included in the analysis and displayed in the subsequent result section.

A holistic-content analysis was applied (Lieblich et al., 1998) and Creswell's (2014) steps for analysing qualitative data were followed to promote organization, clarity and

thoroughness in the analysis process. The focus group and interview recordings were transcribed and the images were scanned. The transcripts and pictures were reviewed several times to develop familiarity with all materials, and a systematic coding process provided detailed analysis to highlight critical elements that were central to the women's experiences. Themes were then developed and connected to create narratives. At each analysis stage, the women's stories and photographs were considered as a collective unit.

Situating the researcher

As the interpreter of the women's shared experiences, the first author engaged in reflexive writing throughout the duration of the study. An abbreviated reflexive journal entry is shared below:

This story is not about me, but I am the interpreter. This means that my worldview had an impact in the narratives you are about to read. I am a 24 year old woman who suffered from chronic pain for 8 months. My chronic pain came on suddenly and disappeared just as suddenly. When I was living with chronic pain I had to deal with fear, frustration, sadness, and loneliness. I had very little guidance as how to manage and deal with these emotions. I am forever living in fear that the pain could come back at any moment, as there were never any answers as to why it was there at all. My experiences with chronic pain have shaped the research process and outcome. These experiences, I believe, allowed me to have an increased sensitivity when hearing these women's stories. Each woman contributed a voice to the outcome of this research, and took me on a journey of her painful emotions and experiences of chronic pain.

Results

Three co-constructed collective narratives⁵ represent the women's affective-emotional chronic pain experiences and the potential role of self-compassion: (a) The Emotional Challenges of Chronic Pain, (b) The Journey to Self-Awareness and (c) The Transition to a Self-Compassionate



Figure 1. Photograph highlighting the work to cover up physical and emotional signs of chronic pain.

Mind-set: A Potential Regulator of Emotions. While the results are presented as co-constructed narratives, they are written in the first person to highlight the collective voice of the participants. Included in the co-constructed narratives are direct quotations and photographs to highlight the women's unique voices and experiences.

The emotional challenges of chronic pain

I woke up today and realized that nothing has changed. The pain never seems to go away. The cycle has repeated itself once again; I went to sleep last night hoping that when I woke up this morning my pain would be gone. I am starting to lose hope because every morning, just like this morning, my pain is still here. 'I feel so frustrated because it is such a consistent thing' (Kelly). I'm really disappointed, but I guess I'll have some breakfast and start my day. I know that I need to ignore the pain to get through my busy day, 'I choose to ignore it most of the time, pretend it's not there and move on until it catches up with me eventually, which it always does' (Macy). Even the simple task of eating my breakfast is tiresome because I am distracted, hoping that I will have the strength to ignore my pain today. Interrupting my thoughts, my mom asks me how I am feeling. Just like every other time she asks, I cover up the truth and lie, 'I'm fine' (Figure 1). I hope that she won't ask me a follow-up question. It's too hard



Figure 2. Photograph representing both responsibilities and emotions piling up and becoming overwhelming and seemingly impossible to manage.

to try and explain to her how I really feel; she never really understands and I doubt she ever will.

Now I'm at school, walking through the crowded loud hallways on the way to my first class. I feel the loneliest when I'm at school, even though hundreds of people surround me. 'I know I am not the only one with chronic pain, but it is still really lonely. I feel like I am the only one going through this. Cause people don't talk about it' (Marie). I'm struggling to pay attention in class because I'm in pain. My pain is always here, always trying to get my attention. I didn't do the readings for my first class last night because I was in too much pain, and now I am here and unprepared and feeling lost in class. I am so frustrated with being lost during class again. I'm losing my patience with this class and myself, so I am packing my things and leaving. I feel exhausted and 'I am so frustrated that I don't have the energy to do everything that I want to do' (Marie). The frustration gets to me sometimes, and right now my frustration is dominating everything. My frustration, disappointment and isolation are completely overwhelming me (Figure 2).

I managed to make it through a couple of classes today, but now that I'm home all I want is to be in bed. I drop my things and go straight

to bed. I am so tired from another day of pretending that I'm okay. 'The fatigue definitely catches up [with me] by the end of the day. It gets a little bit defeating sometimes' (Kelly), especially in times like this when I lay in bed feeling frustrated and alone. I lay in bed succumbing to the exhaustion from my failed attempt at this day.

The journey to self-awareness

One by one, each day I spend struggling with my pain which comes and goes, and I continue to be overwhelmed with frustration, anger and feeling isolated. As I awake from a rare restful sleep and lay in bed, I realize that I deserve more. My pain shouldn't constantly consume me, and I don't need to always feel frustrated and alone. I have a brief sense of comfort in those thoughts and hope that maybe today I won't have to pretend that everything is fine.

I don't have classes until later this afternoon, so I decide to get some fresh air. I like being outside, but I rarely take the time to enjoy it. The weather is a bit cool and there is some snow on the ground, but the crisp air is refreshing. Here I am lying in a field with the sun shining down on me (Figure 3). 'I just lay on the ground and just relax for a while. I am actually in my body, rather than in my mind, or in my work, or the social interactions, or whatever' (Kelly). I am able to lie here in the grass, thankful to have some time for me where I don't have to 'be on' or be pretending. A feeling of peace washes over me in this moment where I can just be and my reality is okay and 'it just is what it is' (Rianne). In these 'moments when I do just lie down and feel it, it is almost relaxing' (Amy). Right now in this moment, I am with the pain. I just sit with it, feeling a sense of relief. I'm not trying to change my pain.

I make my way to class that afternoon, and as I'm sitting here listening to the professor I realize that I am actually paying attention in class! For whatever reason, my typically punishing emotions have subsided. I don't feel as overwhelmed or frustrated as I usually do, and I'm actually paying attention. We have a guest



Figure 3. Photograph suggesting that taking a break from the routine of trying to ignore chronic pain and being consumed by difficult emotions may provide a useful perspective.

lecturer today, and he is telling his life story. He was in a life-threatening car accident when he was 16 and is now a quadriplegic. Feelings of empathy for this man are washing over me. Hearing his story really puts ‘things into perspective when there [are] people that are in significantly more chronic pain and they are not letting it stop them’ (Kelly). I can relate to some of the things that the guest lecturer is talking about, like feeling frustrated when your body won’t do what you want it to do. I am inspired by our guest lecturer’s determination and positive perspective. As I continue to listen, I feel less alone and very self-aware. I begin to feel grateful and incredibly lucky for the body I do have.

The transition to a self-compassionate mind-set: a potential regulator of emotions

My alarm is blaring at me. I wake up feeling a little less disappointed than usual that my pain is still here. I’ve been working on allowing myself to feel my pain without passing judgement on it, and I seem to be getting better at managing my frustration and disappointment. I

decide to lay in bed and let my body rest a little while longer instead of getting up right away and rushing to my first class. In the past when I’ve tried to ignore my pain, I always end up feeling even more frustrated. So I reset my alarm and give myself the permission to doze for a few more minutes. When I wake up a little later I ‘feel a sense of peace from the acceptance over my pain. I can’t always just keep going’ (Kelly). The pain is still here but instead of feeling frustrated with it, I feel calm. I might actually have a good day.

As I eat my breakfast, I keep thinking that maybe my pain is not something I should try to separate from myself. Maybe my pain is part of my normal and maybe that’s okay. If I can accept the pain as part of me then I can start to listen to my body (Figure 4). ‘Maybe if [I] take a moment and am kind [to myself] and then move on, everything is easier’ (Rianne). It’s like I’m having an epiphany. From now on if I wake up in excruciating pain, it is okay to slow my day down and take care of myself.

I made it to school, a little later than normal, but I am forgiving myself for not being perfect. What a refreshing and powerful thought. ‘Usually I feel so much pressure to be perfect,



Figure 4. Photograph showing potential elements of a woman's identity, some of which may be neglected due to chronic pain experiences.

look good, be polite, always do what I should be doing' (Marie), and it's really nice to acknowledge that these are unrealistic expectations that I am setting for myself. As the day goes on, I am making sure to check in with my body. If I find myself struggling to concentrate in class, I tell myself that it is okay instead of getting frustrated or mad at myself.

By the time I get home that evening, I'm exhausted. Even with the extra care I offered myself throughout the day, I am still exhausted. Exhausted from the pain that is still here. As I begin to work on a class paper, I am struggling to concentrate and start to feel frustrated. I think it is important for me to work on finding balance 'and not being hard on myself' (Macy). This personal awareness allows me to be accepting towards myself, and permission to do what my body needs. I realize my feelings of frustration have washed away now that I am allowing myself to just be me, pain and all.

Discussion

The purpose of this study was to explore the potential role of self-compassion in the affective-emotional experiences of women with chronic pain. The co-constructed collective narratives

from seven women's experiences tell a compelling story that suggests self-compassion may be a valuable resource for navigating emotional chronic pain challenges. For these women, self-compassion entails developing self-awareness and recognizing painful emotions. Furthermore, self-compassion may allow for acceptance of one's pain by responding with kindness, understanding and connectedness.

People often turn to maladaptive coping mechanisms, such as avoidance, to manage complex emotions as a result of their chronic pain (Sirois et al., 2015). The women in this study indicated that they had previously used avoidance approaches to manage their experiences (e.g. avoiding social situations), which were deemed largely ineffective and often resulted in being more overwhelmed. Individuals with chronic pain may experience multiple negative emotions simultaneously, such as fear, shame and guilt (Gross, 2008; Price, 2000). Further, individuals with chronic pain report feelings of anxiety, depression, isolation, hopelessness, frustration and being overwhelmed (Werner et al., 2004). The emotions experienced in relation to chronic pain can be complex and require adaptive coping and regulation. Accurately identifying emotions (i.e. emotional granularity; Barrett, 2004) is a cornerstone of emotion regulation (Neff et al., 2007), allowing for adaptive emotion regulation that seeks to resolve root emotions, rather than surface emotions.

Self-compassion may facilitate accurate emotion identification and assist with emotion regulation through the promotion of self-awareness. In particular, the mindfulness component of self-compassion may increase balanced emotional awareness that neither ignores nor amplifies difficult emotions (Costa and Pinto-Gouveia, 2011). Mindfulness is associated with increased awareness, happiness, optimism and adaptive coping, as well as decreased stress and negative affect (Finlay-Jones et al., 2015; Shapiro et al., 2007). The women in this study expressed that self-compassion would facilitate awareness of their emotions and, rather than defaulting to a familiar pattern of

ignoring them, help to recognize what was needed to manage their difficult emotions.

The women acknowledged the importance of accepting that their pain is largely outside of their control and often unpredictable (Sirois et al., 2015). This perspective aligns with self-kindness, which promotes tenderness during times of suffering (Neff, 2003a). People with chronic pain often blame or criticize themselves for their pain (Skevington, 1983). Self-criticism and self-blame can be damaging because they are often associated with negative emotions such as shame and fear (Gross, 2008; Tugade et al., 2004). The women in this study expressed that extending kindness, caring and understanding towards themselves would be useful, rather than blaming themselves and being self-critical. Hence, treating oneself with kindness, as promoted by self-compassion, may help buffer the self-evaluative qualities of chronic pain.

In addition, managing difficult emotions through connectedness was evident in this study. Rather than feeling isolated in their emotional chronic pain experiences, the women explained that it is helpful to acknowledge there are others who go through similar struggles, which reflects the common humanity component of self-compassion (Neff, 2003a). Furthermore, the women discussed that common humanity manifested as an unexpected part of our research process. Participating in focus groups was a self-compassionate experience for the women, highlighting that there are others attempting to manage their emotions and physical pain. This suggests that community, engagement and interaction among individuals may play a critical role in managing the emotional dimension of chronic pain.

Strengths and limitations

Implementing narrative strategies was a strength to our research. Narrative inquiry is a powerful way to understand the uniqueness of human experiences (Clandinin, 2006), and narrative storytelling offered a way to acknowledge each woman's story and understand their emotional experiences of chronic pain. Narrative strategies allowed for authentic and

meaningful stories that highlight the women's lived experiences.

Beyond the benefits of narrative approaches, we present here characterizing traits of our research and invite the reader to evaluate the study in a relativistic manner given our context, conditions and purpose (Sparkes and Smith, 2009). An attempt was made to invite women with chronic pain that stemmed from a variety of reasons and for a range of time. Multiple methods of data generation were included, and participants were invited to member check their transcripts (Creswell and Poth, 2018). Within this study, creative methods were embraced to provide means to explore and describe women's experiences in a meaningful way. The first author maintained a reflexive journal throughout the research process to document her thoughts, feelings and reflections. The first and last authors engaged in ongoing peer debriefing to foster critical reflection of the research process and narratives, and co-constructed collective narratives were developed to blend the women's unique stories together.

Future directions

Two future research directions are evident. First, future research could explore the emotional dimension of chronic pain over time and at different stages of life. Given that adults regulate their emotions differently as they age (Charles and Carstensen, 2008), it would be valuable to hear the experiences of women with chronic pain to identify resources and tools to manage chronic pain at varying ages. Second, as evidence supports self-compassion as a useful emotion regulation strategy, a meaningful research direction is to explore ways to teach individuals with chronic pain self-compassion skills (e.g. writing activities, meditation exercises, body scans). Self-compassion programmes may help individuals manage emotionally challenging experiences related to chronic pain in adaptive ways.

Conclusion

The results of this study highlight self-compassion as a relevant resource for women with chronic

pain to manage their affective-emotional experiences with chronic pain. It is likely that self-compassion would be one of many effective tools to assist with the management of the affective-emotional dimension of chronic pain. For instance, physical activity has been connected to symptom management (e.g. Brittain et al., 2018). Self-compassion may serve a complementary addition to a variety of care programmes, such as those that utilize physical activity and exercise, in the management of chronic pain.

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Notes

1. The first and third authors were primarily responsible for participant recruitment and data collection and applied the same protocols and guides to maintain consistency.
2. The focus group guide is available upon request.
3. Participants have consented to the release and use of all photographs presented below.
4. The semi-structured interview guide is available upon request.
5. The narratives represent a co-construction of experiences informed by the young women participants and the authors' (primarily first author) interpretation of their experiences (Clandinin and Connelly, 2000; Creswell and Poth, 2018; Malterud, 2012). Co-construction emphasizes that knowledge is co-created and value-laden and that the researcher is an integral connected element of the research process (Creswell and Poth, 2018).

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