Review of General Psychology

Self-Compassion: Conceptualizations, Correlates, & Interventions

Laura K. Barnard and John F. Curry

Online First Publication, October 31, 2011. doi: 10.1037/a0025754

Review of General Psychology

1089-2680/11/$12.00 DOI: 10.1037/a0025754

Self-Compassion: Conceptualizations, Correlates, & Interventions

Laura K. Barnard and John F. Curry
Duke University

Within American psychology, there has been a recent surge of interest in self-compassion, a construct from Buddhist thought. Self-compassion entails: (a) being kind and understanding toward oneself in times of pain or failure, (b) perceiving one's own suffering as part of a larger human experience, and (c) holding painful feelings and thoughts in mindful awareness. In this article we review findings from personality, social, and clinical psychology related to self-compassion. First, we define self-compassion and distinguish it from other self-constructs such as self-esteem, self-pity, and self-criticism. Next, we review empirical work on the correlates of self-compassion, demonstrating that self-compassion has consistently been found to be related to well-being. These findings support the call for interventions that can raise self-compassion. We then review the theory and empirical support behind current interventions that could enhance self-compassion including compassionate mind training (CMT), imagery work, the gestalt two-chair technique, mindfulness based stress reduction (MBSR), dialectical behavior therapy (DBT), and acceptance and commitment therapy (ACT). Directions for future research are also discussed.

Keywords: self-compassion, self-esteem, self-criticism, interventions, compassionate mind training

Western psychology has recently begun to study self-compassion, a construct from Buddhist thought (Neff, 2003a). Initial empirical work indicates that individuals who are more self-compassionate tend to have greater life satisfaction, social connectedness, emotional intelligence, and happiness and less anxiety, depression, shame, fear of failure, and burnout (Barnard & Curry, 2011; Mills, Gilbert, Bellew, McEwan, & Gale, 2007; Neff, Hsieh, & Dejitterat, 2005; Neff, Rude, & Kirkpatrick, 2007; Williams, Stark, & Foster, 2008).

The growing body of social psychology research correlating self-compassion with well-being has instigated another body of research that asks whether and how self-compassion can be increased and whether effectively raising self-compassion also reduces clinical symptoms and distress. Clinical psychologists have become interested in developing interventions (e.g., compassionate mind training) or identifying aspects of current treatments (e.g., dialectical behavior therapy) which, although not always originally intended to affect self-compassion, may prove to increase it.

Overall, this article has three main sections. The first seeks to define self-compassion and its three components and to distinguish self-compassion from other self-constructs. The second section reviews empirical work on the correlates of self-compassion. This second section demonstrates that self-compassion has consistently been found to be robustly related to well-being. These correlations demonstrate why there is a need for treatments that can raise self-compassion and potentially its correlates, and the third section reviews such interventions.

Laura K. Barnard, Department of Psychology and Neuroscience, Duke University; John F. Curry, Department of Psychology and Neuroscience and Department of Psychiatry and Behavioral Sciences, Duke University.

Correspondence concerning this article should be addressed to Laura K. Barnard, 417 Chapel Drive, Durham, NC 27705. E-mail: Laura.Barnard@Duke.edu

I. History, Conceptualization, & Assessment of Self-Compassion

Historical Roots

Although Western psychologists have produced a vast amount of empirical work that has examined empathy and *compassion for others*, only recently have they begun to explore *self-compassion* (Neff, 2003a). Buddhism contends that compassion entails being moved by and desiring to alleviate both others' *and* one's own distress (Neff, 2003a; Neff, 2003b). Buddhism asserts that a dichotomy between empathy for others and self-compassion sets up a false separation between self and others (Neff, 2003a). The Tibetan word *tsewa,* translated as compassion, does not distinguish between compassion for self and others (Neff, 2003a). Therefore, some Western psychologists are developing a theoretical and empirical understanding of self-compassion.

Conceptualization

The concept of self-compassion has been recently defined by Kristin Neff (2003a) as having three interrelated components that are exhibited during times of pain and failure. Each component has two parts, the presence of one construct and the negation of another. These three concepts are: (a) being kind and understanding toward oneself rather than being self-critical, (b) seeing one's fallibility as part of the larger human condition and experience rather than as isolating, and (c) holding one's painful thoughts and feelings in mindful awareness rather than avoiding them or overidentifying with them. The following section will elaborate upon these three components.

Self-kindness versus self-judgment. Self-kindness involves extending forgiveness, empathy, sensitivity, warmth, and patience to *all aspects* of oneself including all of one's actions, feelings, thoughts, and impulses (Gilbert & Irons, 2005; Neff, 2003a). People who are self-kind view their worth as unconditional (Ellis, 1973; Maslow, 1968; Rogers, 1961). Self-kindness involves affirming, even after failure, that one's self deserves love, happiness, and affection.

In contrast, self-judgment involves being hostile, demeaning, and critical of one's self or aspects of one's self (Neff, 2003a). People who are self-judgmental reject their own feelings, thoughts, impulses, actions, and worth (Brown, 1998). Self-judgment is often relentless (Whelton & Greenberg, 2005) and the pain it causes can equal or exceed the pain of the eliciting situation (Germer, 2009). However, self-judgment often feels natural to persons, so they may be unaware of their self-judgments, how they could relate differently to themselves, or how self-judgments are a source of suffering (Brown, 1998). Therefore, it is thought that part of becoming more self-kind is becoming aware of self-judgment and its harmful impact (Gilbert & Irons, 2005).

Common humanity versus isolation. Buddhism asserts that we are all intimately connected, that it is an illusion to see oneself as separate from others, and that we all long for connection (Brown, 1998). Common humanity entails recognizing our connection to others, particularly in our confusion, sorrows, imperfections, and weaknesses. Common humanity involves forgiving oneself for being fully human—for being limited and imperfect (Neff, 2003a).

However, many people in times of pain or frustration feel cut off from others. Those who believe that they themselves, their failures, or their emotions are shameful often withdraw, hide their "true selves," and feel that they alone struggle with particular inadequacies or failures.

Mindfulness versus overidentification or avoidance. Mindfulness involves awareness of, attention to, and acceptance of the present moment (Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007). Mindfulness includes not only cognitive attention to but also an affectionate, friendly interest in one's present experience (Kabat-Zinn, 2003). Mindfulness involves observing and labeling thoughts and emotions rather than reacting to them (Kabat-Zinn, 2003). Mindful attention is thought to help one deeply experience and learn from the present without the distractions of self-evaluations or worries about the past or future (Neff, 2003a).

Mindfulness can be thwarted by two opposite alternatives: overidentification and avoidance. Mindfulness resists both of these and can be seen as a middle ground between them. Overidentification involves ruminating on one's own limitations and is thought to result in a tunnel vision that *prevents* deep experiencing of the present moment (Gilbert & Procter, 2006; Neff & Vonk, 2009). People who tend to overidentify may magnify the significance of failures (Neff et al., 2005; Shapiro et al., 2007). The other extreme is avoidance of painful experiences, thoughts, and emotions (Kabat-Zinn, 2003; Neff, 2003a). It is thought that avoidance intensifies negative feelings in the long-term and sacrifices increased understanding (Germer, 2009).

Overall, overidentifying with or avoiding pain both thwart mindfulness, which is thought to help people explore and learn from thoughts, emotions, and experiences (Neff, 2003a).

The relations among the components of self-compassion. Surprisingly little has been written on the relations among the components of self-compassion. Neff (2003b) offers the most comprehensive discussion of this topic, yet even here the discussion is relatively brief. It is not entirely clear whether Neff views the three components as inherently and definitively related or merely as facets that tend to be positively associated or to engender one another. At the very least the facets enhance one another. Moreover, it seems to be the combination of these elements that will help us distinguish self-compassion from other self-themes, a topic that will be explored in the next section. It seems that the question is whether one could be self-compassionate without having all three components: self-kindness, mindfulness, and common humanity. Compassion, whether directed toward the self or other, seems to necessarily entail all three: being touched by suffering, being aware of the pain and not avoiding it, and having a feeling of connection or a desire to alleviate the suffering.

Thus, it is difficult to discuss any one component of self-compassion exclusive of the others. Here, we focus on how each element is thought to strengthen the other components. First, *self-kindness may foster common humanity and mindfulness*. If a person is caring, tender, understanding, and patient toward themselves, they may be less likely to feel ashamed of their faults and to retreat from others (Brown, 1998). Instead of withdrawing and believing that they alone struggle with flaws or failures, they might be more likely to stay in contact with others, share about their struggle, or observe that others have similar struggles. Self-kindness may also foster mindfulness. Self-kindness may allow a person to stay in the painful present and to adopt a balanced view. Whereas self-judgment tends to focus on past or future feared failures and thus to detract from the present, self-kindness is about being patient toward the aspects of oneself that one is experiencing as painful or inadequate. Self-kindness may also allow persons to nonjudgmentally observe their internal dialogue rather than becoming judgmental of their self-critical thought processes (Greenberg, Watson, & Goldman, 1998). It is hypothesized that the kinder people are toward themselves the easier it is to hold limitations in mindful awareness (Neff, 2003a).

Second, *common humanity may foster self-kindness and mindfulness*. People who feel connected to others may judge themselves less harshly for weaknesses as they accept that being imperfect is part of being human. Moreover, they may realize that they would not berate others for their failures and should treat themselves with the empathy and kindness that they extend to others. Common humanity may also foster mindful, clear-seeing of failures, as weaknesses are perceived as less threatening and are thus less likely to be avoided or overidentified with.

Third, *mindfulness may foster self-kindness and common humanity*. Labeling faults may help prevent judging one's self and help one recognize similar faults in others. Overidentifying leads to tunnel vision and shame which prohibit people from feeling connected (Neff, 2003a).

Empirical research is needed to examine these theoretical relations among the components of self-compassion. Factor analytic studies could determine whether self-compassion is a higher order factor composed of all three first level factors, and if so, whether the three component factors contribute approximately equally to the higher order factor, in terms of factor loadings. Intervention studies could be designed to determine whether raising one com-

ponent (e.g., mindfulness) also raises the other two components. Such work would greatly advance our understanding of the concept of self-compassion. Overall, one can intuitively see how the positive components of self-compassion may engender one another and how their absence may make other aspects of self-compassion more difficult.

Assessment

Before we turn to considering empirical work that distinguishes self-compassion from other constructs and examines the relationship of self-compassion to markers of psychological health and distress, it is important to discuss the measure of self-compassion that is nearly universally employed (see Neff, 2003a for more on the scale's development and its psychometric properties).

Neff first devised a measure with one third of the items intended to measure each of the three components of self-compassion (self-kindness, common humanity, and mindfulness). She then piloted her measure with 68 participants in focus groups of 3–5 people who gave feedback on the items' comprehensibility and relevance and who also proposed potential items to be included (Neff, 2003a). In the second phase, an updated draft of the measure was given to 71 participants who were asked to circle any unclear items, and these items were removed or clarified. The self-compassion items that had been generated in pilot testing were then given to a larger sample of undergraduates who also completed self-reports of kindness to self and others, social desirability, self-criticism, and connectedness (Neff, 2003a).

Neff administered the measure to 391 undergraduates, and conducted exploratory and confirmatory factor analyses to test the loading of items onto the three hypothesized factors, self-kindness, common humanity, and mindfulness. Items with loadings less than .40 on the exploratory factor analysis were omitted from the relevant scale. The new version with these items deleted was then analyzed using a confirmatory factor analysis (CFA) to investigate the fit of one-factor models for self-kindness, common humanity, and mindfulness items. Neff found that one-factor models for each component did not fit the data well, NNFI = .80, .43, .76, CFI = .84, .59, .83, respectively. However, two factor models for each component of self-compassion were found to fit the data well, NNFI = .88, .99, .94, CFI = .91, .99, .96, respectively. Thus, self-kindness items were one factor and self-judgment items loaded on another factor. Similarly, common humanity and isolation formed two factors, as did mindfulness and overidentification.

Next, a CFA was used to assess if a single higher-order self-compassion factor could explain the intercorrelations among the six subscale factors. This model was found to fit the data (NNFI = .88; CFI = .90). The overarching factor emerging out of a combination of the subscales was also supported by an internal consistency of .92 for the final 26-item scale. The internal consistencies of the subscales range from .75−.81. An additional study with 232 participants indicated that the scale seems to be measuring a trait rather than state as it has good test–retest reliability with correlations ranging from .85−.93 over a 3-week period of time (Neff, 2003a).

The scale also has demonstrated construct validity. First, undergraduates in the highest quartile of self-compassion had significantly higher mean scores on self-reported kindness to self and others than students who scored in the lowest quartile on self-compassion, $F(3, 386) = 19.67$, $p < .001$ (Neff et al., 2007). Second, Buddhists who practice Vipassana, a type of meditation that cultivates mindfulness, interdependence, and compassion had significantly higher total self-compassion scores in comparison than undergraduates (Neff, 2003b). The Buddhists sampled had been practicing Vipassana for a mean of 8 years (ranged from 1–40 years), and length of practice (in years) was positively correlated with self-compassion. Third, self-reported self-compassion significantly correlated ($r = .32$) with therapists' ratings of participant's self-compassion, even when the therapist has only met the participant once (Neff et al., 2007).

Although Neff's scale is used in self-compassion studies to date, it is not without limitations. Leary (in preparation) has found that some community samples do not understand items such as, "I try to be loving to myself" (item 5). Therefore, Leary has developed a shorter scale that follows a forced-choice format. Participants are presented with situations and asked to select their two most likely responses. This scale is still being constructed and tested but could add to our understanding of self-compassion as well as our ability to measure it.

Overall, the majority of research since the development of the Neff (2003a) scale has used Neff's (2003a) measure. However, this scale is still relatively new, and it is yet to be seen what if any changes will be made as our understanding of self-compassion advances.

Self-Compassion and Other Self-Themes

In defining self-compassion it is important to consider how it is similar to but broader than other aspects of the self that were previously studied in Western psychology including humanistic self-concepts and self-criticism. It is also important to show how self-compassion is distinct from self-esteem, self-pity, self-centeredness, and self-complacency. Here both theoretical and empirical work, when available, will be considered.

Self-compassion and humanistic psychology. The self-kindness component sounds similar to three humanistic themes, which were thought to be key to well-being. First, Rogers' (1961) "unconditional positive regard" involves adopting an unconditionally caring stance toward oneself. This, like self-kindness, does not entail making unconditionally positive evaluations about oneself, but instead involves adopting a less defensive, open stance toward oneself. Second, Maslow's (1968) "B-perception" involves learning to acknowledge and accept personal failings with a nonjudgmental, loving, forgiving orientation to one's being. Third, Ellis' (1973) "unconditional self-acceptance" involves the belief that one's worth is not to be evaluated but assumed, and weaknesses are to be acknowledged and forgiven.

Self-compassion, particularly the self-kindness dimension, is largely consistent with these humanistic constructs. However, Eastern thinkers assert that there is one dangerous common thread in the work of these humanistic psychologists: namely, a focus on the individual (Neff, 2003a). Therefore, Neff (2003a) argues that self-compassion is more encompassing than these humanistic self-concepts as it includes feelings of self-acceptance but bases them on a sense of shared humanity without separating the self from others. Self-compassion is broader than these humanistic themes as it includes the notions of common humanity and mindfulness.

Self-compassion and self-criticism. Before self-compassion was introduced to Western psychology, researchers referred to self-judgment with a variety of terms including but not limited to self-attack, self-contempt, self-disparagement, and self-criticism

(Dunkley, Zuroff, & Blankstein, 2003; Gilbert & Irons, 2005; Whelton & Greenberg, 2005). The relation between self-judgment and these terms is fairly obvious, but self-criticism has also been empirically shown to be related to concepts that are similar to isolation and overidentification.

First, self-criticism may engender isolation. Dunkley and his colleagues (2003) examined self-reports from 163 undergraduates and found that self-critical students reported more perceived criticism from others, $r = .34$, $p < .001$, and less perceived social support, $r = -.57$, $p < .001$. Zuroff and his colleagues (1999) studied 119 nonclinical, self-critical adults from the community and used event-contingent recording to examine their communal activities and their resulting affect. Self-critical adults reported less trait-based and behavior-based communion with others, $r = -.26$, $p < .01$, and less pleasant affect after interactions with others, $r = -.46$, $p < .001$. These results have been interpreted as indicating that self-critics show less intimacy and affiliative strivings perhaps because they fear rejection and disapproval. When self-critics do interact, they garner little reassurance or positive affect. Their social withdrawal may keep them from recognizing that their insecurities are part of the human condition.

Second, in the same study of undergraduates, self-critics tended to cope by avoiding situations that presented opportunities for failures (behavioral disengagement) or by avoiding thoughts and feelings associated with self-criticisms (mental disengagement; Dunkley et al., 2003). Self-critics were found to be avoidant, $r = .53$, $p < .001$, rather than mindfully aware.

Overall, we will treat self-criticism as synonymous with self-judgment; self-criticism may also engender feelings of isolation and behavioral and mental disengagement.

Self-compassion versus self-esteem. Although self-judgment will be treated as synonymous with self-criticism, self-compassion is not synonymous with self-esteem. Self-esteem historically has broadly referred to self-evaluation that is bolstered by attaining goals and threatened by failure (Kernis, 2003). However, in recent years self-esteem has been broken down into two main types. The first type of self-esteem is referred to as contingent or unstable self-esteem (Baumeister, Smart, & Boden, 1996; Kernis, 2003; Leary, Tate, Adams, Batts Allen, & Hancock, 2007). The second type is called true or optimal self-esteem (Deci & Ryan, 1995; Kernis, 2003).

Contingent self-esteem is defined as the degree to which the self is judged to be competent in important life domains (Deci & Ryan, 1995; Neff, 2003a; Rosenberg, 1965). Deci and Ryan (1995) define contingent self-esteem as referring "to feelings about oneself that result from—indeed, are dependent on—matching some standard" (p. 32).

True self-esteem is a more recent conceptualization that stems from researchers, like Deci and Ryan (1995), who began to question whether self-esteem, traditionally defined, is a positive trait. They define true-self-esteem as reflecting secure feelings that are *not* based upon one's actions or living up to some standard. True self-esteem is unconditional and sounds more similar to both humanistic concepts and to self-compassion. Alternative self-esteem scales have been designed to measure true self-esteem (Deci & Ryan, 1995; Kernis, 2003).

Until recently researchers have not been specific about which type of self-esteem they are discussing. For instance, Baumeister and his colleagues (1996) write, "Although some researchers favor narrow and precise concepts of self-esteem, we shall use the term in a broad and inclusive sense. By *self-esteem* we mean simply a favorable global evaluation of oneself" (pp. 5). However, precision is necessary in exploring how self-esteem is similar and dissimilar to self-compassion. It is clear that self-compassion is distinct from contingent self-esteem, since self-compassion is not based upon evaluation of the self, whereas contingent self-esteem is. In fact, it is empirically supported that self-compassion and contingent self-esteem are in fact different and even inversely related constructs, $r = -.47$ (Neff & Vonk, 2009). Furthermore, we have already explored how self-compassion relates to the humanistic themes of unconditional acceptance. Therefore, in this section we will focus on how self-compassion is distinct from *global self-esteem* as frequently measured by the Rosenberg (1965) scale.

Global self-esteem is defined as being about self-liking and self-competence and has been the standard meant by self-esteem for many years (Tafarodi & Milne, 2006). Research supports the conceptual claim that self-compassion is distinct from global self-esteem by demonstrating that (a) they are correlated but not sufficiently so to say that they are the same construct, (b) they have different correlates, (c) self-compassion predicts variation in psychological variables above and beyond global self-esteem, and (d) there are cultural differences in average levels of self-compassion and global self-esteem.

First, the correlations between self-compassion and global self-esteem range from $r = .56$ (Leary et al., 2007) to $r = .68$ (Neff & Vonk, 2009). These correlations indicate that although there is a significant relationship between self-compassion and global self-esteem, they are not so high as to indicate identity of the two constructs.

Second, global self-esteem and self-compassion seem to be distinct constructs because they have different correlates. Differences in the correlates of self-compassion and self-esteem are shown in Table 1. As indicated in the table, in some cases self-esteem is positively correlated with negative constructs but self-compassion is not. For instance, although self-esteem is positively associated with narcissism, self-compassion is not. In other cases, self-compassion appears to be protective against drawbacks and self-esteem is not. For instance, although self-compassion is negatively associated with anger and catastrophizing, self-esteem is not significantly related to these constructs.

It has also been found that both *high and low self-esteem* are positively associated with distorted self-knowledge (either seeing the worst in others or in themselves respectively), but only *low self-compassion* is positively associated with distorted self-knowledge (Leary et al., 2007). Leary and his colleagues videotaped 102 undergraduates making up a children's story. One third of participants rated their own videotape and the other two thirds rated another participant's tape on a variety of adjectives (e.g., awkward, creative, and reasonable). Those high in self-esteem were most likely to rate others as having done poorly, those low in self-esteem and low in self-compassion tended to rate themselves as having performed worse than others rated them, and those high in self-compassion rated their performances the most "accurately," or the most similarly to how others' rated them. In summary, considerable evidence suggests that self-compassion and self-esteem are distinct constructs.

Third, as shown in the semipartial correlations in Table 1, self-compassion predicts unique significant variation in markers of

Table 1
Correlates of Self-Compassion and Self-Esteem

Concept	Study	Self-compassion	Self-esteem
Negative Traits			
Narcissism	Neff, 2003a	.11	.59**
	Neff & Vonk, 2009	−.03 (−.06)	.40*** (.33)***
Self-Rumination	Neff & Vonk, 2009	−.41*** (−.37)***	−.10*** (−.07)
Anger	Neff & Vonk, 2009	−.38*** (−.27)***	.07 (−.06)
Catastrophizing	Leary et al., 2007	−.25* (−.20)*	−.14 (−.04)
Personalizing	Leary et al., 2007	−.42** (−.28)**	−.33** (.08)
Negative affect	Leary et al., 2007	−.34** (−.23)**	−.28** (−.06)
Singular pronoun use	Neff et al., 2007	−.21*	ns
Anxiety	Neff et al., 2007	−.21* (−.21)*	−.11 (.10)
Positive Traits			
Plural pronoun use	Neff et al., 2007	.23*	ns
Equanimity	Leary et al., 2007	.46** (.40)**	.23*** (−.05)
Happiness	Neff & Vonk, 2009	(.29)***	.61*** (.39)***
Optimism	Neff & Vonk, 2009	(.33)***	.64*** (.42)***
Positive Affect	Neff & Vonk, 2009	(.18)*	.35*** (.18)*

Note. Numbers in parentheses are semipartial correlations with the influence of either self-compassion or self-esteem removed. ns = reported only as nonsignificant.
* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

psychological health and distress after self-esteem is controlled for. For instance, even after controlling for self-esteem, self-compassion is still negatively associated with self-rumination, anger, personalizing, and negative affect. Self-compassion also remains uniquely, positively associated with equanimity, happiness, optimism, and positive affect. Moreover, when the role of self-compassion is controlled for, the role of self-esteem is often reduced below the level of statistical significance (see rumination and equanimity in Table 1). In other words, although self-esteem has previously been thought to be negatively correlated with constructs such as negative affect, once the role of self-compassion is partialed out, self-esteem is not significantly related to this and other variables. Overall, Table 1 shows that although both self-compassion and self-esteem are significantly correlated with several constructs, when semipartial correlations are considered, self-compassion remains a significant predictor of variance in these variables and self-esteem does not (Leary et al., 2007; Neff & Vonk, 2009). If self-esteem and self-compassion were the same construct, their contribution would be redundant and self-compassion would not predict additional variation after controlling for self-esteem.

Fourth, one study found possible cultural differences in average degree of self-esteem verses self-compassion (Neff, Pisitsungkagarn, & Hsieh, 2008). These researchers sampled 181 American, 223 Thai, and 164 Taiwanese undergraduates to compare average levels of self-compassion and self-esteem. ANOVAs found a main effect of culture on self-compassion, $F(2, 562) = 31.87$, $p < .001$, and on self-esteem, $F(2, 562) = 41.96$, $p < .001$. Scheffé tests revealed that participants in Thailand on average had the highest self-compassion, then those in the United States, then students in Taiwan. However, undergraduates in the United States were found to have the highest average self-esteem followed by undergraduates in Thailand and Taiwan, who did not significantly differ from each another. This study provides initial evidence that self-compassion and self-esteem may be differentially impacted by culture.

Overall, the research cited here indicates that self-compassion and global self-esteem are not identical. Leary and his colleagues (2007) comment that self-compassion may be particularly beneficial for people who are low or high in self-esteem because self-compassion is available precisely when self-esteem fails (at times of failure) and offers protection against ego-defensive drawbacks of high self-esteem, such as narcissism.

However, it is important to note that literature on self-esteem written before the introduction of the concept of self-compassion may at times be referring to something more like self-compassion than self-esteem, as differentiated here, without using the term self-compassion. For instance, McKay & Fanning (2000) in his theoretical book defines self-esteem as an understanding, accepting (not approving), and forgiving self-view. He also focuses on the critical internal voice that people with low self-esteem may experience. He then presents questions designed to help clients cultivate a "compassionate mind" (p. 93). McKay seems to be defining self-esteem differently than the literature already cited in this section and in fact seems to be talking about self-compassion more than "self-esteem," but he may not have been familiar with the former concept.

Overall, when comparing work on self-esteem and self-compassion it is crucially important to be aware of the authors' definitions of the constructs and to ask whether what they are labeling self-esteem is actually contingent, true, or global self-esteem, or something more like self-compassion even if the term was not yet used.

Self-compassion versus self-pity, self-centeredness, or self-complacency. Researchers who work with patients report that their patients worry that in becoming more self-compassionate they may also become self-pitying, self-centered, or complacent (Gilbert & Irons, 2005). Although, self-compassion has been theoretically distinguished from these concepts, it needs to be distinguished empirically as well.

First, self-compassion is thought to be distinct from self-pity because those who pity themselves are thought to lose a sense of common humanity and to overidentify with their feelings,

thoughts, and experiences. Self-pity is associated with a narrowed scope of vision that is characterized by being engrossed in one's own suffering to the point of exaggerating it. Self-compassion is thought to break self-absorption by relating one's own suffering to others' and by holding pain in mindful awareness (Neff, 2003a, p. 224; Nolen-Hoeksema, 2000).

Second, self-compassion is not thought to engender self-centeredness because of the common humanity component. Buddhist thought asserts that self-compassion should foster social connectedness and compassion for others. Initial empirical work supports this theory. Neff (2003a) found that self-compassion was significantly correlated with self-reported social connectedness ($r = .41$, $p < .01$) in a sample of 391 undergraduates. Moreover, Neff (2003a) found that individuals in the highest quartile of self-compassion were most likely to rate themselves as being equally kind to self and others, $F(3, 386) = 19.67$, $p < .001$.

Third, self-compassion is theoretically distinct from self-complacency. Self-compassion is thought to enable clear seeing of one's failings without a need for being defensive (Brown, 1998; Germer, 2009; Leary et al., 2007; Neff, 2003b). Self-compassion is about equanimity, not indifference or resignation; it's about understanding faults, not colluding with them. Also, having compassion for the self means desiring health and well-being for the self, not stagnation, so self-compassion should encourage growth (Neff, 2003a).

Overall, the common humanity and mindfulness components of self-compassion are thought to separate self-compassion from self-pity and self-centeredness, whereas the clear seeing of faults and motivation to grow are thought to separate self-compassion from self-complacency. Initial research empirically supports these claims (see later sections of this article on the correlations between self-compassion and indexes of achievement and perfectionism).

II. Self-Compassion and Its Correlates

Now that self-compassion has been defined and distinguished from other constructs, the question at stake is whether empirical evidence supports the hypothesis that self-compassion is associated with psychological benefits. Researchers have found that self-compassion is correlated with positive outcomes in a variety of domains such as affect, cognitive patterns, achievement, and social connections. Admittedly the correlational studies reported here fail to establish causality, rely on self-report, and need to be supplemented with other methodologies. Yet these correlations supply initial evidence that *interventions that raise self-compassion may also help effect positive change* in these domains. In this section, the correlates of self-compassion are discussed as well as research that begins to explore mediators and mechanisms of these correlations.

Self-Compassion and Affect

Positive and negative affect. Several studies have found that self-compassion is positively correlated with positive affect and negatively correlated with negative affect (Leary et al., 2007; Neff et al., 2007; Neff & Vonk, 2009).

Neff and her colleagues (2007a) sampled 177 undergraduates and found that self-compassion was positively correlated with positive affect and negatively correlated with negative affect, $r = .34$ and $-.36$, respectively ($p < .05$). Neff and Vonk (2009) sampled 165 students and found that self-compassion remained positively correlated with overall positive affect when self-esteem was controlled for. These results suggest that self-compassion is not only protective when things go wrong, but also that self-compassion plays a significant, unique role in people feeling connected, worthy and acceptable (aspects of the positive affect scale).

Leary and his colleagues (2007) performed a series of experiments to examine the relation of self-compassion to emotions. First, 117 students were asked to recall every 5 days either the worst thing that had happened during the previous 4 days that was their fault or the worst thing that had not been their fault. Participants also rated how they felt in the situation on 20 affect relevant terms. Self-compassion was negatively related to negative feelings such as anxiety, sadness, and self-conscious emotions at the time of the event. In the second study, 123 students were asked to read hypothetical negative scenarios and to imagine how they would feel. Self-compassion was negatively correlated with imagined negative affect. In Study 3, 66 students received either neutral or positive feedback (unrelated to actual performance). Results indicated that self-compassion was negatively associated with negative affect as a result of neutral feedback. In Study 4, 102 students watched a tape of themselves performing an embarrassing task. Participants with high self-compassion experienced more positive emotions (relaxed, happy, proud) when watching themselves $t(33) = 2.43$, $p < .05$ and less negative emotions (embarrassed, irritable, sad, nervous) $F(1, 31) = 7.12$, $p < .01$.

In the last study participants recalled a previous failure and then were in one of four conditions: (a) self-compassion induction (were asked to write on three prompts that fostered the various aspects of self-compassion), (b) self-esteem induction (were asked to write on prompts designed to raise self-esteem), (c) writing control (were just asked to "really let go and explore their deepest emotions as they wrote about the event"), or (d) true control (after recalling the event they completed the dependent measures). They then rated how they felt on scales assessing sadness, anger, and anxiety. The students in the self-compassion induction reported significantly less negative affect than participants in any other condition. Overall, these findings suggest that low self-compassion is associated with greater negative affect and less positive affect in the face of real, imagined, and remembered events.

In a study of 69 Christian clergy, self-compassion was negatively correlated with emotional exhaustion in ministry, $r = -.60$, $p < .001$, and with shame, $r = -.55$, $p < .001$, positively correlated with satisfaction in ministry, $r = .42$, $p < .001$, and unrelated to guilt, $r = .00$ (Barnard & Curry, 2011). Emotional exhaustion is marked by fatigue, irritation, sadness, cynicism, and social withdrawal. Satisfaction in ministry is marked by feeling that one's work is worthwhile and has a positive influence on others. Shame is defined as a negative *self*-evaluation, is correlated with depression and anxiety, and is conceptually distinct from guilt, which is a negative evaluation of one's *behavior* (Tangney, Stuewig, & Mashek, 2007).

These studies highlight the need for interventions that may raise self-compassion and thereby raise positive affect and reduce negative affect, shame, and emotional exhaustion.

Anxiety and depression. As shown in Table 2, self-compassion has been shown to be negatively correlated with anxiety and depression, two types of potentially impairing negative

Table 2
Total and Partial Correlations Between Self-Compassion and Anxiety, Depression, and Life Satisfaction

Study	Anxiety	Depression	Other variables controlled for
Neff, 2003a	$-.65^{**}$ $(-.33)^{**}$	$-.51^{**}$ $(-.21)^{**}$	Self-criticism
Neff et al., 2005	$-.66^{***}$ $(-.47)^{**}$		Fear of failure & perceived competence
Neff et al., 2007	$-.21^{*}$ $(-.21)^{*}$	$-.21^{*}$ $(-.21)^{*}$	Self-esteem
Neff et al., 2007	$-.61^{**a}$	$-.31^{*a}$	
Mills et al., 2007		$-.40^{**}$	
Neff et al., 2008		$-.54^{**b}$	
		$-.61^{**c}$	
		$-.53^{**d}$	
Ying, 2009		$-.44^{***}$	
Raes, 2010	$-.75^{***}$	$-.55^{***}$	

Note. Parentheses indicate partial correlations.
[a] Change scores were correlated, rather than single point in time scores. [b] United States sample. [c] Taiwanese sample. [d] Thai sample.
$^{*}p \leq .05$. $^{**}p \leq .01$. $^{***}p \leq .001$.

emotional states, even after controlling for other variables such as self-criticism and self-esteem. However, it is important to note that unless otherwise specified here the participants were undergraduates with subclinical anxiety and depression.

A few researchers have looked at change scores and mediators to better understand these associations. First, Neff and her colleagues (2007a) employed a gestalt two-chair technique to raise participant's self-compassion and found that increases in self-compassion were associated with decreases in anxiety and depression. Second, Neff and her colleagues (2005) found that the relationship is partially mediated by lesser fear of failure and greater perceived competence when the anxiety is related to academic pursuits, and Raes (2010) found that the relationship is partially mediated by rumination and worry. However, self-compassion also made a significant direct contribution to anxiety after controlling for the mediators.

The negative association between self-compassion and depression has been shown to be partially, but not fully, mediated by a sense of decreased coherence (feeling that life is lacking meaning, incomprehensible, and unmanageable; Ying, 2009) and by brooding and worrying (Raes, 2010). This association has been replicated in Thailand and Taiwan (Neff et al., 2008).

Moreover, as the partial correlations in Table 2 indicate, these relations remain significant even after controlling for factors which have previously been shown to be associated with depression, such as self-esteem and self-criticism. Previous research has suggested that depression can be divided into two distinct subtypes (dependent and self-critical; Blatt & Zuroff, 1992; Greenberg et al., 1998; Zuroff et al., 1999). No empirical work has yet been published on whether self-compassion relates differently to these two different subtypes of depression.

Only two studies have examined the relation of self-reported depression and the subscales of self-compassion (Mills et al., 2007; Ying, 2009). As shown in Table 3, depression was significantly, positively associated with self-judgment, isolation, and overidentification, and was significantly, negatively associated with self-kindness, mindfulness, and in one study with common humanity. However, the strength of the associations with the positive aspects of self-compassion, especially with common humanity, tends to be weaker than those with the negative aspects. Mills and colleagues used 131 undergraduates for their sample and Ying used 65 social work masters students. It is not yet clear if the associations among depression and self-compassion subscales would be different among persons struggling with clinically significant depression, so future work should investigate how the subscales of self-compassion relate to clinical depression.

Well-being, life satisfaction, and happiness. Self-compassion has been shown to be uniquely associated with well-being (Neely, Schallert, Mohammed, Roberts, & Chen, 2009). Neely and her colleagues (2009) define well-being as having a sense of purpose in life, a sense of self-mastery, low perceived stress, low negative affect, and high satisfaction with life. Their index of well-being combines five scales that measure these aspects. Self-compassion predicted variation in self-reported well-being over and above variation predicted by goal regulation, stress, and degree and availability of social support (factors whose relationship with well-being had previously been established), $r = .67$, $p < .05$, $b = .54$, $p < .05$ (Neely et al., 2009).

Self-compassion has been shown to be positively associated with self-reported life satisfaction in two studies of undergraduates in the U.S. and in one study of students in Thailand and Taiwan. Moreover, Neff and colleagues (2005) measured self-compassion after a perceived failure (a low midterm-examination grade) and

Table 3
Correlations Between Depression and The Subscales of Self-Compassion

	Mills et al. (2007)[1]	Ying (2009)[2]
Self-Kindness	$-.38^{**}$	$-.49^{***}$
Self-Judgment	$.52^{**}$	$.49^{***}$
Common Humanity	$-.18^{*}$	$-.23$
Isolation	$.61^{**}$	$.43^{***}$
Mindfulness	$-.19^{*}$	$-.42^{***}$
Over-Identification	$.49^{**}$	$.59^{***}$

Note. [1] $N = 131$. [2] $N = 65$.
$^{*}p \leq .05$. $^{**}p \leq .01$. $^{***}p \leq .001$.

found that self-compassion was correlated with positive reinterpretation, $r = .24$, $p < .01$, and with acceptance, $r = .22$, $p < .05$.

Self-compassion is also uniquely correlated with self-reported happiness, $r = .57$, $p < .05$, and optimism, $r = .62$, $p < .05$ (Neff et al., 2007). Self-compassion predicts variation in happiness and optimism over and above what self-esteem, age, and gender jointly predict, $b = .29$, $p < .001$ and $b = .33$, $p < .001$, respectively (Neff & Vonk, 2009).

Life satisfaction, happiness, and well-being may stem from *and/or* facilitate self-compassion, or these associations may be moderated by other constructs such as coping skills or emotional intelligence. More research is needed to investigate these various explanations.

Emotional intelligence and coping strategies. Self-compassion may be related to affect through emotion regulation and emotional intelligence, constructs that have been related to positive psychological outcomes especially when people have little control over their situation. Emotional intelligence involves attending to and understanding one's own feelings and ability to regulate mood. Neff (2003a) found that self-compassion is positively correlated with the repair and clarity subscales of emotional intelligence, $r = .55$ and $r = .43$, $p < .05$, respectively. She hypothesizes that the mindfulness component of self-compassion facilitates emotional intelligence, but the relation of this subscale to emotional intelligence is yet to be probed.

Neff and colleagues (2005) found that students who were higher in self-compassion were less likely to suppress their emotions following a failure and more likely to use emotion approach coping strategies such as acceptance and reinterpretation (all ps $< .01$).

Together these findings may help explain why self-compassion is positively related to well-being and happiness and negatively associated with negative affect, depression, and anxiety, but direct studies of mediators are required to understand the relations among these variables.

Self-Compassion and Cognitive Patterns

It has been hypothesized that self-compassion is positively associated with mindfulness and negatively associated with rumination, thought suppression, and avoidance (Neff et al., 2005; Neff, Kirkpatrick, & Rude, 2007; Neff & Vonk, 2009; Raes, 2010; Thompson & Waltz, 2008). It has also been hypothesized that these associations partially explain the above associations among self-compassion and affect. The empirical evidence for these hypotheses is explored here.

Mindfulness versus rumination, thought suppression, and avoidance. Self-compassion has been found to be negatively correlated with rumination in studies of 232 undergraduates (Neff, 2003a), 271 undergraduates (Raes, 2010), and 165 undergraduates (Neff & Vonk, 2009), $r = -.50$, $-.55$, $-.41$, $p < .01$, $<.001$, $<.001$, respectively. Raes (2010) found that self-compassion was more strongly associated in a negative direction with brooding than reflective rumination ($r = -.55$ and $-.19$, $p < .001$ and $<.01$, respectively), the former of which is thought to be more maladaptive. Brooding rumination also partially mediated the relationship between self-compassion and depression. Moreover, Neff and her colleagues (2007a) found that increases in self-compassion among 40 undergraduates over a 1-month interval were correlated with decreased rumination ($r = -.40$, $p < .01$).

Second, self-compassion has been found to be negatively correlated with thought suppression and avoidance strategies. In the same one month study, students who experienced an increase in self-compassion also tended to experience a decrease in thought suppression, $r = -.55$, $p < .01$ (Neff, 2007a). Neff (2003a) also found that self-compassion was negatively correlated with thought suppression among 232 students, $r = -.37$, $p < .01$. Neff and her colleagues (2005) also found that among 110 students who felt that they had just failed a midterm, self-compassion was negatively correlated with avoidance-oriented coping strategies such as denial and mental disengagement, $r = -.22$, $p < .05$ and $r = -.20$, $p < .05$, respectively. Moreover, Thompson and Waltz (2008) sampled 210 undergraduates (22 of whom met criteria for posttraumatic stress disorder (PTSD) who had experienced a Criterion A trauma. They found that self-compassion was negatively correlated with avoidance strategies ($r = -.24$, $p < .05$). One of the three symptom clusters of PTSD is avoidance, and avoidance has been shown to maintain PTSD symptoms (Thompson & Waltz, 2008). This study provides initial evidence that self-compassion may be protective against the development and/or maintenance of PTSD.

Self-Compassion and Achievement or Performance

Thus far it has been shown that self-compassion is related to affect and to cognitive patterns; self-compassion is also related to goals, motivation, and achievement.

Goals and motivations. Mastery goals have been distinguished from performance goals. People with mastery goals tend to be motivated by curiosity, to set their own standards, and to accept mistakes as part of learning (Neff et al., 2005). Mastery goals are correlated with intrinsic motivation, which is marked by greater persistence in tasks, willingness to seek help, and enjoyment (Neff et al., 2005). People with performance goals tend to fear being outperformed, fear mistakes, and are motivated to achieve to enhance their self-worth.

Therefore, researchers have examined the relationships between self-compassion and goal and motivation types. Neff and her colleagues (2005) found that among 110 undergraduates self-compassion was positively correlated with mastery goals, $r = .28$, $p < .01$, and with intrinsic motivation, $r = .30$, $p < .01$, and negatively correlated with performance goals, $r = -.21$, $p < .01$. These correlations were partially mediated by fear of failure and self-perceived competence, but self-compassion also had a significant, unique association. However, another study of 91 students failed to replicate these findings (Williams et al., 2008). The authors attribute their null findings to an inferior measure of goals and motivations (it only had six items) and not to a different hypothesis regarding the relationships among self-compassion, goals and motivations.

Procrastination and perfectionism. Initial work that requires replication shows that self-compassion is negatively associated with procrastination and maladaptive perfectionism. Williams and her colleagues (2008) divided 91 students by their self-compassion scores into three groups: low, moderate, and high self-compassion. They found that students with low self-compassion reported significantly more procrastination, $F(2, 86) = 5.53$, $p = .006$.

Neff (2003a) examined the relationship between self-compassion and perfectionism. She found that although self-compassion had no significant relationship with the standards subscale (indicating that individuals who are high in self-compassion do not tend to relax their personal standards), self-compassion was negatively correlated with the discrepancy subscale, which has been called "neurotic perfectionism," $r = -.57$, $p < .01$.

These associations may be in part explained by self-compassion's relationship with goals and motivations, but empirical work has not yet explored any mediators.

Self-perceived competence, efficacy and performance. Thus far it has been shown that self-compassion is related to the ways in which people approach their work (e.g., goals and procrastination). The next two studies examine how self-compassion relates to actual performance or competence (Leary et al., 2007; Neff et al., 2005).

Neff and colleagues (2005) asked 110 undergraduates who were highly dissatisfied with a recent midterm grade to complete measures of self-compassion and perceived competence. They found that individuals with higher self-compassion tended to rate themselves as having greater perceived competence, $r = .33$, $p < .05$, even after controlling for actual performance. They found no relationship between self-compassion and actual test grades. This raises the question whether those high in self-compassion see themselves as more competent than they actually are.

One study provides evidence to the contrary. Leary and his colleagues (2007, p. 897) asked 102 undergraduates to perform an "awkward and mildly embarrassing task" and then to rate their own and others' performances. They found that individuals *low in self-compassion* tended to *underestimate* their own performance. Whereas those high in self-esteem tended to overestimate their performance, *highly self-compassionate* students *were the most likely to accurately assess their performance*, as indicated by having the closest agreement with others' evaluations of how awkward, competent, and confident they were.

Overall, these studies indicate that individuals with low self-compassion underrate their abilities and tend to take failures to be indicative of their competence, whereas individuals who are highly self-compassionate tend to have resilient self-appraisals and may more accurately rate their abilities.

Self-Compassion and Social Factors

Self-compassion is not only associated with affect, cognitive patterns, and performance, but also to the ways in which people interact.

Social connection. Three studies indicate that self-compassion is positively related to a sense of connectedness, as measured by the self-report Social Connectedness Scale. This scale measures the degree of closeness that individuals feel between themselves and friends and society. First, Neff (2003a) found a positive correlation between self-reported social connectedness and self-compassion among 391 undergraduates, $r = .41$, $p < .01$.

Second, Neff and her colleagues (2007a) had 40 undergraduates participate in a gestalt two-chair exercise designed to raise self-compassion. They then had participants complete the self-report self-compassion scale and Social Connectedness Scale. They found a positive correlation between change scores in self-compassion and change scores in connectedness, $r = .35$, $p < .05$ (Neff et al., 2007). Moreover, this relationship remained significant after controlling for the change in anxiety, $r = .29$, $p < .05$.

Third, Neff and her colleagues (2007a) sampled 91 undergraduates and asked them to write about their greatest weakness and a time in the past in which their weakness affected them. They found that individuals who are higher in self-compassion tended to use more first person plural pronouns (e.g., we, our, us), $r = .23$, $p < .05$, and fewer first person singular pronouns (e.g., me, mine, I), $r = -.21$, $p < .05$, when writing about their own weaknesses. In other words, individuals with higher self-compassion tended to discuss their weaknesses with social references to others demonstrating a more interconnected and less separate view of the self.

Social connectedness and the use of first person plural pronouns have been found to be associated with lower depression scores (Neff et al., 2007). Therefore, self-compassion's correlation with social connection may mediate the association between self-compassion and depression, but research needs to investigate this claim.

Agreeableness and desire to please others. Self-compassion has been shown to be positively correlated with agreeableness, $r = .35$, $p < .05$, among 177 undergraduates (Neff et al., 2007). Agreeableness is a construct that has six subcomponents including trust, compliance, straightforwardness, altruism, modesty, and tender-mindedness (Costa & McCrae, 1992). Neff and her colleagues did not examine the subcomponents. Thus, this finding should be cautiously interpreted. For instance, it is not clear whether people who are higher in self-compassion are more likely to be tender-minded or more likely to comply with others' requests. Both theory and an empirical study suggest that self-compassion is more likely to be related to the former than the latter. Barnard and Curry (2011) found that clergy who are higher in self-compassion have *lesser* desire to please congregants and a *greater ability to say no* to requests, $r = .21$, $p < .05$. More research is needed to understand the associations among the subscales of agreeableness, the ability to protect one's own desires in social interactions, and self-compassion.

Self-Compassion and Other Correlates

Initial work also reveals that self-compassion is positively correlated with reflective and affective wisdom (ability to see reality as it is and develop insight), personal growth initiative (making changes needed for a fulfilling life), conscientiousness, and curiosity, $r = .61$, $.26$, $.45$, $.42$, and $.28$, respectively, $p < .05$ (Neff et al., 2007) as well as with ability to separate one's identity and worth from one's job performance, $r = .64$, $p < .001$ (Barnard & Curry, 2011).

Self-Compassion and Correlates With Mixed Evidence

Gender. Neff (2003a) had two opposing hypotheses about the impact of gender on self-compassion. On the one hand, she predicted that females would have higher common humanity, because they tend to have a more interdependent sense of self. On the other hand, she predicted females would have higher self-judgment and overidentification because they tend to be more prone to self-criticism and rumination (Neff, 2003a). However, despite these specific hypotheses related to the subscales of self-compassion, existing research has only

examined gender differences in overall self-compassion; future work is needed that examines the subscales.

Four studies have found evidence that suggests that undergraduate females have less self-compassion than undergraduate males (Neff et al., 2005; Neff et al., 2008; Neff & Vonk, 2009; Raes, 2010), although the magnitude of the difference is modest. Raes (2010) used a t test, $t(269) = 3.63$, $p < .001$. Neff and her colleagues (2008) used analysis of variance with Scheffé follow up tests, $F(1, 179) = 5.64$, $p < .05$. In two other studies simple correlations were considered, $r = -.14$, $p < .05$ (Neff et al., 2005), and $r = -.10$, $p < .001$ (Neff & Vonk, 2009). Neff and Vonk (2009) found that the gender effect remained even after controlling for self-esteem, $r = -.07$, $p < .001$. However, one study of U.S. undergraduates found no significant sex-differences (Neff, Kirkpatrick, & Rude, 2007). Also, no significant gender differences were observed among undergraduates in Taiwan and Thailand (Neff et al., 2008) or in undergraduates in Turkey (Iskender, 2009). Thus, any gender effect may be culturally specific.

Constructs Unrelated to Self-Compassion

Self-compassion *is not* correlated with social desirability (Neff, 2003b) or with having a generally more positive outlook. Participants high in self-compassion did not differ from others in use of negative emotion words when describing past failures (Leary et al., 2007), when writing about one's weaknesses, or reporting the number or severity of experienced negative events or the number of personal faults (Neff & Vonk, 2009). Moreover, participants with high self-compassion report feeling more positive affect while watching themselves perform an embarrassing task, but not while watching others do so, which provides evidence that self-compassion is distinct from more general feelings of compassion for others (Leary et al., 2007). Students in this study performed a mildly embarrassing task while being taped and then watched their own and others' performances. Students who were low in self-compassion evaluated their performance and personal characteristics more negatively than other observers rated them and experienced more negative affect when watching the tape compared with participants who were higher in self-compassion.

III. Interventions for Cultivating Self-Compassion

Self-Compassion Induction Studies

The studies discussed thus far have been conducted at single time points and only examine correlates of self-compassion. However, as the body of research that correlates self-compassion with psychological health develops, social psychologists have begun to conduct intervention studies and clinical psychologists have developed treatments to examine whether (a) self-compassion can be raised, and (b) a raise in self-compassion enhances well-being and reduces distress and dysfunction. Two induction studies provide initial affirmative evidence.

The first study was conducted with 84 college women who exhibited rigid restrained eating attitudes (Adams & Leary, 2007). People with these attitudes rigidly restrict eating, and if the diet is broken (by what is called a "preload"), they tend to increase food consumption. It is believed that the increased eating is a way of coping with negative self-evaluations and distress. Therefore, Adams and Leary (2007) studied whether a self-compassion induction after a preload could be an alternative coping mechanism that would attenuate negative self-evaluation, distress, and food consumption. Their study had three conditions. One group of participants was nondieters and the other two groups were comprised of restrictive dieters. All participants consumed a preload. Only one of the restrictive dieting groups received a self-compassion induction—a mere six sentences in which the research assistant encouraged subjects to remember that everyone eats unhealthily sometimes and to not be too hard on themselves (Adams & Leary, 2007, p. 1129).

The restrictive eaters who received the induction behaved like the nondieters, reducing their food intake after a preload. They also reported increased positive affect (contentment and competency) without increased negative affect (shame, disgust, worry, or disappointment). Dieters without the induction ate more and reported increased negative affect and decreased positive affect. The induction also helped the most restrictive eaters the most. Those who received the induction were able to hold eating goals in mind without ruminating on the preload. This study provides initial evidence that briefly encouraging students with restrictive diets to have self-compassion can (a) raise self-compassion, and (b) influence affect and behavior.

In another induction study, participants were asked to recall a failure, rejection, or loss that elicited negative self-evaluative emotions (e.g., humiliation or shame; Leary et al., 2007). There were four conditions. In the self-compassion induction condition subjects were asked to write down ways in which others have experienced similar events, how they would express understanding to a friend if they had experienced the event, and to list their emotions about the event in an objective and unemotional fashion. In the self-esteem induction condition participants were instructed to write about their own positive characteristics, why they believe the event was not their fault, and why the event does not indicate anything about the type of person they are. The third condition was a writing control condition in which subjects were just instructed to write about the event. The last condition was a true control in which participants filled out the dependent measures immediately after recalling the negative event without any writing. Subjects in all conditions were asked to rate their feelings and the extent to which they believed the negative event was their own fault.

The self-compassion group differed statistically from all the others in that they reported the lowest negative affect and the greatest perception of being similar to others. They also were the most likely to say that the event had been their fault but *not* to exhibit corresponding negative affect ($r = -.03$) whereas internal attributions in other conditions were positively correlated with negative affect. These results suggest that self-compassion may help people take responsibility and may decouple the association between taking responsibility and experiencing negative affect. This provides further evidence that self-compassion does not lead to self-complacency. The self-compassion induction was particularly effective for students who had low trait self-compassion, so it helped those who may have been most likely to experience negative affect.

Overall, these induction studies are encouraging. However, both studies were conducted with undergraduates. It is not clear whether these interventions would prove helpful for clinical populations who deeply struggle with low self-compassion. Adams and Leary (2007, p. 1140) found that the self-compassion induction was not as helpful for participants who had high eating guilt and wrote that

it "might be difficult to counteract for guilt-ridden people in a one-session experiment" the "deeply rooted feelings of guilt" and that these feelings would be "more likely to change over time through psychotherapy" (p. 1141).

Treatment Studies

Since self-compassion has been shown to be associated with psychological health, it may be important to discover and develop therapeutic interventions that increase self-compassion. Moreover, it has been shown that patients who are self-critical tend to make fewer improvements in short-term antidepressant medication (imipramine), placebo, or psychotherapy (interpersonal or cognitive–behavioral) treatment (Blatt, 1995). We therefore need to discern what treatments may reduce distress for highly self-critical individuals by targeting self-judgments and the way one relates to self-judgments (mindfully with recognition of common humanity).

Although new, specialized therapies may be needed for teaching self-compassion, elements of established therapies may raise self-compassion. Some therapies that were designed to treat clinical problems (e.g., depression) may also raise self-compassion, and doing so may be a mechanism of change associated with treatment efficacy.

Common factors in various psychotherapies, such as empathy and self-monitoring may help raise self-compassion. The empathetic relationship allows the patient to discuss vulnerabilities and to be accepted by the therapist, whose modeling of compassion may enhance clients' self-compassion (Greenberg et al., 1998). Self-monitoring of thoughts, feelings, and behaviors may help clients to observe, accept, and affirm the self (Barrett-Lennard, 1997).

Specific psychotherapies or their methods may enhance self-compassion generally or facets of self-compassion. Here we review six such therapies. Four of these therapies, including compassionate mind training (CMT), imagery building, the gestalt two-chair technique, and mindfulness based stress reduction (MBSR), are the therapies that have early research suggesting that they may be associated with increases in self-compassion. The other two therapies, dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT), are included because they are therapies that include Eastern philosophies and emphases on mindfulness, an aspect of self-compassion. Because it is thought that the three components of self-compassion engender one another if not inherently involve one another, we include these two treatments.

After very briefly reviewing the conceptual link between each therapy and self-compassion, we review evidence for changes in self-compassion or facets of self-compassion.

Compassionate Mind Training

Compassionate mind training (CMT) was developed for patients with high self-criticism and shame to teach them how to produce self-soothing and self-reassuring thoughts (Gilbert & Irons, 2005; Gilbert & Procter, 2006). CMT asserts that there are two pathways in the brain, one that is self-judgmental and one that is self-kind, and that these two inhibit one another (Gilbert & Irons, 2004). CMT focuses on enhancing the self-kind pathway so that a cognitive and affective shift is achieved (Lee, 2005). Therapists also help patients examine the function of self-judgments (Gilbert & Irons, 2004). For example, if patients believe that submitting will appease their critical voice, patients are taught how submitting to a hostile dominant other only temporarily reduces stress hormones, how submitting may contribute to depression in the long-term, and how their critical voice is not appeased by submission. Patients therefore learn how to respond with assertiveness rather than appeasement. Patients are taught to think about self-compassion as a skill that can be learned and self-judgment as a habit that can be overcome. CMT aims to help patients develop a compassionate understanding of their distress and a concern for their well-being, and to mindfully tolerate feelings and thoughts.

Evidence of change. Research on CMT is nascent. Only two studies have been published on its effects (Gilbert & Procter, 2006; Mayhew & Gilbert, 2008). The first study employs a prepost design to look at changes in six patients, with a range of psychiatric diagnoses, currently in a day center that employs cognitive–behavioral group programs. These patients, attended 12 2-hr Group CMT sessions (Gilbert & Proctor, 2006). All six participants showed significant reductions in self-reported depression, anxiety, shame, submissive behavior, feelings of inferiority, and in the frequency, power, and intrusiveness of self-critical thoughts. All reported significant increases in ability to be self-soothing. Participants reported increased awareness of their hostility to self, valued focusing on generating feelings of warmth and not just on accuracy of thoughts, and reported improvements in tolerating their distress.

The second study was a series of three case studies of CMT with patients who had been diagnosed with schizophrenia, experienced hostile auditory hallucinations, had responded to treatment, and were not currently experiencing a relapse (Mayhew & Gilbert, 2008). These researchers believe that malevolent voices are similar to self-critical thoughts in patients with depression. Patients who received 12 1-hr sessions of CMT showed prepost decreases in self-reported depression, anxiety, psychoticism, paranoia, obsessive–compulsive symptoms, and interpersonal sensitivity. However, only one participant showed a significant increase in self-compassion. Clearly, controlled clinical trials, research by other investigative teams and studies with larger samples are needed to determine whether CMT increases self-compassion more than other interventions, and whether improved self-compassion accounts for symptom change.

The Compassionate Image

Buddhist schools use visualizations to help followers develop compassion and the ability to be caring and kind toward self and others (Lee, 2005). Western applications of this technique ask patients to visualize the "perfect nurturer" that can offer them unquestioning warmth, nonjudgment, and acceptance (Gilbert & Irons, 2004, Gilbert & Irons, 2005; Lee, 2005). Every time the patient engages in self-judgment they are to call upon their perfect nurturer (Gilbert & Procter, 2006). Although the image starts as something external, the goal is for it to become internalized.

Evidence of change. Gilbert and Irons (2004) investigated the impact of self-compassionate imagery within a CMT protocol with nine individuals receiving Group CMT for depression. Pre- to postcomparison indicated significant increases in self-compassion, $t(7) = 2.94$, $p = .02$, but no significant change in self-criticism. Because imagery work was supplemented by Group CMT, improved self-compassion cannot be attributed to imagery alone. In

sum, visualization may help raise self-compassion, but more empirical work is needed.

Gestalt Two-Chair

The Gestalt two-chair intervention, designed to help patients extend empathy to self and to challenge their self-judgmental, maladaptive beliefs, may raise self-compassion (Gilbert & Irons, 2005; Greenberg et al., 1998; Whelton & Greenberg, 2005). Patients are asked to think of themselves as having two "selves" that relate to one another: a judgmental self and a self that experiences the judgment. They are then asked to move between two chairs acting and speaking like the judgmental self in one chair and the "experiencing self" in the other (Neff et al., 2007). Therapists note both the content of the self-judgments and how the patient responds to their self-judgments (Brown, 1952; McKay & Fanning, 2000). Therapists train patients in compassionately defending themselves and in recognizing the cost of listening to or submitting to their self-judgmental side.

Evidence of change. Neff and her colleagues (2007) conducted a two-chair technique with 40 students who were asked to think about a situation in which they were self-critical. The experimenters guided the students in alternating between two chairs, being critical of themselves in one chair and responding in the other. Students continued until they either resolved the conflict or until it seemed apparent that resolution was unlikely, a process that in total took between 15 and 60 minutes. They measured constructs of interest one week before and three weeks after this technique. They were interested in the *change scores* as a result of having engaged in the exercise. They found significant correlations between changes in self-compassion and changes in self-reported social connectedness, $r = .35$, $p < .05$, self-criticism, $r = -.61$, $p < .01$, depression, $r = -.31$, $p < .05$, rumination, $r = -.40$, $p < .01$, thought suppression, $r = -.55$, $p < .01$, and anxiety, $r = -.61$, $p < .01$. All correlations, except with depression, remained significant after controlling for participants' reductions in anxiety. This study suggests that the gestalt two-chair technique may raise self-compassion and reduce anxiety, depression, rumination, and thought-suppression. However, further research is needed to determine the technique's specific impact, how it compares to other interventions, and whether it would be effective with clinical cases.

Mindfulness Based Stress Reduction and Meditation

One potential way to raise self-compassion is to raise mindfulness. Raising mindfulness, through the interconnections previously discussed, should raise overall self-compassion. Mindfulness based stress reduction (MBSR) is designed to enhance present-moment awareness through disengaging in rumination and intrusive self-judgment (Kabat-Zinn, 2003; Leary, 2004). In MBSR patients learn to tolerate, acknowledge, label, and embrace thoughts and feelings rather than reacting to or avoiding them (Shapiro et al., 2005).

Evidence of change. Three MBSR treatment studies (Moore, 2008; Shapiro et al., 2005; Shapiro et al., 2007) have found robust relationships among self-compassion, mindfulness, and meditation. The first two studies that examined the relationship between MBSR and self-compassion used a manualized treatment modeled after Kabat-Zinn's (1982) protocol that consisted of eight 2-hr weekly sessions (Shapiro et al., 2005; Shapiro et al., 2007). Participants in the first study were healthcare professionals ($n = 10$ in the MBSR group and $n = 20$ in the wait-list control) and in the second, students in a counseling program ($n = 22$ in the MBSR group and $n = 32$ in the nonrandomized cohort control). The professionals who received MBSR reported significantly reduced stress, ($p = .04$) and increased self-compassion ($p = .004$) in comparison to their colleagues in the wait-list control. Similarly, compared to controls, counseling students who received MBSR showed increases in mindfulness ($p < .01$), positive affect, and self-compassion, and decreases in rumination and anxiety (all ps $< .001$). Increases in mindfulness (as measured by a separate scale) predicted increases in self-compassion ($p < .01$).

However, both of these studies used the Neff (2003a) measure of self-compassion, which has items directly related to mindfulness, and neither study ascertained which subscales were impacted by MBSR. Therefore the question is unresolved whether MBSR raises the mindfulness subscale alone or impacts self-compassion more generally. It should be noted that both of these studies supplemented traditional MBSR with loving-kindness meditations, which may be particularly adept at raising self-compassion, so it is unclear to what extent increased self-compassion can be attributed to MBSR alone.

The third MBSR study examined the impact of 14 10-min sessions of mindfulness training on mindfulness and self-compassion in a sample of 10 clinical psychology students using a pre- to posttest design (Moore, 2008). Moore found that although there was a significant increase in self-reported mindfulness ($p = .04$), there was no overall increase in self-reported self-compassion. The only component of self-compassion that showed significant increases was self-kindness ($p = .02$). Overall, these studies suggest that mindfulness practices may raise self-compassion or particular components, but that brief training may not be sufficient to produce significant change. Future work should examine the specific impact of MBSR on self-compassion, when compared to other active treatments; the effective elements of MBSR, and its impact on of self-compassion.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is a comprehensive psychotherapy, originally developed for patients with borderline personality disorder (BPD) or self-harm behaviors. It blends cognitive behavior therapy with Eastern philosophy and mindfulness (Miller, Wyman, Huppert, Glassman, & Rathus, 2007; Stepp, Epler, Jahng, & Trull, 2008). In DBT, therapists move between accepting the thoughts, desires, and behaviors of the patient and encouraging change through confrontation and the use of newly learned skills (Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999). Therapists validate the experiences of patients and help them to examine their needs, learn how to adaptively meet them, and be more self-kind and mindful. DBT includes individual psychotherapy and group skills training. Patients are taught four sets of skills to modulate their emotions and behaviors: mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance (Nicastro, Jermann, Bondolfi, & McQuillan, 2010).

Evidence of change. No studies have examined whether DBT raises self-compassion, but four studies have examined which DBT skills patients find helpful and/or actually use (Lindenboim, Comtois,

& Linehan, 2007; Miller et al., 2000; Stepp et al., 2008) or whether DBT raises mindfulness (Nicastro et al., 2010).

Miller and his colleagues (2000) found that 27 nonsuicidal self-injuring adolescents treated with BPD for 12 weeks rated mindfulness skills as among the most helpful sills they learned in DBT. Two other studies examined patients' diary cards, on which patients circle which DBT skills they use each day. The first study was conducted with 49 suicidal women with BPD (Lindenboim et al., 2007) and the second with 27 outpatients with a range of diagnoses (Stepp et al., 2008). The results of both studies indicate that mindfulness skills were among the most frequently used and were increasingly used over the course of therapy. However, neither study measured whether DBT or skill practice increased mindfulness.

Therefore, Nicastro and her colleagues (2010) examined whether mindfulness actually increased among 82 patients with BPD who received four weeks of intensive DBT (1 hour of individual and 12 hours of group sessions weekly). Patients showed increased mindfulness, including increased ability to describe, accept, and observe experiences nonjudgmentally. Although these increases in mindfulness cannot be confidently attributed to DBT without a control group, this study provides initial evidence that DBT may raise mindfulness.

Overall, these studies indicate that DBT training in mindfulness skills may raise patients' mindfulness. However, given that mindfulness is one of the four skills taught by DBT, it is surprising that more empirical work has not yet been conducted or published on whether DBT actually raises this skill. These four studies make it very clear that more empirical work is needed to document whether DBT raises mindfulness or overall self-compassion. It is important to explore further whether DBT is more effective than alternative treatments for this purpose and whether changes in mindfulness lead to greater self-compassion.

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) aims to help patients live according to their values by expanding their behavioral flexibility and effectiveness (Hayes et al., 2004; Muto, Hayes, & Jeffcoat, in press). ACT's six core processes are cognitive diffusion, acceptance, present-moment focus, self as context, values, and committed action (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). The first three core processes are elements of mindfulness (Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Kocovski, Fleming, & Rector, 2009). The fourth core process, self as context, involves exploring how the self-judgmental side of self relates to the experiencing side (Hayes et al., 2006). ACT focuses on increasing patients' ability to recognize that self-judgments are not necessarily realities. This may promote self-compassion by softening judgments. ACT's fourth and fifth processes teach patients how to take action that is directed toward values (Hayes et al., 2004). ACT emphasizes that no one always acts consistently with their values. This may combat isolation by educating patients on how hard it is for everyone to engage in valued living. It may also foster self-compassion as patients envision the type of person they want to be rather than berate themselves for their failures.

Evidence of change. Although no published studies have examined whether ACT raises self-compassion three studies have examined whether ACT is associated with increases in mindfulness (Forman et al., 2007; Kocovski et al., 2009; Muto et al., in press)**.** Although three of the six core processes are designed to raise mindfulness, again, relatively little work has been done to empirically assess whether ACT is associated with increased mindfulness.

First, Forman and his colleagues (2007) randomly assigned 101 outpatients with severe to moderate anxiety or depression to receive either cognitive therapy (CT) or ACT from 23 novice therapists for 15–16 weeks on average. Patients in both treatments showed the same *degree and rate* of reduction of symptoms and increased self and clinician-rated functioning and quality of life. The researchers administered the Kentucky Inventory of Mindfulness Skills (KIMS), a self-report measure of mindfulness that measures four components of mindfulness including observe, describe, act with awareness and accept without judgment. They also administered the Acceptance and Action Questionnaire (AAQ) to measure experiential avoidance, or the ability to accept negative feelings and take action despite them, to see whether the mechanism of action varied between the two treatments.

CT was associated with increased ability to observe and describe actions and these increases partially mediated the improvements that clients showed from pretherapy to postintervention (Forman et al., 2007). ACT was associated with an increased ability to act with awareness (one of the four aspects of mindfulness measured by the KIMS), acceptance of negative feelings, and decreased experiential avoidance, which partially mediated clients' prepost improvements. The change scores in acting with awareness were correlated with decreased depression and anxiety and increased quality of life, $r = -.57, -.35, .64$, respectively, $p < .01$. This study supplies initial evidence that ACT may increase aspects of mindfulness and acceptance (and different aspects than what CT may raise) and that these increases may mediate treatment gains.

Second, Kocovski and her colleagues (2009) treated 42 patients with social anxiety disorder (SAD) using Mindfulness and Acceptance Based Group Therapy (MAGT). Patients received 12 2-hr group sessions and one follow-up session 3 months later. MAGT is based largely on ACT but is supplemented with additional mindfulness interventions adapted from Mindfulness-Based Cognitive Therapy and MBSR. These authors examined whether MAGT was associated with prepost reductions in SAD and prepost increases in mindfulness and acceptance. They found significant increases in mindfulness, as measured by KIMS and the Mindful Attention and Awareness Scale (MAAS), and in acceptance, as measured by the AAQ, that were maintained at follow-up ($p < .001$). Although this study provides initial evidence that ACT may be associated with increases in mindfulness, a component of self-compassion, MAGT has an increased focus on mindfulness. Therefore, it remains unclear whether ACT alone increases mindfulness. Also, in the absence of a control condition, changes in prepost scores cannot be attributed with confidence to the intervention or specific aspects of MAGT.

Third, Muto and his colleagues (in press) randomly assigned 70 Japanese international students either to a waitlist control or to read a Japanese translation of a self-help book based on ACT. Students took outcome measures, including measures of general health and the KIMS, at recruitment, after 8 weeks, and after 16 weeks. Participants in the active condition read the book over 8 weeks and took quizzes on their understanding of core concepts. At week 8 the waitlist group began to read the book. They found

prepost changes in self-reported accepting without judgment, a KIMS subscale.

They found that there was a significant prepost increase in accepting without judgment associated with reading the self-help book in both groups. Better comprehension of the mindfulness chapters was moderately correlated with changes in general mental health. This study provides initial evidence from a waitlist control design that ACT bibliotherapy may increase one component of mindfulness.

Overall, these studies provide initial evidence that ACT may raise patients' mindfulness, an aspect of self-compassion, and that increases in mindfulness may be mediators of other treatment gains. However, additional studies are needed to determine which versions or elements of ACT are most effective in modifying mindfulness and whether changes in mindfulness are associated with broader changes in self-compassion. It may be that increases in mindfulness are mediators of increases in common humanity and self-kindness, but future work is needed to explore these relationships.

Summary and Conclusion

Overall, there is a growing body of research that asserts that self-compassion is a construct that is distinct from other self-themes and is associated with psychological health. There is also a nascent literature that examines the potential ability of various interventions to raise self-compassion or its components, including mindfulness. As research on self-compassion and interventions for self-compassion are at early stages of development, more research is needed to develop the construct validity of self-compassion, its component elements, how these are associated with various aspects of distress and well-being, and how self-compassion and its various aspects can be fostered, cultivated, and raised in treatment. Future research will need to more carefully consider the various aspects of self-compassion and how they may differentially predict well-being or be cultivated. Future research should also employ other methodologies than correlational analysis (including experience sampling and experimental studies) to determine the directionality of the relationship between self-compassion and psychological health. Moreover, future research will need to sample from diverse populations to determine if the correlations between self-compassion and health and distress can be generalized to other populations. It is also important that future research explore ways to measure self-compassion other than self-report and to investigate the mechanisms of change in interventions designed to raise self-compassion.

References

Adams, C. E., & Leary, M. R. (2007). Promoting self-compassionate attitudes toward eating among restrictive and guilty eaters. *Journal of Social & Clinical Psychology, 26,* 1120–1144. doi:10.1521/jscp.2007.26.10.1120

Barnard, L. K., & Curry, J. F. (2011). The relationship of clergy burnout to self-compassion and other personality dimensions. *Pastoral Psychology.* doi:10.1007/s11089-011-0377-0

Barrett-Lennard, G. (1997). The recovery of empathy: Toward others and self. In A. Bohart & L. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 103–121). Washington, DC: American Psychological Association Press. doi:10.1037/10226-004

Baumeister, R. F., Smart, L., & Boden, J. M. (1996). Relation of threatened egotism to violence and aggression: The dark side of high self-esteem. *Psychological Review, 103,* 5–33. doi:10.1037/0033-295X.103.1.5

Blatt, S. (1995). The destructiveness of perfectionism: Implications for the treatment of depression. *American Psychologist, 50,* 1003–1020. doi:10.1037/0003-066X.50.12.1003

Blatt, S., & Zuroff, D. (1992). Interpersonal relatedness and self-definition: Two prototypes for depression. *Clinical Psychology Review, 12,* 527–562. doi:10.1016/0272-7358(92)90070-O

Brown, B. (1952). *Soul without shame: A guide to liberating yourself from the judge within*. Shambhala Publications.

Brown, B. (1998). *Soul without shame: A guide to liberating yourself from the judge within*. Shambhala Publications.

Costa, P. T., Jr., & McCrae, R. R. (1992). *NEO-PI-R professional manual.* Odessa, FL: Psychological Assessment Resources.

Deci, E., & Ryan, R. (1995). Human autonomy: The basis for true self-esteem. In M. H. Kernis (Ed.), *Efficacy, agency, and self-esteem* (pp. 31–49). New York, NY: Plenum Press.

Dunkley, D., Zuroff, D., & Blankstein, K. (2003). Self-critical perfectionism and daily affect: Dispositional and situational influences on stress and coping. *Journal of Personality and Social Psychology, 84,* 234–252. doi:10.1037/0022-3514.84.1.234

Ellis, A. (1973). *Humanistic psychotherapy: The rational-emotive approach.* New York, NY: Julian Press.

Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D., & Geller, P. A. (2007). A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *Behavior Modification, 31,* 772–799. doi:10.1177/0145445507302202

Germer, C. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions.* New York, NY: Guilford Press.

Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory, 12,* 507–516. doi:10.1080/09658210444000115

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy.* (pp. 263–325). New York, NY: Routledge.

Gilbert, P., & Procter, S. (2006). Compassionate Mind Training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy, 13,* 353–379. doi:10.1002/cpp.507

Greenberg, L., Watson, J., & Goldman, R. (1998). Process-experiential therapy of depression. In L. Greenberg, J. Watson & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 227–248). New York, NY: The Guilford Press.

Hayes, S. C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B. S., Fisher, G., . . . Niccolls, R. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35,* 821–835. doi:10.1016/S0005-7894(04)80022-4

Hayes, S. C., Luoma, J., Bond, F., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes, and outcomes. *Behavior Research and Therapy, 44,* 1–25. doi:10.1016/j.brat.2005.06.006

Iskender, M. (2009). The relationship between self-compassion, self-efficacy, and control belief about learning in Turkish university students. *Social Behavior and Personality, 37,* 711–720. doi:10.2224/sbp.2009.37.5.711

Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry, 4,* 33–42. doi: 10.1016/0163-8343(82)90026-3

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology Science and Practice, 10,* 144–156. doi:10.1093/clipsy.bpg016

Kernis, M. H. (2003). Toward a conceptualization of optimal self-esteem. *Psychological Inquiry, 14,* 1–26. doi:10.1207/S15327965PLI1401_01

Kocovski, N. L., Fleming, J. E., & Rector, N. A. (2009). Mindfulness and acceptance-based group therapy for social anxiety disorder: An open trial. *Cognitive and Behavioral Practice, 16,* 276–289. doi:10.1016/j.cbpra.2008.12.004

Leary, M. R. (2004). *The curse of the self: Self-awareness, egotism, and the quality of human life.* New York, NY: Oxford University Press.

Leary, M. R., Tate, E. B., Adams, C. E., Batts Allen, A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology, 92,* 887–904. doi:10.1037/0022-3514.92.5.887

Lee, D. (2005). The perfect nurturer: A model to develop a compassionate mind within the context of cognitive therapy. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 326–351). New York, NY: Rutledge.

Lindenboim, N., Comtois, K. A., & Linehan, M. M. (2007). Skills practice in dialectical behavior therapy for suicidal women meeting criteria for borderline personality disorder. *Cognitive and Behavioral Practice, 14,* 147–156. doi:10.1016/j.cbpra.2006.10.004

Linehan, M., Schmidt, H., III, Dimeff, L., Craft, J., Kanter, J., & Comtois, K. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *The American Journal on Addictions, 8,* 279–292. doi:10.1080/105504999305686

Maslow, A. H. (1968). *Toward a psychology of being.* New York, NY: Van Nostrand.

Mayhew, S., & Gilbert, P. (2008). Compassionate mind training with people who hear malevolent voices: A case series report. *Clinical Psychology & Psychotherapy, 15,* 113–138. doi:10.1002/cpp.566

McKay, M., & Fanning, P. (2000). *Self-esteem: A proven program of cognitive techniques for assessing, improving, and maintaining your self-esteem.* Oakland, CA: New Harbinger Publications.

Miller, A. L., Wyman, S. E., Huppert, J. D., Glassman, S. L., & Rathus, J. H. (2000). Analysis of behavioral skills utilized by suicidal adolescents receiving dialectical behavior therapy. *Cognitive and Behavioral Practice, 7,* 183–187. doi:10.1016/S1077-7229(00)80029-2

Mills, A., Gilbert, P., Bellew, R., McEwan, K., & Gale, C. (2007). Paranoid beliefs and self-criticism in students. *Clinical Psychology & Psychotherapy, 14,* 358–364. doi:10.1002/cpp.537

Moore, P. (2008). Introducing mindfulness to clinical psychologists in training: An experiential course of brief exercises. *Journal of Clinical Psychology in Medical Settings, 15,* 331–337. doi:10.1007/s10880-008-9134-7

Muto, T., Hayes, S. C., & Jeffcoat, T. (in press). The effectiveness and commitment therapy bibliotherapy for enhancing the psychological health of Japanese college students living abroad. *Behavior Therapy.*

Neely, M. E., Schallert, D. L., Mohammed, S. S., Roberts, R. M., & Chen, Y.-J. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students' well-being. *Motivation and Emotion, 33,* 88–97. doi:10.1007/s11031-008-9119-8

Neff, K. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity, 2,* 223–250. doi:10.1080/15298860309027

Neff, K. (2003b). Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself. *Self and Identity, 2,* 85–101. doi:10.1080/15298860309032

Neff, K., Hsieh, Y., & Dejitterat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity, 4,* 263–287. doi:10.1080/13576500444000317

Neff, K., Kirkpatrick, K., & Rude, S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality, 41,* 139–154. doi:10.1016/j.jrp.2006.03.004

Neff, K., Pisitsungkagarn, K., & Hsieh, Y. (2008). Self-compassion and self-construal in the United States, Thailand, and Taiwan. *Journal of Cross-Cultural Psychology, 39,* 267–285. doi:10.1177/0022022108314544

Neff, K., Rude, S., & Kirkpatrick, K. (2007). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of Research in Personality, 41,* 908–916. doi:10.1016/j.jrp.2006.08.002

Neff, K., & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. *Journal of Personality, 77,* 23–50. doi:10.1111/j.1467-6494.2008.00537.x

Nicastro, R., Jermann, F., Bondolfi, G., & McQuillan, A. (2010). Assessment of mindfulness with the French version of the Kentucky Inventory of Mindfulness Skills in community and borderline personality disorder samples. *Assessment, 17,* 197–205. doi:10.1177/1073191110363551

Nolen-Hoeksema, S. (2000). The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. *Journal of Abnormal Psychology, 109,* 504–511. doi:10.1037/0021-843X.109.3.504

Raes, F. (2010). Rumination and worry as mediators of the relationship between self-compassion and depression and anxiety. *Personality and Individual Differences, 48,* 757–761. doi:10.1016/j.paid.2010.01.023

Rogers, C. R. (1961). *On becoming a person.* Boston, MA: Houghton Mifflin.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-Based Stress Reduction for health care professionals: Results from a randomized trial. *International Journal of Stress Management, 12,* 164–176. doi:10.1037/1072-5245.12.2.164

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1,* 105–115. doi:10.1037/1931-3918.1.2.105

Stepp, S. D., Epler, A. J., Jahng, S., & Trull, T. (2008). The effect of dialectical behavior therapy skills use on borderline personality disorder features. *Journal of Personality Disorders, 22,* 549–563. doi:10.1521/pedi.2008.22.6.549

Tafarodi, R. W., & Milne, A. B. (2006). Decomposing global self-esteem. *Journal of Personality, 70,* 443–483. doi:10.1111/1467-6494.05017

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology, 58,* 345–372. doi:10.1146/annurev.psych.56.091103.070145

Thompson, B. L., & Waltz, J. (2008). Self-compassion and PTSD symptom severity. *Journal of Traumatic Stress, 21,* 556–558. doi:10.1002/jts.20374

Whelton, W., & Greenberg, L. (2005). Emotion in self-criticism. *Personality and individual differences, 38,* 1583–1595. doi:10.1016/j.paid.2004.09.024

Williams, J. G., Stark, S. K., & Foster, E. E. (2008). Start today or the very last day? The relationships among self-compassion, motivation, and procrastination. *American Journal of Psychological Research, 4,* 37–44.

Ying, Y. W. (2009). Contribution of self-compassion to competence and mental health in social work students. *Journal of Social Work Education, 45,* 309–323. doi:10.5175/JSWE.2009.200700072

Zuroff, D., Moskowitz, D., & Cote, S. (1999). Dependency, self-criticism, interpersonal behaviour and affect: Evolutionary perspectives. *British Journal of Clinical Psychology, 38,* 231–250. doi:10.1348/014466599162827

Received April 12, 2011
Revision received September 6, 2011
Accepted September 7, 2011 ■