Self-Compassion in Psychotherapy: Clinical Integration, Evidence Base, and Mechanisms of Change

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Introduction

Imagine that you are a psychotherapist and have a client who suffers from anxiety or depression. During therapy, your client becomes deeply compassionate toward herself. That means that when things go wrong in her life, your client can recognize and validate for herself how she feels rather than getting lost in rumination (mindfulness); she feels connected to other people in the midst of her troubles rather than feeling alone (common humanity); and her internal conversation is mostly reassuring and supportive rather than self-critical (self-kindness). With these mental habits, there is a good chance that her anxiety or depression would have already subsided and she does not need as much therapy anymore, although the challenges of life will inevitably remain.

As this book amply demonstrates, self-compassion is a key ingredient in mental health and psychological well-being. The beneficial impact of self-compassion is perhaps even more evident in psychotherapy where people bring their most challenging life experiences. The purpose of this chapter is to offer a panoramic view of how to integrate self-compassion into *any* form of treatment and also to outline the evidence base and putative mechanisms of change under-

lying self-compassion in psychotherapy. A few empirically supported models of therapy are explicitly compassion-based, such as compassion-focused therapy (CFT; Gilbert, 2009), emotion-focused therapy (EFT; Greenberg, 2006), and internal family systems (IFS; Schwartz, 1995). This chapter is primarily informed by CFT, the most distinctly compassion-based treatment model, and by Mindful Self-Compassion program (MSC; Germer & Neff, 2019; Neff & Germer, 2018), a structured, empirically supported training for the general public designed specifically to cultivate *self*-compassion.

The chapter begins by locating self-compassion in the context of psychotherapy, past and present. Next, we outline the evidence for self-compassion as a transdiagnostic and trans-theoretical mechanism of action in therapy. The majority of this chapter describes three levels by which self-compassion can be integrated into psychotherapy—*compassionate presence, compassionate relationship,* and *compassionate interventions*—along with supporting research. When all three levels are part of treatment, it can be considered fully self-compassion based. Finally, we explore emotion regulation as the basic mechanism by which self-compassion works in psychotherapy, along with underlying neurophysiological and psychological processes, especially the cultivation of secure attachment and the alleviation of shame.

Historical Context

Self-compassion has been part of psychotherapy for over a century under the umbrella of "self-acceptance." Psychotherapy giants such as William James, Sigmund Freud, and B. F. Skinner all considered acceptance of oneself and others to be psychologically beneficial (Williams & Lynn, 2010). Carl Rogers (1951) and other humanistic therapists elevated self-acceptance to the status of a core change process in psychotherapy. Interestingly, both Freud (1957) and Rogers (1951) considered self-acceptance to be a *precursor* to positive therapeutic change and acceptance of others, and this perspective became a focus of empirical investigation well into the 1980s. In the 1990s, clinical research shifted away from acceptance of the "self" to acceptance of "moment-to-moment experience" with the introduction of Buddhist-inspired mindfulness and acceptance-based treatments such as dialectical behavior therapy (DBT; Linehan, 1993), acceptance and commitment therapy (ACT; Hayes et al., 2011), and mindfulness-based cognitive therapy (MBCT; Segal & Teasdale, 2018). Recently, the pendulum has begun to swing back to include acceptance of both moment-to-moment *experience* (mindfulness) and the *experiencer* (self-compassion)—the "self."

Empathy and Compassion

For most of the history of psychotherapy, the term "compassion" has been relatively absent from the research literature. However, we can assume that compassion has not been absent from psychotherapy, but rather implied in the definition of empathy. Empathy refers to experiencing the world of another person as one's own. Carl Rogers (1951) wrote the following about empathy in client-centered therapy:

> It is the counselor's function to assume…the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so…(p. 29).

A modern definition of *compassion* is:

> … a multidimensional process comprised of four key components: (1) an *awareness* of suffering (cognitive/empathic awareness), (2) *sympathetic concern* related to being emotionally moved by suffering (affective component), (3) a *wish* to see the relief of that suffering (intention), and (4) a *responsiveness* or readiness to help relieve that suffering (motivational) (Jinpa (2010) in Jazaieri et al., 2013).

In this definition of compassion, *awareness* and *concern* refer to cognitive and affective empathy, and the *wish* and *readiness* to alleviate suffering are special attributes of compassion—the added component of goodwill in the face of suffering. Since the premise of psychotherapy is the alleviation of psychological distress, we can assume that the wish and readiness to alleviate suffering, or compassion, have always been implied in our clinical understanding empathy.

Empathy is a key ingredient in effective therapy relationships (Elliott et al., 2011; Norcross & Lambert, 2018). Our understanding of empathy has continued to evolve since Carl Rogers, especially with the advent of social neuroscience in the 1990s. Empathy now encompasses not only experiencing the world of another as one's own, but also having *perspective* on the emotional state of another person and the ability to *regulate* one's own empathic distress in order to maintain a compassionate state of mind (Eisenberg & Eggum, 2009). With the addition of perspective and emotion regulation to sustain a positive attitude, the modern definition of empathy moves closer to our understanding of compassion.

Discovering Self-Compassion

Most people are more compassionate toward others than themselves (Knox et al., 2016; Pommier et al., 2020). This disparity comes at a price, however, especially in the clinical arena. Twenty years ago, in 2000, Paul Gilbert had a revolutionary insight while treating depressed clients with cognitive-behavioral therapy (CBT). He realized that his clients could become adept at identifying cognitive distortions and replacing them with

more balanced thoughts, but their symptoms of depression did not diminish as long as they spoke to themselves in a harsh and demanding tone. What his clients needed, Gilbert concluded, was to "warm up the conversation" (personal communication). This understanding led to the development of CFT, a therapy model based on evolutionary psychology, attachment theory, and Tibetan Buddhist compassion practice, that is currently researched and practiced by clinicians throughout the world (Gilbert, 2010a, b).

Three years later, Kristin Neff (2003), a developmental psychologist, operationalized the construct of self-compassion and published the self-report scale, the Self-Compassion Scale (SCS), that is used in most research on self-compassion. Since then, the number of studies on self-compassion has grown exponentially. Most self-compassion research is still correlational, but studies with laboratory mood manipulations and outcome studies on self-compassion training are increasing as self-compassion training and compassion-based therapy becomes widely disseminated. Self-compassion may be considered a psychological *construct* (e.g., Neff's three component model), a *trait* or *state* (Neff, 2003; Neff et al., 2020, respectively), a *practice* (e.g., meditation), or a psychological *process* (mechanism of change). It is possible, for example, to measure self-compassion as an underlying process in therapy without the treatment containing any identifiable self-compassion practices (Galili-Weinstock et al., 2018; Kelly & Tasca, 2016). However, the construct of self-compassion, especially Neff's three component model, guides our understanding of self-compassion as a trait, state, practice, or process.

A New Paradigm

Within the CBT tradition, a "third wave" of therapies (after behavioral and cognitive approaches) began emerging in the 1990s that focus on "being with" challenging moment-to-moment experiences rather than directly changing them (Dimidjian et al., 2016; UliaSzek et al., 2020). This approach has since embraced compassion-oriented treatment and coalesced into a new paradigm—*mindfulness-, acceptance-, and compassion-based psychotherapy* (Germer & Siegel, 2012; Germer et al., 2013). Within this new paradigm, some therapists focus more on mindfulness, others on acceptance, and still others on compassion as the primary mechanism of change in treatment. For example, mindfulness-based clinicians (e.g., Segal et al., 2012; Shapiro & Carlson, 2009; Siegel, 2009) tend to emphasize the role of attention and awareness in how we create, experience, and alleviate emotional suffering. Acceptance-based clinicians (e.g., Hayes et al., 2011; Roemer et al., 2008) focus more on non-avoidance and acceptance of moment-to-moment experience, along with values-based living, and they are less likely to prescribe meditation than mindfulness-based clinicians. Compassion-based therapies, such as CFT, EFT, and IFS, focus primarily on emotion regulation through care and connection. However, elements of mindfulness, acceptance, and compassion can be found in all therapies contained within this paradigm.

Compassion can be directed toward oneself or others and also received from others. However, these directions are not entirely distinct. For example, research shows that cultivating self-compassion often increases other-compassion (Neff & Germer, 2013), and increasing other-compassion enhances self-compassion (Breines & Chen, 2013). Although a therapy model like CFT enhances the flow of compassion in all directions, the primary focus of compassion-based therapy is on helping the client to develop *self*-compassion. Nonetheless, compassion is embedded in all aspects of compassion-based therapy—self-compassion by the client, compassion for the client, and compassion by and for the therapist.

Transdiagnostic and Transtheoretical Change Process

Self-compassion has been proposed as a mechanism of change in mindfulness- and acceptance-based treatment (Baer, 2010). Increasing evidence shows that self-compassion improves mental health in diverse clinical populations, suggesting that it is a *transdiagnostic* mechanism of change. Empirical evidence also indicates that self-compassion increases in clients in different kinds of therapy, suggesting that self-compassion is also a *transtheoretical* change process.

Transdiagnostic Process

There is a growing body of research demonstrating the potential of compassion-based psychotherapy across a range of clinical disorders, including anxiety (Haj Sadeghi et al., 2018), depression (Kirby, 2017), trauma (Au et al., 2017), social anxiety disorder (Gharraee et al., 2018), eating disorders (Kelly et al., 2017), (Braehler et al., 2013), dementia (Craig et al., 2018), addictions (Kelly et al., 2010), and personality disorders (Feliu-Soler et al., 2017; Lucre & Corten, 2013). CFT was the main treatment model studied and the data are encouraging, although many studies were pilot or feasibility studies and more randomized controlled trials are needed (Craig et al., 2020).

A number of meta-analyses support self-compassion as a transdiagnostic mechanism of change. In a meta-analysis of compassion-based interventions for a variety of different diagnoses, treatment significantly relieved psychological distress and increased self-compassion, even when the studies used active control groups (Kirby et al., 2017b). A meta-analysis specifically for *self*-compassion-based interventions found strong effect sizes for eating behavior and rumination and moderate effect sizes for stress, anxiety, depression, and self-criticism (Ferrari et al., 2019). Interestingly, a meta-analysis of compassion-related therapies for chronic *physical* health conditions also found that the treat-

ments increased self-compassion and improved various outcomes (Kılıç et al., 2020).

Self-compassion training programs designed for the *general public* have also been effective in reducing various kinds of psychological distress (Finlay-Jones, 2017). MSC reduced anxiety and depression among adults in the community (Neff & Germer, 2013) as well as depressive symptoms among diabetes patients (Friis et al., 2016). Compassion cultivation training (CCT; Goldin & Jazaieri, 2017) decreased worry and emotional suppression (Jazaieri et al., 2014), cognitively based compassion training (CBCT; Ash et al., 2019), reduced cancer stress (Gonzalez-Hernandez et al., 2018), and online Mindfulness Based Compassionate Living (MBCL; Van den Brink & Koster, 2015) lowered self-criticism and raised self-compassion (Halamová et al., 2020). An online version of Compassionate Mind Training (CMT), a structured program based on CFT principles and practices, decreased self-criticism in a non-clinical sample (Halamová et al., 2020) and reduced analgesic use among people suffering from chronic pain (Dhokia et al., 2020).

In general, trait self-compassion (measured by the SCS) is associated with mental health in clinical and non-clinical populations. High-trait self-compassion is associated with decreased psychopathology in adults (MacBeth & Gumley, 2012) and adolescents (Marsh et al., 2018), and reduced suicidality (Kelliher Rabon et al., 2018; Xavier et al., 2016). Self-compassionate people tend to ruminate less (Fresnics et al., 2019); they recover from negative moods more easily (Diedrich et al., 2017) and are less vulnerable to shame (Ewert et al., 2018; Zhang et al., 2018). Self-compassion is associated with a more positive body image and fewer eating disorders (Braun et al., 2016; Webb et al., 2016). Higher levels of self-compassion are also associated with lessened symptomology among individuals with schizophrenia (Eicher et al., 2013) and obsessive-compulsive disorder (Wetterneck et al., 2013). Self-compassion levels tend to be lower among people with bipolar disorder (Døssing et al., 2015), depression (Krieger et al., 2013), generalized anxiety disorder (Hoge et al., 2013), social

anxiety disorder (Werner et al., 2012), substance use disorder (Phelps et al., 2018), and persecutory delusions (Collett et al., 2016). In a systematic review of studies on self-compassion and trauma, Winders et al. (2020) found that self-compassion was consistently associated with reduced PTSD symptomatology. In sum, based on outcome research with clinical and non-clinical populations, and on correlational research on self-compassion and mental health, self-compassion appears to be an underlying change process that alleviates distress and enhances well-being.

Transtheoretical Process

Although there are currently over a thousand different kinds of psychotherapies, they may be broadly categorized into four paradigms: psychodynamic, cognitive-behavioral, humanistic, and third-wave therapies. These traditions differ theoretically, yet preliminary research evidence suggests that they all increase self-compassion, which implies that self-compassion is a *transtheoretical* mechanism of action.

Schanche et al. (2011) found that both *psychodynamic* and *cognitive* therapy for Cluster C personality disorders (avoidant, dependent, obsessive-compulsive) increased self-compassion, and self-compassion predicted decreases in psychiatric symptoms, interpersonal problems, and personality pathology. Galili-Weinstock et al. (2018) also treated clients with psychodynamic psychotherapy and found that self-compassion levels predicted session-by-session improvement as well as overall therapy outcome.

EFT is a type of *humanistic* psychotherapy and a program adapted for the general public (with elements from CFT and MSC) increased self-compassion and reduced self-criticism (Halamová & Kanovský, 2019). Neff et al. (2007) conducted a study with the two-chair technique from EFT and also found that it increased self-compassion and decreased self-criticism along with fewer experiences of depression, rumination, thought suppression, and anxiety.

Cognitive-behavioral therapy also enhances self-compassion. For example, Hoffart et al. (2015) looked at within-person change in CBT for post-traumatic stress disorder (PTSD) and found that changes in self-compassion predicted PTSD symptoms, while the opposite was not true. Wadsworth et al. (2018) treated patients with CBT and DBT and reported that improvements in anxiety and depression were related to changes in self-compassion.

Unsurprisingly, within the paradigm of *mindfulness-*, *acceptance-*, and *compassion-based* therapies, self-compassion is also related to positive outcomes. Participation in Mindfulness-based Stress Reduction (MBSR; Kabat-Zinn, 2013) and MBCT (Birnie et al., 2010; Goodman et al., 2014; Raab et al., 2015; Taylor et al., 2014) increase self-compassion even though self-compassion is usually taught implicitly in those programs. In mediation analysis—a statistical method used to determine underlying causal mechanisms between two variables (MacKinnon & Lueken, 2008)—self-compassion mediated many of the positive effects in MBSR (Keng et al., 2012; Shapiro et al., 2005) and MBCT (Greenberg et al., 2018; Kuyken et al., 2010). Van Dam et al. (2011) found that self-compassion predicts mental health even more strongly than mindfulness in a large community sample, accounting for ten times more unique variance in symptom severity (anxiety, depression) and quality of life, although mindfulness remains difficult to measure by self-report scales (Park et al., 2013). Hildebrandt et al. (2017) found that mindfulness training and affect training with an explicit emphasis on self-compassion led to a greater increase in self-compassion than mindfulness training alone.

ACT is an acceptance-based therapy model that teaches clients to be kind to themselves in various ways without necessarily mentioning self-compassion (Neff & Tirch, 2013). An ACT training that specifically targeted self-compassion increased self-compassion while reducing psychological distress and anxiety, and a key process in ACT, cognitive flexibility, mediated changes in self-compassion (Yadavaia et al., 2014).

Since self-compassion seems to be implicitly influencing outcomes in therapy, it makes sense to target self-compassion directly in treatment. In a meta-analysis of all three "third wave" therapies—mindfulness-, acceptance- and compassion-based therapy—that supposedly targeted self-compassion, Wilson et al. (2019) found that these therapies all enhanced self-compassion and reduced anxiety and depression, but change scores were not significantly different from those of active control groups. The authors concluded that targeting self-compassion may not make a treatment more powerful than an active control group. Challenging this conclusion, Kirby and Gilbert (2019) noted that the studies included in the Wilson et al. meta-analysis were actually not all compassion-based treatments. For example, Wilson's meta-analysis included manualized MBCT training that contains no explicit self-compassion training. In their own meta-analysis (Kirby et al., 2017a, b), compassion-based interventions reduced psychological distress and increased self-compassion even when compared to active control groups.

Overall, research showing that self-compassion is linked to positive treatment outcomes in different kinds of therapies indicates that self-compassion is a transtheoretical mechanism of action in psychotherapy. Interestingly, ordinary, non-clinical activities also increase self-compassion, such as practicing yoga (Crews et al., 2016), owning a dog (Bergen-Cico et al., 2018), and spending time in nature (Kotera & Fido, 2020). It appears that anything we do for ourselves that promotes a sense of well-being is likely to increase our self-compassion.

Three Levels of Integration into Psychotherapy

Since self-compassion is strongly related to mental health and appears to increase during successful psychotherapy, clinicians are beginning to ask, "Can I help my clients become more self-compassionate while continuing to practice psychotherapy in my own way?" This is possible by considering three levels of integration and their corresponding mechanisms of action. The levels are as follows: (1) *compassionate presence*—how therapists relate to their experience of themselves and the client, mostly non-verbally, (2) *compassionate alliance*—how therapists engage with their clients, verbally and non-verbally, and (3) *compassionate interventions*—how clients relate to themselves, especially during home practice. In the research literature, these categories correspond to therapeutic presence, therapeutic alliance, and therapeutic interventions, respectively. The qualifier, "therapeutic," has been substituted by "compassionate" in this discussion to make the implicit quality of compassion more explicit at each level.

Level 1: Compassionate Presence

Presence is about being with our moment-to-moment experience in a clear, open, and direct way, often without thoughts or words (Brach, 2012; Morgan et al., 2013). The term "presence" is closely related to "mindfulness" (Bourgault & Dionne, 2019; Epstein, 1999). Mindfulness refers to spacious, non-judgmental awareness of what is occurring in the present moment (Germer, 2013; Kabat-Zinn, 2003). Current evidence shows a positive relationship between a therapist's mindfulness (usually measured with trait mindfulness scales) and the therapy alliance (Leonard et al., 2018; Razzaque et al., 2015; Ryan et al., 2012), but the relationship between therapist mindfulness and treatment outcome is less reliable (Escuriex & Labbé, 2011; Grepmair et al., 2007; Perich et al., 2013; Stanley et al., 2006).

Mindfulness and self-compassion may be considered two wings of a bird—we need both to stay present. Mindfulness appears to regulate emotions primarily through attention regulation (Bishop et al., 2004; Malinowski, 2013) whereas self-compassion regulates emotions through care and connection (Finlay-Jones, 2017; Gilbert, 2009). Self-compassion is the *attitude* of mindfulness in the midst of suffering. Mindfulness is likely to diminish when we suffer, for example, when we experience fear and our perceptual field contracts (Bezdek et al., 2015; Zadra & Clore,

2011). Self-compassion—a warm and kind attitude toward the suffering "self"—can support mindfulness and the practice of mindfulness meditation (Evans et al., 2018; Rowe et al., 2016). Clinicians who wish to enhance their presence in psychotherapy are therefore encouraged to have a personal practice of both mindfulness and self-compassion. Personal practice has been emphasized when teaching mindfulness (Shohin & Van Gordon, 2015) and self-compassion (Germer & Neff, 2019) and also when practicing psychotherapy (Bennett-Levy & Finlay-Jones, 2018; Gale et al., 2017; Kolts et al., 2018).

Research has shown that MBSR, the gold standard of mindfulness training, raises levels of mindfulness which can lead to functional and structural changes in the brain (Gotink et al., 2016; Hölzel et al., 2011a, b; Young et al., 2018). Self-compassion training, such as MSC, also raises mindfulness (Neff & Germer, 2013) and mindfulness training increases self-compassion (Golden et al., 2020; Keng et al., 2012; Kuyken et al., 2010). Self-compassion can also be learned by participating in compassion-based training. Yela et al. (2020) found, for example, that MSC increased self-compassion in clinical psychology trainees (but only when the trainees were committed to the training). Furthermore, research shows that individual meditation practices can raise self-compassion, such as loving-kindness meditation (Engel et al., 2019; Weibel et al., 2017) or visualizing a compassionate image (Allen et al., 2015; Naismith et al., 2018).

Mindfulness and self-compassion meditation are usually practiced in isolation, but presence in psychotherapy is distinctly interpersonal. According to Geller (2017), *therapeutic presence* means that the therapist is:

> …first (a) open and *receptive* to clients' experience, attuning to their verbal and nonverbal expressions. You then (b) *attune inwardly* to your resonance with clients' in-the-moment experience, which serves as a guide to (c) *extend and promote contact* (p. 19).

Openness to the experience of the client comes before attuning inwardly because our primary obligation is to the well-being of the client. However, to be open and receptive to our clients,

we need to be open and receptive to our own experience, especially the *impact* our clients are having on us, mentally, physically, and emotionally. "Am I feeling afraid?" "Inspired?" "Annoyed?" If we are capable of holding the "client within" in compassionate awareness, we are more likely to relate compassionately to the client sitting in front of us. Research has shown that self-compassion usually, but not always, enhances compassion for others (Bayır-Toper et al., 2020; Neff & Germer, 2013; Neff et al., 2020).

Bourgault and Dionne (2019) found that self-compassion is clearly linked to therapeutic presence. The authors speculate that self-compassion works by enhancing presence in three ways: with *oneself* by reducing self-criticism and fostering self-kindness (Neff & Vonk, 2009), with the *client* by enhancing consideration of others (Neff & Pommier, 2013), and in the therapy *relationship* by increasing awareness of common humanity and lowering reactivity to relational difficulties (Leary et al., 2007).

There are many legitimate reasons why a clinician might *not* be present during a therapy session. For example, listening to a client's traumatic experience might trigger a similar experience in the therapist and hijack the therapist's attention. Or it might be too distressing to hear what a client is saying so the therapist stops listening. Such lapses are not a problem as long as therapists can find their way back to compassionate presence. Research suggests that loving-kindness and compassion meditation can help to enhance empathy and restore therapeutic presence (Bibeau et al., 2016; Mascaro et al., 2013).

Working with Empathic Distress Psychotherapy can be a challenging profession because clinicians listen to painful experiences of others all day long. Since human beings are hardwired to feel the emotions of others as their own (see below), therapists inevitably experience *empathic distress*. How do therapists cope with empathic distress and still manage to maintain compassionate presence?

Compassion seems to mitigate the negative impact of empathic distress. Tania Singer and

colleagues (Klimecki et al., 2014; Singer & Klimecki, 2014) identified non-overlapping neural networks for empathic distress and for compassion. Empathic distress activated areas associated with empathy and negative affect (anterior insula and the anterior middle cingulate cortex, respectively) and compassion-activated brain areas associated with positive affect and affiliation (medial orbitofrontal cortex and the ventral striatum, respectively). In other words, the pain of others is less stressful when it is wrapped in compassion.

Self-compassion is a way of bringing compassion back into the therapy room. Research shows that self-compassion training protects healthcare professionals against caregiver fatigue (Neff et al., 2020) and that self-compassion buffers caregiver fatigue and burnout among student counselors (Beaumont et al., 2016). One explanation is that self-compassion activates a physiological state of safety and deactivates the threat state associated with empathic distress (Svendsen et al., 2020). Increasing self-compassion also enhances compassion for others (Neff et al., 2020). A practical method for activating self-compassion in therapy is the Giving and Receiving Compassion meditation from the MSC training (Germer & Neff, 2019). When a therapist notices she is anxious or distracted, she can bring her attention to the sensation of breathing, allowing each inhalation to be for herself and each exhalation for her client. Anecdotal evidence suggests that paying attention in this way during therapy enhances compassionate presence.

Mechanisms of Compassionate Presence What underlying mechanisms could help to explain how compassionate presence alone, without even talking, might have a positive impact on a client? To explore this question, we turn to the neurobiology of empathy, mirror neurons, and interpersonal synchrony.

Human beings are hardwired for empathy—to feel in our own bodies what others are feeling in theirs (Bernhardt & Singer, 2012; Decety, 2011; Nummenmaa et al., 2008; Singer & Lamm,

2009). We have specialized neurons dedicated to this process—mirror neurons (Kilner & Lemon, 2013; Rizzolatti et al., 1996). Mirror neurons are activated when we perform an action and when we observe another person performing the same action, thereby allowing us to directly experience in our own bodies what others are experiencing. Similar circuits in the brain are also stimulated when people observe an emotion in others or experience the same emotion themselves (Decety & Lamm, 2006; Keysers et al., 2010). For example, witnessing another person in pain activates similar brain structures in the observer (Marsh, 2018; Saarela et al., 2007). This process has been variously called "brain-to-brain coupling" (Hasson et al., 2012), "neural resonance" (Krautheim et al., 2019), and "interpersonal synchrony" (Cacioppo et al., 2014).

Interpersonal synchrony is a robust, multidisciplinary field of research which explores how two or more people synchronize their neural, perceptual, affective, physiological, verbal, and behavioral responses (Koole & Tschacher, 2016; Wheatley et al., 2012). There are many methods of measuring interpersonal synchrony, including brain imaging (Lecchi et al., 2019) heart rate (Feldman et al., 2011), breathing (McFarland, 2001), pupil size (Kret & De Dreu, 2017), hormone levels (Edelstein et al., 2017), as well as vocal pitch (Imel et al., 2014), skin conductance (Palmieri et al., 2018), and body movements (Gupta et al., 2019; Ramseyer & Tschacher, 2011). Sophisticated technologies are used to measure brain synchrony, for example, dual EEG (Lecchi et al., 2019) and functional near-infrared spectroscopy (Zhang et al., 2020).

Koole and Tschacher (2016) argue that interpersonal synchrony is important for emotion regulation. In research with children, interpersonal synchrony has been shown to enhance a child's ability to downregulate emotional distress (Feldman, 2015). Parent–child synchrony generates a sense of familiarity in the child, which enhances the child's ability to internalize the parent and use the parent's image to manage distress even when the parent is absent (Symons & Johnson, 1997). Interpersonal synchrony also increases compassion, presumably due to

enhanced familiarity (Valdesolo & DeSteno, 2011).

In psychotherapy, interpersonal synchrony is likely to function in a similar manner: synchrony helps a client and therapist to feel emotionally connected, it facilitates the therapist's compassion, encourages the client to internalize the therapist, and promotes emotion regulation in the client. For example, if a therapist maintains compassionate presence while a client describes a traumatic experience, the therapist's compassion will be felt by the client through emotional attunement, compassion will co-mingle with the traumatic memory, and the memory will be recalled slightly differently going forward. Over time, exposure to a therapist with compassionate presence, and with whom the client identifies, and is likely to change how a client thinks and feels about herself. Therefore, if therapists want their clients to become more self-compassionate, the first step is for the therapist to cultivate compassionate presence.

Level 2: Compassionate Alliance

The next level of integration of self-compassion in psychotherapy is the *compassionate alliance*, variously called the therapeutic alliance, therapeutic relationship, working relationship, or therapeutic bond. Whereas compassionate presence is mostly about how therapists relate non-verbally to their experience of the client and themselves in the therapy relationship, the compassionate alliance involves another layer—verbal interaction.

Sigmund Freud (1927, in Horvath & Luborsky, 1993) was the first to recognize that a positive relationship is necessary to do the difficult work of therapy. Almost 50 years later, Bordin (1975, 1994) proposed the *therapeutic alliance* as a common factor in effective therapy. The alliance has 3 factors: agreement on the *goals* of therapy (e.g., alleviation of anxiety or shame), consensus on the *tasks* that they will engage in to reach those goals (e.g., dialogue, home practice), and a strong, positive *bond* between the client and therapist (e.g., rapport and mutual regard). In this widely accepted view of the alliance, the therapy

relationship refers specifically to the bond between client and therapist and is not identical to the alliance. However, it is difficult to accomplish any tasks or goals, especially challenging ones, without a strong bond between the client and therapist. Research shows that the therapeutic alliance is a robust predicter of therapy outcome across many different kinds of therapy (Horvath et al., 2011).

Overall, research on psychotherapy outcome indicates that 75–80% of people who participate in psychotherapy receive some benefit (Lambert & Ogles, 2004). Averaging across thousands of outcome studies, Norcross and Lambert (2019) determined that approximately 30% of therapy outcomes are attributable to "common factors," most notably the therapy relationship and client and therapist factors. Treatment techniques only account for 15% of improvement and the placebo effect is another 15% (the largest percentage of therapy outcome, 40%, is due to factors outside therapy such as social support or getting a new job). Among the factors related to therapy itself, 30% of therapy outcome is attributable to the patient, 15% to the therapy relationship, 10% to the therapist, and the treatment method accounts for about 10% of outcome (Norcross & Lambert, 2019). However, the therapeutic alliance and treatment methods cannot be clearly delineated. For example, Barber et al. (2006) found that when there was a strong therapeutic alliance, adherence to a treatment manual did not affect outcome whereas a weak alliance required a moderate level of adherence for the best outcome. In other words, "treatment methods are relational acts" (Safran & Muran, 2000).

Meta-analyses of psychotherapy outcome highlight the importance of compassion in the therapy alliance. Bohart et al. (2002) determined in their meta-analysis that empathy accounts for more outcome variance than treatment interventions. Other researchers found that empathy and positive regard (e.g., affirmation, respect, warmth, support, validation, prizing) are important aspects of the therapy relationship (Elliott et al., 2019; Farber et al., 2019) and that therapists who score higher on interpersonal skills like empathy and warmth have better treatment

outcomes (Anderson et al., 2009). Lambert and Ogles (2004) concluded in their meta-analysis that successful therapists tended to be warmer, more empathic, understanding, and supportive of their clients, and are less likely to blame, ignore, neglect, or reject the clients.

Unfortunately, although research indicates that therapists can learn empathy skills in the classroom, those skills do not necessarily generalize to the therapy office (Lambert & Ogles, 1997). Could compassion training enhance warmth and empathy in psychotherapy? Bibeau et al. (2016) reviewed the literature on meditation as a means of cultivating empathy among psychotherapists. Three decades of research on mindfulness meditation have been encouraging, but not conclusive, about whether mindfulness meditation increases empathy (Boellinghaus et al., 2013; Raab, 2014; Shapiro et al., 1998) or treatment effectiveness (Grepmair et al., 2007; Ivanovic et al., 2015; Ryan et al., 2012). In mindfulness meditation, the attitude of warmth is mostly implicit, however. Therefore, the question arises whether *explicitly* training a warm attitude through loving-kindness or compassion meditation might have a more reliable impact on empathy in therapy and treatment outcome. Boellinghaus et al. (2014) explored this question and found that mindfulness meditation tended to increase self-compassion but not necessarily compassion for others, whereas loving-kindness meditation was more likely to achieve both these outcomes. In another literature review, Bibeau et al. (2016) determined that loving-kindness and compassion meditation have a positive impact on numerous variables related to empathy, such as altruism, positive regard, prosocial behavior, affective empathy, and empathic accuracy. Later qualitative research showed that compassion meditation impacted both therapist empathy and the therapeutic relationship (Bibeau et al., 2020). At the present time, however, we still do not have enough empirical evidence to determine whether compassion training (for oneself or others) increases empathy or compassion in psychotherapy or improves treatment outcomes.

The Compassionate Therapeutic Relationship In the following discussion, we focus specifically on the therapeutic relationship, or bond, in the therapeutic alliance. There are three factors (three Rs) that constitute a compassionate therapeutic relationship—radical acceptance, resonance, and resource-building. *Radical acceptance* is the overall attitude of the treatment process, *resonance* is the primary mode of engagement, and *resource-building* is the desired outcome of the therapy relationship. The three Rs are based on the "inquiry" method used in mindfulness training (Brandsma, 2017; Wolf & Serpa, 2015) which was specifically adapted for self-compassion training in the MSC program (Germer & Neff, 2019).

R1: Radical Acceptance. Radical acceptance is the *attitude* or *intention* of a compassionate therapeutic relationship. Marsha Linehan (1993) first coined the term "radical acceptance" as the attitude that therapists need to adopt toward their clients with borderline personality disorder (BPD) in order to keep them engaged and working in therapy. Radical acceptance is also the attitude that BPD clients are encouraged to adopt toward their own emotional challenges to reduce their suffering. "Radical acceptance is the fully open experience of what is, entering into reality just as it is, at this moment. …acceptance without the haze of what one wants and does not want it to be" (Robins et al., 2004, pp. 39–40). Radical acceptance does not mean accepting harmful behavior or being complacent in the face of injustice; rather, it refers to abandoning the fight against our inner experience as it arises in the present moment.

Radical acceptance is a tall order. On a continuum on acceptance—curiosity, tolerance, allowing, and friendship (Germer, 2009, pp. 27–28)—radical acceptance refers to friendship with difficult emotions. Radical acceptance goes beyond just tolerating difficult emotions. For example, consider how much better it feels

when your anger is embraced rather than just endured, when your vulnerability is welcomed rather than merely tolerated, and when your trauma is honored rather than simply acknowledged. Radical acceptance by clients means doing that for themselves. For therapists, radical acceptance is an invitation to hold the client and the client's pain in a compassionate embrace, especially when it hurts, without rushing to fix it.

There is a dialectic between radical acceptance and change (Linehan, 1993). The goal of compassion-based therapy is to alleviate suffering, but the main question is "how" therapists alleviate suffering—do we resist and avoid what is happening in the present moment, which usually makes suffering persist or amplify, or do we accept what is happening as a foundation for change? Radical acceptance takes clients just as they are, without judgment or an obligation to change. The central paradox of self-compassion is: "When we suffer, we practice self-compassion not to feel better but *because* we feel bad" (Germer & Neff, 2019, p. 109). The challenge is to temporarily suspend the change agenda and allow kindness to flow naturally in response to suffering. This is a radical step for most therapists, and a subtle distinction that can make all the difference in therapy.

R2: Resonance. Resonance is the primary *mode of engagement* in a compassionate therapeutic relationship. It refers to affective attunement between the therapist and client— a sense of "feeling felt" (Siegel, 2010, p. 136). Daniel Stern (2018) defined affective attunement as "the performance of behaviors that express the quality of feeling of a shared affect state without imitating the exact behavioral expression of the inner state" (p. 142). Attunement between a parent and child is necessary precondition for healthy emotional attachment (Schore, 1994). When attunement was lacking in childhood, it can be learned in psychotherapy. The process of attunement in psychoanalysis is known as *intersubjectivity*. Buirski et al. (2020) wrote about intersubjectivity: "We now appreciate that in addition to attuning to affect and putting words to affective

experience, the analyst's care and love for the other makes a significant contribution to the transformative process" (p. 6). In compassion-based psychotherapy, resonance is enabled by the therapist's own compassionate presence, but it has the added element of being actively engaged, usually verbally, with a client.

Interpersonal synchrony is an interesting way of measuring resonance and exploring how it works in the therapeutic relationship (Altmann et al., 2020; Koole & Tschacher, 2016). For example, synchrony in vocal pitch between clients and therapists was found to be associated with therapist empathy (Imel et al., 2014) and synchrony of body movements predicted the quality of the alliance as rated by the patient at the end of therapy (Ramseyer & Tschacher, 2011). Recently, Lecchi et al. (2019) found a significant correlation between the perceived strength of the alliance and neural synchrony as measured by dual EEG in therapist–client dyads, and Zhang et al. (2018) discovered that the therapeutic alliance was particularly strong when the right temporo-parietal junction, a part of the brain associated with mentalizing and understanding, was synchronized between counselors and clients.

There appears to be a strong relationship between interpersonal synchrony and treatment *outcome* (Altmann et al., 2020; Galbusera et al., 2018; Ramseyer & Tschacher, 2011, 2014), including that low therapist–client synchrony is associated with premature termination of treatment (Schoenherr et al., 2019). Clients tend to feel seen, heard, and understood by their therapists when they are synchronized. However, Paulick et al. (2018) found that patients with the best therapy outcomes experienced only a *medium* level of interpersonal synchrony during therapy. This may be because a therapist sometimes needs to regulate a client's emotional arousal by embodying an emotional state *opposite* that of the client, such as calmness in the midst of fear. There also seems to be a trade-off between the enjoyment of interpersonal synchrony and the ability to self-regulate—the more we rely on others to regulate our emotions, the

less we may regulate our own emotions (Galbusera et al., 2019).

The relationship between interpersonal synchrony and the therapeutic *alliance* is also strong, but it is less reliable than treatment outcome (Koole & Tschacher, 2016). For example, Reich and colleagues (Reich et al., 2014) found that synchrony of vocal pitch of the patient and therapist negatively correlated with ratings of the therapy relationship. The authors surmised that matching of pitch, especially if a client is depressed, could amplify the distress of the client or that it could be interpreted by the client that the therapist lacked confidence in how to move the session forward.

Currently, there does not appear to be any research on self-compassion and interpersonal synchrony. However, one study found that a sense of perceived emotional synchrony during collective dancing explained increases in kindness and a sense of common humanity on a self-report scale of compassion for others (Pizarro et al., 2020).

On a practical level, how might a therapist maintain resonance while being actively engaged with a client? A helpful practice taught in MSC teacher training that is applicable to psychotherapy is to "follow the pings" (Germer & Neff, 2019). A ping is a moment of salience that a therapist experiences in his or her body, or "what stands out" while the client is talking, usually an emotion such as fear, sadness, relief, or awe. When it is the therapist's turn to speak, the therapist can share her or his embodied experience in a validating, clinically relevant manner. For example, a therapist can say to a client, "When you spoke about how angry you were toward your son, I felt sad because I know how important it is for you to have a close relationship with your son." Carl Rogers (1951) noted that empathy in psychotherapy was not simply sharing the emotions of a client, but also "sensing meanings of which [the client] is scarcely aware" (p. 142). This is a practice of listening and speaking from embodied experience rather than getting caught up in our thoughts and having intellectual conversations in therapy.

R3: Resource-Building. The third "R" of the therapeutic bond is resource-building—the desired *outcome* of psychotherapy. In compassion-based psychotherapy, the desired outcome is enhanced emotion regulation by cultivating the resource of self-compassion. In this section, we go beyond resonance and engage our clients in explicit conversations about their experience in- and outside of therapy to help them respond to their difficulties a more compassionate manner.

Resource-building continues to rely on the inquiry method, especially listening and speaking from embodied experience. Inquiry is a self-to-other dialogue that mirrors the self-to-self relationship that mindfulness and compassion teachers wish to cultivate in their students. In MSC training, inquiry usually follows an experiential practice (e.g., meditation, class exercise), but in psychotherapy we do not necessarily have a practice to anchor the conversation so we focus on emotional challenges that the client may experience during or outside therapy. The therapist then asks the client to share precisely what was experienced and how the client responded. For example, in the clinical vignette given earlier, after the therapist shared the "ping" of feeling sad while the client was speaking, and if the client acknowledged he was actually quite sad about fighting with his son, the therapist follow up by asking, "And how do you care for yourself when you are sad?" or "Right now, what do you think you need when you feel sad like this?" or "If you had a friend in the same situation as you, what might you say to your friend, heart-to-heart?" All these questions direct the client to explore how he could respond compassionately to his emotional pain, thereby building the resource of self-compassion. The conversation also opens the door to practicing at home what was discovered in session.

In compassion-based psychotherapy, the "pings" are not always moments of pain and self-compassion is not the only resource that is cultivated. In order for clients to do the hard work of engaging with suffering, their strengths also need

to be validated and reinforced, such as courage, perseverance, insight, or sense of humor. Positive regard in good times and bad is a hallmark of effective psychotherapy. In a meta-analysis of positive regard in therapy, Farber et al. (2019) found that positive regard significantly predicted treatment success. The authors suggested that positive regard strengthens a client's sense of agency and ability to succeed in therapy. They advised therapists to "allow yourself to express positive feelings to clients" but also to "monitor your positive regard and adjust it as a function of particular patients and specific situations." (p. 314). Positive regard needs to be tempered with clinical wisdom, or, as Marsha Linehan (2009) quipped, "What good is compassion if it doesn't actually help!"

In sum, the three Rs of radical acceptance, resonance, and resource-building can serve as a guide for creating a compassionate therapeutic relationship. Next, we turn our attention to the third level of integrating self-compassion into psychotherapy—compassionate interventions. Skillful application of compassionate interventions relies on the previous two levels—compassionate presence and the compassionate alliance.

Level 3: Compassionate Interventions

An intervention in psychotherapy is broadly understood as an action taken to bring about positive change in a client or patient. In the psychodynamic tradition, interventions are typically embedded in the therapeutic relationship (e.g., attunement or intersubjectivity) while the client is invited to explore hidden feelings or reflect on the experience of therapy itself. In CBT, interventions usually refer to tasks that are designed to achieve specific goals, such in vivo exposure or challenging irrational thinking to alleviate social anxiety. Interestingly, naturalistic research has shown that clinicians conducting brief psychodynamic therapy frequently included CBT interventions in their psychodynamic treatment, a phenomenon known as the "smuggling hypothesis" (Ablon & Jones, 1998; Ablon et al., 2006). CBT interventions in psychodynamic psycho-

therapy have been shown to enhance both the therapeutic alliance and treatment outcomes (Samstag & Norlander, 2019).

To explore the impact of therapeutic interventions on self-compassion levels and treatment outcome, Galili-Weinstock et al. (2020) compared the use of directive interventions (e.g., teaching skills, encouraging behaviors, reviewing homework) to common factors interventions (e.g., validation and empathic listening) in the context of psychodynamic psychotherapy. Positive change in therapy was predicted by directive interventions. Interestingly, clients with low self-compassion at the outset of therapy showed greater increases in self-compassion after treatment when their therapists used *less* validation and empathic listening. In light of earlier research that the alliance is less related to treatment outcome in short-term therapy (Blatt, 1995), the authors speculate that validation might be more useful in longer-term therapy. Another explanation could be that old relational wounds are more likely to be activated when a therapist is empathic and validating (see "backdraft," below).

In the current discussion, we are referring only to *directive* interventions as compassionate interventions. Less directive interventions, such as when the therapy relationship itself is the treatment intervention, were already discussed in the context of compassionate presence and the compassionate alliance. Compassionate interventions are exercises and practices that clients can practice at home between therapy sessions. Directive interventions make sense because psychotherapy is usually only 1 h per week and practicing self-compassion at home multiples the amount of time available to cultivate a new mental habit. We know from research on neuroplasticity that the practice of meditation can change the structure of the brain (Kang et al., 2013; Lazar et al., 2005; Valk et al., 2017) and that the quantity and quality of meditation practice impact the results (Goldberg et al., 2020; Hasenkamp & Barsalou, 2012).

There are still relatively few research studies that test the efficacy of individual self-compassion practices in clinical populations. Most outcome research on self-compassion training evaluates

multicomponent self-compassion training (e.g., MSC, CMT). Individual meditation practices, such as loving-kindness meditation or compassion meditation, are not usually designed to cultivate *self*-compassion. There are a few exceptions in the research literature, such as brief self-compassion meditation training for body image distress (Albertson et al., 2015; Toole & Craighead, 2016) and chronic pain (Lutz et al., 2020).

Nonetheless, there are wealth of practices available to clinicians that can be customized for individual clients to cultivate self-compassion. For example, the MSC training program contains seven formal meditations and twenty informal practices (mindfulness and/or self-compassion) (Germer & Neff, 2019). CFT provides a range of compassion and self-compassion practices focused on (1) developing an inner compassionate self, (2) compassion flowing out from oneself to others, (3) compassion flowing into oneself, and (4) giving compassion for oneself (Gilbert, 2010a, b; Kolts, 2016). Workbooks are proliferating that help readers to cultivate self-compassion (e.g., Bluth, 2017; Irons & Beaumont, 2017; Neff & Germer, 2018). Learning self-compassion from a workbook alone has been shown to increase self-compassion levels (Held et al., 2018).

CBT has traditionally emphasized directive interventions and many CBT exercises can be reconfigured to cultivate self-compassion. For example, if a person wants to do exposure therapy for agoraphobia, intentional self-soothing practices can be practiced during the exposure experience. Similarly, behavioral activation for depression, such as scheduling enjoyable activities, could be accompanied by a practice to motivate oneself to do those activities with kindness and encouragement rather than self-criticism. Third-wave CBT, such as ACT, can also be enhanced with explicit self-compassion (Neff & Tirch, 2013). For example, ACT focuses on making space for cognitive distortions, rather than disputing or succumbing to them. Therapists could explicitly add self-compassion by encouraging clients to be kind and understanding toward *themselves* precisely because our minds have a tendency to distort the facts of our lives.

Interventions should be built on the foundation of therapeutic presence and the therapeutic alliance. If self-compassion practices are suggested to a client without a strong therapeutic bond and agreement about the tasks and goals of therapy, the client is less likely to practice them, especially when difficulties arise. Non-compliance with directive interventions does not have to end compassion-based therapy—it is simply an invitation to back up and collaborate more meaningfully in the process of designing home practices. Some clients entirely refuse to do home practices, which means that therapists need to focus on enhancing self-compassion through their compassionate presence and a compassionate alliance until their clients are motivated to practice on their own.

A helpful challenge for therapists who want to design home practices for their clients is to do so without ever mentioning the term "self-compassion." This is because striving to become more self-compassionate can be demoralizing, especially for clients who are low in self-compassion. Ideally, interventions should be co-created with clients based on what transpired in the therapy session. Rather than "teaching" self-compassion, clinicians can help their clients notice their emotional pain in the here-and-now, recognize ways that they are not alone, and respond with kindness as they might with a good friend. A client is more likely to follow a treatment recommendation when a home practice is a genuine relief, which makes the practice self-reinforcing. It is easy for clinicians to work in this way when they adopt an attitude of radical acceptance. Rather than striving to fix the client or remove their pain, the challenge is to meet "what is" with kindness and compassion, both in the therapy relationship and during home practices.

Self-Compassion for Emotion Regulation

Due to the proliferation of therapies, clinical scientists have turned to discovering underlying mechanisms or processes of change to make sense of what is happening in therapy (Carey et al., 2020). Emotion regulation is a key mechanism of change in psychotherapy (Gratz et al., 2015; McRae & Gross, 2020). Emotion regulation refers to the ability to attend to, appraise, and modulate the intensity and duration of emotional states (Gross & Muñoz, 1995). As described above, self-compassion also has much in common with other mechanisms of change such as the therapy alliance, empathy, positive regard, and interpersonal synchrony. However, self-compassion is most closely associated with emotion regulation in the research literature (Allen & Leary, 2010; Finlay-Jones et al., 2015; Neff et al., 2007).

The role of self-compassion as an emotion regulation process is particularly evident in the clinical arena (Inwood & Ferrari, 2018; Kraiss et al., 2020; Trompetter et al., 2017). Research shows that self-compassion helps to regulate emotions associated with depression (Bakker et al., 2019; Diedrich et al., 2017; Diedrich et al., 2014), anxiety (Bergen-Cico & Cheon, 2014; Finlay-Jones, 2017), childhood maltreatment (Vettese et al., 2011), trauma (Barlow et al., 2017; Dahm et al., 2015; Scoglio et al., 2018), substance use (Wisener & Khoury, 2020), bulimia nervosa (Hessler-Kaufmann et al., 2020), obsessive-compulsive disorder (Eichholz et al., 2020), sexual pain (Vasconcelos et al., 2020), and caregiver distress (Finlay-Jones et al., 2015; Neff et al., 2020).

Trauma treatment illustrates the role of self-compassion in emotion regulation. Most people who experience trauma do not develop PTSD. How trauma survivors regulate challenging emotions statistically predicts PTSD better than trauma exposure itself (Barlow et al., 2017). PTSD is maintained by experiential avoidance (Marx & Sloan, 2005) and self-compassion helps people to acknowledge and accept their feelings rather than avoid them (Thompson & Waltz, 2008). Research shows that self-compassion mitigates the effect of trauma among people with childhood abuse and neglect (Vettese et al., 2011) as well as women with severe and repeated interpersonal trauma (Scoglio et al., 2018). Self-compassion was also found to mediate the link between perceived parental maltreatment (abuse or indifference) and mental health symptom severity among adult psychotherapy patients (Westphal et al., 2016). In a systematic review of the literature on self-compassion, trauma, and PTSD, Winders et al. (2020) found consistent evidence that increased self-compassion was associated with reduced PTSD. Self-compassion has also been linked to greater post-traumatic growth and healing (Wong & Yeung, 2017).

An argument can be made that each of the three components of self-compassion—mindfulness, common humanity, and self-kindness—are individually effective for regulating emotion. For example, mindfulness is well-established as a change process in psychotherapy (Alsubaie et al., 2017; Hölzel et al., 2011b). Common humanity has rarely been studied as a change process in psychotherapy, but the opposite of common humanity—a sense of isolation—is known to negatively impact mental health (Leigh-Hunt et al., 2017; Ma et al., 2020; Wang et al., 2017). Research on self-kindness is also scarce, but the opposite of self-kindness—self-criticism—is prevalent in most forms of psychological distress (Kannan & Levitt, 2013; McIntyre et al., 2018). Therefore, we can conclude that each of the three components of self-compassion probably has a beneficial effect on mental health.

The impact of the three components on mental health can be measured using the SCS (Neff, 2003). For example, Van Dam et al. (2011) found that the isolation and self-criticism subscales significantly predicted anxiety symptoms and quality of life in a sample of people with mixed anxiety and depression. This is a legitimate use of the SCS, but some clinical scientists attempt to separate the positive subscales (i.e., mindfulness, common humanity, self-kindness) from the negative subscales (i.e., overidentification, isolation, self-criticism) into two categories—self-warmth and self-coldness, respectively (Brophy et al.,

2020; Muris & Otgaar, 2020). The developer of the SCS, Kristin Neff, argues that self-compassion is a dynamic system in which all six subscales change simultaneously, and there is ample evidence to support this view (Neff & Tóth-Király, 2020). Dividing the components of self-compassion into two subconstructs may be interesting but given that self-warmth and self-coldness change in tandem it is not clear how relevant it is to therapeutic interventions. Also, 95% of the reliable variance in responding to SCS scale items is explained by a general factor of self-compassion and splitting the scale into two positive and negative factors has not been shown to be psychometrically valid (Neff et al., 2019, 2020; Neff & Tóth-Király, 2020). Accordingly, self-compassion is best seen as a global psychological mindstate.

Neurophysiological Mechanisms

Increases in self-compassion are associated with changes in the sympathetic and parasympathetic branches of the autonomic nervous system. The sympathetic nervous system (SNS) directs the body's response to dangerous or stressful situations and the parasympathetic nervous system (PNS) allows the body to rest and relax following sympathetic arousal. The SNS increases heart rate and the PNS reduces heart rate. People with high self-compassion had reduced arousal of the SNS when confronted by a social stressor, as measured by both salivary alpha-amylase (Breines et al., 2015) and interleukin 6 (Breines et al., 2014). Training in self-compassion also lowered salivary alpha-amylase and subjective anxiety responses to stress (Arch et al., 2014).

People with high-trait self-compassion have more PNS activity, as measured by vagally mediated heart rate variability (vmHRV) (Kirschner et al., 2019; Petrocchi et al., 2017; Rockliff et al., 2008; Steffen et al., 2020; Svendsen et al., 2016). The PNS uses the vagus nerve to regulate heart rate, and when there is a lot of variability between heartbeats (i.e., high vmHRV), it is a sign that the PNS is actively regulating emotional arousal (Holzman & Bridgett, 2017). VmHRV may be considered a measure of self-soothing and safeness, often associated with social cues like calm voice or a gentle touch (Porges, 2007). Porges proposes that the PNS both downregulates the SNS (fight/flight) and motivates affiliative behaviors such as proximity seeking or caring responses. If a person is stuck in emotional arousal, such as during anxiety or depression (Chalmers et al., 2014; Kemp et al., 2010), then arousal is less regulated and vmHRV is reduced.

Overall, vmHRV is considered a marker for emotion regulation (Appelhans & Luecken, 2006) and compassion is positively linked to higher vmHRV (Di Bello et al., 2020). *Self-compassion* is also associated to higher vmHRV (Svendsen et al., 2020). For example, speaking to oneself in a soothing, compassionate manner while looking in a mirror has been found to increase mvHRV along with positive affect (Petrocchi et al., 2017). Self-compassionate people are also more likely to maintain higher vmHRV in response to stress (Luo et al., 2018).

The CFT model of therapy is anchored in physiology, especially by using compassion to regulate three subsystems of the autonomic nervous system—threat and protection (adrenalin and cortisol); drive and excitement (dopamine); and contentment, soothing, and safeness (oxytocin, endorphins) (Gilbert, 2010a, b; Panksepp, 1998). Most therapies help clients to manage challenges arising from overactive threat or drive systems (Gilbert, 1993). Compassion shifts our physiology into contentment, soothing, and social safeness, which is also the physiology of enhanced vmHRV (Geller & Porges, 2014; Kirby et al., 2017a, b). However, compassion is not always soothing. For example, compassion may need to be fierce and protective, such as defending a child against danger or saying "no" to an unwelcome advance. In that case, we still need to calm and steady ourselves to behave in a wise manner, perhaps like a martial artist (Clapton & Hiskey, 2020), which would engage multiple motivational systems.

Brain Research

Recent research offers insight into the neurological processes underlying self-compassion (see Stevens et al., 2018). Longe et al. (2010) explored brain activation differences between self-criticism and self-reassurance using functional magnetic resonance imaging (fMRI). They found that self-criticism was associated with activation in the dorsolateral prefrontal cortex (dlPFC; active while switching attention and response inhibition) and self-reassurance activated the anterior insula (AI; active during interoceptive awareness). However, Kim et al. (2020) found that self-criticism activated and self-reassurance de-activated the dlPFC, suggesting that the two functions operate in tandem in the same brain region.

Parrish et al. (2018) conducted a fMRI study on self-compassion during a stress test. The ventromedial prefrontal cortex (vmPFC; active during information processing and decision-making) is commonly thought to downregulate activity in the amygdala (active while feeling emotions, esp. fear) during threat-related emotion regulation. The researchers found that greater negative correlation between the vmPFC and the amygdala was associated with high-trait self-compassion and positive correlation was associated with low-trait self-compassion. Therefore, this fronto-limbic circuitry may be considered a neurological mechanism by which self-compassion protects against stress and negative emotions. In a brain imaging study (Berry et al., 2020; Lutz et al., 2020) on the impact of 2 weeks of self-compassion training on chronic back pain, where patients were exposed to self-critical thoughts while in the scanner, the dlPFC reacted more strongly to self-criticism after training, suggesting that participants were actively regulating their emotional response. Patients with high-trait self-compassion had even higher dlPFC responses, indicating that self-compassion training helped them deal better with self-criticism.

In an fMRI study exploring how self-compassion protects against depression, Liu et al. (2022) found that depressed adolescents with high-trait self-compassion had *lower* activity in the right dlPFC when looking at sad images of themselves, and they also scored lower on depression severity. The researchers speculated that self-compassionate adolescents required less cognitive effort to regulate their affect because they were more accepting and less ruminative about negative personal information. Interestingly, when viewing *another* person's sad face, self-compassionate youth had more activity in brain regions associated with empathy (insula, postcentral gyrus, and inferior parietal lobule). The combined results of this study suggest that depressed youth who are also self-compassionate are less focused on their own distress, more empathic toward others, and require less effort to regulate their emotions.

A groundbreaking study on the neurogenetic mechanisms of self-compassion found that carriers of a particular form of the gene OXTR (responsible for affiliation and associated with oxytocin) displayed high self-compassion (Wang et al., 2019). The researchers observed that activity in the empathy network of the brain (right angular gyrus, mPFC, and the anterior cingulate cortex) and also in the executive control network (right dlPFC and inferior parietal cortex) mediated the association of OXTR with self-compassion. Similar to the Liu et al. (2022) study, these findings suggest that highly self-compassionate people do not require as much effort to be empathic or to regulate their emotions. In sum, at least two areas in the prefrontal cortex that are commonly associated with emotion regulation—the vmPFC and dlPFC—seem to be associated with self-compassionate responding, but we still have much to learn about how the neurophysiology of self-compassion.

Psychological Mechanisms

Developing Secure Attachment

The psychological construct most commonly associated with self-compassion is secure attachment (Gilbert & Procter, 2006; Homan, 2018; Neff & McGehee, 2010; Shaver et al., 2017). Insecure attachment is consistently linked to psy-

chopathology (Gazzillo, et al., 2020; Mikulincer & Shaver, 2012, 2016; Shorey & Snyder, 2006) and enhancing attachment security ("earned secure" attachment: (Levy & Johnson, 2019; Pearson et al., 1994) correlates with improvements in therapy (Kinley & Reyno, 2013; Reiner et al., 2016). Therefore, an underlying mechanism of self-compassion in psychotherapy is likely to be the development of secure attachment.

Attachment theory is based on the idea that children seek proximity with attachment figures, especially parents, in stressful situations (Bowlby, 1969, 1973, 1980). A caregiver's ability to provide comfort and security is internalized by children as an attachment style. When caregivers are sensitive and responsive, the child will develop a secure attachment style that guides the child's feelings, thoughts, and expectations about self and others. When caregivers fail to reliably comfort and soothe the child, the child develops insecure attachment, especially anxious, avoidant, or disorganized attachment (Ainsworth et al., 1978; Brennan et al., 1998). Insecure attachment is associated with emotion dysregulation (Girme et al., 2020; Mikulincer & Shaver, 2019; Moutsiana et al., 2014).

Self-compassion is shaped by a person's attachment history. Since children internalize how they are treated, and if they received comfort and support from primary caregivers when they were in distress, they will probably do the same for themselves later in life (Neff & McGehee, 2010; Ross et al., 2019). From a physiological perspective, when a child feels securely attached to caregivers, her or his soothing system has a chance to develop, and when a child is insecurely attached, the threat system will become overly developed (Gilbert & Procter, 2006). Therefore, the shift from insecure to secure attachment in compassion-based therapy is a shift from threat-dominated physiological arousal to safeness and soothing.

In correlational research, insecure attachment is associated with lower levels of self-compassion (Joeng et al., 2017; Mackintosh et al., 2018; Raque-Bogdan et al., 2011; Wei et al., 2011). Parental rejection, criticism, overprotection, and stressful family relationships are negatively related with self-compassion (Neff & McGehee, 2010, Pepping et al., 2015) and early memories of warmth and safeness are positively linked to self-compassion (Cunha et al., 2014; Homan, 2018; Steindl et al., 2018). Self-compassion appears to mediate the relationship between insecure attachment and emotional distress (Mackintosh et al., 2018), subjective well-being (Wei et al., 2011), and mental health in general (Raque-Bogdan et al., 2011). The impact of insecure attachment can also be intergenerational. Moreira et al. (2015) found that when mothers had insecure attachment to their own mothers, their children reported lower quality of life, but self-compassion mitigates the negative impact of a mother's insecure attachment on their children.

Can cultivating self-compassion *increase* attachment security? At the present time, no studies were found showing that self-compassion priming in the laboratory or self-compassion training enhanced secure attachment. However, Pepping et al. (2015) found that secure attachment priming (imagining a person with whom you felt safe) increased self-compassion. Additionally, a type of attachment-based compassion therapy increased secure attachment and self-compassion mediated that outcome (Navarro-Gil et al., 2020). In spite of the lack of direct evidence that self-compassion training increases secure attachment but considering that self-compassion mediates the link between insecure attachment and mental health, we can conclude attachment, self-compassion, and emotion regulation are important, overlapping themes in mental health (Finlay-Jones, 2017).

Working with Fears of Compassion

According to attachment theory, if a child was neglected or abused by early attachment figures, the child is likely to be dismissive, harsh, or critical as an adult and also likely to feel unworthy or unacceptable (Gilbert & Procter, 2006; Shaver & Mikulincer, 2007). Furthermore, when positive emotions arise in relationship to others, they are likely to trigger painful childhood memories of

rejection or harm. These memories feel threatening just as the actual experiences were threatening in the past. When painful memories are triggered by compassion, a person is likely to develop is likely to develop "fears of compassion" (Gilbert et al., 2011; Matos et al., 2017).

Examples of fears of compassion are "If I am too compassionate with myself, others will reject me," "Being too compassionate makes people soft and easy to take advantage of," and "I try to keep my distance from others even if I know they are kind" (Gilbert et al., 2011). Research shows that fears of compassion are consistently associated with mental health difficulties (Kirby et al., 2019), including anxiety (Merritt & Purdon, 2020), depression (Hart et al., 2020), body image and disordered eating (Ferreira et al., 2019), alcohol misuse (Forkus et al., 2020), and psychosis (Martins et al., 2017). Fears of compassion can be considered patterns of avoidance that prevent painful childhood memories from being restructured in the relative safety of therapy sessions. Therefore, fears of compassion need to be explicitly addressed in therapy.

Baldwin et al. (2020) provide evidence that people with insecure attachment may feel threatened by compassion. They found that, after a compassion-focused imagery exercise, insecurely attached individuals had significantly lower vmHRV. However, after they were primed for secure attachment ("visualize someone who makes you feel safe and secure"), a subsequent imagery exercise actually increased vmHRV, suggesting that the exercise had become comforting and soothing. In other words, insecurely attached individuals may need additional support to benefit from self-compassion practices.

The distress that arises when people give compassion to themselves or receive compassion from others is known as "backdraft" (Germer, 2009, pp. 150–152; Germer & Neff, 2019). Backdraft can take the form of *thoughts* and *beliefs*, such as "I'm unlovable;" *emotions,* such as grief or shame; *body* aches and pains; and automatic *behaviors,* such as withdrawal or aggression. Backdraft is an intrinsic part of the transformation process of compassion-based therapy. Compassion activates old memories and makes them available for reprocessing—it provides an opportunity to receive the kindness and understanding that was probably lacking when the painful experiences originally occurred. This is a delicate process and therapists need to make sure that their clients remain within the "window of tolerance" (Siegel, 1999), especially when backdraft consists of traumatic memories. As the resource of self-compassion develops, however, clients feel safer within themselves and develop a "secure base" (Bowlby, 2005) from which to explore the inner and outer world. In this manner, compassion-based therapy can be understood as a process of *reparenting*. Research (cited above) showing that self-compassion mediates the link between insecure attachment and psychological well-being supports this understanding.

Alleviating Shame

The alleviation of shame is another mechanism by which self-compassion appears to work in psychotherapy. Shame is a "self-conscious" emotion characterized by negative self-evaluation. Helen Block Lewis (1987) wrote that shame is "one's own vicarious experience of the other's scorn…. the self-in-the-eyes-of-the-other" (p. 15). In a moment of shame, our attention is either directed *externally* toward what others are thinking about us, or *internally* toward our own personal characteristics and behavior, but the common denominator of shame is how we imagine ourselves to exist in the minds of others (Gilbert & Irons, 2009).

Human beings are social animals and need to be accepted and valued by others to feel safe (Baumeister & Leary, 1995). Shame seems to appear very early in life—an early precursor of shame is when an infant drops its eyes and head in response to losing facial communication with a parent (Tomkins, in Stipek, 1983). The full emotion of shame arises around the second half of the second year of life when a child becomes self-aware (Lewis, 2016). Patterns of rejection in early childhood—being blamed, attacked, ignored, or abandoned by a primary caregiver—can make a person shame-prone (Claesson &

Sohlberg, 2002). Shame is also closely linked to insecure attachment (Matos & Pinto-Gouveia, 2014; Schore, 1998). Shame is likely to arise at any stage of our lives, however, when our relationship security is compromised or our social standing is in jeopardy (Gilbert, 2007).

Shame has a long history as a predisposing factor in psychopathology, associated with a broad spectrum of disorders including depression, anxiety, eating disorders, PTSD, and substance abuse (Dearing & Tangney, 2011). Shame itself can also be traumatic. Steindl et al. (2018) argue that when a shame memory is central to an individual's personality, it is more likely to be traumatic. Shame becomes central in our lives when we relive it in words, images, smells, thoughts, behaviors, and emotions. Conversely, trauma can lead to shame when people blame themselves for their traumatic experiences, perhaps concluding that they are "bad," "defective," or "powerless" (Scoglio et al., 2018). Traumatized people may also behave in ways that cause more shame, such as engaging substance abuse, aggression, or withdrawal (Briere, 2019).

Self-compassion is the opposite of shame. The three qualities that oppose self-compassion in Neff's (2003) definition of self-compassion—self-criticism, isolation, and overidentification/rumination—are qualities of shame. Research shows that shame and self-criticism occur in tandem, especially in psychopathology (Gilbert & Irons, 2005; Werner et al., 2019). Shame is also associated with social isolation (Hartling et al., 2004; Thoresen et al., 2018) and rumination (Cândea & Szentágotai-Tătar, 2017; Orth et al., 2006). All three factors can be pathogenic. Self-criticism, in particular, is considered a transdiagnostic risk factor in depression, social anxiety, eating disorders, personality disorders, and psychotic symptoms (Löw et al., 2020; Werner et al., 2019).

Many studies have shown that self-compassion and shame are inversely associated. In the clinical arena, self-compassion was associated with lower levels of shame and psychological distress among people struggling with depression (Sick et al., 2020; Steindl et al., 2018), trauma and depression (Ross et al., 2019), eating disorders

(Ferreira et al., 2014; Serpell et al., 2020), body image problems (Ferreira et al., 2013; Huellemann & Calogero, 2020), shame proneness (Woods & Proeve, 2014), and stress related to fertility (Galhardo et al., 2013), HIV (Skelton et al., 2020), imposter feelings (Wei et al., 2020), sexual minority stigma (Chan et al., 2020), parenting (Sirois et al., 2019), and caregiving (Biddle et al., 2020).

In a particularly interesting study, Zhang et al. (2018) found that self-compassion, but not contingent self-worth, mediated the link between shame and depression. Contingent self-worth refers to feeling good about ourselves based on the support we receive from external sources (e.g., family, friends) whereas self-compassion enhances self-worth by how we treat ourselves. Self-compassion is a more stable source of self-worth because it is not dependent on others. In the Zhang study, self-compassion dampened the impact of shame, and therefore the symptoms of depression, presumably by enhancing self-worth.

Shame and self-compassion were also inversely related in *therapeutic interventions* for depression (Johnson et al., 2018), PTSD (Au et al., 2017), narcissistic personality disorder (Kramer et al., 2018), eating disorders (Kelly et al., 2017), body weight shame (Carter et al., 2020), social anxiety disorder (Khoramnia et al., 2020); and stress due to intellectual disability (Goad & Parker, 2020), and body image (Albertson et al., 2015; Amy et al., 2020).

Shame is becoming a target for psychological interventions, especially with the emergence of compassion-based treatments such as CFT, EFT, and IFS. CFT was originally developed by Paul Gilbert to treat depressed people who suffered from high levels of shame and self-criticism (Gilbert, 2010a, b). He observed that people who were shamed in childhood found it difficult to access feelings of warmth, kindness, and compassion. These clients were also afraid of compassionate connections that might heal those old wounds. Therefore, the primary objectives of CFT treatment are to address fears of compassion and to help clients activate compassion for themselves. Preliminary outcome studies on CFT have shown reductions in shame along with clinical

improvement in eating disorders (Carter et al., 2020; Kelly et al., 2017), depression (Gilbert & Procter, 2006), social anxiety (Boersma et al., 2015), PTSD (Au et al., 2017), perfectionism (Matos & Steindl, 2020), chronic pain (Håkansson et al., 2015), and personality disorder (Lucre & Corten, 2013) although well-controlled studies are still needed to confirm that CFT reduces shame across diagnoses.

Shame is also a focus of treatment in the EFT model and is considered a central feature of psychopathology (Greenberg, 2010; Greenberg & Iwakabe, 2011). The purpose of EFT is to help clients regulate their emotions. EFT assumes that maladaptive emotions such as toxic shame are not changed through reasoning or new skills, but rather by activating more adaptive emotions such as anger, grief (Shahar, 2020). EFT for shame begins by helping clients acknowledge shame, usually by a therapist empathizing with painful emotions underlying shame, such as betrayal or humiliation. When the client is ready to address shame, a new experience may be created to transform the painful emotion, for example, by using the two-chair dialogue technique in which clients enact two parts of themselves—the self-critic and the object of criticism (Shahar et al., 2012). The two-chair technique evokes self-compassion, which is considered in EFT to a transformative emotional experience (Shahar, 2020).

EFT and CFT are both based in attachment theory. The role of the therapist is to facilitate secure attachment by creating corrective emotional experiences that are internalized by the client over time (Karris & Caldwell, 2015). CFT therapists are more likely than EFT therapists to explicitly teach self-compassion through home practices. Karris and Caldwell (2015) recommended blending of EFT with CFT for couples struggling with trauma and shame.

IFS is another empirically supported, self-compassion-based therapy that works directly with shame. IFS was developed by Richard Schwartz (Schwartz, 1995; Schwartz & Sweezy, 2019) and works entirely with parts, or subpersonalities, of ourselves. This approach is particularly helpful for treating shame because shame can lead to dissociation and splitting of conscious-

ness into parts (Dorahy et al., 2017; Platt et al., 2017). In IFS, the emotion of shame is a burden carried by an "exile"—a child part, tucked away and stuck in time. Self-criticism is the work of a "manager" who is trying to suppress the emotion. Unfortunately, self-criticism is likely to cause more shame, which then evokes a "firefighter" who may engage in risky behaviors or be aggressive toward others (Sweezy, 2013). Each part is trying to help us in some way and needs to be treated with deep respect and compassion, and when that happens, the part feels safer and is willing to let go of its burdens or responsibilities. The physiological basis of change in IFS is similar to CFT and EFT, namely, the reduction of threat and the cultivation of inner safety and security.

Conclusion

In summary, self-compassion is a key factor in mental health with wide-ranging implications for psychotherapy. Self-compassion has been present throughout the history of psychotherapy but is now emerging as a unique construct and specific target of treatment within the mindfulness-, acceptance-, and compassion-based psychotherapy paradigm. Compassion-based therapy is mostly oriented toward cultivating *self-*compassion in the client. Self-compassion appears to be a transdiagnostic and transtheoretical change process underlying most, if not all, forms of therapy. Self-compassion can also be integrated into therapy by cultivating compassionate presence, a compassionate therapeutic alliance, or by customizing compassionate interventions for clients. Ideally, all three levels are blended together in self-compassion-based treatment.

Understanding the mechanisms of change underlying self-compassion in psychotherapy can assist in the process of integrating self-compassion into therapy. For example, self-compassion in therapy has much in common with positive regard, empathy, and mindfulness as common factors in effective treatment. Interpersonal synchrony is also linked to self-compassion, albeit indirectly through therapeutic presence and the treatment alliance. The mecha-

nism of change most commonly associated with self-compassion is emotion regulation. Under the umbrella of emotion regulation, self-compassion appears to calm the sympathetic nervous system and activate the parasympathetic system, along with enhancing executive functioning in the brain. Self-compassion also appears to be a resource that can help clients move from insecure to secure attachment and reduce the harmful effects of shame in their lives.

The field of self-compassion in therapy is currently in its adolescence. The empirical research base is expanding rapidly and is quite promising, but there still are relatively few, well-controlled therapy outcome studies that specifically target self-compassion. Indirect evidence for the importance of self-compassion in therapy is robust, however, such as numerous studies on self-compassion as a mediator of positive therapy outcomes and correlational studies consistently showing a close association between self-compassion and secure attachment and an inverse relationship between self-compassion and shame. Ongoing efforts by clinical scientists and practitioners will inevitably deepen our understanding of how self-compassion works in therapy and enhance the effectiveness of treatments for a broad range of psychological conditions and diverse populations.

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