The Impact of Positive Self-Constructs

- exploring and reviewing some positive self-constructs of relevance to psychotherapy

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Thesis for the Professional Programme
The Department of Psychology

The University of Oslo

Spring 2011

Acknowledgements

I would first of all like to thank my wonderful and hardworking husband for all his love and patience, and for making this study possible for me. It would never have happened without you.

Then I would like to thank my two supervisors Lene Berggraf and Ellen J. Hartmann. To Lene Berggraf for providing me with the idéa for the objective of this thesis, and also for useful and necessary remarks, and feedback. To Ellen Hartmann for being positive and supportive from day one, and for providing indispensible advise along the way. Writing this thesis has been fun and instructive, but also quite challenging for me. The expertise, insight and help from good supervision have prevented me from going astray time and again.

I would also like to thank Leigh McCullough. Meeting you, and your Affect Phobia Model has had an impact on me as a future psychologist.

Thank you all very much!

Ann-Mari G. Bardum

Hvaler, June. 2011

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http://www.duo.uio.no/

Print: Reprosentralen, Universitetet i Oslo

Abstract

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Title: The Impact of Positive Self-Constructs.

Supervisors: Lene Berggraf and Ellen J. Hartmann

Background: In psychotherapy today there is a growing focus on enhancing the client's ability to an enhancement of wellbeing and a way to care for self and others. In the different therapy-traditions there are many constructs in use that are related to the enhancement of these abilities. Two relatively new concepts in psychological theory and clinical practice are *compassion* and *self-compassion*. Today there is a growing interest for these terms. Even though they seem to represent a "new trend" in psychotherapy there have been suggested related terms that have conceptualized the enhancement of positive feelings towards the self earlier. For instance was *self-empathy* suggested by Barrett-Lennard already in 1997.

Objective: The aim of this thesis was therefore to explore the constructs *self-empathy*, *compassion, self-compassion* and *self-acceptance*. I wanted to investigate how these constructs have originated, how they are used in therapy, and how they are built up as constructs. I also wanted to explore the impact they have had in psychotherapy, in other words if and how are they different or do they have the same meaning?

One aim of this study was therefore to explore what the original meaning of these positive self-constructs was. Another aim was to consider how they were constructed and used in therapy. The third aim was to investigate if *compassion*, *self-compassion* and *self-acceptance* would have a different impact in therapeutic settings compared to *self-empathy*.

The methods that were used in this study were etymological searches, and then a literature search in the databases PsycINFO, EMBASE, MEDLINE, PubMed, ISI-Web of Science and Google Scholar. All the constructs were given an equal treatment throughout the thesis.

Results: Results from the etymological searches conveyed that empathy and *compassion* are closely related although they are not used or understood in the exact same manner in psychotherapy. An evaluation of the constructs conveyed that *self-compassion* might be eligible to be the construct with most explanatory value. Results from the database search also

conveyed that research regarding these constructs in relation to psychotherapy was scarce, and the studies that were done were mainly observational. With basis in the studies that were considered *self-compassion* proved to be the construct with the most convincing impact, but the reason for this may not necessarily because of the construct, but the scarce amount of research in this area.

More research with more controlled studies is necessary regarding the impact of positive self-constructs in psychotherapeutic settings, so that it would be possible to evaluate the different constructs' unique contributions to positive change.

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Introduction

Within psychotherapeutic practice and research there is no secret that some of the important factors that are contributing to positive therapeutic change are related to the therapist's ability to feel and express unconditional positive regard and empathy for the client (Rogers, 1957). But what constitutes psychotherapeutic change? And why is positive regard and empathy helpful? There are of course no simple answers to these questions. Rogers (1957) defined psychotherapeutic change in a common sense way, as change in an individual's personality structure. This would mean greater integration and less internal conflict and more utilizable energy to live a more satisfactory life. A plausible explanation to why unconditional positive regard and empathy are effective could be that human beings are relational (Wachtel, 2008). We need other people and we need a safe environment for development to be optimal (Bowlby, 1979). We also need to interact with others in order to be able to explore ourselves and our environment (Stern, 1998; Tomasello, 1999), and we need others to help regulate our emotions (Stolorow, Atwood, & Brandchaft, 1987), and learn to be able to soothe ourselves (Gilbert, 2010; Greenberg, 2002).

Thus many theories points to the fact that a supportive environment promotes development, exploration and change, and a soothing and empathic attitude from the therapist will benefit the patient. Bohart (1991) has suggested that empathy from the therapist helps because it provides a model for the clients to learn to relate to themselves (Bohart, 1991). An important therapeutic objective would therefore not just be to express positive regard and empathy for the client, but also to enhance the ability for the client to empathize with or soothe his or her own self. In this respect a focus in several therapeutic traditions has also been on concepts that are related to the self and to the concept of helping the client to soothe the self.

An early contribution in this respect was *self-empathy* (Barrett-Lennard, 1997). *Self-empathy* refers to a mode of respectful inner listening, with readiness to take seriously whatever signal that arises from within. This will lead to an inner feeling of greater unity with and affirmation for the different aspects of the self (Barrett-Lennard, 1997).

A quick look at some of the different therapy traditions of today will reveal that many different concepts related to an empathic stance toward the self are in use. For example is a central focus in Short-Term Dynamic Therapy to enhance the patient's ability to experience

positive feelings for self and others during the therapeutic process (McCullough, Kuhn, Andrews, Kaplan, et al., 2003), and in Relational Psychodynamic Psychotherapy (Wachtel, 2008) the term *self-acceptance* is emphasized. A traditional focus within the Cognitive Behavioral tradition has been to help the patient to become aware of negative thinking and automatic thoughts. However in some of the branches of Cognitive Behavioral Therapy there is also a focus on enhancing positive self-feelings. Rational-Emotive Behavior Therapy (Ellis & Ellis, 2011) emphasizes *unconditional acceptance for self,* others and life, although this was not emphasized in the early years of this theory (Ellis, 1962). Lately there has been a focus on constructs that are related to *compassion* (Gilbert, 2005, 2010; McCullough & Thornes, 2007; Neff, 2003a, 2003b). A relatively new therapy-model within the cognitive tradition is Compassion Focused Therapy (Gilbert, 2010), which is also emphasizing the therapist's ability to help the individual to develop *compassionate* and soothing capabilities towards the self. An aim of this thesis is therefore to examine the content and meaning of some of these constructs, and the impact they have had in therapy.

Aims of study

In this thesis some positive self-constructs from the dynamic, cognitive and the humanistic traditions will be explored. The terms *self-empathy*, *positive feelings for self, self-acceptance, compassion* (for self) and *self-compassion,* will be referred to as positive self-constructs. Today there is a growing interest for, and a growing body of research on the impact of both *compassion* and *self-compassion*, while research on *self-empathy* is scarce. But is *compassion for self* really all that different from *self-empathy*? Is *compassion* or *self-compassion* very different from *self-acceptance o*r *positive feelings for self*? Are the different psychotherapy traditions using different constructs that basically refer to the same? In this thesis I will explore to what extent these constructs refer to the same, or how they differ? The aims of this study will therefore be:

> What was the original meaning of these positive self-constructs?
>
> How are they constructed and used in therapy?
>
> Will *compassion* (for self), *positive feelings for self* or *self-compassion* and *self-acceptance* have a different impact in therapeutic settings compared to *self-empathy*?

The main body of this thesis will consist of two theoretical and one empirical section. In the theoretical sections I will try to answer the first two questions by exploring and discussing the background and the rationale for the use of the positive self-constructs in therapy. In doing this they will be given an equal treatment throughout the thesis. Since the constructs are connected to the self-concept, it is reasonable first to make a brief account of the self-concept. This will be done in section one. In this section other general terms will also be accounted for. The existence of positive self-constructs and their clinical use is of course much more extensive than what is possible to convey in this thesis. Self-esteem is for example a central term in psychological theory, therapy and research. Self-esteem will be mentioned in section two, together with an explanation for why it will not be further included in the study. In order to find the original meaning of the concepts the etymologic roots of the terms, *self, empathy, compassion, acceptance,* will be briefly investigated and discussed. The concepts (apart from self) are not originally linked to the self, so it is therefore reasonable when investigating their roots to do this without the link to the self.

In section two I will look at how the positive self-constructs *self-empathy, compassion, self-compassion* and *self-acceptance* are constructed. After this follows a brief review of how *self-compassion, self-acceptance* and *compassion (for self)* are emphasized in different traditions of therapy. I will discuss to what extent they have the same meaning and significance within the different therapy-traditions.

In section three, the impact of the positive self-constructs in psychotherapy will be examined and discussed. A review of research connected to the positive self-constructs and psychotherapy will be given. The method to be used will be a literature search for articles published the last five years in the databases PsycINFO, EMBASE, MEDLINE, PubMED, ISI-Web of Science and Google scholar. The results from the literature search will be conveyed and discussed.

The different theories and therapy traditions alternates in using the client or patient. In this thesis I will consequently use the term client. When discussing studies I will also use the term participant instead of patient.

1 Section one – A search for origin

1.1 Background

1.1.1 The self

With the exception of *compassion,* psychotherapeutic use of positive self-constructs can be traced to psychoanalysis and later self-psychology. Barrett-Lennard's (1997) *self-empathy* is an outgrowth of client-centered therapy. I therefore find it reasonable to give a brief account of Heinz Kohut's (1913-1981) and Carl Roger's (1902-1987) contributions regarding the self-concept and the concept of empathy.

Kohut

Heinz Kohut is regarded as the one who lifted the self out from being overshadowed by the ego (Karterud, 1997). Searches in PsycInfo on February 24, 2011, with 'self' in the abstract confirmed that the self no longer lives in the shadows of the ego. It yielded 85.562 full-text research articles, compared to 3.857 when 'ego' was submitted.

But how did Kohut define the self? In his book 'The Analysis of the Self' (1971), Kohut defined the self as the content of the mental apparatus, but also as a psychic structure inside of the mind. He goes on to say that the self is analogous to the representations of objects and the content of the mental apparatus, but not one of its constituents. He explained that various and frequently inconsistent self-representations can exist at the same time in the id, ego and superego (Kohut, 1971). Kohut thought of these self-representations as being a system, and that it was the conscious part of this system that constituted the self (Karterud, 1997). Kohut's initial view of the self was that it constituted to polarities (the bipolar self.) The bipolar self was characterized by the desire for power and success on the one hand (the grandiose self), and individual goals and personal values (the ideal seeking self) on the other hand. In his book 'How Does Analysis Cure?' (1984), he added a third element (the twin seeking self), which emphasized a person's need for a self-object to confirm his or her own self by similarity. 'Self-object' refers to 'the function and impact other human beings, animals, things, cultural manifestations (e.g., art) or an idea tradition have for maintaining one's sense of being a cohesive and meaningful self' (Karterud, 1997). These instances are rooted in what

Kohut called the nuclear self and are related to self-objects. It was a failure in the transference (self-object failure) between the self and the self-object that would lead to an inadequately developed sense of self.

Kohut also thought that the properties of the self could be described, by distinguishing between its constituents and attributes. The attributes of the self were qualities like cohesion, vigor (vitality) and harmony (Kohut, 1984). Cohesiveness can be understood as an experience of wholeness or endurance vs. fragmentation. Self-cohesion referred to the self as whole or intact, and vigor referred to an experience of feeling invigorated vs. devitalized and inner harmony represented a feeling of calmness or being soothed (Silverstein, 1999).

As can be seen Kohut's definition of self is quite complex, and Kohut revised his concept of the self throughout his authorship. It had also been criticized for lacking clarity (Silverstein, 1999). It is amazing that a concept that has grown to have such an enormous theoretical and clinical impact can be so difficult to define. Kohut himself made a point of this when he wrote that although his work contained hundreds of pages dealing with the psychology of the self, it never explained how the essence of the self should be defined. He went on to say,

> " *We cannot, by introspection and empathy, penetrate to the self per se; only its introspectively and empathically perceived psychological manifestations are open to us*." (Kohut, 1977; p. 311).

In essence the self in this respect will therefore refer to a system of representations that seeks goals, personal values, power and success, together with a desire for confirmation or acceptance from self-objects. The healthy self would also feel a sense of coherence, vitality and harmony.

Rogers

Carl Rogers had a view of the self as dual and as a result of his concepts organismic experience and openness to experience (Rogers, 1956). Rogers meant that openness to experience was a property belonging to the fully functioning person. Openness meant that all types of stimulus could fully pass through the nervous system so that they had the properties of being available to awareness. What is important is that the route is open to conscious representation, but that at the same time it is impossible for the fully functioning person to be aware of everything that is going on within. Rogers suggested that the awareness took place

on two levels. At the primary level the experience is not self-conscious, even though the experience is felt by the person and expressed in spontaneous behavior. It may well have sensory qualities but they are integrated at the level below the brainstem activation. Rogers called this organismic experience (Rogers, 1961). At the second level is the level for expressing articulate consciousness. It involves a transformation of primary subjective experience from the first level, and into a symbolic form. Rogers thought that the self and personality emerged through experience rather than for experience to be translated and adapted into a preconceived self-structure. He explained that the self was both a participant and an observer of organismic experience. In this way there exists an I-self that is receptive to the persons underlying organismic experience. He saw the self as an articulate, reflective self with values, goals and intentions (Rogers, 1961).

To summarize, there are similarities and differences in Kohut and Rogers view of the self. While Kohut came to understand the self as consisting of three mental instances, Rogers had a dualistic view of the self. Both had a somewhat cognitive view of the self, either as representing a mental content or as emerging in the moment on basis on experiences. They also both saw the self as seeking goals and personal values. The difference between their views of the self was that in Kohut's view the self represented unconscious material in need of interpretation, while Rogers had a more here and now view of the self as emerging from moment-to-moment. From my point of view it's hard to see why one of these definitions should exclude the other since we know that everything that goes on in the self cannot be conscious to us. Both Kohut and Rogers makes a point of this to, whether it is old or already experienced material or material in the here and now that needs interpretation. In that case both definitions will be considered and for our purpose we could say that that the self represents various instances that seeks goals, values, unity and gratification. It has the quality of emerging in the moment but it is also affected by earlier experiences. Some of these experiences can be unconscious.

1.1.2 Empathy

Empathy was first introduced by Rogers (1957), and later by Kohut (1971). Although they both considered empathy to be an essential factor to contribute to change in psychotherapy they defined empathy in different ways.

Rogers

Carl Rogers defined empathy as the therapist's ability to sense the clients own private world as if it was his own, but without losing the as if quality (Rogers, 1957). He exemplified that one must be able to sense the clients anger or fear but without confounding it with his own fear and anger. When the client's world is that clear to the therapist and he can so to speak ”move about freely” in it, then the therapist can communicate that he has an understanding of what is already known to the client, but also suggest meanings in the clients experience which the client may not be aware of (Rogers, 1957). This understanding of empathy differs from the psychoanalytic understanding of empathy, which has a focus on grasping the clients' unconscious structure of experience. Empathy in client-centered therapy is more oriented towards the present moment-to-moment meaning and experiencing, and it is not the same as unconditional positive regard. Bohart & Greenberg (1997) also claimed that it is not meant to be the same as being sympathetic or compassionate but instead one of the three therapeutic conditions that Rogers postulated as necessary and sufficient for therapeutic change to occur (Rogers, 1957).

Kohut

Heinz Kohut had a different view of empathy. Or actually two (MacIsaac, 1997). He experienced through his clinical work that the experience-distant way that clinicians understood their clients was not very helpful. Kohut meant that it would be better for the therapist to try to place himself into the experience of the client through what he called ”vicarious introspection” (Kohut, 1984). Vicarious introspection meant that only through introspection in our own experience could we learn what it would be like for a client in a similar circumstance. Our experience did not have to be similar to that of the client, in that our own experience would allow us to approximate what the client would experience. Kohut observed that in addition to facilitating insight, expressing empathic understanding could facilitate the therapeutic process because it made patients more open to receive interpretations from the therapist. This definition of empathy established empathy as a therapeutic tool, or mode of observation by which the science of psychoanalysis collected data. Kohut thought that only by introspection into our own selves, or by vicarious introspection into the clients experiences would we be able to observe the clients inner life (MacIsaac, 1997).

The other definition Kohut offered for empathy was:

- *the capacity to think and feel oneself into the inner life of the other person* (Kohut, 1984; p. 82).

This definition was more humanistic, and not so technical. It allowed the therapist to experience elements of the client's inner world. The precursor to this definition was from the German term 'Einfülung'. The connotation to einfühlung is a way to feel oneself into the inner world of the client. In this way empathy is experience-near (MacIsaac, 1997). There were also misunderstandings connected to this definition of empathy. It was not the same as guessing what the client may be feeling, nor was it the same as becoming the other so that one became overwhelmed by the intensity of the others feelings. Empathy was a long term process of trial and error by which the psychologist "tasted the flavor" of the clients experience while still maintaining his or her objectivity (MacIsaac, 1997). A common error in this respect was that empathy was equated with action. Kohut was clear that empathy should not be equated with a deed or act or quality in a person's interactions that is commonly identified with love, compassion or any other intense emotion. At the same time Kohut recognized that empathy would only be relevant to human interactions if it resulted in a response or action. MacIsaac (1997) uses the example of the mother who hears her baby cry. It is not her empathy that satisfies the baby but her actions. But in order to give the right response she must be guided by empathy. Empathy in everyday situations and in therapeutic settings is value-neutral. This means that empathy is determined by the nature of the relationship and the conscious or unconscious motives of the ones involved. Actions resulting from empathic observations can serve positive therapeutic purposes, but also negative or manipulative or even sadistic aims. Kohut emphasized that the mere presence of empathy in a setting is of more benefit to people than indifference. Even if it is not of a positive kind. Hence it is better to be killed by someone who hates us than to be exposed to the indifference of persecutors (MacIsaac, 1997).

Empathy is a central concept in psychotherapy although its definitions and mechanism seems to vary. Bohart & Greenberg (1997) outlined three categories of empathy. Empathy can be understood as kindness, a global understanding and tolerant acceptance of a client's frame of reference. It can also be understood as an "experience-near understanding" of the client's world. The focus for the therapist then will be to try to emphatically understand what it is like

to be the client and try to explore factors involved in the client's world. In the first sense of this the therapist will need details of the clients values, relationships etc., in order to help to understand the clients frame of reference. In the second sense the clients life story will give the therapist a deeper understanding of what it is like to be the client, and a likely response from the therapist could be: "no wonder you are feeling this" (Bohart & Greenberg, 1997). A third category could be as "communicative attunement" which involves a moment by-moment attunement where the essence is to try to communicate exactly what the client is experiencing at that exact moment (Bohart & Greenberg, 1997).
An alternative conception of empathy is deep empathy (Amlund, 2008; Hart, 1997). In deep empathy the therapist steps into the client's world. The therapist feels what the patient feels, and re-experiences and shares the experiences of the client (Amlund, 2008). In other words the therapist goes beyond the 'as if' quality that characterizes Rogers understanding of empathy, and deeper in to the clients experience. An experience of recognition and value in the relationship between client and therapist can lessen the client's sense of aloneness. It can shape the sensitivity and invite the client to deeply tune into and empathize with him or herself (Amlund, 2008).
Empathy is a concept which is largely focused on in psychotherapeutic research and practice, but as Barrett-Lennard (1997) has argued, empathy for self is a largely neglected aspect of client change (Barrett-Lennard, 1997).

To summarize, Rogers defined empathy as the ability to sense the client's inner world without loosing the touch of ones own. Kohut defined empathy either as vicarious introspection or the capacity to feel oneself into the other. If we here take focus on the experience near aspect of empathy that is the ability to feel oneself into someone, will it then be very different from compassion?

1.1.3 Compassion

In considering *compassion* I have chosen to focus on the western understanding of compassion although there are theorists that are focusing on the Buddhist conceptualization of compassion (e.g., Gilbert, 2005; Neff, 2003a, 2003b).

In western culture *compassion* is one of the Christian emotion-virtues, and Roberts (2007), has an understanding of *compassion* as a form of love for a fellow sufferer. Not as family

affection or friendship, neither as love for spouse or for fellow believers. The main factor in *compassion* is an understanding of fellow suffering or fellow deficiency, and an understanding that the weakness, suffering or dysfunction that is seen in others also can be seen in oneself. Thus to be compassionate is to suffer with, or be vulnerable to suffering, weakness and death, and to have an understanding for dysfunction as something one has in common with every human being. This is a kind of fellowship one can have with everybody that comes along (Roberts, 2007).

An intuitive understanding of *compassion* does not seem to differ very much from a therapeutic tool like *empathy.* So why is it that *compassion* has not been really appreciated in psychology until recently?

In a review article on religion and mental health (Koenig & Larson, 2001) the authors claims that religious organizations often were the first to offer compassionate care to the mentally ill, but at the same time also the ones who persecuted the mentally ill. The article also reviews different opinions regarding religion held by Sigmund Freud (1856-1939) and Albert Ellis (1913-2007), on the one side, and Carl Jung (1875-1961) on the other. The article cites a passage from Freud (1927):

> "*Our God, Logos (reason), will fulfill whichever of these wishes nature outside us allows, but will do it very gradually, only in the unforeseeable future, and for a new generation of man. He promises noncompensation for us, who suffer grievously from life. On the way to this distant goal your religious doctrines will have to be discarded, no matter whether the first attempts fail, or whether the first substitutes prove untenable. And you know why: in the long run nothing can withstand reason and experience, and the contradiction which religion offers to both is all too palpable*" (Freud, 1927; p. 54 in Koenig & Larsen, 2001).

They also refer to an argument by Albert Ellis where he claimed that the less religious people are, the more emotionally healthy they will be (Ellis, 1980; 1988, in Koenig Larson, 2001).

So, to suggest an answer to the earlier posed question of why *compassion* has not been emphasized in treatment of people with psychological disorders, may well be that the impact of characters like Freud and Ellis and their view of religion could have contributed to this. But this view of religion versus health was also contradicted. A passage from Jung's book

“Modern Man in Search of Soul” (1933) is also cited in Koenig & Larson’s article, and he has a different view, namely that

> “ - *religion will bring about emotional stability and resolution of mental conflict*” (Jung, 1933; p. 229 in Koenig & Larson, 2001).

Koenig & Larson have reviewed articles that have found both positive and negative associations between religious interventions and mental health. In trying to explain the positive association, one of the factors they mention is *compassion.* They argue that most religious teachings prescribe support and care for another, and that they promote forgiveness, mercy, kindness, *compassion*, and generosity toward others. They think that these outward directed behaviors may distract people from their own problems and enhance wellbeing through seeing others benefited, and thereby facilitate the resolution of their own emotional distress (Koenig & Larson, 2001).

1.1.4 Acceptance

Carl Rogers (1957) defined ‘unconditional positive regard’ for the client as ‘the therapist’s ability to experience a warm acceptance for each aspect of the clients experience as being a part of the client’. In his article “The Necessary and Sufficient Conditions of Therapeutic Personality Change” (1957), Rogers referred to an unpublished doctorial dissertation by Standal (1954), who argued that there are no conditions to this *acceptance.* It involves a feeling of *acceptance* regardless of whether the client expresses “bad” painful, fearful, defensive, abnormal feelings as well as “good,” positive, mature, confident, social feelings. Together with an *acceptance* for ways in which the client behaves in an inconsistent as well as a consistent manner (Standal, 1954 unpublished; in Rogers, 1957).

We have seen how the concepts *self, empathy, compassion* and *acceptance* have been introduced into psychology. But a problem is that some of them (e.g., *self* or *empathy*) are difficult to define, and the result of this is that they have many definitions. It is also unclear to what extent they differ from each other (e.g., *empathy* versus *compassion)*. On a daily basis this may not be so important, but for research and clinical practice unclear terms are problematic and needs to be clarified. It could therefore be useful when exploring these concepts to start by considering their etymological roots.

1.2 Etymological searches

An intuitive understanding of *empathy* is that it means to have a common understanding with somebody, not just cognitively but also affectively. The same goes for *compassion,* but maybe the affective component is more salient in *compassion* than in *empathy? Compassion* may also connote to a more suffering aspect compared to *empathy*. *Acceptance* on the other hand seems to me to be more cognitive, and maybe more pragmatic than the other terms. In that it is possible to *accept* something without feeling anything for it. So, how were these terms originally understood? I conducted an etymological search in order to examine the original meanings of *self, empathy, compassion* and *acceptance*.

Self. The etymologic dictionary did not have much to say about *self* other than it was a Mid English term from before 900. The webpage had a quotation from the British philosopher Alan Wilson Watts (1915-1973) that lends support to Kohut's statements about the difficulties with defining the self:

> "*Trying to define yourself is like trying to bite your own teeth*" [Alan Watts] (downloaded on March 31. 2011 from www.etymonline.com).

Empathy. The origin of *'empathy'* is from Greek *empátheia* meaning 'affection', equivalent to em + path which has its root in páshein to suffer + eia. Among the synonyms to *empathy* are *compassion,* s*ympathy* and *communion. Compassion* means to suffer with, while sympathy depicts having fellowship or a community of feelings with someone. Communion also depicts oneness or a union (downloaded on March 31. 2011, from www.etymonline.com).

Compassion. *'Compassion'* is an old French term from the middle of the 14th century, which means 'to suffer with or to have concern for or pity the sufferings of others'. 'Com' - means 'together' and 'pati' is from 'passion' and means 'to suffer' (downloaded on January 18. 2011, from www.etymonline.com). To suffer means to bear, and to have concern for refers to taking or having the responsibility or be related to the sufferings or pity (of Latin: *pietãt*), which again is a synonym for compassion.

Acceptance. The term '*accept'* can be traced back to the late 14-century French *accept* or Latin *acceptare* which means to *'take or receive voluntarily*.' It is an offspring of accipere, which stems from ad-, and capere and means 'to see capable'. Of synonyms that are related to

accept are 'to acknowledge' meaning 'to understand or to recognize', 'to acquiesce' which means 'to become calm or to be satisfied with and to tolerate'. An antonym to accept is to reject (downloaded on March 31. 2011, from www.etymonline.com).

Results from the etymological search revealed that *empathy* and *compassion* have different origins, but surprisingly the same meaning in that they both depict the affective component of suffering 'páshein (passion). They both also connote to a sense of fellowship with someone in that 'com' in *compassion* means 'together' while 'em' in *empathy* means 'in'. In other words 'em' means 'to feel into' someone. *Empathy* was translated into German 'Einfülung' in 1903 by Rudolf Lotze (1817-1881), and literally means 'feeling in', while *compassion* means 'feeling with'. If by *empathy* it is meant to 'feel your way into the suffering of the other' it means the same as 'suffering with' and have the same meaning as *compassion*. So, due to their common aspect of 'suffering with', *compassion* and *empathy* are relatives. A synonym to both *empathy* and *compassion* is 'sympathy', but sympathy does not refer to the aspect of suffering with. In sympathy feelings can be shared but they may not necessarily be of the suffering kind. Communion depicts change in that one becomes like the other, or that two (or more) unites into something larger, or something different. *Accept* does not have the affective aspect as *empathy* and *compassion*. To take or receive voluntarily does not necessarily have an affective element linked to it. Neither does to see capable, but it is not totally without an affective component. A related synonym to *accept* is acquiesce which is related to soothe.

So where have these searches lead us? We knew the self was difficult to define but we did have sort of a 'combined' definition of self. Lent to us from Kohut and Rogers. The etymologic search could only confirm the difficulty in defining self. Empathy is also a concept with many definitions but it is confirmed that the true or at least the essential meaning connotes to 'feel your way into' someone but so does *compassion*. Although *compassion* seems to have a more suffering ring to it, the surprise was that empathy originally also had that. *Acceptance* has more of a value neutral connotation not completely free from affect in that it is related to soothing, but it is unconditional.

In the next section I will consider some examples of how the positive self-constructs are used in psychotherapy, and then how they are constructed.

2 A search for constructs

As mentioned earlier Barrett-Lennard viewed *self-empathy* as a largely neglected aspect of client change (Barrett-Lennard, 1997). With basis from earlier work in relational therapy (Barrett-Lennard, 1981, 1993) he suggested a model for helping clients to enhance self-empathy. His construct will be considered in this section.
The etymologic search conveyed that *empathy* is related to *compassion*, and *compassion* and *self-compassion* can obviously not be so very different from each other either, or can they? And what about *acceptance*? How are these constructs implemented in therapy, and how are they constructed? In considering the therapeutic use of the positive self-constructs the constructs will be extracted from the therapeutic theories.

2.1 Use of positive self-constructs in psychotherapy

2.1.1 Self-Empathy

Self-empathy can be conceptualized as empathy directed inward (Barrett-Lennard, 1997). Barrett-Lennard took basis in a combination of Rogers understanding of the self as dual. This is mentioned earlier in this thesis, but it will be briefly repeated. Openness meant that all types of stimulus could fully pass through the nervous system and become available to awareness. But since it is impossible for the person to be aware of everything that is going on within at the same time, Rogers suggested that it took place on two levels. The primary level is what Rogers called organismic (not self-conscious experience). The secondary level was where the expression or articulate consciousness went on. It involved a transformation of primary subjective experience to a symbolic form. Barrett-Lennard called these levels for 'the organic self' and the 'I-self' (Barrett-Lennard, 1997). It is through enhancing the unity between these two instances that self-empathy would occur.
In order to enhance the communication and unity between the organic and the I-self, Barrett-Lennard proposed a four-stage model. The objective for this model was to enhance *respectful inner listening,* which would lead to a stage of *formative recognition* and enhance *inner communication* and culminate in a stage of *received empathy.*

Respectful inner listening

Barrett-Lennard proposed that a precondition for empathy to occur would be to listen with truly interested attention and non-judgmental receptivity. The person must listen with readiness to take seriously whatever signals that arise internally. He called this for respectful inner listening. The I-self would be fully aware of the inner flow of the signals from the organic self and these signals could then be encoded into articulate consciousness in the I-self. He also suggested that inner signals, which normally could be detected by the I-self, could be muted in the absence of self-empathy, but that the signals would not disappear (Barrett-Lennard, 1997). A good illustration of this ability is that the client should listen to his or her 'gut-feeling' (E. Hartmann, personal communication June 9, 2011).

Formative recognition

This stage referred to a condition that would happen when respectful inner listening was established. It would refer to a quality of energy arousal that happened when new meaning came to life due to the attention of the I-self to the signals from the organic self. Barrett-Lennard compared this to the "aha experience" in classical accounts of insight (Barrett-Lennard, 1997).

Inner communication

Full reception of inner signals and an accurate recognition by the attending I-self would result in the process of inner communication between the I-self and the organic self (Barrett-Lennard, 1997).

Received empathy

The above-mentioned stages would culminate in a phase of received empathy from the impact of recognizing and articulating the message from a deeper precognitive level. In this moment the "dual-self" would be "one", and there would be a sensation of integration and wholeness. The self-empathic process would be activated and enhanced through the experience of sustained emphatic sensitivity and response from any caring human source, and *self-empathy* would in turn bring about the potential for sensitive attunement and therefore empathy towards others (Barrett-Lennard, 1997).

Barrett-Lenard's (1997) construct *self-empathy* comprises respectful inner listening, formative recognition, and inner communication and received empathy.

2.1.2 Compassion focused therapy - *Compassion*

Paul Gilbert (2010) has recently proposed Compassion Focused Therapy (CFT). CFT builds on his conception of *compassion* and many of the principles from Cognitive Behavioral Therapy. There is also implemented elements from other therapies, for instance exposure, chair work, behavioral experiments, mindfulness, psycho-education, and more (Gilbert, 2010).

Compassion Focused Therapy (CFT) was developed with and for people with chronic and complex mental health problems. It is inspired by an evolutionary, neuroscientific and a social psychological approach. It is linked to the psychology and neuropsychology of both giving and receiving care. It is suggested that different mixes of motives, emotions and information processing routines gives rise to different internal patterns of neurophysiologic activity that is called a social mentality (Gilbert, 2005, 2010). 'Social mentality' is defined as the 'organization of various psychological competencies and modules guided by motives to secure specific types of social relationship' (Gilbert, 2005). The social mentality enables humans to seek out and form certain forms of relationships like for instance sexual, tribal, competing for status or caring. The basic idea is that brain patterns are organized in different and particular ways to make us fit to pursue "species general evolved biosocial goals and motives", e.g., seeking out sexual partners, looking after offspring, forming friendship and alliances or competing for status. He suggests a system that is underpinning the social mentality by introducing a model with three interacting regulatory systems that affects the brain. Each system has different functions.

The threat and self-protection system is functioning to detect hazards or threats quickly, and then to find the correct response in relation to this. For instance fight or flight responses or other coping strategies. This system will trigger affects such as anxiety, anger or disgust. It will also become enabled if we discover that our friends or someone we love is in danger.

The incentive and resource-seeking system gives us energy if we achieve something we want, for instance if we pass an exam etc. Gilbert proposes that clients with major depression may have problems with this system because it can easily fluctuate between high and low

activation. When it is balanced by the other two systems this system leads us to important objectives. When our ability to achieve our desires is blocked, it connects to the threat and self-protection system so that we can become angry, frustrated or anxious. The incentive and resource seeking system is primarily regarded as activating.

The soothing, contentment and safeness system allows for comfort, tranquility and relaxation toward the self. It makes it possible for individuals to regain balance if they have been upset. This system gives a sense of satisfaction when one is not striving to achieve or to avoid something. The system is also connected to affection and kindness. Of importance for this system is that affection and kindness from others gives us a sense of security and comfort that act on brain systems in ways that are similar to those that produce gratification and satisfaction, such as endorphins. It is this system that is important in connection to *compassion* training, which is part of CFT (Gilbert, 2005, 2010).

The theory of CFT suggests evolutionary origins for some of the components regarding care and compassion. It offers an explanation to how these components creates prosocial and soothing features via the creation of safeness for self and others, and also how *compassion* towards self and others can be pleasant and rewarding for some people, and yet very hard for others. Gilbert suggests that if a client is feeling anxious his protection and safety system will be activated and not his care-giving and safe mentality. On the basis of these different systems for processing different aspects of emotions in the brain, he argues that the alternative thoughts that therapist and client is trying to replace in therapy may not be experienced as helpful because it is difficult for clients to actually be able feel this difference because another emotional system is activated in the client (Gilbert, 2010). For example when we are in a care-giving mental state we focus our attention on the distress and need of the other or our selves, but when we are in a protection and safety seeking mentality we will respond by fighting or fleeing, and when we are in an achieving and activating mental state we are more active and competitive (Gilbert, 2010).

Gilberts understanding of *compassion* is also inspired from The Dalai Lama, and the Buddhist way of conceptualizing it. He argues that Buddhism understands *compassion* as basic to human nature, while the basic view in the western countries is that human nature is basically more cruel than kind (Gilbert, 2005). This may be related to Freud’s view of the functions of id in the unconscious. His view of the human nature became even more pessimistic in the period after 1920 when he introduced the death wish ‘thanatos’ as a repressed instinct. In his

dual instinct theory (1920), Freud viewed aggression and sexuality as a source of basic instinctual energy that drove mental processes (Mitchell & Black, 1995).

Gilbert (2005) argues that psychology has largely focused on empathy, positive regard and similar concepts, but that *compassion* is little emphasized in Western psychology. *His* concise definition of *compassion* is 'to bee open to the suffering of self and others, in a non-defensive and non-judgmental way'. It also involves a desire to relieve suffering, by relieving cognitions related to the understanding of the causes of suffering, and it includes the behavioral aspect of acting with *compassion.*

He proposes that *compassion* offers a new approach to psychotherapy, and that it opens up for new research. He argues that empathy has been difficult to define because it has been so many different definitions of empathy. Gilbert also defines 'theory of mind' as 'empathic mind reading' and claims that some forms of empathic mind reading also can be used to manipulate and exploit people because it does not have to involve care and interest at all (Gilbert, 2005).

He proposes that we can react to external and internal stimuli as if the were the same, and refers to an example of an external sexual stimulus that may cause arousal, but so would an internal fantasy (Gilbert & Procter, 2006). This can also be seen in regard to self-criticism, and can be developed over time into a critical inner voice, and a way of negative self-relating. Abilities that are related to *compassion* are in contrast linked to evolved motivational, emotional and cognitive-behavioral competences, which is related to the caring for others. In order to increase chances of survival for self and others this involves a motivational aspect to care for the well being of the other. One of the elements In CFT is Compassion Focused Mind Training (CMT). An aim in CMT is to enhance *compassion* abilities (Gilbert & Procter, 2006). A number of key elements are mentioned as *compassion* abilities:

Distress sensitivity is related to the ability to detect and process distress, instead of denial and dissociation. **Sympathy** is related to being emotionally moved by distress. **Distress tolerance** refers to the ability to tolerate distress and painful feelings in another instead of avoidance and seeking to control the emotions of the other. **Empathy** is understood as intuitive and cognitive abilities or theory of mind skills to understand the source of distress, and what it takes to help the one who is distressed. **Non-judgment** is related to the ability to be non-critical of the others situation or behaviors. And finally all of these need the emotional tone of

warmth, and problems in any of these elements can make *compassion* difficult. *Self-compassion* refers to the use of these abilities towards the self (Gilbert & Procter, 2006).

The construct *compassion* comprises openness to the suffering of self and others, a desire to relieve suffering, by relieving cognitions related to the understanding of the causes of suffering, and the behavioral aspect of acting with *compassion.* It consists of distress sensitivity /recognition, and distress tolerance, and also sympathy, empathy, non-judgment and warmth.

2.1.3 Short-Term Dynamic Therapy – Positive feelings for self *(Self-Compassion)*

Within the tradition of Short Term Dynamic Therapy, Leigh McCullough has developed a psychotherapy model for understanding and working with the emotional problems clients may experience due to what is conceptualized as Affect Phobia (McCullough, Kuhn, Andrews, Kaplan, et al., 2003). This means that the client is unable to experience and express the adaptive true emotion he or she feels, and instead uses a defense mechanism. The defense mechanism is often also linked to the client's feelings of anxiety or shame upon themselves because he or she feels just as he or she does. McCullough argues that in behavioral terms this can be reframed as a phobic avoidance of ones adaptive feeling (McCullough, Kuhn, Andrews, Kaplan, et al., 2003; McCullough-Vaillant, 1997). One important therapeutic objective in this model is to restructure the client's sense of self and others. The hypothesis is that by strengthening the client's positive feelings for self and others, the client would develop a more well adjusted sense of self. In the Affect Phobia model positive feelings for self are seen as a group of feelings that are directed towards the self. They are conceptualized as a blend of Tomkins's basic positive affects interest-excitement and enjoyment-joy (Tomkins, Karon, & Silvan S. Tomkins Institute, 2008), which are directed towards the self. Their function is to maintain positive self-esteem and to protect the integrity and care for the self (McCullough, Kuhn, Andrews, Kaplan, et al., 2003).

McCullough and associates have developed a scale to measure levels of achievement of therapeutic objectives (ATOS), during sessions of therapy (McCullough, Kuhn, Andrews, Valen, et al., 2003). One of the dependent variables in the ATOS is the level of sense of self that is experienced by the client during sessions of therapy. The variables to measure sense of self comprises pride in own strengths, affirming own wants and needs, ability to be

compassionate of own weakness, and the ability to have a sense of *self-compassion* and *self-acceptance*. The level of shame or self-blame the client is experiencing is also measured. So inherent in level of sense of self is *compassion, self-compassion and acceptance*. Change in the Affect Phobia model is seen as helping the client to become aware of his or her use of a defense mechanism that is blocking the adaptive affect. Then the client would be exposed to his or her adaptive self-affect, which in this case would be positive feelings for self, and then to regulate the anxiety that is felt by the client so that the positive self-affect can be accessible to the client.

2.1.4 Self-Esteem *versus Self-Compassion*

One of the more famous constructs that have grown out of the self-concept is 'self-esteem'. A significant issue regarding self-esteem is that it can be understood as a human quality that is active in both positive and negative situations (Mruk, 2006). It has therefore been defined in various ways (e.g., state versus trait, global versus local). It can also be understood as a continuum from low to high (Mruk, 2006). Since much of the research regarding self-esteem refers to global self-esteem this will be referred to here. Global self-esteem can be understood as people's evaluative component of their self-knowledge (Baumeister, Campbell, Krueger, & Vohs, 2003). A favored hypothesis among some theorists was that high self-esteem would act as a kind of buffer that would enable people to feel less anxious (Pyszczynski, Solomon, Greenberg, Arndt, & Schimel, 2004). In the end of the 80's in the United States, self-esteem was considered to be so significant that several national programs (e.g. California Task Force two Promote Self-Esteem, 1990) were initiated to enhance people's self-esteem. It was assumed that enhancing peoples self-esteem would have economic and hence political consequences (Baumeister, et al., 2003; Baumeister, Krueger, & Vohs, 2005). Low global self-esteem has also been related to several types of mental disorders. In a study with 957 psychiatric patients, the researchers found that all of the patients suffered some degree of low self-esteem. Low global self-esteem was especially related to patients suffering from depressive disorders, eating disorders and substance use disorders (Silverstone & Salsali, 2003) Silverstone & Salsali also suggests that there is a bidirectional relation between psychiatric disorders and self-esteem. But a more recent Norwegian study that investigated different predictors of self-esteem in psychiatric outpatients, revealed that psychological distress and interpersonal distress were found be more significant contributors to lowered levels of global self-esteem than psychiatric diagnoses (Bjørkvik, Biringer, Eikeland, &

Nielsen, 2008). So the relationship between self-esteem and mental health seems to be more complex than first hypothesized. In the case of high global self-esteem it does seem to be correlated to more happiness, and less depression (Baumeister, et al., 2003), but it has also been associated with narcissism (Morf & Rhodewalt, 2001). And studies have revealed that high global self-esteem do not improve academic performance or prevent people from drinking and taking drugs, and is therefore not sufficient for a person to become a well-functioning member of society (Baumeister, et al., 2003; Baumeister, et al., 2005; Baumeister, Smart, & Boden, 1996). In reviewing the impact of enhancing self-esteem researchers did not find evidence that boosting self-esteem by therapeutic interventions or school programs was beneficial for the society (Baumeister, et al., 2003).

It is in light of some of this newer research on self-esteem that some researchers have proposed *self-compassion* (McCullough & Thornes, 2007; Neff, 2003b; Neff & Vonk, 2009). Neff & Vonk (2009) have argued that *self-compassion* is a more useful construct than self-esteem. Neff & Vonk defines *self-compassion* as treating oneself with kindness, recognizing one's shared humanity, and being mindful when considering negative aspects of oneself (Neff & Vonk, 2009). In a study comparing global self-esteem with *self-compassion,* they found that *self-compassion* was associated with more stable feelings of self-worth that were less contingent on particular outcomes than self-esteem was. They also found a stronger negative association with social comparison, self-evaluative anxiety, anger and closed-mindedness with *self-compassion* than they found with self-esteem (Neff & Vonk, 2009). It is with basis in these arguments that *self-compassion* will be examined instead of self-esteem.

*Self Compassion**

McCullough & Thornes (2007)

McCullough and the staff at Modum bad has through working with severely ill Axis II client population experienced that the enhancing of clients capacity for *self compassion* had powerful effects.

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* In their article McCullough & Thornes does not use a hyphen when referring to self compassion. In order to differ between their construct and Neff's construct I will refer to McCullough and Thornes construct without the hyphen.

They noticed that the capacity to feel *compassion* for self was easier to bear for some of their patients but not for others (McCullough & Thornes, 2007).

Self compassion is here understood as one of the activating feelings in the variable sense of self, which is measured in the ATOS. It is emphasized by McCullough & Thornes in this context as a result of a growing interest in restructuring the general category of positive feelings for self (McCullough & Thornes, 2007). With basis on the background of their clinical experience and through reviewing the literature McCullough & Thornes (2007) defines *'self compassion'* as:

> '- *unconditional, wholehearted, positive regard and loving kindness directed toward the self. Self compassion means acceptance of all that is within us; our strengths and accomplishments as well as our mistakes and failure*' (McCullough & Thornes, 2007; p. 36).

They also emphasize that *self compassion* does not condone bad or destructive behavior, nor deny the need for standards and values. *Self compassion* helps us to acknowledge that we are imperfect human beings, like all other human beings, and that it is a struggle to be human, and that life is a challenge to us all (McCullough & Thornes, 2007).

McCullough & Thornes' construct *self compassion* comprises unconditional positive regard, loving kindness and acceptance, and an understanding of human imperfection.

Neff (2003)

Kristin Neff has done much research concerning the construct *self-compassion*. She has also developed a scale that measures *self-compassion* (Neff, 2003a). Neff understands *self-compassion* as related to the more general definition of *compassion* which refers to being touched by the suffering of others instead of pulling away from or disconnecting from others when they feel pain. It also contains a whish for trying to express feelings of kindness and for alleviating the suffering of others. And it involves a kind of nonjudgmental understanding towards those who fail or do wrong (Neff, 2003b). *Self-compassion* involves being touched by, open to, and not to disconnect to one's own suffering. Instead one will have a desire to alleviate and heal one's own suffering with kindness. It also involves a nonjudgmental attitude towards one's own pain, inadequacies and mistakes so that the experience is seen as part of a larger human experience. Being *compassionate* towards the self does not mean to be

self-centered. Instead it will contribute to enhance feelings of *compassion* and concern for others (Neff, 2003b).

Three different aspects are then emphasized in the construct *self-compassion*. These aspects represent opposing subscales and are identified by their positive quality. It is that when faced with experiences of suffering or personal failure, *self-compassion* entails:

- Extending kindness towards the self instead of judgment and harsh criticism.
- Common humanity, which refers to seeing ones experiences as part of a larger human experience instead of isolation.
- Mindfulness, which refers to holding ones experiences in a balanced awareness, and with a detached stance rather that over-identifying with them (Neff, 2003b).

2.1.5 Relational Psychoanalytic Psychotherapy – *Self-Acceptance*

Relational psychoanalytic psychotherapy is as an outgrowth of Psychoanalysis. With its emphasis on context and relationships and two person perspectives it can be understood as a more soft approach than traditional Psychoanalysis. Paul Wachtel (2008) has proposed a Cyclical-Contextual Model (Wachtel, 2008), where the aim is to unite the traditional psychodynamic view that our behavior is governed by the past, with the more modern view that people are responsive to their immediate context and changes in it (Wachtel, 2008). This means that we have a tendency to perceive and behave in a manner that is likely to evoke the old in the new. The clients actions are not only understood with basis in his or her earlier history, but the solutions the client have developed earlier will eventually become part of the problem he or she has today, and thereby be a maintaining factor in the problem (Nielsen, 2008).

Wachtel argues that the only way to be supportive and affirmative in the therapeutic context is to provide the client with the experience of being fully understood, and that the therapist can make the client feel that he or she will have a better understanding of what the client may experience as his or her weak or dark side. The importance of making room for the thoughts and feelings that the client may find shameful and frightening is emphasized, and understood as a better way to get in touch with and be able to work with what the client finds difficult.

Wachtel emphasizes a new understanding of anxiety where it is more important to reduce anxiety than to convey unconscious material (Hartmann, 2009). He also argues that even if insight is an important factor for therapeutic change to occur, it is not sufficient for the client to become more conscious or to gain insight. Many patients must also become less self-rejecting (Wachtel, 2008), and the implication of that would be to be more self-accepting.

In Wachtel's theory self-acceptance is not defined and can therefore not be defined as a construct, but it is still a central concept in Relational psychoanalytic psychotherapy. *Self-acceptance* is defined in Rational-Emotive Behavior Therapy.

2.1.6 Rational-Emotive Behavior Therapy – *Self-Acceptance*

Rational-Emotive Behavior Therapy (REBT) was established in 1955 by Albert Ellis as Rational Therapy. It was renamed into Rational-Emotive Therapy in 1962, and renamed again into Rational-Emotive Behavior Therapy in 1993. It is regarded as one of the "grandparents" of Cognitive Psychotherapy, and was proposed nearly a decade before Aaron Becks Cognitive Therapy (Beck, 1967). It's cognitive or (rational) aspect has a phenomenological emphasis, in the sense that we respond to events, as we perceive them, or the extreme beliefs we hold about them, not like they necessarily are. The affective-experiential (emotive) aspect emphasizes and encourages people to have passionate positive and negative responses to things that are important to them as long as these responses are healthy (Dryden, 2009). Its experiential focus is that it encourages people to fully experience feelings even though it is thought that unhealthy negative feelings are not curative, but they can help people to identify the irrational beliefs that underpin their feelings (Dryden, 2009). REBT also have a behavioral emphasis with its view that people are happiest when they are actively pursuing meaningful goals (Dryden, 2009). REBT like cognitive therapy in general, utilizes an ABC model, but it is distinct in that A stands for the aspect of the situation that we respond to, B stands for the beliefs that are held about A, and C stands for the response that are made (Dryden, 2009).

REBT emphasizes *unconditional accept for self,* others and for life (Ellis & Ellis, 2011). To unconditionally accept the self means to have *acceptance* for the self with its flaws and failings. It focuses on learning from our mistakes, but not to put ourselves down or falsely think that we are mistakes or failures. It encourages us to know that our worth as humans exists just because we exist, and not as a result of our acting in good or saintly ways. This

means to accept and respect ones self, whether or not one performs well and gains approval of others (Ellis & Ellis, 2011).

The construct *unconditional acceptance for self* comprises acceptance, learning from mistakes and a sense of being valued as human beings.

To summarize, *self-empathy* as a construct consists of respectful inner listening, formative recognition, inner communication and received empathy. In *Compassion* the emphasis is openness to the suffering of self, a desire to relieve suffering by relieving cognitions related to an understanding of the causes of suffering, and acting with *compassion.* It comprises a sensitivity or recognition of inner distress and also tolerance of it. It also comprises sympathy, empathy, non-judgment and warmth. McCullough & Thornes (2007) understanding of *self compassion* focuses on unconditional positive regard, loving kindness, acceptance and an understanding of human imperfection. Neff's (2003b) understanding comprises treating self with kindness, recognizing shared humanity, being mindful when considering negative aspects. Inherent in the construct *self-accept* is acceptance, learning from mistakes and a sense of being valued as human beings.

We have now had a glimpse of how these constructs are implemented into different therapies. They all have the common emphasis that viewing the client's ability to get access to his or her own positive feelings for self is of value. An important point is also their common view that enhancing positive feelings for self also will bring about positive feelings for others. We have seen what the different constructs consist of, and they can now be compared. The themes mentioned in this summary will be elaborated further in the discussion of the constructs that follows.

2.2 Discussing constructs

2.2.1 Comparison

An important aspect of enhancing positive feelings for self is that it also will affect others. This is a common view for the therapy traditions that have been mentioned here. Barrett-Lennard (1997) proposed that the *self-empathic* process will be sustained and held active through the experience of empathic sensitivity and responses from others, and that this in turn would bring about the potential for empathy or sensitive attunement towards others. In

Wacthel's (2008) Cyclical-contextual model a somewhat similar mechanism is proposed in that people in our contexts will react to or give us feedback on our behavior. In other words if we are more accepting towards ourselves this will be part of a cycle that will affect others, and they will in turn affect us. Gilbert (2005) has a similar focus regarding social mentalities. If for example we are in a care-giving mental state we focus our attention on the distress and need of others or our selves and act with openness towards the suffering of self and others. In the Affect-Phobia Model (McCullough, Kuhn, Andrews, Kaplan, et al., 2003) the focus is that that the restructuring of sense of self is linked to level of sense of others. An important focus is to develop an adaptive balance between meeting ones own needs and the ability to be receptive and responsive to the needs of others (McCullough, Kuhn, Andrews, Kaplan, et al., 2003). In REBT (Ellis & Ellis, 2011) there is unconditional positive regard for self, but also for others, and also for the world. Neff (2003b) also has this emphasis in that we are to understand our setbacks as a part of the common human experience and hence to se our experience in light of a larger picture. This will enhance our compassion for self, but also our feelings of compassion for others. So these to aspects, that enhancing self-feelings is beneficial for self and others, link all these constructs together. But what separates them?

We will start by comparing the constructs *self-empathy* and *compassion*. S*elf-empathy* consists of respectful inner listening, formative recognition, inner communication, received empathy, and *compassion* has openness to the suffering of self and others, a desire to relieve suffering, by relieving cognitions related to the understanding of the causes of suffering, and acting with *compassion.* Respectful inner listening may not be different from openness to the suffering of self. But the openness in respectful inner listening seems more open to all kinds of signals and stimuli, so that more than just suffering could pass through the nervous system.

In *Self-empathy* there is focus on the energy or arousal that will happen when respectful inner listening is established; *compassion* focuses on sensitivity or recognition of inner distress. Again we can se that the focus for *compassion* is more towards the suffering aspect than what seems to be the case with *self-empathy.* The next aspect of *self-empathy* is inner communication, which is a full reception of inner signals together with an accurate recognition of the message from within. *Compassion* has an understanding of what it is that is causing suffering. Also here does *self-empathy* seem more open in that inner communication can be regarding more than just an understanding of the cause of suffering. On the other hand an understanding of what causes suffering needs a form of inner communication. This can

also be compared to the learning from mistakes, which is a part of the *self-acceptance* construct. Inner communication is thus the most open of these aspects in that it is open to more that just suffering and mistakes. The next aspect concerns empathy. *Self-empathy* is received after the stage of inner communication. In the *compassion* construct empathy is seen as a part of *compassion* and a way to know the source of the distress, and what it takes to help resolve the suffering. So the conceptions of empathy in *self-empathy* and *compassion* are different in that empathy represents a final stage in *self-empathy* like an insight, while in *compassion* its an aspect and a stage or part of an act to reach *compassion.*

The construct *compassion* has more facets than self-empathy. A next aspect is sympathy, and sympathy depicts a "feeling with", but without the suffering aspect so it is more like the aspects of *self-empathy*. Tolerance is a prerequisite for recognition and understanding of inner distress and its causes. This is not emphasized in *self-empathy* but mentioned in a more unclear form in that sustained empathic sensitivity is mentioned. Non-judgment can be understood as similar to acceptance and unconditional positive regard. They will be discussed in relation to *self-compassion* and *self-acceptance*.

Warmth is an aspect of *compassion* but it is lacking in *self-empathy*. Warmth is regarded an important factor in human development because it will make us feel safe enough to be able to explore. A variant of warmth is found in both of the *self-compassion* constructs. McCullough & Thornes (2003) has loving kindness and Neff's (2003b) construct has self-kindness. McCullough and Thornes' construct (2007) has loving kindness, unconditional positive regard and kindness. It is a bit difficult to see what the difference between these two aspects is. Earlier in this thesis Rogers discussion of unconditional positive regard was mentioned. He referred to Standal (1954, unpublished) who argued that therapists experience of warm acceptance is defined as unconditional positive regard, and this involves a feeling of acceptance of the clients expressions of negative "bad", fearful, defensive or abnormal feelings as for his expression of "good", mature, confident and social feelings (Rogers, 1957). Neff's (2003b) construct *self-compassion* has self-kindness, shared humanity and mindfulness. Self-kindness has already been considered, but shared humanity has not been considered. It is also to be found in *self-acceptance* in sense of being valued as human, so this construct also comprises a sense of or identification with others or even more so humanity. McCullough and Thornes (2007) are also touching upon this in their understanding of human imperfection. The last aspect to be considered is mindfulness. Mindfulness is in itself a

popular construct with many connotations and links to therapy e.g., Mindfulness Based Cognitive Therapy (Kuyken et al., 2010). Neff's definition of mindfulness is

> "- *a balanced state of awareness that avoids the extremes of over-identification and dissociation with experience and entails the clear seeing and acceptance of mental and emotional phenomena as it arises*" (Neff, 2003b; p. 88).

So, inherent in mindfulness is the potential to experience respectful inner listening, openness to self-suffering, formative recognition, understanding of the causes of suffering, inner communication, tolerance, acceptance, and unconditional positive regard. This is why mindfulness is repeated several times in table 2.1, which presents an overview of the elements in the different constructs. The elements that are related are placed in the same columns (e.g., Respectful inner listening, openness to self-suffering and mindfulness).

Table 2.1: Comparison of constructs										
Self-empathy	Respectful inner listening	Formative recognition	Inner communication	Received empathy						
Compassion	Openness to self - suffering	Sensitivity/ recognition to inner distress	Understanding of causes to suffering	Empathy	Sympathy	Tolerance	Non-judgment	Warmth		
Self compassion							Unconditional positive regard	Loving kindness	Understand human imperfect-ion	Acceptance
Self-compassion	Mindfulness						Mindfulness	Self-kindness	Shared humanity	Mindfulness
Self-acceptance			Learning from mistakes						Sense of being valued as human	Acceptance

An answer to the question of what makes the constructs similar is then considered, and also how they are different. As seen in table 2.1 *self-empathy* lacks the aspect of warmth. *Compassion* is a complex construct in that it specifies many aspects, but like *self-compassion* the focus is on alleviating suffering compared to *self-empathy*. *Self-compassion* and *self-acceptance* also has a humanity aspect inherent which makes them different from *self-empathy* and *compassion.* But are any of the constructs adequate? In the exploration of constructs it also has to be considered what a good construct comprises.

2.2.2 Construct validity

Construct validity is an important aspect in research when considering if a construct conveys what it is meant to convey. In this respect what could be considered in construct validity is face validity, content validity and predictive validity.

Face validity refers to whether a construct seems to cover or explain what it is meant to cover (Svartdal, 2009). We could say that constructs are meant to cover a psychological process, and the psychological process the positive self-constructs are meant to cover in this case is enhancement of wellbeing, and a way to care for self and others. But does all the self-constructs we are exploring seem reasonable in that they connote to a way of enhancing wellbeing or a way care for self and to others? The next question is how valid their content is. Which of these constructs will organize and cover enhancement of wellbeing and care for self and others in the best way?

We have compared the constructs, and *self-empathy, compassion, self-compassion* and *self-acceptance* all seem to have fairly good face validity. But to bee adequate they constructs must contain enough elements as to convey the psychological process that is the basis of what is observed. This is referred to as content validity, or theoretic validity (Svartdal, 2009). It will be beyond the scope of this thesis to validate all these constructs, and face validity by it self may not be the optimal method for validating a construct. Since a construct also can be viewed as a hypothetical definition or term until it is validated by research (Svartdal, 2009), I will therefore compare them to a set of criteria for a good definition. Three criteria could be mentioned in that respect. The elements in the definition should not overlap. The contents in the definition should have an explanatory value (that they convey what is meant to be conveyed). But it will be too easy just to add terms in order for a construct or a definition to have adequate explanatory value. A construct should in the same fashion as a good definition or a good theory also bee simplistic (Svartdal, 2009). The third reasonable criteria is therefore to subject the constructs to the Franciscan friar from the 14th century, William Occam's razor (or The Law of Parsimony):

> "*One should not increase, beyond what is necessary, the number of entities required to explain anything*".

So which of the constructs will in the best way include and organize the elements of an ability to care about and soothe self and others?

Self-empathy with its four elements respectful inner listening, formative reconditioning, inner communication and received empathy seems to lack the important aspect warmth and also tolerance. Though it may be implicit that in order to listen and recognize and communicate, tolerance will be necessary. Maybe even tolerance could be linked to warmth?

It's hard to imagine that *compassion,* which includes openness to self-suffering, sensitivity to inner distress, understanding of causes to suffering, empathy, sympathy, tolerance, non-judgment and warmth, is lacking any elements. It has specificity in that many terms are used in the construct. But this does not fit well with Occam's razor. Are all these terms necessary to describe or the ability to care for and soothe self and others? On the other hand it's also hard to find any of these terms as overlapping.

Self compassion has unconditional positive regard, loving kindness, understanding of human imperfection and acceptance. As mentioned earlier unconditional positive regard and acceptance seems to overlap. The other element that is included here is an understanding of human imperfection, but this may also slightly overlap with acceptance. Neff's shared humanity would probably have differentiated the terms in the construct better.

Self-compassion has only the three elements mindfulness, self-kindness and sense of shared humanity. They seem to be mutually exclusive. An important aspect here seems to be mindfulness. According to Neff's definition of mindfulness (which is considered in 2.2.1), it seems to me that mindfulness comprises openness to suffering, formative recognition, inner communication, empathy, sympathy, tolerance and unconditional positive regard. They do not overlap with common humanity and self-kindness, which can be understood as warmth. However, a salient point may be that mindfulness is an independent construct in it's own right. This will be discussed further in section 3. 2 in the discussion of the impact of *self-compassion.*

Self-acceptance has also three elements inherent in the construct. Learning from mistakes, sense of being valued as human and acceptance. These also seem to be mutually exclusive but they lack the element of warmth.

In accordance with the criteria that were proposed for a good construct, Neff's construct *self-compassion* is the most elegant in that it uses few terms to explain the different aspects. They

do not overlap, and the three terms are easy to operationalize. They also have a god explanatory capability.

In sum, in these two sections we have explored the origin of the positive self-constructs and discovered that empathy and *compassion* originally are relatives in that they have the common meaning to suffer with. In section two we have seen that their use in therapy differs because *self-empathy* does not necessarily refer to the suffering aspect, but it is more open to other internal signals as well. As constructs *self-empathy* lacks the element of warmth and tolerance, while compassion has many elements that may be explained with fewer terms.

Self-compassion can be understood as an outgrowth of compassion. Neff's construct seems to be the most elegant construct because it does not use many terms to cover many aspects, the terms do not overlap, and the they are mutually exclusive. The roots of *self-acceptance* have connotations to a more pragmatic and value free approach, and could also do well with warmth included.

So what does have to research to say regarding these constructs, and what impact have they had in psychotherapy? In the next section I will explore this.

3 A search for impact

3.1.1 Method

In order to examine the research that has been done regarding the various constructs and their impact in therapy, a search was conducted in the databases PsycINFO, MEDLINE, EMBASE, PubMed, ISI-Web of Science and Google Scholar. The search was conducted from February 15. 2011 and through March 29. 2011. The relevant search terms were *self-empathy, compassion, self-compassion,* and *self-accept.* The search was conducted in three steps.

Step 1. Preliminary searches.

In the preliminary searches multi field search forms were used, and I applied for the search terms and "all fields" (af.) As was expected, this query gave many results, especially for the terms *compassion* and *self-accept. Self-empathy* on the other hand yielded only a few results. Results from the preliminary searches can be viewed in table 2.1.

Table 2.1: Results from preliminary searches in databases.

Search terms	Databases					
All fields (a.f)	PsycINFO	MEDLINE	EMBASE	PubMed	ISI Web of Knowledge	Google Scholar
Self-empathy	30	6	6	3	8	15
Compassion	8804	3671	4763	3864	4323	More than 408000
Self-compassion	249	13	25	20	55	1400
Self-accept	2454	319	497	341	465	710

Step 2. 2. Main searches

In order to refine the search several inclusion criteria was therefore introduced. These were: English-only publications, published in the last five years (or from 2005 to 2011 for Google Scholar), and that the search terms *self-empathy, compassion, self-compassion or self-accept* would be contained in the abstract.

The query still yielded many results, so to further refine the search, more inclusion criteria that were primarily relevant to psychotherapy was introduced. As the various databases had different search options, emphasis was based on relevant pre-defined classification codes from PsycINFO (an overview of the classification codes that were used is presented in appendix A, table 1). EMBASE, MEDLINE and PubMed did not have these classification codes, but the same terms that corresponded to the classification codes in PsycINFO were used adding "and" (e.g., *Compassion* "and" Affective Disorders). However the term "Psychiatric Disorders" were not among the predefined classification codes in PsycINFO, but because many of the classification codes are psychiatric terms, I found it reasonable to add this as a search term. The purpose of this was to try to make the search and treatment of all constructs in the different databases as similar as possible. Table 2. 2 presents a list of the inclusion criteria, and table 2. 3 presents an overview of the results from the query.

Table 2. 2: Inclusion criteria for searches in databases.

Inclusion criteria	
Abstract	• Construct in abstract
Language	• Only English publications
Study/design	• Clinical trials • Qualitative studies • Survey designs
Period	• Last 5 years
Classification codes	• See appendix A

Table 2. 3: Search results after the inclusion criteria were submitted.

Search terms	Databases						Sum
Combined with classification codes	PsycINFO	MEDLINE	EMBASE	PubMed	ISI Web of Knowledge	Google Scholar	
Self-empathy	5	2	1	0	2	0	10
Compassion	110	14	8	51	34	*	217
Self-compassion	8	11	19	18	23	16	95
Self-accept	23	3	8	6	47	5	92

* The Google scholar database was different from the other databases in that when a search term (e.g., *Compassion)* was added together with the inclusion criteria (e.g., Affective Disorders), it added only the option “or”, not “and”. In that case the terms were not combined but added, with the result that both Affective Disorders and *Compassion* was revealed in the query, but not with both terms in the abstract but either *Compassion* or Affective Disorders. This gave a large amount of results, and many without relevance for this study. The scope and time limit of this thesis also have to be taken into consideration. For this reason results from Google scholar was not further included in this study.

Step 3. Manual searches

As can be seen from the sum in table 3. 2, *compassion* still yielded many results. These results were manually gone through, and books reviews and obituaries, theoretical articles, and doctorial dissertations were excluded from the query. Only articles related to clinical trials, surveys and qualitative studies were chosen.

3.1.2 Results

The results from the database search had no relevant articles for *self-empathy*, 3 articles for *compassion*, 4 for *self-compassion* and 4 for *self-acceptance*. In the following I will give a brief presentation of the articles and in the next section their impact will be discussed.

Self-empathy

The search in databases yielded 0 articles for *self-empathy*. When only the inclusion criteria: “last five years”, “English only” publications and “construct in abstract” was submitted the result was 7 articles, but none that would fit the criteria’s for this query. There was one article regarding ethical considerations in relation to neuroimaging, one book, and a study with adolescent participants. There was also a doctorial dissertation where Barrett-Lennard’s name was mentioned in relation to the use of The Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1986). In addition there were to experimental studies, and a qualitative study. The two experimental studies were related to family therapy and relationships or the ability for partners in relationships to be forgiving, but they had no relation to clinical trials. Since the focus for this study is clinical trials and qualitative studies related to psychotherapy, the

studies regarding *self-empathy* was not further considered. An overview of the two experiments and the qualitative study can be viewed in appendix A, table 2.

The negative finding for *self-empathy* has implications for the last question that comprised the aims of this study. The question if *compassion*, *positive feelings for self* or *self-compassion* and *self-acceptance* have a different impact in therapeutic settings compared to *self-empathy* will not be answered. Even if this question cannot be answered the impact of the remaining constructs can still be evaluated. In this section I will give a brief presentation of the studies that were selected, after that the impact of the constructs will be evaluated. I will start with *compassion*, then *self-compassion* and *self-acceptance*.

Compassion

The search results for *compassion* yielded one clinical trial and two pilot-studies. The clinical trial explored the effects of positive affects related to symptomatic change in bipolar disorder (Gruber et al., 2009). The other two pilot studies explored the effects of Compassionate Mind Training (CMT) for clients diagnosed with personality disorders and paranoid schizophrenia (Gilbert & Procter, 2006; Mayhew & Gilbert, 2008). CMT is an earlier aspect of Compassion Focused Therapy (Gilbert, 2010), which is considered in section 2.1.2.

In the clinical trial the aim was to examine how positive affects predicted symptomatic change for clients diagnosed with bipolar disorder. This was measured with semi-structured interviews and self-report forms. The participants reported lower levels of joy, *compassion,* love, awe and contentment compared to controls. *Compassion* predicted decreased mania severity after a six-month follow up, and amusement predicted increased depression severity. Pride predicted decreased severity for depression (Gruber, et al., 2009).

In the two pilot studies the aims were to explore the effects of a 12-week Compassionate Mind Training program (CMT) on groups of clients. The results for both pilot studies were measured with self-report forms and through a weekly dairy written by the participants. The participants in one of the studies were a group of day-care clients diagnosed with personality disorders (Gilbert & Procter, 2006). The intervention was a group therapy program. The post treatment results were measured with self-report forms. The results for the participants were reduced levels of depression, anxiety, self-criticism, shame, self-hate, feeling of inferiority

and submissive behavior. All the clients also reported that they felt less depressed and anxious at week 12.

In the other pilot study consisting of clients diagnosed with paranoid psychosis, the results were mixed. The duration of this therapy was also 12 weeks, and the results were also measured with self-report forms and diaries. All the participants had decreased symptom levels when measured with SCL-90. The study had three participants. Participant 1 had no major changes in *self-compassion* and self-criticism scores at 6-month follow-up. His hated-self and inadequate-self scores slightly increased post CMT. His level of engagement with voices remained the same. It was reported that he appeared to intellectually understand the concept of *self-compassion* but found it hard to feel *self-compassionate*. He had rated himself as highly *self-compassionate* pre-treatment. Participant 2 had no major changes in levels of *self-compassion* and self-coldness scores as measured by Self-Compassion Scale (SCS) at the 6-month follow-up. He showed some decreases in self-persecution, inadequate self and hated-self scores. Scores for reassured-self increased. The scores that measured preoccupation with voices decreased. This participant also rated himself as highly self-compassionate at start of CMT. Participant 3 had increases in self-correction and self-reassurance scores, a decrease in self-persecution and inadequate-self scores. His hated-self scores remained low. His preoccupation with voices decreased. Level of *self-compassion* increased but also level of self-coldness (Mayhew & Gilbert, 2008). The results for *compassion* are presented in Table 3. 4.

Table 3. 4: Results for *Compassion*

Authors	Objective	Research method	Participants	Results from study
Gruber et al., 2009	To examine if positive emotions predict symptomatic change in bipolar disorder	Clinical trial	n = 87 (55 patients+ 32 controls)	Patients previously diagnosed with bipolar disorder reported lower joy, compassion, love, awe and contentment compared to controls. Compassion predicted decreased mania severity

Gilbert, Procter, 2006	To explore individuals acceptability, understanding and abilities to practice compassion focused processes	Pilot study, uncontrolled clinical trial	n = 6 (2 male, 4 female) patients in day-care centre	Significant reductions in depression, anxiety, self-criticism, shame, inferiority and submissive behavior
Mayhew, Gilbert, 2008	To explore the value of compassionate mind training (CMT) with paranoid psychotic voice hearers	Pilot study (Preliminary case study)	n = 3 patients male	Decrease for all in some sub scales measured with SCL-90. No major changes in levels of self-compassion and self-criticism scores for 2 of the participants. Auditory hallucinations became less malevolent, less persecuting and more reassuring for all participants.

Self-Compassion

The search for *self-compassion* yielded one qualitative study (Pauley & McPherson, 2010) and three clinical trials. Two of the clinical trials were related to Mindfulness Based Cognitive Therapy (Kuyken, et al., 2010; Van Dam, Sheppard, Forsyth, & Earleywine, 2011), and one explored the relationship between tolerance of pain and self-compassion (Costa & Pinto-Gouveia, 2010).

The aim of the qualitative study was to explore the meaning an experience of *compassion* and *self-compassion* for individuals diagnosed with depression and anxiety. Another aim was to get an understanding of how the participants experienced the efforts to develop and maintain *self-compassion* while they were experiencing depression or anxiety (Pauley & McPherson, 2010). The participants were interviewed with a semi-structured interview that was developed drawing on the literature relevant to *compassion* and *self-compassion* (Gilbert & Procter, 2006; Neff, 2003a). On basis of an analysis of these interviews the researchers identified three

superordinate themes from the participants answers. They were that the participants viewed *compassion* as a kind and active process, that *self-compassion* was meaningful and useful, but that it was difficult to be *self-compassionate*, and that the participants thought that the negative impact of depression and anxiety might have contributed to this difficulty.

Of the three clinical trials one explored *self-compassion* and acceptance related to tolerance of pain. In this study it was investigated whether tolerance of pain was related to *self-compassion* or severity of psychopathology. Specific groups of patients and their tolerance of pain could be identified with basis of scores on the Chronic Pain Acceptance Questionnaire (CPAQ). A cluster analysis was conducted and the results supported the researchers hypothesis concerning three subgroups of patients. These groups could be divided into clients with: Low, intermediate, and high tolerance of pain. One-way ANOVA showed that the three subgroups differed from each other in relation to psychopathology and *self-compassion*. The intermediate subgroup showed less depression and stress compared to the low acceptance subgroup. For *self-compassion* the low-acceptance group scored higher on self-judgment, isolation and over-identification as compared to the intermediate subgroup. The groups also scored differently on common humanity, and mindfulness (Costa & Pinto-Gouveia, 2010).

In one of the studies regarding mindfulness and *self-compassion* the researches were investigating whether treatment effects as a result of Mindfulness Based Cognitive Therapy (MBCT) mediated by mindfulness and *self-compassion* was strengthened in the course of treatment, and /or as changes in post-treatment reactivity (Kuyken, et al., 2010). The study was a randomized controlled trial that compared the effects of MBCT that lasted for 8 weeks, with maintenance antidepressants (mADM). There was also a follow-up for 15-months after the intervention. Mindfulness and *self-compassion* were measured both before (baseline) and after (post-treatment measured one month after). Post treatment relapse was measured at 15 month after the MBCT group termination and at the equivalent time for the mADM group. 123 participants who had experienced 3 or more depressive episodes, and who had positive effects from ongoing use of medication were randomly assigned to either the mADM group or the MBT group. The participants in the MBCT group stopped using medication during treatment, while mADM group continued drug use.

The outcome measures for depressive symptoms and relapse was assessed during the 15-month follow-up. Mindfulness and *self-compassion* were measured with self-report forms. Cognitive reactivity was operationalized as change in depressive thinking in connection with

a laboratory-controlled manipulation of mood, where the participants were induced into a sad mood by listening to sad music and rehearsed a sad memory.
The researchers found that the effect of MBCT was mediated by mindfulness and *self-compassion* during the treatment period. They also found that MBCT had a positive effect on the relationship between post-treatment reactivity, and relapse, because higher post-treatment reactivity predicted relapse for the participants in mADM group. This relationship could not be seen for the MBCT group. Both mindfulness and *self-compassion* significantly mediated the effect of MBCT on depressive symptoms at the 15-month follow up, and it changed the relationship between post treatment reactivity and depression. An important finding in this study was that post-treatment reactivity had a weaker relation for participants who had shown greater adherence to *self-compassion* during the treatment period (Kuyken, et al., 2010).

The other study was an investigation of whether *self-compassion* or mindfulness was a better predictor of anxiety, depression and worry, and then quality of life (Van Dam, et al., 2011). A comparison of responses to the questionnaires Self-Compassion Scale (SCS) and Mindful Attention Awareness Scale (MAAS) was done to see how these scores predicted anxiety, depression, worry and quality of life. The study was done on a community population, but the participants were people who sought self-help for anxiety and worry (n = 504). Multivariate and univariate analysis showed that *self-compassion* was a more robust predictor of psychopathologic symptoms in relation quality of life. *Self-compassion* did explain more of the variance on the dependent variables than mindfulness (Van Dam, et al., 2011). Table 3. 5 presents an overview of the results for *self-compassion*.

Table 3. 5: Results for *Self-Compassion*

Authors	Objective	Research method	Participants	Results from study
Pauley, McPherson, 2010	To explore the meaning of compassion and self-compassion for individuals with depression or anxiety	Qualitative IPA-analysis	n = 10 9 female and 1 male, diagnosed with depression or anxiety	• "Compassion is a kind and active process" • "Self-compassion is meaningful and useful" • "Being self-compassionate

				is difficult"
Costa, Pinto-Gouveia, 2010	An exploration of whether specific subgroups of clients could be identified on basis of Chronic Pain Acceptance Questionnaire (CPAQ) scores	Clinical trial	n = 103 Portuguese clients from primary and tertiary health care setting	The intermediate acceptance of pain subgroup reported less depression and stress compared to the low-acceptance of pain sub-group. Concerning self-compassion the low acceptance subgroup reported higher self-judgment, isolation and over identification compared to the intermediate subgroup. The groups also differed in common humanity and mindfulness
Kuyken et al., 2010	To examine whether Mindfulness-based cognitive therapy (MBCT)'s treatment effects are mediated by enhancing mindfulness and self-compassion across treatment and/ or by alterations in post treatment reactivity	Clinical trial, RCT	n = 123 patients with recurrent depression	MBCT effects were mediated by enhancement of mindfulness and self-compassion across treatment. MBCT
Van Dam, Sheppard, Forsyth & Earlywine, 2011	Comparison of the ability of Self-compassion scale (SCS) and Mindful Attention Awareness Scale (MAAS) to predict anxiety, depression, worry and quality of life	Clinical trial	n = 504 Community sample of participants seeking self-help for anxious distress. 396 (78,6%) female	Self-compassion is a more robust predictor of depressive and anxious symptoms and quality of life than mindfulness

Self-acceptance

The results for *self-acceptance* yielded a survey design (Macinnes, 2006), two qualitative

studies (Inder et al., 2008; Svanborg, Baarnhielm, Wistedt, & Lutzen, 2008), and one clinical trial (Nierenberg et al., 2010).

The survey design examined the relationship between self-esteem and *self-acceptance* and the association between these two concepts and mental health (Macinnes, 2006).
The aims of the study were to determine the levels of self-esteem, *self-acceptance* and psychological health in cohorts of clients with mental health problems. To examine the correlational relationship between self-esteem, *self-acceptance* and psychological health, and to assess whether the different levels of self-esteem and *self-acceptance* was associated with severity of mental health.
53 participants with severe or enduring mental health problems (diagnosed with schizophrenia, depression on bipolar disorder) were evaluated in relation to level of self-esteem, *self-acceptance*, depression, anxiety and psychological well-being. The results showed that compared to the general population the participants scored lower on *self-acceptance* and self-esteem but higher on anxiety, depression and psychological ill health. The concepts of self-esteem and *self-acceptance* were found to be related but not synonymous. Self-esteem was more related to affect, and higher levels of self-esteem seemed to indicate lower levels of depression. *Self-acceptance* was more associated with general psychological well-being and seemed to be an important contribution in clinical work with general mental problems (Macinnes, 2006).

In one of the qualitative studies correlations between clients' percepts of factors that can be helpful for remission of dysthymia and panic disorder was examined. This study was a combination of qualitative and quantitative methods since it was combined with objective measures of outcome to uncover the mechanisms that contribute to maintaining recovery (Svanborg, et al., 2008). 23 clients diagnosed with dysthymia and 15 diagnosed with panic disorder participated in a 9-year naturalistic follow-up study of psychotherapy and the use of antidepressants. The degree of remission was evaluated with SCID I & II recordings, as well as with self-report forms. A qualitative content analysis of depth interviews with all 38 participants was done to investigate the participants' recovery in the form of perceived helpful or inhibitory factors, factors that were common to and specific for the diagnostic groups, and the correlation between the clients' subjective view of the recovery with an objective diagnostic evaluation.

About 50% of the participants were in full or partial remission. Subjective and objective measures of the degree of recovery were seen as "tools to use to deal with life". Common helpful factors were self-understanding, more flexible thinking and better relationship with antidepressant medication, and faith in the therapist's help and support. A perceived main difficulty for the participants was the difficulty of negotiating in order to get adequate treatment. Those who were in whole or partial remission had come through these difficulties, while many of the participants that were in non-remission had difficulty expressing their needs, and thus get the help they needed. A typical description from the participants regarding the relationship with the therapist was as a "parent" or "coach". Specific areas that appeared to influence remission were *self-acceptance* and *compassion*, an ability to solve relational problems, and increased attention on managing their own emotions (Svanborg, et al., 2008).

The other qualitative study explored how the development of sense of self and identity could be affected by having a bipolar disorder (Inder, et al., 2008). This study was a part of a larger RCT study that sought to compare Specialist Supportive Care (SSC) with Interpersonal Social Rhythm Therapy (IPSRT) for clients between 15 and 35 years. Participants were clients diagnosed with bipolar disorder I, II or NOS. Participants for the qualitative study were selected in two phases. In the initial phase 6 clients were randomly selected out of 36 who had completed the initial three sessions of psychotherapy.
For the second phase 10 out of 19 clients who had completed 18 months of therapy were selected. Data was drawn and transcribed from 15 clients and 49 hours of therapy sessions were transcribed. A thematic analysis was conducted to identify relevant themes.
Findings from this study indicated that bipolar disorder affected the development of self and identity. Bipolar disorder caused feelings of confusion, and self-doubt. This made it difficult for the individuals to establish a coherent sense of self. Their lives were characterized by the external definitions of self, based on their illness and fragmented experiences. It was considered possible to develop a more integrated self through *self-acceptance* and by the enhancement of integrating various aspects of the self (Inder, et al., 2008).

In the clinical trial the aim of the study was to examine impaired mental well-being and overall life quality for clients with minor depressive disorder (Min D) (Nierenberg, et al., 2010). 93 clients were assessed with a section of the Quality of Life questionnaire that measured enjoyment and satisfaction (Q-LES-Q) and the Psychological Well Being Scale

(PWBS). The results were compared with results from clients diagnosed with major depressive disorder (MDD) and results from normative community samples.
The total scores on Q-LES-Q for clients with Min D were on average two standard deviations lower than the scores from the normative samples. Next 40% of the Min D clients had Q-LES-Q scores in the lowest percentile for the general population. The answers on the Q-LES-Q forms for the participants with Min D was closer to the answers for clients diagnosed with MDD than the answers from the normative range.
Average standardized PWB scores were extremely low for Environmental Mastery and Self-Acceptance, low for Purpose in Life and Positive Relations with others, but normal for Personal Growth and Autonomy.
QQL and PWB measures had low correlations with the severity of depressive symptoms and scores were similar regardless of previous history of MDD.
The researchers conclude that concerning environmental mastery and poor *self-acceptance*, Min D is associated with major impairments as measured with QOL and PWB.
These findings can be taken in support to the hypothesis that lesser quality of life, and psychological well-being may be an inherent cognitive aspect in Min D with or without previous history of MDD. The researchers suggests that it may therefore be unnecessary in the DSM IV-TR to exclude Min D if the clients have had a prior episode of MDD (Nierenberg, et al., 2010). Table 3. 6 presents the results for *self-acceptance.*

Table 3. 6: Results for *Self-Acceptance*

Authors	Objective	Research method	Participants	Results from study
Macinnes, 2006	An examination of the relationship between self-esteem and self-acceptance and their effect on psychological health	Survey design	n = 53 Inpatients with severe mental illnesses from two mental health units	Participants had lower self-acceptance and self-esteem and higher rates of anxiety, depression than the general population. The concepts self-acceptance and self-

				esteem were found to be similar but not synonymous
Svanborg, Bäärnhielm, Wistedt & Lützen, 2008	Examining factors that are helpful or a hindrance for remission in dysthymia and panic disorder	Naturalistic study Qualitative content analysis of interviews	n = 38, 23 clients diagnosed with dysthymia, and15 diagnosed with panic disorder	Proposition of a general model of recovery involving: • Understanding self and illness mechanisms • Enhanced flexibility of thinking • Change from avoidance coping to approach coping, and emphasis of the relationship to the health care provider as vehicle of change
Inder et al., 2008	Exploration of the impact of having bipolar disorder on the development of sense of self and identity	Qualitative study	Phase 1: n = 6 Phase 2: n = 10 Clients diagnosed with Bipolar I, II or NOS	Focus on the importance of viewing bipolar disorder within a framework of psychosocial development and to consider the impact on development of self and identity. Suggestions of target areas for interventions.
Nierenberg et al., 2010	An investigation of deficits in psychological well-being (PWB) and quality of life (QOL) for clients with minor depressive disorder (Min D)	Clinical trial	n = 93 participants entering a treatment study for min D	Mild depressive symptoms associated with major deficits in QOL and PWB. • Minor depression exists along a continuum • Deficits of

			psychological well-being and quality of life in minor depression are severe • No difference in these measures if minor depression existed with or without a history of major depression

To summarize, all together the searches in the databases yielded 11 studies. 3 qualitative studies, 5 clinical trials, 2 pilot studies and 1 survey design. Compared to the amount of results from the beginning of this query the results are to be interpreted as scarce. One could speculate if that is because some of them, like for instance *self-compassion* and *compassion* are quite new to psychotherapy. But then again Barrett-Lennard's *self-empathy* was suggested 15 years ago. There are however more research that are related to positive self-constructs and psychopathological vulnerability, but they are mainly conducted on students and therefore not clinical trials. Barrett-Lennard's proposition from 1997 regarding *self-empathy* has vanished, but what kind of clinical impact would the remaining three constructs have?

3.2 Discussing impact

To help clients in the enhancement of well being and to care for self and others could be regarded as a psychotherapeutic invention. There are several ways to evaluate the effects of interventions. One way would be to calculate the effect size. The results from this query yielded an amount of mixed studies regarding methodology. There was also a rather scarce amount of studies, and for some of them scarce concerning number of participants. I therefore find it reasonable to evaluate impact by considering clinical and statistical significance from the findings. I will go through the results of the studies and look for statistically significant results from interventions that have been done in relation to the positive self-constructs.

However, statistically significant results does not guarantee for the results to have clinical significance. For an intervention to be clinically significant it needs to prove that the client has had a benefit from the intervention. In other words that the remediation of the problem produced by treatment returned the client to the point where the problem was no longer troublesome (Kendall, Holmbeck, & Verduin, 2004). This means that one criterion must be an amelioration of the presented problem. This could be measured as compared to a normative sample or against the clients' own perceptions of quality of life (Kendall, et al., 2004), or an objective measure of quality of life. The criteria for clinical significance will therefore be that the results are measured against a normative sample or another client-group. That there is confirmed an increased quality of life for the client either subjectively or objectively. For our purpose this means that for the intervention to have adequate impact some of these criteria must be met. For this evaluation I have categorized the studies according to type of study and connected them to the construct. They can be viewed in table 3. 7.

Table 3. 7: Overview of types of studies connected to positive self-constructs

	Authors	Construct
Qualitative studies	• Pauley, McPherson, 2010	*Self-Compassion*
	• Svanborg et al., 2008	*Self-Acceptance*
	• Inder et al., 2008	*Self-Acceptance*
Clinical trials	**Observational**	
	• Gruber et al., 2009	*Compassion*
	• Costa & Pinto-Goveia, 2010	*Self-Compassion*
	• Nierenberg et al., 2008	*Self-Acceptance*
	Interventional	
	• Kuyken et al., 2010	*Self-Compassion*
	• Van Dam et al., 2011	*Self-Compassion*
Pilot-studies	• Gilbert & Procter, 2006	*Compassion*
	• Mayhew & Gilbert, 2008	*Compassion*
Survey Design	• Macinnes, 2006	*Self-Acceptance*

Qualitative studies

Self-compassion

The qualitative study that were related to *self-compassion* sought to explore the meaning and experience of *compassion* and *self-compassion* for individuals diagnosed with depression and anxiety, (Pauley & McPherson, 2010). A qualitative open exploration like this is of value, and the study offers support to the two constructs *compassion* (Gilbert, 2005) and *self-compassion* (McCullough & Thornes, 2007; Neff, 2003a, 2003b) It's also interesting to note that the 'self' in relation to *compassion* had to be prompted by the interviewers before the participants reflected on *compassion* as related to their selves. This could either indicate that they had no sense of *self-compassion* or they had lost this ability during their experience of depression or anxiety. However the study did not have an intervention to evaluate the effect of, and was therefore descriptive. The impact of an intervention cannot be evaluated from this study.

Self-acceptance

The other qualitative study is also exploratory. This study explored if the development of sense of self and identity could be affected by having a bipolar disorder (Inder, et al., 2008). The impact of the construct cannot be evaluated from this study either since there was no intervention. However, with basis of the results the study also points to the importance of an enhanced focus on self and *self-acceptance* as important interventions in therapy.

The third qualitative study was a mix of qualitative and quantitative methods (Svanborg, et al., 2008). (It is categorized as qualitative here simply because it needs to be categorized, and also because there seems to be used slightly more qualitative than quantitative methods). This study explored the helpful and hindering factors in relation to remission of dysthymia and panic disorder. This study had therapeutic and medical interventions, and the degree of remission was evaluated with structuralized interviews and self-report forms and depth-interviews (open-ended interviews). Taken together the degree of total remission or partial remission at the 9-year follow-up was 46%, which is deemed statistically significant. The remission was evaluated by both objective a subjective measures so this is clearly also a clinically significant intervention, but was self-acceptance a contributor in this respect? Some

of the clients had used both psychotherapy and medication, some had only used medication and yet some of the clients had only participated in psychotherapy. One of the main helpful factors that were identified from interviews with the participants with dysthymia was the enhancement of *self-acceptance* and *compassion*. Among the other factors that were identified as helpful was feedback from the others in the group and that they had participated in several therapies. So even though enhanced *self-acceptance* and *compassion* are valued by the clients, their impact are confounded with many other aspects.

So, the qualitative studies are interesting and valuable, but they are not sufficient to evaluate impact in this respect. I will now consider the clinical trials.

Clinical trials

Clinical trials can be divided into trials that are observational and trials that are interventional, so again in concerning observational trials the same problem that goes for the qualitative studies is encountered here. They have no intervention. But as we saw in the qualitative studies they contributed in validating aspects of the constructs, so I will therefore briefly consider the observational trials.

- Observational trials

Compassion

In the clinical trial with clients who were diagnosed with bipolar disorder (Gruber, et al., 2009)**,** the study does not mention any interventions done to enhance *compassion* or other positive emotions between base line and the six-month follow up, but *compassion* was found to predict decreased mania severity after a six-month follow up. *Compassion* in this study was also understood as an other-oriented emotion that would promote a shift of attention away from oneself and toward vulnerable individuals. This study is therefore rendered as irrelevant for further consideration in the search for impact of self-constructs.

Self-Compassion

The study by Costa & Pinto-Gouveia (2010) explored *self-compassion* and acceptance as related to the tolerance of pain. The researchers identified three subgroups that differed from each other in relation to psychopathology and *self-compassion*. In relation to *self-compassion*,

the low-acceptance group scored higher on self-judgment, isolation and over-identification as compared to the intermediate subgroup. The subgroups also scored differently on common humanity, and mindfulness. An increase of willingness to accept pain seems to be an important therapeutic focus in conjunction with pain relief. The researchers suggests *self-compassion* to be a mediator in this respect (Costa & Pinto-Gouveia, 2010). Again we see a clinical trial without an intervention. However the study has interesting correlations in that the total score for *self-compassion* had a strong positive correlation to acceptance of pain and activity engagement significant at $p \leq 0.001$ level. It is suggested that by enhancing the tolerance of pain for the clients through enhancing *self-compassion,* the clients will increase their quality of life. The study is correlational and it may well be that quality of life makes the clients tolerate more pain, or also to be more engaged in activities. It is still a study that contributes to the hypothesis that the enhancement of *self-compassion* has impact on acceptance for pain and quality of life. Enhanced *self-compassion* in relation to mastering pain seems to have clinical significance.

Self-Acceptance

In the clinical trial that were related to *self-acceptance* the researchers investigated the mental well-being and the quality of life for clients with minor depressive disorder (Min D) (Nierenberg, et al., 2010). This study used descriptive statistics. Data was obtained through self-report forms and inventories. Clients diagnosed with Min D had scores on Q-LES-Q that measured overall satisfaction that were closer to the scores for clients diagnosed with major depression than to the participants from community sample. On the Quality of Life inventory the Min D sample had scores that averaged nearly 2 standard deviations below the community sample. For nearly 40% of the Min D sample the overall Q-LES-Q score was in the lowest percentile for the population. For scales in PWB that measured Environmental Mastery and Self-Acceptance the participants with Min D scored 1 standard deviation below the normative community sample. This study also confirms a significant relation between *self-acceptance* and minor depressive disorder, but since the study is observational the direction of the impact is unclear.

- Interventional trials

Self-Compassion

Self-compassion yielded two studies that were related to Mindfulness Based Cognitive Therapy, and they were both randomized controlled trials. In the study that were investigating if treatment results as a result of MBCT was mediated by *self-compassion* and mindfulness for recurrent depression, the researchers found that the effect of MBCT was mediated by mindfulness and *self-compassion* during the treatment period (Kuyken, et al., 2010). They also found that MBCT had a positive effect on the relationship between post-treatment reactivity, and relapse, because higher post-treatment reactivity predicted relapse for the participants in mADM group. This relationship could not be seen for the MBCT group. Both mindfulness and *self-compassion* significantly mediated the effect of MBCT on depressive symptoms at the 15-month follow up, and it changed the relationship between post treatment reactivity and depression. An important finding in this study was that post-treatment reactivity had a weaker relation for participants who had shown greater adherence to *self-compassion* during the treatment period. (Kuyken, et al., 2010).

The study is a brilliant example of a solid study and it fits the criteria for clinical significance. This study does not compare participants to normative controls but to other clients on medication, so in that respect if the intervention gives a better effect than medication it has powerful clinical significance. The intervention can also account for a lessening in depressive symptoms both at post-treatment, and at 15-month follow up. MBCT was associated with significantly greater improvement on the Self-Compassion Scale (SCS) and the Kentucky Inventory of Mindfulness Skills (KIMS) scale. MBCT was associated with greater improvement on these two scales with KIMS showing a stronger relation to improvement than SCS. The problem with the study is that it confounds *self-compassion* and mindfulness. *Self-compassion* is seen as an important contributor under the umbrella of MBCT. In this respect it is also interesting that mindfulness is one of the components in Neff's construct (Neff, 2003a, 2003b).

Nevertheless, so far *self-compassion* as related to enhancement of pain and related to mindfulness seems to have a certain clinical significance.

The other randomized controlled trial investigated whether *self-compassion* and mindfulness was a better predictor of anxiety, depression and worry, and therefore quality of life (Van Dam, et al., 2011). The variables that proved to have the most predictive utility were the subscales self-judgment and isolation in the SCS. This can be taken as support for *self-compassion* as a robust and important predictor in relation to mental health. In this study *self-compassion* is therefore proposed as an important component in Mindful Based Interventions

(MBI) for anxiety and depression (Van Dam, et al., 2011). *Self-compassion* was shown to be a better predictor than mindfulness regarding psychopathologic symptoms and quality of life. It also explained more of the variance on the dependent variables than mindfulness did. In a multivariate analysis *self-compassion* had the most powerful effect in predicting depression and worry.

I have earlier raised the question whether *self-compassion* and mindfulness are easy to confound since mindfulness is an element of *self-compassion* and *self-compassion* seems to be mentioned in relation to mindfulness. The researchers in this study also speculated if these were basically the same constructs, but correlational and regression analysis suggested that the subscale of the SCS was measuring another construct than what MAAS did. What was more interesting was that when the researchers subjected SCS and MAAS to a multiple univariate prediction for individuals with mixed anxiety and depression SCS seemed to be able to predict outcome variance almost independently of the MAAS. The decrease in predicted outcome only fell by 1-3% when MAAS was subtracted, while the predictive power of MAAS alone fell by 10-26% without SCS (Van Dam, et al., 2011). Regarding the clinical significance of *self-compassion* this study gives this construct quite impressive support, and points to that fact that it can do well as a construct in it's own right, without the support of more mindfulness than it already has inherent.

Taken together the clinical trials that are interventional gives promising support to the impact of *self-compassion* in clinical interventions.

Pilot-studies

Compassion

In the two pilot studies that explored CMT in relation to clients diagnosed with personality disorders and schizophrenia there were no randomization and no control group, but the intervention was CMT. The results for the day-care clients (Gilbert & Procter, 2006) were statistically significant and reduced levels of depression, anxiety, self-criticism, shame, self-hate, feeling of inferiority and submissive behavior as measured with self-report forms (Statistically significant for small groups). All the clients also reported that they felt less depressed and anxious at week 12. In the other pilot-study (Mayhew & Gilbert, 2008)

All three participants had decreases in many of the sub scales measured with SCL-90. But SCL-90 can is not a reliable long-term indicator since it only measures the last 7 days. The participants did not show any major changes in *self-compassion* or self-criticism

It's difficult to generalize from these two studies because they had a small number of participants, and no control group. At face value it looks as if CMT may not be as beneficial for clients diagnosed with psychosis than for clients diagnosed with personality disorders, even though the psychotic clients did have some positive effects. Taken together the samples in these studies are too small to be compared. However the studies seems to give support to *compassion* training as having some clinical significance. The objective measures post treatment showed positive improvement on most of the measures. All the clients in the day-care unit reported that they felt better, one of the clients in the other study also did that, so *compassion* also seems to have a fair impact. But more studies, and better controlled studies would be needed in order to confirm this.

Survey-design

Self-acceptance

The survey design (Macinnes, 2006) was conducted to explore the relationship between self-esteem and *self-acceptance*. The results showed that inpatients diagnosed with schizophrenia, depression or bipolar disorder had lower scores related to self-esteem and *self-acceptance* than the general population. The researchers found a strong correlation between *self-acceptance* and well-being, but weaker correlations between *self-acceptance* and anxiety and *self-acceptance* and depression. All the results were significant. There was also a correlation between *self-acceptance* and self-esteem but self-esteem had a stronger association to depression than *self-acceptance* had. The researcher suggests that self-esteem is more closely associated with affect than *self-acceptance,* and that *self-acceptance* refers to a more general sense of psychological well-being rather then specific emotional concepts, since the correlations between *self-acceptance* and anxiety, and *self-acceptance* and depression were small. These results lend support to the earlier consideration of *self-acceptance* as a more value neutral and pragmatic construct than the other constructs. It is of clinical relevance to

know that that these constructs are different, and may well be that *self-acceptance* has an impact for well being, but it may also be the other way around since the study is correlational.

In sum it seems that *self-compassion* seems to be the construct that has best explanatory power and also the most convincing impact. However the studies regarding the relation between positive self-constructs and psychotherapy are few. It may not be that *self-compassion* is the construct with best psychotherapeutic impact in all areas, but so far it is the construct which hast he most convincing research to confirm its impact.

4 Conclusion

In this thesis I have explored the positive self-constructs *self-empathy, compassion, self-compassion* and *self-acceptance.* In order to find their origin and to answer the question of how they are built up, I have considered some historical and theoretical contributions as to how 'self' and 'empathy' were introduced into psychology, and also considered some of the roots of 'compassion' and 'acceptance'. In this quest I also used etymological searches in order to find the original meanings of these terms. The etymological searches revealed that empathy and *compassion* have the same roots, meaning 'to suffer with' inherent. This makes them relatives, and this also opens for *self-compassion* to belong to this relation*. Self-acceptance* had a more value free and not so affect loaded connotation.

To provide an answer to how the positive self-constructs are constructed and used in therapy, I have considered the use of the positive self-constructs in different therapy traditions, and extracted the constructs from the theoretical definitions of them. They have been compared and evaluated in respect of criteria for what a good construct or definition should comprise.

To find out if *compassion*, *positive feelings for self* or *self-compassion* and *self-acceptance* has a different impact in therapeutic settings compared to *self-empathy*? I conducted a literature search in the databases PsycINFO, EMBASE, MEDLINE, PubMed, ISI-Web of Science and Google scholar. Findings in relation to this question were negative, because there were no positive findings in relation to *self-empathy* in clinical use today that would fit the search criteria. An evaluation of the impact the other constructs have in therapy was nevertheless attempted. Taken together the searches in this study reveals that *self-compassion* is the best construct, and the construct with the most convincing impact. However there is not much research available to confirm this. I will therefore end this query by suggesting more research that could more clearly measure interventions, so as to contribute to clarifying the impact of the positive self-constructs.

References:

Amlund, E. (2008). Forståelse av depriverte pasienter gjennom dyp empati. *Tidsskrift for Norsk Psykologforening, 45*(8), 949-957.

Barrett-Lennard, G. T. (1981). The Empathy Cycle - Refinement of a nuclear concept. *Journal of Counseling Psychology, 28*(2), 91-100.

Barrett-Lennard, G. T. (1986). The relationship inventory now: Issues and advances in theory, method and use. In W. M. Pinsof & L. S. Greenberg (Eds.), *The psychotherapeutic process: A research handbook* (pp. 439-476). New York: Guilford.

Barrett-Lennard, G. T. (1993). The Phases and Focus of Empathy. *British Journal of Medical Psychology, 66*, 3-14.

Barrett-Lennard, G. T. (1997). The recovery of empathy - toward others and self. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered new directions in psychotherapy* (1 ed., pp. 103-121). Washington, DC: American Psychological Association.

Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does high self-esteem cause better performance, interpersonal succes, happiness, or heathier lifestyles? *Psychological Science in the Public Interest, 4*(1), 1-44.

Baumeister, R. F., Krueger, J. I., & Vohs, K. D. (2005). Exploding the self-esteem myth. *Scientific American, 1*.

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*(1), 5-33.

Beck, A. T. (1967). *Depression: clinical, experimental, and theoretical aspects*. New York Hoeber Medical Division.

Bjørkvik, J., Biringer, E., Eikeland, O.-J., & Nielsen, G. H. (2008). Predicting self-esteem in psychiatric outpatients. *Nordic Psychology, 60*(1), 43-57.

Bohart, A. C. (1991). Empathy in Client-Centered Therapy - a Contrast with Psychoanalysis and Self Psychology. *Journal of Humanistic Psychology, 31*(1), 34-48.

Bohart, A. C., & Greenberg, L. S. (1997). *Empathy reconsidered new directions in psychotherapy* (1 ed.). Washington, DC: American Psychological Association.

Bowlby, J. (1979). *The making & breaking of affectional bonds*. London: Tavistock Publications.

Costa, J., & Pinto-Gouveia, J. (2010). Acceptance of pain, self-compassion and psychopathology: Using the Chronic Pain Acceptance Questionnaire to identify patients' subgroups. *Clinical Psychology & Psychotherapy*.

Dryden, W. (2009). *Rational emotive behaviour therapy: distinctive features*. London: Routledge.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus, N.J.: Lyle Stuart.

Ellis, A., & Ellis, D. J. (2011). *Rational emotive therapy*. Washington, DC: American Psychological Association; US.

Gilbert, P. (2005). *Compassion: conceptualisations, research and use in psychotherapy*. London: Routledge.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. New York, NY: Routledge/Taylor & Francis Group; US.

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*(6), 353-379.
Greenberg, L. S. (2002). *Emotion-focused therapy coaching clients to work through their feelings*. Washington, DC: American Psychological Association.
Gruber, J., Culver, J. L., Johnson, S. L., Nam, J. Y., Keller, K. L., & Ketter, T. A. (2009). Do positive emotions predict symptomatic change in bipolar disorder? [Peer Reviewed]. *Bipolar Disorders, .11*(3), pp.
Hart, T. (1997). Transcendental empathy in the therapeutic encounter. *The Humanistic Psychologist, 25*, 245-270.
Hartmann, E. (2009). Det kliniske intervjuet i et interpersonlig psykoanalytisk perspektiv. In M. H. Rønnestad & A. L. v. d. Lippe (Eds.), *Det kliniske intervjuet* (2 ed., pp. 73-88). Oslo: Gyldendal akademisk.
Inder, M. L., Crowe, M. T., Moor, S., Luty, S. E., Carter, J. D., & Joyce, P. R. (2008). "I actually don't know who I am": The impact of bipolar disorder on the development of self. [Peer Reviewed]. *Psychiatry: Interpersonal and Biological Processes, .71*(2), pp.
Karterud, S. (1997). Heinz Kohuts selvpsykologi. In S. Karterud & J. T. Monsen (Eds.), *Selv psykologi utviklingen etter Kohut* (1 ed., pp. 13-28). Oslo: Gyldendal Akademisk.
Kendall, P. C., Holmbeck, G., & Verduin, T. (2004). Methodology, design, and evaluation in psychotherapy research. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5 ed.). New York: John Wiley & Sons, Inc.
Koenig, H. G., & Larson, D. B. (2001). Religion and mental health: evidence for an association. *International Review of Psychiatry, 13*(2), 67-78.
Kohut, H. (1971). *The analysis of the self : a systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York: International Universities Press.
Kohut, H. (1984). In A. Goldberg & P. E. Stepansky (Eds.), *How does analysis cure?* Chicago: The University of Chicago Press.
Kuyken, W., Watkins, E., Holden, E., White, K., Taylor, R. S., Byford, S., et al. (2010). How does mindfulness-based cognitive therapy work? [Peer Reviewed]. *Behaviour research and therapy, .48*(11), pp.
Macinnes, D. L. (2006). Self-esteem and self-acceptance: an examination into their relationship and their effect on psychological health. *Journal of Psychiatric and Mental Health Nursing, 13*(5), 483-489.
MacIsaac, D. S. (1997). Empathy: Heinz Kohut's contribution. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered new directions in psychotherapy* (pp. 245-264). Washington, DC: American Psychological Association.
Mayhew, S. L., & Gilbert, P. (2008). Compassionate mind training with people who hear malevolent voices: A case series report. [Peer Reviewed]. *Clinical Psychology & Psychotherapy, 15*(2), pp.
McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003). *Treating affect phobia : A manual for short-term dynamic psychotherapy*. New York: Guilford Press.
McCullough, L., Kuhn, N., Andrews, S., Valen, J., Hatch, D., & Osimo, F. J. (2003). The reliability of the achievement of therapeutic objectives scale: A research and teaching tool for Brief Psychotherapy. *Journal of Brief Therapy*(2), 75-90.
McCullough, L., & Thornes, K. (2007). Self Compassion: An important key to emotional well-being. *The Ad Hoc Bulletin of Short-Term Dynamic therapy: Practice and theory, 11*(1), 35-48.

McCullough-Vaillant, L. (1997). *Changing character / short-term anxiety-regulating psychotherapy for restructuring defenses, affects, and attachment*. New York: BasicBooks.
Mitchell, S. A., & Black, M. J. (1995). *Freud and beyond : a history of modern psychoanalytic thought*. New York: Basic Books.
Morf, C. C., & Rhodewalt, F. (2001). Unraveling the paradoxes of narcissism: A dynamic self-regulatoryprocessing model. *Psychological Inquiry, 12*(4), 177-196.
Mruk, C. J. (2006). Self-esteem research, theory, and practice toward a positive psychology of self-esteempp. xiv, 294 s.).
Neff, K. D. (2003a). Development and validation of a scale to measure self-compassion. *Self and Identity, 2*, 223-250.
Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*, 85-102.
Neff, K. D., & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. [Peer Reviewed]. *Journal of Personality, .77*(1), pp.
Nielsen, G. H. (2008). Psykiske problemer og psykoterapi i lys av moderne interpersonlig psykoanalyse. In E. D. Axelsen & E. Hartmann (Eds.), *Veier til forandring* (pp. 23-44). Oslo: Cappelen Damm AS.
Nierenberg, A. A., Rapaport, M. H., Schettler, P. J., Howland, R. H., Smith, J. A., Edwards, D., et al. (2010). Deficits in psychological well-being and quality-of-life in minor depression: Implications for DSM-V. [Peer Reviewed]. *CNS Neuroscience & Therapeutics, .16*(4), pp.
Pauley, G., & McPherson, S. (2010). The experience and meaning of compassion and self-compassion for individuals with depression or anxiety. [Peer Reviewed]. *Psychology and Psychotherapy: Theory, Research and Practice, .83*(2), pp.
Polansky, M., Lauterbach, W., Litzke, C., Coulter, B., & Sommers, L. (2006). A qualitative study of an attachment-based parenting group for mothers with drug addictions: On beeing and having a mother. *Journal of Social Work and Practice, 20*(2), 115-131.
Pyszczynski, T., Solomon, S., Greenberg, J., Arndt, J., & Schimel, J. (2004). Why do people need self-esteem? A theoretical and empirical review. *Psychological Bulletin, 130*(3), 435-468.
Roberts, R. C. (2007). *Spiritual emotions: a psychology of Christian virtues*. Cambridge: Wm. B. Eerdmans Publishing Co.
Rogers, C. R. (1956). Becoming a person - Part II. What it means to become a person. [Journal; Peer reviewed]. *Pastorial Psychology, 7*(63), 16-26.
Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103.
Rogers, C. R. (1961). *On becoming a person / a therapist's view of psychotherapy*. Boston: Houghton Mifflin.
Silverstein, M. L. (1999). *Self-psychology and diagnostic assessment : identifying selfobject functions through psychological testing*. Mahwah, N.J.: Lawrence Erlbaum.
Silverstone, P. H., & Salsali, M. (2003). Low self-esteem and psychiatric patients: Part I - The relationship between low self-esteem and psychiatric diagnosis. *Annals of general hospital psychiatry, 2*(1), 2.
Stern, D. N. (1998). *The interpersonal world of the infant : a view from psychoanalysis and developmental psychology*. London: Karnac.
Stolorow, R. D., Atwood, G. E., & Brandchaft, B. (1987). *Psychoanalytic treatment : an intersubjective approach*. Hillsdale, N.J.: Analytic Press.

Svanborg, C., Baarnhielm, S., Wistedt, A. A., & Lutzen, K. (2008). Helpful and hindering factors for remission in dysthymia and panic disorder at 9-year follow-up: A mixed methods study. *Bmc Psychiatry, 8*.

Svartdal, F. (2009). *Psykologiens forskningsmetoder* (3. utg. ed.). Bergen: Fagbokforl.

Tomasello, M. (1999). Having intentions, understanding intentions, and understanding communicative intentions. In P. D. Zelazo, J. W. Astington & J. Wilde (Eds.), *Developing theories of intention: social understanding and self-control* (pp. 63-75). Mahwah, NJ: Laurence Earlbaum.

Tomkins, S. S., Karon, B. P., & Silvan S. Tomkins Institute. (2008). *Affect imagery consciousness : the complete edition*. New York: Springer.

Van Dam, N. T., Sheppard, S. C., Forsyth, J. P., & Earleywine, M. (2011). Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. [Peer Reviewed]. *Journal of Anxiety Disorders, .25*(1), pp.

Wachtel, P. L. (2008). *Relational theory and the practice of psychotherapy*. New York: Guilford Press.

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Appendix A

Table 8: Predefined classification codes from PsycINFO. Used in all databases. *Psychiatric Disorders were not a predefined option but were added.

Classification code	Name
3210	Psychological Disorders
*	Psychiatric Disorders
3211	Affective Disorders
3213	Schizophrenia & Psychotic States
3215	Neurosis & Anxiety
3217	Personality Disorders
3233	Substance Abuse & Addiction
3260	Eating Disorders
3310	Psychotherapy & Psychotherapeutic Counseling
3311	Cognitive Therapy
3314	Interpersonal & Client Centered & Humanistic Therapy
3315	Psychoanalytic Therapy

Table 9. Results for *Self-empathy*

Authors	Objective	Research method	Participants	Results from study
Polansky, Lauterbach, Litzke, Coulter & Sommers, (2006)	To evaluate the effect of participation in a parenting group to increase maternal sensitivity for mothers with drug addictions	Qualitative study*	n = 7	
Hodgson & Wertheim, (2007)	To examine two forms of forgiveness and their disposition to forgive others and self		n = 110 n = 104	
Busby & Gardner, (2008)	Use of 4 measures of empathy to evaluate models to predict relationship satisfaction		n = 207 couples	

The qualitative study was done with a group of 7 mothers who were addicted to drugs to evaluate whether participating in the group would increase maternal sensitivity for their children (Polansky, Lauterbach, Litzke, Coulter, & Sommers, 2006). The focus of the group-intervention was, by using the Travistock Approach modified for use in group therapy, to encourage the mothers to reflect on their own childhood, and on how they had been reared by their mothers. They were further encouraged to use their *self-empathy* as a guide in caring for their own children. There was no clear definition of empathy in the study, it was referred to as 'understood' and 'accepted' as who they were. The mother's self-knowledge and or *self-empathy* (not defined) were thought to increase their empathy for rearing their children.

Results were that all of the mothers in the group increased their use of empathy as a guide to parenting. Participating in the group also strengthened their feeling of community and the aspect of helping the women with their addiction. None of the participants left the group during the group during the six weeks the group was ongoing (Polansky, et al., 2006).

*Only the qualitative study is mentioned in the text since it has more significance for this study.