Self-compassion
in Mindfulness-Based Cognitive Therapy for Recurrent Depression

A theoretical analysis and empirical review of self-compassion as a construct and therapeutic mechanism

Victoria Forsberg

Dissertation submitted at the Department of Psychology
UNIVERSITY OF OSLO
Autumn 2016
Self-compassion in Mindfulness-Based Cognitive Therapy for Recurrent Depression

© Victoria Forsberg
2016
Self-Compassion in Mindfulness-Based Cognitive Therapy for Recurrent Depression
Victoria Forsberg
http://www.duo.uio.no
Reprosentralen, Universitetet i Oslo
Abstract

Author: Victoria Forsberg
Title: Self-Compassion in Mindfulness-Based Cognitive Therapy for Recurrent Depression
Supervisor: Bergljot Gjelsvik; Co-supervisor: Catherine Crane

Mindfulness-Based Cognitive Therapy (MBCT) is a cognitive science-based skills training programme developed to prevent depressive relapse in individuals suffering from recurrent major depression. The programme combines mindfulness meditation, psycho-education, movement exercises, and exercises adapted from Cognitive Behavioural Therapy. There is robust evidence that MBCT prevents risk of depressive relapse when compared to treatment as usual, and is equivalent to active control treatments including maintenance antidepressant medication. Preliminary evidence suggests that self-compassion is an important mechanism underlying MBCTs effects. However, as MBCT does not explicitly target self-compassion, it is not readily clear how self-compassion is facilitated. There is also confusion and critique surrounding conceptualisation and measurement of self-compassion, and how it relates to mindfulness.

This dissertation includes a theoretical analysis of self-compassion as a construct; a critical examination of the most frequently used measurement of self-compassion, the Self-Compassion Scale; and a review of preliminary evidence on self-compassion as an underlying mechanism in MBCT for recurrent depression. The discussion is supplemented by qualitative interviews with MBCT experts, in which three themes on how and why self-compassion might be cultivated during MBCT were identified; (1) non-specific factors (e.g., the group setting); (2) the teacher modelling and embodying self-compassion; and (3) the mindfulness meditation exercises involving; (a) that self-compassion may mediate or interact with decentering; (b) that self-compassion may have a reinforcing effect on letting go of goals/expectations; and (c) a discussion of whether self-compassion should be explicitly targeted in MBCT. I conclude that both theoretical models and preliminary evidence indicate that self-compassion is an important change mechanism underlying MBCTs preventive effects on depressive relapse. This may be due to several different aspects of the programme. However, explicitly advocating self-compassion may not benefit this population – in fact, it might backfire. Directions for future research include development of more psychometrically sound measurements of self-compassion, as well as research designs which are able to disentangle effects of self-compassion on depressive relapse from other possible mediators and moderators involved in MBCTs preventive effect.
Sammendrag

Forfatter: Victoria Forsberg
Tittel: Selvmedfølelse i Mindfulness-basert kognitiv terapi for tilbakevendende depresjon
Veileder: Bergljot Gjelsvik; Biveileder: Catherine Crane

Mindfulness-based Cognitive Therapy (MBCT) er et ferdighetstreningprogram utviklet for å forebygge depressive tilbakefall hos individer som lider av tilbakevendende depresjon. Gruppeprogrammet kombinerer mindfulness-meditasjon, psyko-edukasjon, bevegelse og elementer fra kognitiv atferdsterapi. Det er nå solid evidens for at MBCT forebygger depressive tilbakefall sammenlignet med vanlig behandling, og at programmet har tilsvarende effekt som aktiv behandling. Foreløpige funn tyder på at selvmedfølelse (self-compassion) er en viktig endringsmekanisme i MBCT. Dette er paradoksalt siden programmet ikke eksplisitt fokuserer på selvmedfølelse, og man kan derfor spørre hvordan og hvorfor selvmedfølelse utvikles gjennom MBCT. I tillegg er det uenighet rundt definisjonen av selvmedfølelse, særlig relatert til mindfulness, og eksisterende mål av selvmedfølelse har nylig blitt kritisert.

Denne avhandlingen omfatter en teoretisk analyse av selvmedfølelse som et begrep, en kritisk undersøkelse av the Self-Compassion Scale (som er mest brukt for mål av selfmedfølelse), og en gjennomgang av foreliggende evidens på selvmedfølelse som en underliggende endringsmekanisme i MBCT for tilbakevendende depresjon. Litteraturgjennomgangen er supplert med kvalitative intervjuer med MBCT eksperter. Oppsummert ble tre tema omhandlende hvordan og hvorfor selvmedfølelse kan styrkes gjennom MBCT diskutert; (1) ikke-spesifikke faktorer (e.g., gruppen); (2) instruktøren kommuniserer selvmedfølelse; og (3) meditasjonsøvelsene som involverer; (a) at selvmedfølelse fremmes eller interagerer med desentrering; (b) at selvmedfølelse kan ha en forsterkende effekt på evnen til å gi slipp på mål eller forventninger; og (c) en diskusjon om hvorvidt selvmedfølelse bør formidles eksplisitt i MBCT. Jeg konkluderer med at foreløpig evidens indikerer at selvmedfølelse er en viktig endringsmekanisme til grunn for MBCTs forebyggende effekt på depressive tilbakefall. Likevel vil det ikke være hensiktsmessig å adressere selv-medfølelse direkte for denne pasientgruppen. Hvordan og hvorfor selvmedfølelse fungerer som en mekanisme avventer ytterligere forskning. Fremtidige studier bør utvikle bedre psykometriske målmetoder av selvmedfølelse samt anvende forskningsdesign egnet til å teste hvorvidt selvmedfølelse spiller en unik rolle i forebyggingen av depressive tilbakefall.
Preface & Acknowledgements

This dissertation is the result of a number of factors and events. Ever since beginning to practice yoga, contemplative traditions including Buddhist philosophy and meditation, have intrigued me. Parallel to studying psychology I have studied History of Ideas that included readings of subjects within philosophy, religion, history, and literature. As a result, I have often been inspired by an interdisciplinary approach when studying psychology and training to be a psychotherapist, and how contemplative ideas on self-compassion and acceptance challenge notions of productivity, effectivity, goal-oriented thinking, and perfectionism, which are highly present in our culture. As psychological treatment is a process of change - indeed the urge for change is the reason many individuals start therapy in the first place - it is an intriguing idea that acceptance in the context of self-compassion and meditation may lead to psychological change.

With these ideas in mind, and after attending a seminar on Mindfulness-based Cognitive Therapy for treating recurrent depression by Dr Bergljot Gjelsvik, I wanted to learn more about how mindfulness-based treatments may have therapeutic effects, and chose this to be the topic of my dissertation. This encounter also resulted in my exchange to the Oxford Mindfulness Centre at the University of Oxford - a visit that allowed me to work on my dissertation while surrounded by some of the leading experts within this field. I am very grateful for the opportunity to exchange to the University of Oxford. Without this exchange I would not have written this dissertation, and the visit left me full of inspiration and experiences that benefited my work, as well as me personally.

First of all, I would like to greatly thank my supervisor Dr Bergljot Gjelsvik – a wonderful, highly skilled, and fearless individual – for agreeing to supervise me and encouraging me from the very beginning, for emotional support, and for enormously helpful feedback on various drafts. Thank you for guiding me in the process and journey of writing this dissertation. I also sincerely thank my co-supervisor Dr Catherine Crane for most appreciated feedback, for sharing ideas, and giving proficient advice.

I thank everyone in the team at the Oxford Mindfulness Centre for welcoming me with kindness and teaching me everything I needed to know about the English way. I warmly thank my compassionate and mindful MBCT teachers Marie Johansson and Conroy Harris for guiding
me in my personal mindfulness practice. Special thanks to Mark Williams, Melanie Fennell, Willem Kuyken, Tim Stead, Christina Surawy, Rhoda Schuling, Per Einar Binder, Jan Reidar Stiegler, Odd Arne Tjersland, and Michael De Vibe for talking with me and discussing my ideas.

Some of my brilliant friends have generously helped me as well, for which I am very grateful; my dear friend Emilie W. Guttormsen, with her humour, clarifying questions, and enthusiasm; my friend (and more) Martin Asperholm, with helpful comments that made me laugh, but also think; and my kind Oxford friend, Francis Vergunst, with stimulating conversations over coffee, guitar playing, and proofreading - all of which helped me in writing this dissertation.

Victoria Forsberg

Oslo,
October 2016
“Accept what is - and what is, changes.”

Fritz Pearls

“All humanity’s miseries derive from not being able to sit quietly in a room alone.”

Blaise Pascal
# Table of Contents

1. Introduction ........................................................................................................................... 1  
   1.1. Research questions and methods ..................................................................................... 3  

2. MBCT for Recurrent Depression .......................................................................................... 5  
   2.1. What is MBCT? ................................................................................................................. 5  
      2.1.1. What is depression and why does it recur? ................................................................. 5  
      2.1.2. The Differential Activation Hypothesis ........................................................................ 8  
      2.1.3. Outline and design of MBCT ..................................................................................... 10  
   2.2. Does MBCT reduce risk of depressive relapse? .............................................................. 11  
   2.3. How does MBCT work? .................................................................................................. 13  

3. What is Self-Compassion? ................................................................................................. 17  
   3.1. Theoretical conceptualisations of self-compassion.......................................................... 17  
   3.2. Measuring Self-Compassion: The Self-Compassion Scale ............................................. 20  
   3.3. Are self-compassion and mindfulness separate constructs? ........................................... 24  
      3.3.1. Theoretical clarification ............................................................................................. 25  
      3.3.2. Empirical investigation .............................................................................................. 27  

4. Does MBCT Facilitate Self-Compassion? .......................................................................... 32  
   4.1. Theme 1: Self-compassion attributed to non-specific factors of MBCT ......................... 33  
   4.2. Theme 2: Self-compassion attributed to the MBCT teacher ............................................ 37  
   4.3. Theme 3: Self-compassion attributed to mindfulness meditation ..................................... 40  
      4.3.1. Subtheme A: Self-compassion mediates and interacts with decentering .................. 41  
      4.3.2. Subtheme B: Self-compassion and letting go of goals............................................... 45  
      4.3.3. Subtheme C: Implicit versus explicit focus on self-compassion in MBCT ............... 51  

5. Concluding Remarks ........................................................................................................... 56  

References................................................................................................................................ 59
1. Introduction

Mindfulness-based Cognitive Therapy (MBCT) is a manualised 8-week treatment programme developed by Zindel Segal, Mark Williams and John Teasdale in 2002 (second edition 2013) for preventing relapse in individuals suffering from recurrent depression. The course is taught in a group setting, and is a cognitive science informed modification of Mindfulness-based Stress Reduction (MBSR; Kabat-Zinn, 1990), aiming at learning and training skills that are hypothesised to protect participants against depressive relapse. MBCT, MBSR, and other newly developed therapies such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999); and Dialectical Behaviour Therapy (DBT; Linehan, 1993) incorporate mindfulness meditation derived from Buddhist practises, and are regarded to represent what has been termed the third wave within Cognitive Behavioural Therapies (CBT) (Hayes, 2004).

Third wave therapy approaches are contrasted to the first wave of behaviour therapies that emphasised stimulus-response associations and behaviour analysis; and a second wave sparked by the Cognitive Therapy movement (CT; Beck, Rush, Shaw, & Emery, 1979) pioneered by Aron Beck in the 1970s. Through further development, behavioural and cognitive techniques were combined seeking to weaken undesirable thoughts and maladaptive behaviour through their detection, testing, correction, and disputation. Since then, CBT has become a dominant and empirically supported treatment for various psychological disorders (Wampold, 2001). However, CBT has been criticised by, among other things, for accentuating the form, frequency or situational sensitivity of cognitions and emotions, neglecting their function and metacognitive perspectives (Hayes, 2004). MBCT and other third wave therapies emphasise experiential change, contact with the present moment, mindfulness, and interceptive awareness, and claim to put acceptance and compassion to the fore (Segal, Williams, & Teasdale, 2013). Self-compassion has also recently received increased attention in Norway (e.g, Binder, 2014).

In the lasts decades there has been an exponentially growing amount of research on mindfulness-based applications in psychological treatment, and there is now robust evidence that MBCT significantly reduces risk of relapse in patients suffering from recurrent depression (e.g. Kuyken et al., 2016). Still, it is not only important to know that MBCT causes therapeutic

---

1 Even though such a term contributes in understanding therapy development, it is important to bear in mind that the inherent focus is on shared similarities, even though the term includes heterogeneous treatments (Hofmann & Asmundson, 2008).
change, but also to comprehend how and through which mechanisms MBCT works. Identifying mechanisms underlying treatment effects is critical in order to identify targets for clinical intervention, better matching MBCT to individuals, and offering suggestions for theory development (Kazdin, 2007; Segal et al., 2013). However, research on mechanisms underlying MBCTs preventive effects is only in the initial phase.

MBCT is premised on the assumption that reacting to depressive symptoms with wishing them to go away (i.e., reflected in rumination, suppression, avoidance) keeps individuals stuck in depressogenic maintenance processes. Consequently, increased acceptance and self-compassion in relation to depressive symptoms have been put forth as crucial mechanisms in bringing about positive change for individuals vulnerable to relapse into depression (Gu, Strauss, Bond, & Cavanagh, 2015; Segal et al., 2013; van der Velden et al., 2015). Indeed, a study by Kuyken and colleagues (2010) investigating underlying mechanisms in MBCT found that self-compassion significantly mediated effects of MBCT in a sample of individuals with a history of recurrent depression. This finding was interpreted to suggest that self-compassion represents an important change mechanism in MBCTs preventive effect on recurrent depression. However, this can be considered paradoxical given that MBCT does not explicitly target self-compassion during the sessions. Thus, one can question how MBCT may cultivate self-compassion.

This paradox is further complicated by a conceptual confusion in the literature regarding what self-compassion might be taken to mean. A recent review of definitions and measurement of compassion highlighted the difficulty of defining this construct and the lack of robust measurements (Strauss et al., 2016). For instance, inconsistencies appear concerning whether compassion primarily is a feeling, a motivational state, an attitude, a behavioural response or moral insight or principle. Another problematic aspect of existing attempts to capture compassion is doing so through several related concepts (e.g., empathy, kindness, and acceptance) that are also difficult to define, measure, and differentiate (e.g. Feldman & Kuyken, 2011; Goetz, Keltner, & Simon-Thomas, 2010; Strauss et al., 2016). Currently, the most used measurement of self-compassion in mindfulness research is the Self Compassion Scale (SCS; Neff, 2003a). This scale was developed for use in non-clinical populations, but is now often used in trials with clinical samples such as individuals suffering from recurrent depression. The SCS has recently been criticised on several grounds; (1) because of difficulties to replicate its factor structure in various samples including individuals suffering from recurrent depression (Williams, Dalgleish, Karl, & Kuyken, 2014b); (2) for correlating with other known constructs related to psychopathology and
wellbeing (Muris, Otgaar, & Petrocchi, 2016; Muris & Petrocchi, 2016); and (3) for overlapping with the construct of mindfulness to such a degree that researchers question whether self-compassion and mindfulness are separate concepts or not (e.g. Feldman & Kuyken, 2011; Goetz et al., 2010; Segal et al., 2013; Strauss et al., 2016; Tirch, 2010).

In sum, self-compassion is hypothesised to be an underlying mechanism in MBCT. However, this claim needs additional investigation and empirical support, which in turn depend on measuring self-compassion reliably and in keeping with the underlying theoretical assumptions (construct validity). Because, if self-compassion and mindfulness are indeed two aspects of the same overarching construct, it would be tautological to argue that self-compassion is a therapeutic mechanism in the change process facilitated by mindfulness training in MBCT. And if these constructs can be considered separate, how are they related, and how might MBCT facilitate self-compassion?

1.1. Research questions and methods

The research questions are as follows:

1. How might one understand self-compassion, and how does it relate to mindfulness? Is it meaningful to talk about cultivating self-compassion in a therapeutic context?

2. How might participation in MBCT increase levels of self-compassion in individuals suffering from recurrent depression? Can this be attributed to aspects of the course, and if so, how and why?

3. What is the evidence that self-compassion mediates the effect of MBCT in preventing depressive relapse? Can self-compassion be considered as a mechanism underlying this effect, and if so, how can this be understood or explained?

This dissertation includes a theoretical analysis of self-compassion as a construct and a review of existing evidence on self-compassion as an underlying mechanism in MBCT for recurrent depression. The discussion will be supplemented by interviews with two clinical psychologists with expertise in treatment development and delivery of MBCT. I will start by outlining the development and essential features of MBCT. In chapter three, I will discuss definitions and measurement of self-compassion. In chapter four I will investigate how MBCT might facilitate self-compassion. Here I will juxtapose qualitative data from the interviews with relevant theory and evidence to discuss the research questions. Concluding remarks and directions for future research will be given in the last chapter.
Whilst this is a narrative rather than a systematic review, I would like to point out the scope of the literature search. The point of departure for selecting relevant literature was the most recent systematic reviews or meta-analyses, as well as the recent editions of the manual for Mindfulness-based Cognitive Therapy for Depression (Segal et al., 2013) and The Clinical Handbook of Mindfulness (Didonna, 2009). Initial searches focused on the theory and evidence behind MBCT for recurrent depression, before focusing on definitions, measurement, and evidence regarding self-compassion. Databases used included Web of Science, Google Scholar, PsycINFO and BIBSYS.

The interviews were conducted by the author in spring 2015, England, UK. The subjects were selected on the basis of expertise and experience. The interviews were taped and transcribed before thematic analysis was done in accordance with Braun and Clarke’s guide (2006). This guide was used because of its flexible nature, and because analysis was attempted to be exploratory rather than theory driven. The corresponding transcripts were re-read several times, and themes were identified through an iterative process of refinement. Ideas, thoughts, and suggestions were identified and differentiated as themes on the basis of their ability to “capture something important in relation to the overall research questions (Braun & Clarke, 2006, p. 82). Emphasis was on detailed analysis rather than providing a rich description of the data set as a whole.
2. MBCT for Recurrent Depression

2.1. What is MBCT?
MBCT was developed as a prevention programme for individuals with a history of recurrent depression currently in remission and builds on a specific model of recurrent depression (Segal et al., 2013). In order to appreciate the content and design of the programme, the cognitive science account of recurrent depression underlying MBCT should be elaborated on, as the outline and design is intimately tied with a specific understanding of recurrent depression.

2.1.1. What is depression and why does it recur?
Depression is characterised by a disturbance of mood, the general level of activity, and ways of thinking (WHO, 2003). It is one of the most prevalent and disabling mental disorders, associated with suicidal risk, and only second after cardiovascular disease in causing reduced life quality (Feliciano, Renn, & Areàn, 2012). Lifetime prevalence for experiencing one episode of depression is estimated to around 17%², though the amount of individuals affected directly and indirectly is of course significantly higher. A large contribution to the prevalence is the relapse (i.e., return of symptoms of depression before a full remission has been reached) and the recurrence of an episode (i.e., return of an episode after initial recovery from a previous episode) (Feliciano et al., 2012; Mueller et al., 1999). In fact, the risk accumulates with every consecutive episode: After one episode of depression, the risk of relapse is around 50%, increasing to about 70% with a second, and with a third to approximately 90% (Barnhofer & Crane, 2009).

The etiology of depression has been suggested to be a complex combination and interaction of genetic (the aggregated estimate of heritability is between 31-42%), psychological, social, and environmental factors, including triggers such as exposure for stressing life events and/or psychosocial stress (Feliciano et al., 2012). Interestingly, stressful life events become decreasingly important in predicting relapse (e.g., Lau, Segal, & Williams, 2004; Monroe & Harkness, 2005). In consequence, research into understanding the vulnerability to depressive relapse has become less interested in why individuals become depressed to begin with, and more focused on understanding mechanisms underlying the strong tendency to relapse.

⁲ Norwegian lifetime prevalence estimates for depression are 15-25% (women) and 7-12% (men) (NorskHelseinformatikk, 2013)
So, how can the increased vulnerability to relapse be explained? I shall argue that learning and cognition is important not only in dealing with distressing life events, but in dealing with experiences of repeated depressive episodes for risk of relapse and in maintaining depressive episodes (Teasdale et al., 2000). It is hypothesised that rumination, i.e., a negative, repetitive, self-critical and maladaptive processing style (Huffziger & Kuehner, 2009; McLaughlin & Nolen-Hoeksema, 2011; Nolen-Hoeksema, 1991; Nolen-Hoeksema, Wiso, & Lyubomirsky, 2008) maintain depressed mood by a focus on regret, self-judgment, avoidant coping strategies, and self-discrepancy (i.e., the perceived distance between current and ideal self-representations or self-guides) (Feliciano et al., 2012; Higgins, 1987). Moreover, rumination is linked to experiential avoidance, defined as the attempt to avoid the direct experience of challenging thoughts, emotions, and body sensations (Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013), and may result in maladaptive problem solving (Feliciano et al., 2012). Whilst a depressed individual may intend to try to solve an emotional problem, rumination actually backfires, i.e., maintains the depressed mood it intended to solve.

Moreover, measures of both rumination and avoidance have been found to significantly negatively correlate with self-compassion, and it has been hypothesised that less self-compassionate individuals tend to be more avoidant, ruminate more easily, and are thus more likely to experience depressive symptoms (Krieger et al., 2013). In this study, depressed patients differed significantly from never depressed individuals on measures of self-compassion; how self-compassion was related to avoidance and rumination; and whether rumination and avoidance acted as mediators in the relationship between self-compassion and depressive symptoms (Krieger et al., 2013). Effect size was small but significant, also after controlling for depressive symptoms. In fact, Gilbert (2000) argues that not only the presence of self-criticism, but also the lack of self-compassion is a key driver in depression. This claim is supported by a consistent finding in the literature suggesting that self-compassion is inversely correlated with depression and anxiety (Krieger et al., 2013; Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007).

In a meta-analysis, MacBeth and Gumley (2012) investigated the relationship between self-compassion (The Self-Compassion Scale (SCS); Neff, 2003a) and psychopathology (i.e., depression, anxiety, and stress) in 14 heterogeneous studies, and reported that higher levels of self-compassion were significantly associated with lower levels of any kind of symptomatology (r= -0.54). Findings from non-clinical samples have also found a link between self-compassion and psychological functioning, where individuals who score high on self-compassion (SCS)
compared to those with lower scores are less likely to suppress unwanted thoughts and emotions (Leary, Tate, Adams, Allen, & Hancock, 2007; Neff, 2003a); more likely to acknowledge that their emotions are valid and important (Leary et al., 2007; Neff et al., 2007); ruminate less (Neff, Rude, & Kirkpatrick, 2007); have better emotional coping skills, are more willing to try again after failing, and have a greater ability to deal with negative emotional states (Neely, Schallert, Mohammed, Roberts, & Chen, 2009). Moreover, another recent meta-analysis found that self-compassion (SCS) significantly positively correlated ($r=0.47$) with psychological well-being (Zessin, Dickhäuser, & Garbade, 2015). Self-compassion (SCS) has also been found to be a stronger predictor of healthy functioning than self-esteem (Neff & Vonk, 2009), and it is suggested that self-compassion provides greater emotional resilience and stability because self-compassion, in contrast to self-esteem, does not entail self-evaluation or comparisons with others.

Still, a correlation between self-compassion and symptomatology cannot ascertain questions of causality, i.e., if self-compassion protects against psychopathology, or whether the association is due to high levels of self-compassion or simply low levels of self-judgment. For instance, self-criticism is known to be an important predictor of depression (Zuroff, Igreja, & Mongrain, 1990), so a link between self-compassion and psychopathology may simply reflect this fact. However, increased self-compassion has been understood as a protective psychological buffer against depressogenic stressors also after controlling for self-criticism (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006; Kuyken et al., 2010; Neff, 2003a). Evidence including physiological measures can further strengthen this hypothesis. One study reported an association between increased self-compassion and reduced levels of the stress hormone cortisol (Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008), and higher heart-rate variability (which is associated with the ability to self-soothe when stressed) (Porges, 2007).

To sum up, the reviewed evidence suggests a robust association between psychological functioning and self-compassion. In addition; rumination, avoidance, and lack of self-compassion are likely key features of depression and maintenance of depressed mood. This evidence is important as MBCT and other third wave therapies aim to increase acceptance and self-compassion when treating mental disorders like recurrent depression (Hayes, 2004). The notion of targeting acceptance and self-compassion when treating psychological pain builds on how the instinctive response to pain is to withdraw, avoid, worry, and ruminate (Feldman & Kuyken, 2011; Hayes, 2004; Segal et al., 2013). Reacting to aversive emotions or thoughts in this way is
hypothesised to further lead to what has been characterised as a second layer of suffering, involving self-criticism, judgment, blame, aversion or resignation. These reactions may contribute to intensify suffering and distress, creating a circle of magnification as well as obstructing other more adaptive responses. This argument inherits a paradoxical conclusion; that acceptance creates change. In line with this argument, MBCT is built on a specific understanding of underlying mechanisms hypothesised to explain the increasing vulnerability to relapse with repeated experiences with depression.

2.1.2. The Differential Activation Hypothesis

MBCTs design is predicated on a specific cognitive model of recurrent depression and risk of depressive relapse. This model, the Differential Activation Hypothesis (DAH; Teasdale, 1988), is an alternative understanding of recurrent depression than the one seen in Beck’s cognitive model for depression (Beck et al., 1979). According to the Beckian understanding, the vulnerability to relapse lies in external events triggering and activating trait-like depressogenic schemas and dysfunctional attitudes regarding the self, others and one’s surroundings. In consequence, CBT aim to identify, test, and change the automatic, negative thinking patterns hypothesised to maintain depressive episodes. However, research has failed to predict a history of depression based on levels of such depressogenic schemas or attitudes (Segal et al., 2013).

In contrast, the DAH suggests that a prolonged vulnerability for relapse is not due to trait-like depressogenic attitudes, but rather individual differences in how easily a depressogenic processing style is activated by transient low mood. According to the DAH, associations between depressive symptoms are formed and strengthened through co-activation with every new depressive episode, becoming an associative network or depressogenic mode in the individual’s memory. The network can remain latent as a vulnerability to relapse even when a person is in remission. In this way, the DAH explains why trait-like depressogenic attitudes may not be detected in individuals with a history of recurrent depression who are currently in remission. However, the depressogenic network can be retriggered by subtle depressive symptoms and reactivate the whole depressive mode of mind, including painful content (e.g., self-critical, negative, global) and maladaptive processing styles (e.g., rumination, worrying, problem solving, avoidance). That is to say, what for individuals without a history of recurrent depression would have been transient low mood will for recurrently depressed individuals reactivate a depressogenic mode, and possibly reactivate the whole depressive network causing the individual to spiral into another depressive episode. This process has been termed cognitive reactivity, and is
held to be empirically supported (Lau, Segal, & Williams, 2004).

Cognitive reactivity has certain features including: (1) a thinking style that is ruminative, abstract, analytic, critical, and self-referent; (2) a motivation/striving to solve the problem, fix oneself or to avoid emotional experiences; and (3) a focus on perceived self-discrepancies (e.g., feeling sad and wanting to feel happy) and trying to reduce these. Discrepancy-based processing has also been termed ‘doing’ mode (Williams, 2008). ‘Doing’ mode is critical in every day practical problem solving, but can become maladaptive when applied to emotional or negative self-referential processing (Jones, Papadakis, Hogan, & Strauman, 2009; Nolen-Hoeksema et al., 2008), and is associated to a reduced ability to retrieve specific autobiographical memories that are necessary to handle difficult situations (Raes et al., 2006; Williams et al., 2007). When ‘doing’ mode is applied to emotional and self-referential discrepancies, attempts to fix difficult feelings, and reduce the perceived distance between what is and what the individual wishes for or thinks that should be, this will actually increase distress thereby increasing the perceived discrepancy and further lower mood while heightening the risk of depressive relapse (McLaughlin, Borkovec, & Sibrava, 2007; Williams, 2008). Consequently, ‘doing’ mode is argued to initiate a spiral towards relapse and a new depressive episode. For that reason, and in contrast to CBT, MBCT does not aim at changing the content of negative thoughts, but focuses on bringing awareness to, and changing the way the individual relates to, thoughts, feelings, and awareness itself – thereby actually changing the processing style or mode of mind and as a result also the content of mental states (Barnhofer & Crane, 2009; Segal et al., 2013; Williams, 2008).

To summarise, the premise underlying MBCT is that subtle low mood does not in itself cause depressive relapse, however, the way the individual responds to and processes mental events (e.g., thoughts, feelings, bodily sensations) is what can reactivate the underlying depressive network causing a new depressive episode. In other words, reacting to psychological pain with worry, rumination etc., which may be attempts to reduce suffering, actually contributes in reinforcing the current state. What are the clinical implications of this hypothesis? Would learning an alternative response to psychological pain reduce risk of depressive relapse? This is precisely MBCTs intention. Through the practice of mindfulness meditation, the programme focus on training the ability to switch from ‘doing’ mode to ‘being’ mode, an intentional, experiential, and mindful mode of mind (Segal et al., 2013; Williams 2010).

The term mindfulness is an English translation from the Pali word sati, meaning “memory or recollection, and refers to the cultivation of a certain presence of mind that remembers to
attend with persistent clarity to the objects of present experience” (Olendzki, 2009, p. 42). However, this original definition of mindfulness in a Buddhist context has been moderated to various versions in its use in modern psychotherapy such as MBCT and MBSR. An often cited definition by John Kabat-Zinn describes mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p. 145). Still, several authors have pointed to the difficulty of defining or measuring mindfulness (e.g. Chiesa, 2012), and it has been argued that one needs to experience mindfulness in order to understand it because cultivating mindfulness is a deeply personal journey (Olendzki, 2009). In addition, mindfulness is considered to be a mental skill that can be taught and need practice (Olendzki, 2009).

Mindfulness is hypothesised to be achieved by three related abilities (Segal et al., 2013): (1) intentionally paying attention to moment-by-moment internal or external events; (2) noticing habitual and automatic reaction to such events (often including aversion, avoidance, rumination or attachment); and (3) cultivating the ability to respond with an open, curious, accepting and compassionate attitude. Indeed, the second edition of the MBCT manual now explicitly states that MBCT aims to cultivate mindfulness and self-compassion (Segal et al., 2013).

2.1.3. Outline and design of MBCT

As to the clinical utility of MBCT, if there indeed are individual differences in cognitive reactivity to transient low mood, and repeated experiences with depression represents a vulnerability in this regard, what are the clinical implications? MBCT was developed as a prevention programme attempting to strengthen skills assumed to protect against future relapse while the individual is in remission. The eight-week MBCT course combines the practice of mindfulness meditation with psycho-education, movement exercises, and elements from Cognitive Behavioural Therapy (CBT) (Segal et al., 2013). The course consists of weekly two hour sessions, pursuing a theme through a multifaceted curriculum. There is also a one-day silent session. Different guided meditation practices are introduced, including eating meditation (e.g., eating a raisin with complete awareness), the body scan (i.e., practicing sequentially moving awareness from body part to body part), mindful movement (e.g., yoga stretches and walking meditation), and sitting meditation (i.e., directing awareness to the breath as an anchor while observing present mental events). Formal meditation practices are taught and practiced in the weekly sessions, and given as homework assignments (e.g., practising up to 40 minutes of meditation per day). Following the meditation exercises and assignments are subsequent
enquiries, inviting participants to reflect on personal experiences including encountered difficulties and/or struggles with the practice. The focus of the enquiries is on the experiential rather than didactic. Sessions also include psycho-education about depressive and vulnerability mechanisms leading to relapse, combined with exercises highlighting the interaction between emotions, thoughts, and body sensations.

The aim of the first four sessions is practicing to direct attention on the breath and bodily sensations, increase awareness of thoughts, feelings, and sensations, how they interact and influence each other, and notice how the mind switches between ‘doing’ mode and ‘being’ mode. These sessions are intended to increase metacognitive awareness and metacognitive insight into the nature of the mind. In the second part of the programme the training moves toward recognising and dealing more specifically with difficult thoughts (e.g., self-criticism, blame or judgment), painful or challenging emotions (e.g., feelings of sadness, anger or shame), and identifying triggers of negative mood in everyday life. Towards the final sessions participants are encouraged to integrate learned skills in their everyday life in a way that fit their needs and can be maintained over a longer period of time (Segal et al., 2013).

Mindfulness meditation is hypothesised to increase awareness of signature characteristics of the discrepancy-based mode, when it is operating at inappropriate times or maladaptive ways, and how experiential avoidance (i.e., not wanting to feel or think certain things that are already present) interferes with the process of the meditation practice itself. The meditation practises give many opportunities to practice a more accepting and compassionate relationship to the self-critical reactions to this challenging exercise. According to theory underlying MBCT, training the ability to switch from ‘doing’ mode to ‘being’ mode will protect against depressive relapse.

2.2. Does MBCT reduce risk of depressive relapse?
Turning now to the empirical research on MBCTs protective effects, what does the evidence suggest? When evaluating the effectiveness of an intervention, several levels of investigation might be considered. At the lowest level, pilot studies may indicate whether the intervention has the hypothesised effect, secondly case control studies can inform whether preliminary findings are indeed replicable, and thirdly, randomised controlled trials (RCTs) (i.e., trials that randomly allocating participants to treatment and control groups to minimise selection bias) can by virtue of including control groups (usual care or active controls) determine treatment superiority. In addition, dismantling designs of trials can disentangle possible moderators or effective
therapeutic elements. The forth and highest level of evidence are systematic reviews and meta-analyses, which pool the results of existing studies to produce an overall measure of the intervention’s strength or effectiveness. This level of evidence is considered to give the most precise picture of the current evidence base of interventions like MBCT for recurrent depression.

The first meta-analysis of RCTs investigating the effect of MBCT on recurrent depression reported a significant reduced risk of relapse of 34% for MBCT compared to usual care (maintenance antidepressant medication) or placebo (risk ratio 0.66, 95% CI=0.53-0.82) (Piet & Hougaard, 2011). Additionally, sub-group analysis suggested that MBCT was more helpful for patients with three or more previous episodes with a relative risk reduction of 43%, while there was no risk reduction in those with only two previous episodes. The protective effects of MBCT on depressive relapse were recently replicated by Kuyken and colleagues (2016) in an independent patient data meta-analysis including 1258 patients. The authors included the same six studies as in the first meta-analysis and added three more recent RCTs (Bondolfi et al., 2010; Godfrin & van Heeringen, 2010; Huijbers et al., 2012; Kuyken et al., 2008; Kuyken et al., 2015; Ma & Teasdale, 2004; Segal et al., 2010; Teasdale et al., 2000; Williams et al., 2014a). Analysis showed that MBCT reduced risk of depressive relapse within a 60 week follow-up compared to patients who received treatment as usual (TAU) (31% reduced instances of relapse, Hazard Ratio: 0.69, 95% CI=0.58-0.82). Results were still significant after controlling for demographic variables, although a reduction in protective effects over time was observed.

An important question rising from these results is whether the protective effects of MBCT are comparable or superior to those of other evidence-based psychological or pharmaceutical treatments for recurrent depression. That is, comparing MBCT to usual care can only indicate whether some kind of additional treatment effect results in a positive change. Therefore, designs that compare MBCT to other active treatments (that share all the non-specific factors with MBCT) is key in order to specify which ingredients explain the therapeutic effects of MBCT. With a complex treatment intervention such as MBCT with several interwoven elements, it can be difficult to establish if MBCT’s effects are attributable to specific (e.g., mindfulness meditation practice) or non-specific factors (e.g., the group setting or treatment expectancy).

Indeed, in their meta-analysis, Kuyken and colleagues (2016) reported a significant but not superior effect of MBCT when compared to active control treatments over a 60 week follow-up period (21% reduced instances of relapse, HR: 0.79, 95% CI=0.64-0.97). Compared with active controls MBCT was found to have an equal preventive effect. Active control conditions include;
maintenance antidepressant medication (Kuyken et al., 2008; Kuyken et al., 2015; Segal et al., 2010); an MBCT-equivalent cognitive psycho-education group treatment excluding mindfulness meditation (Williams et al., 2014a), a structurally MBCT-equivalent active control group (Cognitive Behavioural Analysis System of Psychotherapy) (Michalak, Heidenreich, Meibert, & Schulte, 2008); and a validated Active Control Condition for depressive relapse prevention (Shallcross et al., 2015). Another recent meta-analysis on the effectiveness of all psychological treatments aimed at preventing depressive relapse, compared with TAU or antidepressant medication, reported that the protective effects of MBCT were equivalent to those for cognitive therapy and interpersonal therapy (Biesheuvel-Leliefeld et al., 2015).

However, accumulating evidence suggests that MBCT compared with active treatments is particularly helpful for patients especially vulnerable to depression, e.g., patients with a history of childhood trauma or abuse (Kuyken et al., 2015; Williams et al., 2014a), and patients with earlier onset and/or three or more previous depressive episodes (Ma & Teasdale, 2004; Teasdale et al., 2000). Preliminary evidence also suggest that MBCT may reduce residual depressive symptoms in chronic depression; reduce risk of depressive relapse in patients prone to maladaptive processing even with a history of less than two previous depressive episodes (Geschwind, Peeters, Huibers, van Os, & Wichers, 2012); and reduce symptom severity in treatment-resistant depression compared to TAU (e.g. Eisendrath et al., 2016). In addition, it has been suggested that MBCT might be less effective for individuals where depressive episodes are triggered by stressful life events (Ma & Teasdale, 2004). Thus, factors related to heightened vulnerability to depression may moderate the protective effects of MBCT. However, this preliminary evidence needs backing by replication with larger sample size and research designs that clarify the particular psychological characteristics of patients who respond best to MBCT (Davidson, 2016).

2.3. How does MBCT work?
There is now robust evidence that MBCT prevents risk of depressive relapse for individuals with a history of recurrent depression when compared to TAU, and is comparable or possibly superior compared to active control treatments for those especially vulnerable to depressive relapse. Yet, how and why MBCT reduces relapse requires a deeper understanding of the mechanisms in the therapeutic process, i.e., identifying essential variables that facilitate change in psychological processes (Crits-Christoph, Conolly Gibbons, & Mukherjee, 2013; Kazdin, 2007). A mechanism in the psychological process has been defined as the “events in psychotherapy sessions, or
constructs thought to change during, or in between, therapy sessions as a consequence of therapeutic interactions that subsequently lead to change in problems, symptoms, and functioning” (Crits-Christoph et al., 2013, p. 299).

According to the MBCT manual (Segal et al., 2013), the mechanisms hypothesised to underlie MBCTs protective effects include four factors: (1) The awareness and recognition of automatic activation of habitual dysfunctional cognitive processes like rumination. (2) Decentering involves disengaging from and observing such processes by redirecting attention to the present moment, letting thoughts, emotions, and bodily sensations come and go without over-identifying with them or trying to change them. Decentering does not mean distancing oneself from difficult experiences, but rather recognising thoughts and feelings as mental states separate from the self-concept while staying close to these experiences. (3) The development of meta-awareness by observing thoughts and feelings as temporary passing events, rather than perceiving them as the truth about reality. In learning to decenter and observe the mind and its internal commentary, it is argued that cognitive processing shift from the content of awareness to awareness itself, i.e., meta-awareness (Williams, 2008). Thus, the meaning given to the thoughts themselves are thereby hypothesised to change (Barnhofer & Crane, 2009). (4) Bringing the individual to observe and relate to the constant change and fluidity of feelings, thoughts, and physical sensations with an attitude of non-judgment, curiosity, acceptance and compassion.

In order to empirically establish a variable as a possible mechanism, statistical mediation must be investigated. A mediator is a variable that accounts for (or explains) the relationship between a predictor and a criterion variable (e.g., change in self-compassion accounts for the association between MBCT and reduced risk of relapse). While a moderator affects the relationship in terms of direction or strength (e.g., individuals with child-hood trauma benefit more from MBCT) (Baron & Kenny, 1986). Mediation requires that the relationship between intervention and outcome becomes non-significant when controlling for the variance attributed to the mediator and to symptom change (Kazdin, 2007). Measuring symptom change and change in the mediator variable at several points in time during treatment, can test if the hypothesised mediator changes before the outcome variable and rule out reverse causation (Kazdin, 2007). However, inconsistency does not necessarily mean that a mediator is not involved, due to potential unmeasured moderator variables affecting the mediated relationship. Likewise, even though mediation is recognised, this does not necessarily mean detection of a mechanism (Kazdin, 2007).
Two recent meta-analyses have investigated mechanisms underlying the effect of MBCT on depressive relapse. Van der Velden and colleagues (2015) reviewed 23 clinical trials and identified several variables as mechanisms of change. Analysis showed that alterations in mindfulness, self-compassion, rumination, worry, and meta-awareness were associated with, predicted or mediated MBCT’s effect on treatment outcome. Also, they reviewed preliminary evidence indicating that alterations in attention (e.g., regulate attention, disengage from depressogenic thinking), memory specificity, self-discrepancy, activity pleasantness appraisal, emotional reactivity, and momentary positive and negative affect could in part account for the effect of MBCT on risk of depressive relapse. The authors reasoned that these mechanisms are in keeping with the cognitive science account of recurrent depression, on which MBCT is predicated. Nevertheless, they called for more rigorous designs able to depict the degree to which these mediators are causally involved in preventing depressive relapse.

The second systematic review and meta-analysis, conducted by Gu and colleagues (2015), evaluated mechanisms in both MBCT and MBSR in heterogeneous clinical and non-clinical samples. The review included a total of 20 studies, of which only nine included depressive symptoms as an outcome variable. Other outcomes included anxiety, stress, mood state, quality of life, and anger expression. This systematic review/meta-analysis demonstrated evidence for cognitive and emotional reactivity, mindfulness, rumination, and worry as significant mediators. There was preliminary, but insufficient and mixed evidence for self-compassion as a mediator. Still, the authors suggested that this may be due to methodological limitations.

The only RCT which has investigated self-compassion as a mediator in MBCT for recurrent depression (i.e., three or more previous episodes), is the study by Kuyken and colleagues (2010). They compared MBCT with an active control group receiving maintenance antidepressant medication. Analysis suggested that enhancement in both self-compassion (SCS) and mindfulness (measured with the Kentucky Inventory of Mindfulness Skills (KIMS); Baer, Smith, & Allen, 2004) significantly and independently mediated treatment effects of MBCT on residual depressive symptoms at 15-month follow-up, when adjusted for depressive symptoms and history. However, changes in mindfulness and self-compassion did not predict depressive relapse, which was near significant (p= .058). The authors suggested that the small sample size in the MBCT group (n=49) could be too small to detect a prevention effect, and that severity of depressive symptoms is known to predict risk of relapse. Another variable included in the study was cognitive reactivity, operationalised as change in depressive thinking during a laboratory
mood induction. In the control group, greater reactivity predicted increased risk of relapse. Such an association was not found in the MBCT group. That is, there was a reduced link between cognitive reactivity and depressive relapse only in the MBCT group, even though cognitive reactivity increased post treatment. Moreover, only increases in self-compassion, and not mindfulness, mediated this association. This finding suggests that cultivation of self-compassion may protect against relapsing by decoupling the association between reacting to negative emotions with depressive thinking and re-triggering a depressive episode.

Studies investigating the role of self-compassion in MBCT for populations other than the recurrently depressed, have also found significant increases in self-compassion following MBCT, e.g.; in pregnant women (Dunn, Hanieh, Roberts, & Powrie, 2012) and trainee clinical psychologists (Rimes & Wingrove, 2011). As these populations presumably are non-clinical generalisation must be made with caution. Equally, studies investigating self-compassion in other presumably non-clinical groups (e.g., community samples, students and health care professionals) have also reported significant increases in self-compassion following MBSR (e.g. Bergen-Cico & Cheon, 2013; Birmie, Speca, & Carlson, 2010; Keng, Smoski, Robins, Ekblad, & Brantley, 2012; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007).

In sum, there is a sound theoretical rationale as well as emerging empirical evidence that self-compassion is both an outcome of MBCT and a mechanism underlying MBCTs protective effects on risk of depressive relapse. However, what self-compassion refers to, and how it should be measured, is not straightforward. Thus, a more nuanced assessment of this construct is needed. Kuyken and colleagues (2010; 2016) propose that future research would benefit from using behavioural and neuroscience measures. Moreover, they argue that future research efforts should adopt research designs (e.g., experimental manipulations, individual differences designs, or RCTs) which further unpack and disentangle components of MBCT while examining each mediator separately. In fact, investigating self-compassion as a possible mediator in MBCT rests on the assumption that self-compassion and mindfulness are distinct constructs. As we shall see, this is an assumption that is questionable. Thus, a critical investigation both of the concept of self-compassion and mindfulness is required in order to review the evidence and discuss how beneficial effects might come about.

3 Mediation and outcome should be seen as independent issues because even though one can find an increase in self-compassion (outcome), this does not necessarily mean that experiencing more self-compassion explains a decreased risk of relapse (mediator). That being said, there is a possible link between the two and they will probably overlap to a large degree, i.e., a mediator is often also an outcome as well (Kazdin, 2007).
3. What is Self-Compassion?

Research on MBCT for recurrent depression indicates that the programme has an effect in reducing risk of depressive relapse, and preliminary findings suggest that self-compassion may be a key mechanism underlying this effect (van der Velden et al., 2015). Kuyken and colleagues (2010) demonstrated MBCT did not reduce cognitive reactivity, but strengthened the tolerance for reactions to negative mood. However, how might self-compassion be conceptualised? Knowing what is meant by self-compassion is necessary to make sense of an investigation of self-compassion as a mechanisms underlying MBCTs preventive effect. Should self-compassion be regarded as primarily a feeling, a motivational state, an attitude, a behavioural response or rather as a moral insight or principle? How is self-compassion related to mindfulness, and should these concepts be considered as separate or part of the same overarching construct?

There are several possible gateways into clarifying the concept of self-compassion. One might look at theoretical conceptualisations including classical definitions in Buddhist teachings; questionnaires developed to measure self-compassion; neurological findings and evolutionary explanations; or investigating the predictive utility of measured self-compassion on outcome. First, theoretical conceptualisations of self-compassion combined with neuropsychological findings will be considered. Secondly, the most used self-report measure of self-compassion, the Self-Compassion Scale (SCS; Neff, 2003a), will be evaluated. Finally, evidence clarifying the association between self-compassion and mindfulness will be discussed.

3.1. Theoretical conceptualisations of self-compassion

The word compassion stems from the Latin compati, meaning to suffer with (Strauss et al., 2016), and self-compassion is generally viewed as compassion directed inward towards the self (e.g., Neff, 2003b). According to classical Buddhist literature, the cultivation of mindfulness is substantially associated with compassion and an ethical development, i.e., being of service to others, and practicing patience and loving kindness (Purser & Milillo, 2014). Germer (2013) argues that mindfulness is acceptance in action, and Buddhist mindfulness meditation is a way of cultivating compassion as mindfulness is a way to change one’s relationship with suffering - which is in itself as an act of kindness. According to Buddhist theory, compassion is additionally
suggested to arise from *insight* into impermanence, mental suffering, and the constructed nature of a separate self (Feldman & Kuyken, 2011). It has been argued to be problematic that many of the developers of existing mindfulness scales do not have sufficient knowledge about the original conceptualisation of compassion within Buddhism, where it is not only seen as an emotional response but also “a response founded on reason and wisdom which is embedded in an ethical framework concerned with the selfless intention of freeing others from suffering” (Strauss et al., 2016, p. 17). Straus and colleagues (2016) argue that a lack of understanding of this complexity could bias future research into self-compassion in relation to mindfulness by narrowing the original concept. This could be problematic when attempting to measure both constructs and provide empirical evidence for the effect of mindfulness training on self-compassion in MBCT. A more complex understanding of mindfulness and compassion may be beyond measurement using questionnaires. This issue will be returned to in section 3.2.

In a recent review on theoretical conceptualisations of compassion, Straus and colleagues (2016) propose a new joint definition of compassion as a complex phenomenon with “a cognitive, affective, and behavioural process consisting of five elements that refer to both self-compassion and other-compassion” (p. 19). These elements are as follows: 1) Recognising suffering; 2) Understanding the universality of suffering in human experience; 3) Feeling empathy for the person suffering and connecting with the distress (i.e., emotional resonance); 4) Tolerating uncomfortable feelings aroused in response to the suffering person and thereby being open to and accepting of the person suffering; and 5) A motivation to act/acting to alleviate suffering. This definition attempts to capture and include all elements attributed to compassion in various other definitions.

Halifax (2012) problematizes this issue even more, and criticises current definitions of compassion as separate static feature or state (as the SCS). She stresses that compassion should be regarded as an emergent and contingent process that entails a mutual, reciprocal, and asymmetrical interaction between the individual and its surroundings. According to Halifax; “Compassion is an emergent process arising out the interaction of a number of interdependent somatic, affective, cognitive, attentional, and embodied processes, all of which themselves can be trained in” (2012, p. 6). That is, compassion can only be primed through the development of specific underlying factors (e.g., attention to inner reactions and recognising the presence of suffering, developing an ethical intention to respond to suffering). In other words, one cannot *directly* increase self-compassion, but by facilitating the underlying components compassion will
develop as a result of cultivating these components.

In their review, Strauss and colleagues (2016) also distinguish compassion from other related constructs such as empathy, kindness, and acceptance. Compassion is differed from empathy in that compassion is felt specifically in response to suffering, whereas empathy may encompass all feelings of others and can apply to a broader range of situations, i.e., not just individuals’ struggles. Others have suggested that compassion is an emotion in its own right, while empathy is the vicarious experience of another's emotions (Goetz et al., 2010). Strauss and colleagues (2016) argue that compassion entails a desire to act to alleviate suffering, which is not the case in empathy, but that both concepts may fit under the broader term kindness. Kindness and compassion share similarities, but are differentiated in that compassion contains additional elements to kindness (e.g., being touched by suffering) (Strauss et al., 2016). Similarly, kindness is not only linked to suffering, but may involve other situations as well. The feeling of pity also shares similarities with compassion, but does not necessitate an intention to help. It has been suggested that compassion is feeling for, not feeling with, the other - a distinction potentially supported by preliminary research reporting differential activation of neural networks for compassion and empathy training compared to controls (Klimecki, Leiberg, Ricard, & Singer, 2013). After empathy training, and while watching videos of individuals suffering, researchers found increases in self-reported negative affect and neural activation in brain areas (i.e., anterior insula, anterior midcingulate cortex) associated with empathy. In contrast, after compassion training there was no increase in negative effect, but increases of positive affect combined with greater neural activation in a different neural network (i.e., ventral striatum, pregenual anterior cingulate cortex and medial orbitofrontal cortex). This suggests that self-compassion may strengthen resilience and emotion regulation when confronted with other’s distress.

Compassion has also been conceptualised in an evolutionary perspective. This view posits that compassion is an evolved psychological capacity and adaptive motivation whose primary function is to facilitate cooperation, nurture, and protection of one's offspring, the weak, and those who suffer (de Waal, 2008; Gilbert, 2009; Goetz et al., 2010). Compassion may also have evolved through sexual selection in primates as a desirable criterion in mates that facilitates cooperative relationships (de Waal, 2008; Goetz et al., 2010). Gilbert (2009) defines compassion in this context by including dimensions of care, soothing, sympathy, empathy, and non-judgment, while integrating biological underpinnings of human behaviour, evolution, and human attachment experiences with significant others. According to his model, the brain has three different evolved
functional, and emotional systems (e.g., a system responding to threats; incentive/excitement system seeking out resources; and a care system for seeking soothing and safeness) (Gilbert, 2009). Self-compassion is hypothesised to deactivate the threat-system (associated with insecure attachment, defensiveness, and sympathetic activation) by activating the care-system (associated with secure attachment, safety, and the oxytocin-opiate system) (Gilbert & Tirch, 2009; Goetz et al., 2010). This deactivation process is hypothesised to similarly deactivate the depressive and critical way of relating to the self, making it possible to learn more caring ways of attuning to oneself (Gilbert, 2007; Gilbert et al., 2006; Gilbert & Irons, 2005).

Gilbert (2009) suggests that compassion is part of an evolved system with a neurological foundation responding to observed suffering with a motivation to care and soothe. Moreover, it appears that meditation could affect this care-system. For instance, neuroimaging research has reported an increased thickness in both the prefrontal cortex and the right insula in individuals who had been practicing mindfulness meditation for a longer period of time (Lazar et al., 2005). These areas have been suggested to be involved in the experience of compassion and empathy, and are generally associated with caregiver behaviour (Hölzel et al., 2007; Wang, 2005). Compassion has also been related to distinct processes involved in responding to observing suffering in others and signalling caring behaviour (e.g., touch, posture, and vocalisation), as well as physiological activation motivating the individual towards social approach behaviour that differs from behaviour that is motivated by distress, sadness, or love, suggesting that compassion can be regarded a distinct phenomenon (Goetz et al., 2010).

To sum up, self-compassion can be understood from several perspectives. Whatever conceptual perspective is chosen, the ability to reliably measure self-compassion is crucial to improving understanding of the concept. The Self-Compassionate Scale (SCS; Neff, 2003a) is a self-report scale, and is the most widely used self-compassion measure in mindfulness-based interventions and MBCT research (Neff, 2015; Strauss et al., 2016).

3.2. Measuring Self-Compassion: The Self-Compassion Scale

The SCS was developed to measure self-compassion through three dimensions consisting of one positive and one negative opposite (Neff, 2003a). The three dimensions/subscales are as follows:

---

4 When reviewing evidence on neural activation associated with compassion, Goetz et al. (2010) reported that compassion involved noticing suffering expressions in others and mirroring these emotional experience (interior frontal cortex, insula, temporal pole), evaluating relevance or deservedness of the sufferer (midventral mPFC), coping with empathic distress (dorsal mPFC/interior frontal cortex), feeling warmth/tenderness towards the other (periaqueductal gray, substantia nigra, and ventral tegmental area), and a motivation to approach (heightened left hemisphere).
(1) Self-kindness versus Self-judgment, (2) Common humanity versus Isolation, and (3) Mindfulness versus Over-identification. Items are scored on a five-point Likert scale ranging from 1 (almost never) to 5 (almost always). According to Neff (2003b), self-kindness involves being gentle, supportive, and understanding toward oneself (e.g., I try to be understanding and patient towards those aspects of my personality I don’t like), in contrast to being self-judgmental (e.g., I am disapproving and judgmental about my own flaws and inadequacies). Self-kindness is argued to involve self-acceptance and the ability to soothe or comfort oneself when facing distress. The second dimension, common humanity, involves recognising that imperfections and mistakes are part of everyone’s life, thereby feeling connected with others (e.g., When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most individuals). Common humanity is contrasted with feeling isolated and like the only one who is inadequate or suffers (e.g., When I fail at something that is important to me, I tend to feel alone in my failure). Mindfulness, the third dimension of self-compassion, entails awareness of the present moment experience of suffering with tolerance (e.g., When something painful happens, I try to take a balanced view of the situation), in contrast to over-identifications, which involves becoming absorbed in negative narratives about experiences or oneself (e.g., When I fail at something important to me, I become consumed by feelings of inadequacy).

Neff (2003b) argues that these six features are all likely to fluctuate across time and situations, but should essentially be seen as trait-like qualities. This stands in contrast to conception of compassion as a contingent process as argued by Halifax (2012). More recently, Neff (2015, 2016) has accentuated that self-compassion is better conceptualised as a dynamic, interactive system composed of multiple factors that simultaneously impact on one another. For instance, being kind and understanding toward oneself when experiencing personal inadequacies can lessen harsh self-judgment, and contribute to a sense of not being the only one struggling in life while soften feelings of isolation. Or, mindfulness may lower self-judgment, in that a reduction of self-judgment and development of self-kindness over time may make it easier to maintain mindful awareness on one’s thoughts and emotions. There is also evidence that self-compassion can be developed through repeated explicit practice and cultivation in MBCT equivalent programmes such as Mindful Self-Compassion (Neff & Germer, 2013).

What is not clear from this conceptualisation is how the different elements interact to give rise to self-compassion, as it may be that some subscales are facilitators of self-compassion, yet they could also be hypothesised to be emergent factors from other subscales rather than defining
features themselves. The SCS may also lack essential elements of self-compassion when juxtaposed to the definition suggested by Strauss and colleagues (2016) as the *motivation* to relieve suffering is an element missing in the SCS. It has also been suggested that the SCS tap a number of already known protective factors, e.g., mindfulness, belongingness, and self-soothing - which resemble the dimensions of common humanity and self-kindness (Strauss et al., 2016). This calls into question the utility of the SCSs to measure a separate and meaningful construct. Still, Strauss and colleagues (2016) conclude that the SCS was the most valid and reliable measure of self-compassion compared to other measurements. It rated satisfactory for content validity, convergent validity, and adequate for reliability of the total score and subscale scores, as well as satisfactory of test–retest reliability. Confirmatory factor analysis has been able to replicate both a six-factor model and a hierarchical model in mixed clinical and non-clinical samples (e.g. Castilho, Pinto-Gouveia, & Duarte, 2015).

However, reliability, validity, and factor structure of the SCS has recently been criticised as a recent study failed to replicate the factor structure in a community sample, a meditator sample and a clinical sample concocting of patients with recurrent depression currently in remission (Williams et al., 2014b). This finding has potentially important implications given that the SCS is frequently used to assess changes in self-compassion in these populations, and raises questions about which parameters the SCS actually capture. If the factor structure of the SCS is indeed not replicable, this challenges previous interpretations of findings using this instrument. A key question arising from these studies is to what degree the SCS measures a coherent phenomenon or is better viewed as an instrument capturing different facets, which may not necessarily be coherently linked. Indeed, Muris and colleagues (2016) argue that the SCS may be better suited to measure six independent qualities rather than one overarching construct.5

A second critique of the SCS is that, insofar as self-compassion is a protective mechanism, the scale should not measure both the presence of compassionate behaviour and the lack of uncompassionate behaviour. The three negative components (i.e., self-judgement, isolation, and over-identification) represent vulnerability to distress, and so depicts absence rather than the manifestation of self-compassion (Muris & Petrocchi, 2016). Indeed, the meta-analysis by Muris and Petrocchi (2016) explored the associations between the SCS subscales and

---

5 On a theoretical level, researchers have also proposed a two-factor model of self-compassion, where the positive and negative dimensions (self-compassion and self-criticism) would represent the two factors (e.g. Lopez et al., 2015). Responding to these propositions, Neff (2015) advocates a bi-factor model of self-compassion instead, where each item loads directly on to a general factor as well as their respective subscale; this may be better suited to researchers who then could select whether to analyse subscale scores separately or use a total SCS score depending on their objectives.
psychopathology, and found that the inversely scored negative components (i.e., Self-judgment, Isolation, and Over-identification) were more strongly associated with psychopathology than the positive components (i.e., Self-kindness, Common humanity, and Mindfulness). For instance, self-judgment shows similarities to self-criticism; isolation shows similarities with social withdrawal and loneliness; and over-identification shows similarities with self-focused rumination - all of which are associated with psychopathology (e.g., Lyubomirsky & Nolen-Hoeksema, 1995; Rubin & Coplan, 2004; Zuroff et al., 1990). Indeed, if the negative factors of the SCS tend to be more powerful predictors of psychopathology than the positive factors, a total score could result in an inflated relationship to symptoms of psychopathology, and thereby overestimate the alleged protective role of self-compassion.

Neff (2016) replied to this critique citing neurological evidence suggesting that both negative and positive subscales of self-compassion are relevant for the conceptualisation of the construct. Like Gilbert (2009), she points out that the self-soothing and self-criticism aspects of self-compassion are related to different neurological systems. Self-soothing has been linked to the contentment and safeness system associated with the parasympathetic nervous system, while self-criticism is hypothesised to tap into the threat-defence system associated with the sympathetic nervous system (Gilbert & Tirch, 2009). For instance, Longe and colleagues (2010) found that self-reassurance (ventrolateral PFC) and self-criticism (dorsolateral PFC) were associated with activation of different brain areas, and thus being compassionate versus critical to oneself was suggested to have demonstrably distinct neural bases. This evidence suggests that self-compassion and self-criticism are separate systems at the physiological level. Moreover, one of the indicators of safeness and contentment in an organism has been argued to actually be the lack of threat (Gilbert, 2009), and there is evidence that the two systems continuously interact and co-vary (Porges, 2001). Hence, including the lack of a threat response may be relevant to measuring the presence of a sense of safety, and likewise, including items that assess the absence of self-judgment as well as the presence of self-kindness would make sense. Self-compassion may enhance positive wellbeing via increased self-kindness, common humanity, and mindfulness, and simultaneously reduce psychopathology by lessening self-judgment, isolation, and over-identification. However, as Muris and Petrocchi (2016) point out, the lack of a vulnerability may be interpreted as a protective factor, just as the lack of a protective factor could be interpreted as a vulnerability. Thus, the definition of self-compassion may in this sense become tautological.

A third problematic aspect of the SCS, as with all measurement relying on self-report, is
that its validity critically depends on the understanding and insight of the individual (e.g., whether the SCS measures how self-compassionate a person really is, or how self-compassionate the person thinks he/she is), as well as being subject to well-known biases associated with self-report (e.g., by means of demand characteristics). Alternative measurements could include observable compassionate behaviour/responses (e.g., using a soft tone of voice), and biobehavioural measures in prospective, longitudinal or experimental designs to further inform the conceptualisation of self-compassion. Still, it has been argued that acts of compassion are often invisible and difficult to measure, and that there is a danger of “measuring what is easy to quantify, rather than what is important” (Dewar, Pullin, & Tocheris, 2011, p. 32). Social desirability may also play a role in self-reported measures, especially when answering the questionnaire following completion of MBCT. However, self-compassion appear not to correlate with measures of social desirability (Neff, 2003b). An increase in self-compassion measured with the SCS following MBCT may also reflect that individuals internalise a vocabulary or focus on self-compassion without actually being more self-compassionate. However, as MBCT can be said to adopt more of an implicit focus on self-compassion when addressing acceptance, kindness, and openness, self-compassion levels may not be overestimated for this reason.

Thus, it is interesting that self-compassion is cultivated during MBCT without directly targeting self-compassion. However, even though MBCT does not teach meditation practices in which compassion is explicitly mentioned researchers have argued that compassion permeates the programme from beginning to end, both in terms of delivery and focus of the meditation practices (Feldman & Kuyken, 2011). A question that follows logically from this is whether self-compassion and mindfulness are part of the same overarching concept, and whether increase in self-compassion merely reflects an increase in mindfulness over the course of the programme. It is to this issue that I now turn.

3.3. Are self-compassion and mindfulness separate constructs?
The degree to which self-compassion and mindfulness are distinct concepts has recently received increased attention (Chiesa, 2012; Neff & Dahm, 2015). This question is important because if self-compassion and mindfulness are indeed two aspects of the same overarching construct, it would be tautological to argue that self-compassion is a therapeutic mechanism in the change process facilitated by mindfulness training in MBCT. I will discuss this issue, first, by examining theoretical models, followed by a subsequent empirical review.
3.3.1. Theoretical clarification

The Buddhist tradition from which the concept of mindfulness is derived, depicts awareness and compassion as dependant on each other, and it is argued that compassion develops in the context of mindfulness (Tirch, 2010). An illustrative metaphor describes these concepts as two wings of one bird, and both need to be in balance for the bird to fly. Thus, “mindfulness has at least two important components: that we pay attention and how we pay attention” (Sears & Kraus, 2009, p. 170). Likewise, the MBCT manual emphasises that mindfulness is not reducible to awareness itself, but that mindfulness entails paying attention with a certain kind of attitude - an attitude of openness, curiosity, acceptance, non-judgment and compassion (Segal et al., 2013). The developers of MBCT point out that decentering can be done in several ways, but that the mindful approach is one of “welcoming and allowing”, “invitational and compassionate”, and open to all experience with an attitude of gentleness (Segal et al., 2013, p. 56). In other words, the authors argue that mindfulness represents a fundamental shift in how the individual relates to mental events, and that this shift depends on the ability of bringing friendliness and compassion to the present-moment experience. Thus, they include compassion when defining mindfulness as “attending to the present moment is in itself an act of self-care and kindness” (2013, p. 139).

In contrast, other researchers such as Chiesa (2012) and Bishop (2004) argue that even though the concept of mindfulness frequently is equated with the concept of acceptance and friendliness, this is not in line with the classical perspective of mindfulness where acceptance is seen as an attitude that is brought to the repeated refocusing of attention - but is not in itself an inherent aspect of mindfulness. The attitude of acceptance prevents negative thoughts (e.g., self-judgment and aversion) from arising and inhibiting the meditation practice. Hence, self-acceptance and self-friendliness (i.e., self-compassion) can thought of as qualities of awareness, and therefore distinct from mindfulness. These qualities could be understood as outcomes of mindfulness meditation, or as skills that contribute in developing mindfulness (Bishop, 2004). The lack of correlation between mindfulness subscales like Awareness and Non-judgment would broadly support the view that these two constructs are independent (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Cardaciotto, Herbert, Forman, Moitra, & Farrow, 2008).

Another way mindfulness has been distinguished from self-compassion is that mindfulness is seen as a way of relating to all internal experience and awareness itself, whereas self-compassion is a way of relating to the experiencer who is suffering (Germer, 2013). That is, mindfulness involves non-judgmentally accepting all thoughts, emotions, and sensations that
arise in present moment awareness. Compassion on the other hand, involves a desire and motivation to soothe and comfort the person/self who is suffering (in line with the new definition proposed by Strauss et al. (2016)) which would require attention, but is distinct from mindfulness (in line with self-compassion as defined by Neff (2003a)).

In sum, theoretical definitions illustrate that mindfulness and self-compassion can be considered as two separate constructs (Model 1). However, this depends on the conceptualisation. If mindfulness is defined by including qualities of compassion, acceptance/non-judgment, and kindness, self-compassion can be understood as an interdependent part of mindfulness. On the other hand, kindness, acceptance, and compassion can also be seen as qualities of awareness, and thereby as a related but separate part of mindfulness. This reflects a narrower appreciation of mindfulness. Lastly, as in the SCS, mindfulness could also be a dimension of self-compassion, as awareness to the present moment is required to notice suffering.

Model 1: Figurative illustration of mindfulness and self-compassion conceptualised as separate but overlapping constructs.
3.3.2. Empirical investigation

When empirically approaching the question of whether self-compassion and mindfulness are separate or distinct constructs, one can examine whether the constructs correlate; evaluate the factor structure of each scale and investigate the predictive utility of both constructs to see if they have shared variance; or test whether mindful and self-compassionate modes of processing self-relevant information involve overlapping or distinct neural substrates.

Whilst some degree of correlation would be expected between self-compassion and mindfulness (e.g., as Mindfulness is a subscale in the SCS), high correlations would suggest that the instruments target the same underlying construct. Studies investigating correlations between the SCS and mindfulness scales have demonstrated a positive correlation in heterogeneous samples (e.g., adults without meditation experience and students). However, correlations vary widely depending on which mindfulness measure is applied, e.g., range from .28 (Birnie et al., 2010) using the Mindful Awareness and Attention Scale (MAAS; Brown & Ryan, 2003) to .69 (Hollis-Walker & Colosimo, 2011) using the Five Factor Mindfulness Questionnaire (FFMQ; Baer et al., 2006). Yet, these inconsistencies are not unexpected given that the various scales developed to measure mindfulness differ in their definitions. In fact, available scales designed to measure mindfulness only correlate modestly or not at all (Baer et al., 2006). For instance, the FFMQ depicts mindfulness as multi-faceted, including: (1) Non-reactivity to inner experience; (2) Acting with awareness; (3) Describing; (4) Non-judging of experience; and (5) Observing/noticing. The Kentucky Inventory of Mindfulness Skills (KIMS; Baer et al., 2004), also includes non-judgment/acceptance. In contrast, the MAAS represents an attempt to measure mindfulness as a single-faceted construct (i.e., present-centred attention). This scale builds on a theoretical understanding of mindfulness as a form of metacognition and attention regulation strategy alone (Chiesa, 2012), and does not include attitudinal components such as non-judgment. This single-facet operationalization of mindfulness has been criticised for being reductionist insofar as it does not include core attitudinal features suggested in the original Buddhist meaning of mindfulness (e.g. Grabovac, Lau, & Willett, 2011; Harrington & Dunne, 2015). Thus, when discussing the association between self-compassion and mindfulness, specificity is required as to whether both attentional and attitudinal components are involved in mindfulness, or not.

Measuring mindfulness is further problematized by findings that suggest changes in the factor structure depending on meditation experience. A recent confirmatory analysis of the factor structure of the FFMQ showed that a four-factor hierarchical model (minus observing/noticing)
fitted a community sample and clinical sample of individuals suffering from recurrent depression. Interestingly, a five-factor hierarchical model (including observing/noticing) best fitted a meditator sample (Williams et al., 2014b). The authors suggest that observing one’s experience may have different meanings for meditators and non-meditators, and so it may be problematic to use the FFMQ to measure changes in mindfulness pre to post MBCT if the factor structure changes as a consequence of meditation experience. Indeed, it has been argued that, according to the classical Buddhist teachings, an in-depth understanding of mindfulness is only achieved through a large amount of personal mindfulness meditation practice as it is related to the cultivation of wisdom and ethical behaviours as well (Chiesa, 2012). In consequence, taking mindfulness out of its original Buddhist context might have led to a loss of core understandings of the concept and practice (Williams & Kabat-Zinn, 2011). Developers of existing mindfulness scales have been criticised for lacking such a deep understanding, creating a bias in mindfulness research by narrowing the original perspective of mindfulness into an understanding based on a small set of cognitive abilities (Brown, Ryan, & Creswell, 2007; Chiesa, 2012; Grossman, 2008).

As Mindfulness is one of three subscales in the SCS, and Non-judgement (i.e. acceptance) is a subscale of mindfulness in the FFMQ, researchers have put forward a potential tautology inherent in the SCS when applied to measure change in self-compassion pre to post MBCT completion (Muris & Petrocchi, 2016). Neff and Dahm (2015) justify the inclusion of mindfulness as a defining element in the SCS by arguing that the ability to recognise suffering (i.e., being mindfully aware) is necessary for the ability to extend compassion towards the self. In addition, Neff (2016) argues that mindfulness in the SCS taps a somewhat different kind of mindfulness than mindfulness measures in existing mindfulness scales. In the SCS, mindfulness is defined as “being aware of present moment experience in a clear and balanced manner so that one neither ignores nor ruminates on disliked aspects of oneself” (Neff, 2003b, p. 224). Neff and Dahm (2015) argue that this definition of mindfulness in the SCS is a more narrow definition than mindfulness as operationalised in the FFMQ or equivalent scales, because it is limited to awareness of negative thoughts and feelings, whereas other mindfulness scales refer to mindful awareness of any experience. However, this argument only points out that the scales measure the same construct – only in different contexts/situations.

Moreover, Neff and Dahm (2015) argue that self-compassion is a broader construct than mindfulness because it also includes the elements of self-kindness and common humanity, even though “feelings of self-kindness and common humanity may accompany the practice of
mindfulness”. That is, self-compassion may automatically co-arise with mindfulness even though they do not always co-arise because “it is possible to be mindfully aware of painful thoughts and feelings without actively soothing and comforting oneself, or remembering that these feelings are part of the shared human experience” (Neff & Dahm, 2015, p. 130). However, when juxtaposing scales like the FFMQ and the SCS, the face validity of the Non-judgement subscale of the FFMQ can be seen as similar to the Self-kindness subscale in the SCS. How can one distinguish non-judging/acceptance from self-compassion? Yet, if kindness and mindfulness are present in both scales, this would leave Common humanity as the only subscale that is unique to the SCS. In sum, investigating the factor structure of these scales suggests some overlap which potentially implies that these scales tap into the same overarching construct.

Another approach to empirically draw a distinction between mindfulness and self-compassion is to investigate whether their predictive value differs (e.g., whether the two constructs account for independent variance in outcome). Kuyken and colleagues (2010) reported that both increases in mindfulness (as depicted by the FFMQ) and self-compassion (as measured by the SCS) independently accounted for less severe depressive symptoms across all participants (n=123) at 15-month follow-up. However, only self-compassion, and not mindfulness, mediated the association between cognitive reactivity (i.e., change in depressive thinking during a laboratory mood induction) and depressive symptoms in the MBCT group (n=61). This suggests that self-compassion and mindfulness have different predictive value, and that self-compassion may be a more powerful predictor of depression severity (and possibly also relapse) than mindfulness. Intriguingly, this suggests that even though these constructs seem to overlap to a large degree, it is meaningful to distinguish self-compassion (SCS) and mindfulness (FFMQ).

Van Dam and colleagues (2011) examined the predictive ability of self-compassion (SCS) compared to mindfulness (as depicted by the MAAS) in a sample of individuals with moderate to severe anxiety and/or depression (n=504). They found that individual differences in self-compassion explained significantly more variance in terms of anxiety, worry, depression, and quality of life compared to mindfulness (15-41% versus 7–19% respectively). The SCS subscales Isolation and Over-identification most strongly predicted anxiety and worry, while Self-judgment and Isolation most strongly predicted depression. However, since the MAAS endeavours to measure mindfulness as a single facet, this may not be surprising. The authors point out that attitudes towards the self may be easier to report than past incidences of mindful awareness. However, one study that compared the predictive utility of self-compassion (SCS) with multi-
faceted mindfulness (FFMQ) also identified both measurements as significant independent predictors of psychological wellbeing (Baer, Lykins, & Peters, 2012). Still, self-compassion predicted wellbeing almost twice as strongly as mindfulness. It must be noted that the present sample was not from a clinical population, but included experienced meditators and non-meditators, so generalisation to clinical populations must be made with caution.

In a recent study by Woodruff and colleagues (2013) the predictive variance of the MAAS and the FFMQ were compared with self-compassion (SCS) on psychological health in a student sample. They found that these measures indeed accounted for unique variance. Interestingly, and contrary to the other cited studies, their findings suggested that mindfulness was in fact a stronger predictor of psychological health than self-compassion. When comparing the total score of the MAAS and the SCS, 34 % of the predicted variance was common to both predictors, 10 % was unique to single-factor mindfulness, and 56 % was unique to self-compassion. Similar predictions were found when comparing the FFMQ and the SCS. However, analyses of subscales showed that the sum of all unique variance attributed to the five FFMQ subscales equalled or exceeded the unique variance attributed to the six SCS subscales. This suggests that the link between mindfulness and psychological health may in fact be stronger than self-compassion and mental health. These findings must be treated with some caution given the relatively modest sample size (n=147) combined with a large number of measures used. Soysa and Wilcomb (2013) also investigated whether facets of mindfulness (FFMQ) and self-compassion (SCS) independently predicted depression among 204 undergraduates. They found that facets of mindfulness (i.e., Describing, Non-judging, and Awareness) were stronger single predictors of depression than subscales of self-compassion (i.e., Isolation and Self-judgment).

In sum, these data from heterogeneous studies show a differential predictive utility of mindfulness and self-compassion account on outcome, suggesting that these two constructs are indeed distinguishable. However, results are mixed regarding the question whether mindfulness or self-compassion is the strongest predictor on depressive/anxiety symptoms. As Kuyken and colleagues’ (2010) study is the only one comparing self-compassion with multi-faceted mindfulness (FFMQ) in a sample of recurrently depressed individuals post MBCT, their findings may be given the most weight in the context of this discussion. Still, replication with larger sample size is required to clarify if self-compassion is a stronger predictor than mindfulness.

It has been suggested that self-compassion taps into differently evolved physiological systems than mindfulness (Gilbert, 2009). A comprehensive review of neurophysiological
underpinnings of meditation is beyond the scope of this dissertation. However, neuro-scientific studies can provide a useful basis for gauging the degree to which two concepts are overlapping. A recent meta-analysis investigated 78 functional neuroimaging studies with non-clinical meditator samples on state effects of different kinds of meditation (Fox et al., 2016). This included mindfulness and compassion meditation. Analyses showed dissociable activation patterns of brain areas that were consistent with the psychological and behavioural intentions (e.g.,) of each meditation. This suggests that it is meaningful to differentiate between different kinds of meditation practices, including mindfulness and self-compassion. Compassion meditation was linked to activation clusters in the right anterior insula (associated with empathy and mentalising); secondary somatosensory areas (awareness of bodily sensations, feelings of empathy and the perception of pain); and the parieto-occipital sulcus. Mindfulness meditation also showed significant clusters of activation in the insula (which is also associated with awareness of body signals). Activation unique to the mindful state were identified in the left inferior frontal gyrus, supplementary motor area, and premotor cortex (all associated with the voluntary regulation of thought and action). Deactivation was found in the right thalamus, suggesting less sensory gating - fitting with the aim of being open to sensory stimuli in mindfulness meditation. Activation clusters were also found in the rostro-lateral prefrontal cortex and mid-dorsolateral prefrontal cortex (associated with cognitive control and metacognitive awareness), but these were non-significant. A message from these data is that mindfulness meditation and compassion meditation can be distinguished – also at a neurophysiological level.

The literature reviewed here show that there are mixed findings regarding the association between self-compassion and mindfulness. Nevertheless, conceptual differences, the ability to demonstrate differential predictive utility for certain outcomes, and differential findings from neuroscience studies, suggest that a distinction between these constructs is empirically and theoretically sound. However, as both self-compassion and mindfulness scales are multi-dimensional, future studies need to evaluate the subscales in greater detail. Future research may include behavioural and neuroscience measures to better assess and differentiate self-compassion from mindfulness.

Provided that self-compassion can be treated as qualitatively distinct from mindfulness, and is a likely mechanism underlying the effect of MBCT on depressive relapse, an important question is how MBCT facilitates self-compassion. It is to this that I now turn.
4. Does MBCT Facilitate Self-Compassion?

To further explore how self-compassion might be facilitated and act as a mechanisms underlying MBCTs effects, and as only one study (Kuyken et al., 2010) till this date has investigated self-compassion as a mediator in MBCT for recurrent depression, I chose to interview two experts on this topic. Informants were chosen on the base of expertise on MBCT and clinical research. The intention with the interview was to pinpoint key questions in the discussion about the facilitation of self-compassion in MBCT, rather than providing a representative view across a wide range of MBCT teachers and researchers. The interviews were semi-structured, and hinged on the following questions:

1. How is self-compassion facilitated in MBCT?
2. How can one understand self-compassion as an underlying mechanism in MBCT for recurrent depression?
3. If self-compassion is important - why not focus explicitly on self-compassion in MBCT?

The thematic analysis of the transcripts identified three main themes concerning how informants reflected on these questions (see Table 1). Self-compassion was attributed to (1) non-specific factors such as the group setting in which the course is taught; (2) the teacher of the course modelling and embodying self-compassion; and (3) the mindfulness meditation practice itself. Theme three was divided into three subthemes; (a) self-compassion may mediate and/or interact with decentering; (b) self-compassion may have a reinforcing effect on letting go of goals and/or expectations through mechanisms of evaluative condition and/or emotional change; and (c) a discussion of whether self-compassion should be explicitly or implicitly pronounced in in the meditation practices during MBCT. Theme three (a and b) was interpreted to contain explanations of both why self-compassion may increase and how self-compassion may act as a mechanism in the therapeutic processes in MBCT. These themes are not meant to provide a rich and representative description of the data set as a whole; rather they represent a detailed analysis of some key topics that captured something revealing in relation to the research questions.
4.1. Theme 1: Self-compassion attributed to non-specific factors of MBCT

Both informants mentioned non-specific factors when explaining how self-compassion may be cultivated. The importance of the group setting was highlighted several times, emphasising the fact that all participants have experienced at least three episodes of depression, therefore, as one informant explained, many “will have concluded that this means there is something very wrong with them as individuals and that they are fantastically inadequate, worthless”. Thus, being in a group of individuals all of whom share such experiences, the group could create a feeling of identification with the other participants:

“[Participants are] having quite an intense experience over eight weeks of working with the same people, so you do get to know them to some degree. You’re chatting over tea and you’re having conversations in the classes and practically everybody actually is perfectly normal. […] I think that’s a really important message and most people I think who are highly self-critical are much better able to be kind and compassionate to others. So there’s a kind of interest, a warmth, a kindness towards one another and then I think that sort of maybe comes back to themselves as well because they receive it from others and then I think there’s a process of realising well you know if these guys can be depressed and I like them, they’re OK then maybe I am I suspect”.

This quote highlights how non-specific factors such as being in a group of equals, sharing an experience, and sensing the support from others can have an effect on feelings of isolation, self-criticism, acceptance, kindness and compassion. Researchers early on pointed to the possible contribution of non-specific factors, like the group setting, in the effects of MBCT, and expressed the need to disentangle non-specific factors from specific factors (e.g. MacKenzie & Kocovski, 2016). In fact, researchers of group therapy in general have long emphasised the importance of group dynamics to outcome in group-based treatment interventions (Yalom & Leszcz, 2005). However, this issue is argued to be a gap in the literature on MBCT (MacKenzie & Kocovski, 2016), and there are no trials investigating the effect of the group on self-compassion in MBCT.
However, there is qualitative evidence for the importance of the group for feelings of acceptance and communality. This was noticed by Allen and colleagues (2009) when they interviewed MBCT participants on their experiences of participating the programme. Participants' comments suggested that the group process was a key aspect of what helped them change. This included conversations in class, during which participants listen to the struggle of others, and felt themselves reflected in the experiences of other participants. In the interviews participants described the group as a place of care and support, partly rooted in a strong sense of shared identity. The other individuals in the group were described “like a mirror” or an “echo” (Allen et al., 2009, p. 420), and this was experienced as facilitating greater self-acceptance, and decreasing feelings of being abnormal or mad. Several participants reported that because of the accepting culture of the group, they were able to open up to their emotions that they had previously buried, leading to increased awareness and tolerance of these emotions. The authors suggested that learning how to listen to another with tenderness, care, and without blame, taught participants how to listen to themselves. Similar findings were reported by another qualitative study interviewing participants with recurrent depression after receiving MBCT. All participants reported that the familiar faces of the group was a supportive and learning experience despite some initial concerns to the contrary, and important themes identified included changes in attitude towards acceptance (Mason & Hargreaves, 2001). However, none of these qualitative investigations reported the explicit mentioning of self-compassion.

Interestingly, a study that explored the extent to which MBSR groups (606 adults in 59 groups) differed in levels of symptom change reported by participants pre to post participation, found that the group accounted for 7% of the variability after controlling for pre-treatment symptom severity (Imel, Baldwin, Bonus, & Maccoon, 2008). The authors argue that the effect of the group on outcome may be due to several factors: (a) that characteristics of the group influences the capacity of participants to learn and practice mindfulness techniques, (b) that characteristics of the group influences outcome through other factors (e.g., expectation of change, group support, group cohesion), or (c) a combination of these (Imel et al., 2008). The results from this study suggest that treatment effects of group interventions, including MBCT, may be overestimated if not accounting for the nested structure of data in group-based interventions as group members influence each other, and thus create dependencies between observations.

However, these results do not explain the unique effect of being in a group on outcome, or on levels of self-compassion. In order to determine whether increases in self-compassion levels
are specifically attributable to specific (e.g., meditation) compared to non-specific factors (e.g., group support, compassionate teacher), dismantling designs are required that compare MBCT to active control groups, which are similar bar the key hypothesised ingredient. Indeed, several trials have tried to disentangle some of these factors. Even though none of them included self-compassion as a measure, they demonstrate how research designs in future trials could investigate whether self-compassion predicts outcome, or to which factors self-compassion might be attributed.

One dismantling trial compared MBCT with cognitive psycho-education (CPE), a version of MBCT that is structurally equivalent, and TAU in preventing depressive relapse in patients currently in remission (n=274) (Williams et al., 2014a). The CPE condition shared the same format and non-specific factors (e.g., group, compassionate teacher), however, whilst participants were taught about mindfulness, the programme included no mindfulness meditation exercises. Results suggested that treatment condition had no significant effect on risk of depressive relapse over 12 months, suggesting that other factors than mindfulness meditation could explain MBCTs effect on relapse risk. Thus, it may be that psycho-education and/or group support provided by both MBCT and CPE interventions are factors that explain some of the effect of MBCT (van der Velden et al., 2015). However, sub-group analysis showed that MBCT did provide significant protection against relapse for participants with a history of childhood trauma, indicating that MBCT is particularly helpful for more vulnerable patients. This is in keeping with previous studies, in which it has been suggested that MBCT is particularly effective for those especially vulnerable to depression (e.g. patients with childhood adversity), and less effective for populations where episodes are provoked by stressful life events (Ma & Teasdale, 2004).

A recent RCT comparing MBCT to a structurally equivalent psycho-educational programme for currently depressed patients who had not achieved remission following the use of antidepressants, found that the MBCT group had significantly larger improvements in depressive symptoms, quality of life, and mindfulness (Chiesa et al., 2015). Yet, one may not be able to generalize from this finding regarding a sample of currently depressed individuals not responding to antidepressants, as this group may differ from individuals suffering from recurrent depression currently in remission. However, one study did find support for the preventive effect of the specific ingredient of formal mindfulness meditation in MBCT for individuals suffering from depression currently in remission (Crane et al., 2014). In this study, participants who reported that they engaged in formal home practice on at least three days a week during the course, were
almost half as likely to relapse as those who reported fewer days of formal practice (also when controlling for the potentially confounding variable of treatment credibility). No significant association between informal home practice and outcome was found, though this may be due to difficulties in quantifying informal, every-day mindfulness practice. Individuals who manage to keep a regular formal practice may also exhibit certain qualities that make them less likely to relapse. Still, this study suggests that there may be specific elements of MBCT, like mindfulness meditation, that are central in MBCTs effect in lowering risk of depressive relapse. In support of this, a recent review on mindfulness meditation and psychological health (e.g. subjective well-being, psychological symptoms and emotional reactivity, and behavioural regulation) concluded that there was a significant association between these variables (Keng, Smoski, & Robins, 2011).

In sum, there is evidence suggesting that non-specific factors (e.g., the group setting) are important for the effectiveness of MBCT. Still, evidence also indicates that specific factors (e.g., mindfulness meditation) can account for MBCTs protective effects in some populations (e.g., those especially vulnerable to relapse). None of the dismantling studies included self-compassion measures, thus the degree to which MBCT facilitates self-compassion relative to active control conditions (e.g., CPE) is not known. Increases in self-compassion might be due to mindfulness meditation (as mindfulness is a dimension of the SCS). Alternatively, self-compassion could be linked to group support (as the sense of identifying with other participants may increase the sense of common humanity) and/or psycho-education (as this possibly impacts self-judgement, self-kindness or common humanity). Thus, studying the association between discrete variables (e.g., treatment adherence) and group-based variables (e.g., group climate or cohesion) may be an important next step in understanding the complexity of the processes underlying the effects of MBCT, how self-compassion is facilitated, and how the group context influences outcome.

However, the distinction between specific and non-specific factors in the context of MBCT is not straightforward. In fact, Allen and colleagues (2009) point out the difficulty of drawing a definite division: “It is interesting that in participants’ accounts, the development of awareness, acceptance and behavioural change has a basis in both specific MBCT techniques (i.e., the mindfulness practice) and non-specific factors (i.e., group processes)” (p. 424). Moreover, specific and non-specific factors may mutually reinforce one another in the learning process in ways that account for their respective effect. Thus, one might question whether it is possible to meaningfully separate factors such as group support and meditation practice. One could argue that the idea of suffering as an aspect of our shared humanity develops through mindfulness
meditation as well as in the group setting, thereby possibly making such a distinction difficult. Allen and colleagues (2009) reported that social comparisons inevitably occurring in groups appeared to reduce individual self-devaluative thinking in participants. Similarly, mindfulness and self-compassion may be cultivated by being in a group-setting, but also individually through mindfulness meditation, and these parallel processes may influence and reinforce one another. It seems that existing evidence rises even more questions, and future research will need to use designs that disentangle the various elements in order to gain a clearer picture of which factors account for MBCTs effect, and whether self-compassion may be attributable to group effects.

4.2. Theme 2: Self-compassion attributed to the MBCT teacher

The second theme concerns the importance of the mindfulness teacher for the cultivation of self-compassion. This was emphasised by both informants. One informant talked about two ways in which self-compassion is facilitated in MBCT; through the compassionate instructions during mindfulness meditation exercises, and by the embodiment of self-compassion by the teacher:

“the teacher’s words equally encourage people to turn towards themselves with compassion […] and if their mind wanders, not to be hard on themselves but to recognise that that’s normal and to bring the mind back kindly and gently and patiently. So I think it [self-compassion] is actually very present but not in an explicit way”.

“[…] when the teacher is just repeatedly actually behaving towards them [participants] in a very different way with warmth, with empathy, with acceptance, with interest, with kindness and they’re not just staying stuff but actually embodying those qualities then they’re (participants) getting a very different kind of experience”.

Further on, it was suggested that the qualities of compassion and acceptance are embodied through the instructions. For instance, an informant explained: “[…] just in the way you lead the meditation, your tone of voice. Tone of voice, body language, etc. will all be intended to embody steadiness, gentleness”. Moreover, it was distinguished between embodying and modelling:

“It’s interesting the distinction between modelling and embodying – it is quite subtle but modelling is a sort of like “copy me” and embodying is a sort of a more implicit invitation, to invite the person, because of your own interest in the process, to then become interested. To join you in your interest […]”.

One could interpret this quote as saying that copying compassion is a more explicit process, whereas the embodiment of compassion is an “invitation” to a joint exploration, and may be a more implicit learning process. In order for embodiment to happen, one informant explained that the teacher must be genuinely curious (e.g., during the inquiry), and participants must feel that the
teacher is authentic. The distinction between copying self-compassion and being invited to a compassionate exploration could mean that a self-compassionate attitude within the teacher could increase self-compassion in different ways among participants. One possibility is that participants learn to be self-compassionate by observing and copying the behaviour and attitude of the teacher, in line with social learning theory (Bandura & Walters, 1977). Another possibility is the teacher facilitates self-compassion in participants through creating a compassionate atmosphere for exploration, thereby also promoting a caring and loving relationship between the teacher and participants or among the participants themselves. That is, teacher embodiment could affect the relationships and sense of support and care in the group, which in turn would have an effect on outcome in line with the theory of common factors, including the therapist’s relational skills and ability to create a strong alliance in psychotherapy (Laska, Gurman, & Wampold, 2014).

The importance of the teacher is similarly highlighted in the MBCT manual where the responsibility of cultivating self-compassion is placed on the teacher’s ability to embody self-compassion through pervasive indirect and implicit instructions. Segal and colleagues describe teacher embodiment as “indirect routes to the practice of self-compassion” (2013, p. 139). They argue that kindness should be conveyed by “the teacher's personal warmth, attentiveness, and welcoming stance” and “reinforced throughout the programme by the gentle approach taken with participants, especially in the presence of negative affect such as sadness and anger” (p. 140). The role of the teacher is that of a facilitator inviting participants to reflect on their experiences with openness and curiosity, thereby modelling a sense of openness and compassion (especially to difficult thoughts and feelings in class), without having to resort to problem solving and attempts to fix or change the current state (Barnhofer & Crane, 2009).

Moreover, Segal and colleagues (2013) argue that the teacher should not only act with a compassionate manner towards participants, but also towards himself/herself. In so doing, the teacher is supposed to model self-compassion. The content of the instructions are seen as important, but it is suggested that the most important teachings on compassion are conveyed through the teacher’s presence so that participants actually see compassion in action. Mindfulness and compassion is argued to be “caught and not taught” (p. 140). the ability of embodying a compassionate attitude in class is also linked to MBCT teachers personal experience with mindfulness meditation and a regular, daily practice (Barnhofer & Crane, 2009; Segal et al.,

---

6 However, this notion has been criticised, and it has been pointed out that if programmes rely on teacher warmth to convey the importance of self-compassion, it is unclear how long this effect will last when individuals have finished their programme and are facing difficult situations in their personal lives (Neff & Dahm, 2015).
As learning to shift from ‘doing’ and ‘being’ modes of mind is at the core of MBCT, the authors stress that this teaching is impossible without the teacher's experience of ‘being’. That is, embodying a mindful and compassionate attitude will influence how mindfulness practices are taught, how individual and group enquiry is handled, and in turn how this impacts outcomes for participants. Another reason why teachers need to have their own regular mindfulness practice, is that this will make them more able to empathise and assist when participants are struggling with the practice - as teachers with a personal practice have gained more than just an intellectual knowledge of this struggle (Segal et al., 2013). It is argued that the teacher needs to have cultivated compassion in relation to his/her life and experience with mindfulness practice, because such an experiential learning is a pre-requisite to teaching others and will be experienced by participants as an embodied teacher who ‘walks the walk’ (Segal et al., 2013).

So, are these claims supported by empirical evidence? The emphasis in MBCT research has predominantly focused on intervention-specific ingredients. Indeed, authors have highlighted the lack of investigation of other factors such as teacher effects in mindfulness-based interventions (MacKenzie & Kocovski, 2016). Even though there is a considerable body of literature produced primarily by MBCT/MBSR teachers and researchers drawing on their direct experience of the process that gives clear descriptions of how a personal mindfulness practice is essential for the teaching process (e.g. Crane, Kuyken, Hastings, Rothwell, & Williams, 2010; Crane et al., 2012b; Kabat-Zinn, 1990; Segal et al., 2013), there is as yet no clear evidence detailing the association between MBCT teachers with their own mindfulness practice and increased self-compassion, or subsequent relapse prevention in participants.

However, an emphasis on personal mindfulness practice is reflected in the training of MBCT teachers. Alongside developing technical abilities of delivering the approach, mindfulness teachers in training are encouraged to engage in a personal process of exploring their own experience in their mindfulness practice when training to become mindfulness teachers (Crane et al., 2010; Segal et al., 2013). This represents a shift in emphasis from other CBT approaches, in which there is a strong weight on therapists developing skill and expertise, but less emphasis on personal practice as an essential aspect of being a therapist. However, the interest in qualities of the psychotherapist is increasing, and accumulating evidence suggests that therapist qualities (e.g., acting empathic, affirming, compassionate, and interested in relation to patients) account for variability in outcomes to a greater extent than specific therapy techniques or other variables (Hartmann, 2013). A commonly reported estimate of therapist influence on psychotherapy
outcome is 8%, versus 5% for the alliance, and 1% for specific ingredients (Kim, Wampold, & Bolt, 2006; Laska et al., 2014; Wampold, 2001).

Interestingly, a review by Davis and Hayes (2011) on the benefits of mindfulness meditation for psychotherapy reported that meditation promotes empathy and compassion in therapists, and contribute in developing counselling skills (e.g., being more attuned to themselves and clients). The authors identified mixed, but promising evidence suggesting improved client outcomes of therapists who meditate (Davis & Hayes, 2011). For instance, a RCT found more positive treatment outcomes including greater symptom reduction for clients of psychotherapists who meditated before therapy sessions (Grepmair et al., 2007). Moreover, a qualitative study that interviewed ten therapists and their patients regarding their experience of first using mindfulness in therapy session, found that both clients and therapist reported that the practice of mindfulness had a positive impact on the therapeutic relationship (Horst, Newsom, & Stith, 2013). However, this finding rests on the assumption that mindfulness and compassion are separate concepts, which might be questionable, making this argument circular. It may also be problematic to draw parallels between individual psychotherapy and MBCT. However, these findings may add to the argument that the teacher’s personal mindfulness practice is important for MBCT’s effects.

In sum, both informants talked about the importance of the teacher for facilitating self-compassion. This suggestion is in line with the MBCT manual, personal accounts by MBCT teachers, and preliminary findings in psychotherapy research. However, because of the lack of empirical evidence specifically investigating of the role of the teacher for cultivating self-compassion or preventing depressive relapse, conclusions are not possible.

4.3. Theme 3: Self-compassion attributed to mindfulness meditation
The third theme identified through thematic analysis of the transcripts concerned suggestions on how self-compassion may be attributed to the meditation practice in MBCT, and how self-compassion might act as a mechanism in MBCT for recurrent depression. Given that the mindfulness meditation exercises taught in MBCT do not explicitly target self-compassion, this might appear counter intuitive. In one of the interviews this incongruity was described as the paradox of mindfulness - that self-compassion develops when one is doing attentional training;

“[…] the idea that you’re helping people by training their attention which seems to have nothing to do with whether they feel positive or negative, and that you are asking people just to train an attentional muscle, to have an open presence, to see things clearly and the compassion seems to come naturally out of that […]”.
Theme three was divided into three subthemes; (a) self-compassion may mediate, be mediated by, and/or interact with the ability of decentering; (b) the practice of letting go of goals and/or expectations (i.e., self-ideals, desired mental states) during mindfulness meditation may make self-compassion increasingly more available to the individual in the face of difficulties, and reduce self-discrepancies through mechanisms of evaluative conditioning and/or emotion regulation; and (c) a discussion of whether self-compassion should be explicitly pronounced in the meditation practices during MBCT.

4.3.1. Subtheme A: Self-compassion mediates and interacts with decentering

In the interview, one informant linked self-compassion specifically to the attentional training (i.e. refocusing of the awareness) and decentering (i.e., disengaging from/observing thoughts, emotions, and bodily sensations, letting them come and go without over-identifying with them or trying to change them), which are both part of mindfulness meditation: “And so there’s something about, yeah, paying attention in this non-judgemental way seems to invite self-compassion. Curious isn’t it? [...]”. It was pointed to an ambiguity concerning how self-compassion and decentering are associated; “whether self-compassion is a by-product of what we’re doing and the critical thing is the decentering, but self-compassion is a marker of how much you’ve been able to decentre, or whether self-compassion actually does the business”. One could interpret this quote to suggest a likely association between decentering and self-compassion. However, self-compassion can simply be a by-product of practicing mindfulness meditation, i.e., not a change mechanism. On the other hand, self-compassion may be the central therapeutic ingredient mediating the effect of decentering on the prevention of depressive relapse. Adding to these possibilities, one informant pointed to the possibility that this association could be reversed - decentering might mediate self-compassion:

“[…] I think it would be interesting eventually to see whether loving kindness meditation in Barbara Fredrickson’s work and compassion meditations in Kristin Neff’s work actually for some people work through the mediating mechanism of mindfulness and decentering. And it’s almost bound to be a reciprocal relationship and therefore that means there are bound to be multiple gateways”.

“[…] it may be that mindfulness sometimes works or attentional training works because you’re cultivating compassion. And it may be different in different contexts with different teachers and a different pupil and I think that’s the interesting thing; that these are different ways in to somewhere - there’s obviously similar phenomena which is not taking your thoughts so seriously, to let yourself off the hook […]”.
These quotations suggest that there is a reciprocal link between self-compassion and decentering (see Model 2): (1) Self-compassion may mediate the effect that decentering has on risk of relapse (e.g., observing self-critical thoughts as mental events without over-identifying with them could bring the individual to notice habitual reactions and make it possible to intentionally respond with self-kindness and self-care instead); (2) Decentering may mediate the effect the cultivation of self-compassion has on risk of depressive relapse (i.e., increases in self-compassion may facilitate the ability of decentering, in that, being kind and caring with oneself may support the act of observing self-critical thoughts and emotions as they come and go, tolerating them, or staying with them without avoiding or suppressing them); (3) Decentering and self-compassion could in combination mutually strengthen the capacity of the other, thereby having an interaction effect on reducing risk of depressive relapse.

Model 2: Self-compassion may mediate the effect of the practice of decentering on risk of depressive relapse. Decentering may also mediate the effect of self-compassion on relapse risk. Self-compassion and decentering may also mutually reinforce each other generating an interaction effect on risk of depressive relapse.

The suggestion of decentering and self-compassion interacting is similar to Neff’s (2003b) conceptualisation of self-compassion consisting of three separate but interacting elements. Neff and Dahm (2015) suggest that becoming kinder to the self would enable individuals to become more accepting, making it easier to be mindfully present in the moment. However, this argument rests on the ability to meaningfully distinguish mindfulness from self-compassion, and carries the risk of being circular if being mindful in the present moment also means accepting whatever is experienced in that moment with kindness. On the other hand, it may be that becoming more mindful, and thereby more aware of the magnitude of self-critical thoughts, an individual would actually score lower on self-compassion as she is now more aware of the lack of self-compassion. However, it may not be surprising if the ability to decenter increases after programmes like Mindful Self-Compassion (MSC; Neff & Germer, 2013), as mindfulness meditation is part of MSC. More unexpected is the evidence suggesting that self-compassion increases after MBCT.
How might the practice of decentering boost self-compassion?

Both informants mentioned Gilbert’s (2009) evolutionary model on compassion when discussing this question. Gilbert (2009) suggests that compassion is part of an evolved system with a neurological foundation responding to observed suffering with a motivation to care and soothe (see section 3.1.). Pursuing this line of argument; could decentering bring the individual to observe their own suffering, thereby activating the care-system? When the self becomes the object of observation, could this activate the care-giving system and thereby a kind and compassionate attitude available towards oneself? Could enabling self-care this way potentially curb the automatic self-criticism and blame (i.e., the threat-defence system) hypothesised to be intrinsic to the clinical manifestations of depressive relapse? In other words, when the individual becomes aware of how much she has suffered or is suffering, she may see these cognitions and habitual processes from a decentred perspective, thereby activating another way of relating to suffering - a compassionate and accepting way. This would be an alternative response to ‘doing’ mode which would activate the threat-defence system. This argument rests on the assumption that the same care-giving system is activated when observing others and when observing the self. If so, one would predict an association between self-compassion and compassion for others given that they would have to tap into the same evolved system in the brain.

If self-compassion and compassion for others are part of the same system, one prediction would be that there are overlapping neural substrates supporting both modes of mind. For example, one imaging study using fMRI technology found that being self-reassuring evoked neural activity in converging brain areas of the brain that have previously been linked to empathy for others, (i.e., left temporal pole and insula) (Longe et al., 2010). This result has been interpreted to suggest that the tendency to respond to suffering with compassion is a general process applied to both oneself and others, and that self-compassion and other-focused concern is indeed related (Neff & Pommier, 2013). However, as empathy and compassion have been differed at a neurological level, these findings might not support the hypothesis of converging neural networks for self-compassion and compassion for others.

Studies investigating correlations between self-compassion and compassion for others have yielded mixed results. One study found a non-existing correlation between self-compassion (SCS) and compassion for humanity (Santa Clara Brief Compassion Scale; Hwang, Plante, & Lackey, 2008) in a student sample (Neff & Pommier, 2013). However, this scale measures compassion for strangers, and as the ability of compassion for close others and for stranger may differ, the lack of
correlation may reflect this distinction. However, it has been reported that compassion for humanity and close relations correlate \(r = .47-.56\) (Sprecher & Fehr, 2005). Studies have found significant, but low, correlations between self-compassion and compassion for humanity in practicing meditators \(r = .28\) and a community sample \(r = .31\) (Neff & Pommier, 2013), and in a therapist sample \(r = .21\) (Gilbert, McEwan, Matos, & Rivos, 2011).

Correlational results must be interpreted with caution. Group differences may be possible moderators of an association; clinical populations (e.g., recurrent depression) could differ from non-clinical samples (e.g., students) in some respects. Moreover, meditation experience might also be a moderator (e.g., meditation experience would affect compassion to both self and others). A study on practitioners of Buddhist meditation reported significantly higher levels of self-compassion and compassion for humanity compared to a sample of community adults and undergraduates (presumably with no prior experience of meditation) (Neff & Pommier, 2013). Years of meditation practice significantly predicted levels of self-compassion and compassion for humanity in the meditator sample, suggesting that meditation experience could strengthen the ability to be kind and understanding to both self and others. Again, correlation does not imply causation, and individuals motivated to regularly practice meditation could share important characteristics (i.e., a third variable). The association between self-compassion and other-compassion may also be moderated by initial levels of self-compassion (e.g., individuals low on self-compassion may be compassionate toward others, whereas individuals with high scores may be compassionate to both themselves and others). In fact, it has been reported that individuals scoring high on the SCS report being equally kind to themselves and others, while individuals with lower scores reported that they tended to be kinder to others than themselves (Neff, 2003a).

The data reviewed here show mixed support for an association between self-compassion and compassion for others. However, this may be due to psychometrical issues, and how the concepts are operationalized. For instance, the item ‘compassion for humanity’ might not validly reflect the degree to which people feel compassion for close others in their daily life, but rather measure the degree to which people aspire to compassion in a more abstract way. Neurological evidence may be a better method to investigate this association by possibly revealing convergent neural networks. However, evidence from this field is preliminary, and needs backing.

In sum, one hypothesis may be that self-compassion is facilitated during MBCT because mindfulness practice is hypothesised to evoke decentering from mental events, including difficult and painful mind states. This may activate the care-system making compassion and care available.
to the self, thus preventing depressive relapse (if self-compassion and other compassion indeed are associated and part of the same neurological system). However, the association between self-compassion and decentering is likely to be complex. To investigate mediation and/or interaction between decentering and self-compassion one could investigate whether participants who develop the ability to decenter during MBCT, also show parallel increases in self-compassion, and whether high scores on both decentering and self-compassion predict risk of depressive relapse. Weekly measures could detect how scores in these two measures change across sessions and whether one (e.g., decentering) precedes and predicts the other (e.g., self-compassion).

4.3.2. Subtheme B: Self-compassion and letting go of goals

A second subtheme emerging in the transcripts focussed on how self-compassion might be cultivated in the context of mindfulness meditation through the practice of letting go of goals (e.g., desires and expectations concerning thoughts, sensations and desires pass) during mindfulness meditation. This process could have a reinforcing or “cascading” effect (i.e., leading to changes in the depressive network through mechanisms of evaluative conditioning and/or emotional change), and explain how self-compassion might act as a therapeutic mechanism by bringing the individual into a positive spiral that prevents depressive relapse or even changes the latent depressogenic network. These processes could account for the protective effects of MBCT on depressive relapse.

One informant spoke of how the initial starting point of the instructions in mindfulness meditation is the invitation to adopt an open, accepting, and curious attitude:

“[You] notice that your mind repeatedly wanders and you don’t need to be hard on your mind. You don’t need to be hard on yourself for that because that’s actually what they’re designed to do and not only that but it’s not that you’ve got it wrong; in fact this is a wonderful opportunity to see what your mind gets up to when you just let it do its thing”.

This curious attitude was contrasted to one of the main features in depression, which is the ubiquitous criticism and discrepancy-based processing about the self (i.e., increasing the gap between an ideal-self and the actual-self). One informant spoke of how this processing style involves a “cognitive incompletion system” that scans unfinished activities and marks goals/tasks yet to be done. Mindfulness meditation was described as an exercise in letting go of such goals/expectations about how things should be, while letting them be as they are, thereby reducing self-discrepancies. Letting go in this sense may be a first step in the cultivation of self-compassion:

“[…] letting go of expectation is the first cousin I think of non-judgement, which is the first cousin of compassion and kindness. And also kindness is probably slightly easier than
compassion, so in a sense when you see it says ‘letting go of expectations’, cultivating non-judgement helps cultivate kindness. Kindness I think helps cultivate compassion.”

“[…] when we do monitor and notice that we’ve gone off track there’s something to be done other than blaming ourselves. And so in a micro way many, many times during meditation we have opportunities to cultivate the opposite of I’m a bad person because I made an error but it’s in this very, very, very tiny form and the fact that doing all that in a formal practice over 35 minutes in lots and lots of tiny ways then seems to affect the big; it does speak to the possibility of training up the mind to let go of bigger things than just ‘my nose is itchy’.”

One important message from these quotes is a possible gradual movement from letting go of goals, to non-judgment, to kindness, and to self-compassion. In addition, these quotes suggest that it all begins with the practice of letting go of the impossible goal of keeping awareness on the breath, as this is practiced multiple times during a simple breathing exercise in MBCT. This points to two aspects of mindfulness meditation in regard to letting go; firstly that practicing to let go is a way of accepting what is without criticism and blame, and secondly that this is practiced countless times during a meditation exercise because the focus of awareness constantly wanders and shifts. So that, even though this process involves simple, small desires, such as scratching an itch, the ability of letting things be with an accepting and compassionate attitude, is possibly transferable to larger issues in life. The cultivation of self-compassion may in fact facilitate the shift from ‘doing’ mode (i.e., focusing on achieving goals, striving to reduce discrepancies, and ruminate), to ‘being’ mode:

“[…] And I think where self-compassion comes in is because some of those things that aren’t complete will not only be tagged with ‘I’m not done’ but ‘you are a bad person for not doing me’ so it’s got that extra tag, an extra flag and I think the ability to be compassionate with yourself both takes account of what you haven’t done and says ‘it’s OK I’m going to park it for now’. […] And you decentre from that and you decentre from the fact that that goal is waving at you”.

One informant stressed that shifting to ‘being’ mode is not just a conceptual recognition, but a kind of experiential learning that involves emotional change: “suddenly you can see, even if only for a moment, that there’s another way to relate to yourself and that it feels quite different”. The informant added: “And I think that’s the value of learning compassion through something like the meditation practice because that’s more emotional, more of a body thing that’s experienced gut level learning”. One key message from this quote is that the experiential and emotional experience during mindfulness meditation are important for the attitude change (e.g., from a critical, blameful attitude to a self-compassionate attitude), in that, it is not only an intellectual
learning process, but a new emotional experience for the individual.

Moreover, one informant seemed to suggest that self-compassion not only develop from letting go of micro goals and unfinished tasks, but also that self-compassion is a way of dealing with all the uncompleted goals making it possible to let go of them, and creating the feeling that one has dealt with them or that they were not as important as one thought. This process was linked to a reduction of experienced self-discrepancy by creating a “cascading” effect:

“I think a model that says that the reason why you feel compassion or that releases compassion is that you released yourself from these micro goals that you didn’t know you had and the micro goals that seem so important but actually that you can release yourself from because you’re no longer then in a ‘discrepancy situation’ and if you add to that the possibility that if you release from one of these it actually has a cascade effect […]”.

“It’s almost like you get a sudden cascade of a release of associations of other things that you learn during that session […]. So it may well be that if you can release yourself from even some of the judgements you make that then has a cascade effect on a lot of other things in the network. How to measure that I’m not quite sure”.

Interpreting these quotes, it may be that self-compassion, when first accessed, has a reinforcing effect on letting go of goals, expectations or desires, creating a cascade or spiral with the following hypothesised steps; observing the mind, letting it do its thing, letting go of goals and expectations, adopting a non-judging and kind attitude, becoming more self-compassionate, and thereby being able to stay with whatever experience that is present, without feeling as a failure, and letting go of unfinished goals and expectations (see Model 3). Along the way, the individual is released from the goals of ideal self-states, meaning that discrepancy-based processing and rumination diminishes, thereby reducing risk of depressive relapse.

**Model 3**: Model of how mindfulness meditation can lead to self-compassion, subsequently decreasing risk of relapse.
Can these hypotheses explain the increase in self-compassion or the preventive effects of MBCT on depressive relapse? Wrosch and colleagues (2007) define goal regulation as consisting of two abilities; the ability to disengage from unachievable goals, and the ability to pursue alternative goals. In a study, they found that greater goal regulation predicted lower levels of perceived stress and individuals who could easily give up goals also reported fewer, and less severe, depressive symptoms in a community sample. Another study found that participants receiving MBCT reported significantly more specific life goals post treatment, and regarded themselves more likely to achieve important goals, compared to a waitlist group. This suggests that MBCT could allow participants to clarify their important goals and thereby increase their self-confidence in achieving them (Crane, Winder, Hargus, Amarasinghe, & Barnhofer, 2012a).

Crane and colleagues (2008) investigated self-discrepancy in individuals with a history of recurrent depression currently in remission, and found increases from baseline to follow-up in the control group, but not in those receiving MBCT. Results indicated reduced self-discrepancy and more adaptive ideal self-guides post treatment in the MBCT group, and this was not associated with changes in residual depressive symptoms. The authors argue that MBCT may protect against reactivation of self-discrepancies and reduce risk of depressive relapse through the practice of decentering and observing mental processes. This may limit the extent to which perceived self-discrepancies magnify as a result of changes in mood. Secondly, Crane and colleagues (2008) point to the emphasis on self-acceptance, self-kindness, and non-striving in MBCT which may encourage individuals to re-evaluate and abandon problematic or perfectionist goals or ideals (e.g., to be happy all the time) in favour of more useful/realistic goals, thereby reducing self-discrepancies and risk to relapse.

Another question is; what might set off the “cascading” effect described above? One informant pointed to evaluative conditioning as a possible underlying mechanism. Evaluative conditioning is defined as an effect explaining changes in the evaluation of, or attitude towards, a neutral stimulus when being paired with a desirable/undesirable stimulus (De Houwer, 2007; Walther, Weil, & Düsing, 2011). It has been argued that evaluative conditioning explains how negative self-evaluations lead to and maintain depression and anxiety, by reinforcing maladaptive behaviour (e.g., thinking one is a failure may lead to social withdrawing), thus reinforcing negative self-evaluations (e.g., being a failure) and low mood (Fulcher, Mathews, Mackintosh, & Law, 2001). If so, what might be the relevance of self-compassion? Self-compassion may be an alternative intention or self-evaluation, hypothesised to generate and reinforce alternative
behavioural responses (e.g., intending to care for oneself when in distress may lead to caring behaviour, which may reinforce a caring attitude towards the self over time). In other words, self-compassion could act as a distinguisher of the automatic response of rumination, doing-mode, and discrepancy-based processing which activates the depressive network. Thus, self-compassion unlearns the automatic, depressogenic response, breaks up the associative networks, and offset the risk of relapse. Following from this hypothesis is the question of what kind of change this process of unlearning is. According to the model of recurrent depression underpinning MBCT, the programme prevents the activation of the depressive network following transient low mood. However, the idea of a cascading effect of self-compassion may change the conditioned evaluation of the self. Could it be that mindfulness meditation and the cultivation of self-compassion not only prevents the network from being activated, but also changes the depressive network itself over time?

One informant described the effect of self-compassion on the depressigenic network with a metaphor: “[…] bringing compassion to your suffering - it’s almost like growing so many flowers in the garden the weeds can’t flourish, rather than having to pull up the weeds. The original word ‘meditation’ meant ‘cultivation’ […]. So compassion is like growing flowers to make little space for the weeds.” This quote suggests that cultivating self-compassion will over time change what ‘grows in the garden’. Thus, self-compassion may change, or rather eradicate, the depressive network through meditation practice, in that caring for oneself becomes available and grows. This can asphyxiate the self-critical evaluation and blame that would normally automatically follow failure or difficulties in life. On this tenet, the depressive network is not only prevented from being activated, but self-compassion is intrinsic to creating a new network – thereby sparking a structural change.

This reasoning is in line with the principle of changing emotion with emotion; meaning that a maladaptive emotional state can only be transformed by “undoing” it with another more adaptive emotion. This rests on the assumption that positive emotions are incompatible with negative emotions, and thus act as ‘antidotes’ to negative emotions (despite not challenging them directly) (Greenberg, 2008; Greenberg, 2012; Greenberg & Paivio, 2003). According to this principle, the co-activation of an adaptive emotion with, or in response to, a maladaptive emotion supports transformation (e.g. of the of the depressogenic network) and presence of the maladaptive emotion (which sounds similar to the effect in evaluative conditioning). This principle highlights that although thinking usually changes thoughts, only experiencing a new
feeling can fundamentally change emotions. This idea has been supported empirically (Choi, Pos, & Magnusson, 2016; Herrmann, Greenberg, & Auszra, 2016), and linked to a neuropsychological level, where withdrawal emotions (e.g., sadness, shame) from one side of the brain appear to be transformed by approach emotions (e.g., compassion, interest) from another part of the brain, and vice versa (Davidson, Jackson, & Kalin, 2000). In other words, by accessing self-soothing and compassion these states could act as transformative on negative emotions like sadness and shame.

Extending this idea, Baer (2003) claims that exposure to previously avoided emotions, thoughts, or bodily sensations is a key mechanism in using mindfulness-based interventions, as mindfulness increases awareness and tolerance of affect. The principle of exposure may be linked back to a claim by one informant, that mindfulness training involves experiential and emotional learning: “[…] change happens through exploration on the one hand and experiencing in a different way [on the other hand]. Exploring and avoidance on one dimension, and experiencing and elaboration/rumination on another dimension”. Self-compassion was also perceived as having a potential of creating insight: “[…] the recognition that you have dukkha, that is suffering is occurring - and if you are bringing compassion to that situation that’s going to be useful because it potentially re-codes what’s happening as dukkha”. Indeed, mindfulness has been linked to emotion regulation (Chambers, Gullone, & Allen, 2009). The informant added: “Not using compassion to get another feeling but using compassion and kindness to move in close, to reduce fear, to see clearly - and in the clear-seeing comes the insight and wisdom and perhaps other solutions […]”. These quotes appear to suggest that self-compassion not only changes how suffering is experienced or related to, but also how this may bring the individual to see alternative behavioural responses to the current situation. It has also been suggested that positive emotions broaden action tendencies/repertoires that accesses personal resources (Fredrickson, 2004), and positive emotions may trigger upward spiral of positive emotion and adaptive behaviour (Garland et al., 2010). Indeed, affect change and affect integration (i.e., the capacity to increase awareness of, tolerate, differentiate, express and communicate emotional states to others) have been deemed vital to the process of therapeutic change (Solbakken, Hansen, Havik, & Monsen, 2012).

In sum, meditation practice may itself be an initial point of departure for developing self-compassion by enabling participants to let go of thoughts, feelings, sensations, expectations, desires, and ‘micro goals’ (e.g., relieve an itch, keep awareness on the breath). This process may have a reinforcing (i.e., cascading) effect and change the depressive network through mechanisms
of evaluative conditioning and/or emotional change, thereby preventing depressive relapse.

4.4.3. Subtheme C: Implicit versus explicit focus on self-compassion in MBCT

The discussion concerning an implicit versus and explicit focus on self-compassion in MBCT is the third theme I explore in this thesis. It represents a practical implication of subtheme A and B. If self-compassion is cultivated through mindfulness meditation and mediates MBCTs effect on preventing depressive relapse, why not target self-compassion more explicitly in MBCT meditation practices? In fact, one informant pointed out that: “[…] throughout the whole programme there is interwoven a theme of responding to your experience and to yourself and to your mind and so forth with kindness and patience and compassion and in particular when you turn towards what is difficult and painful […]”. However, in both interviews informants emphasised that MBCT was developed for recurrent depression (i.e., individuals especially vulnerable to depression), and this was given as a reason for how an explicit focus on self-compassion would be problematic. Why might that be the case?

One informant argued that it would be difficult for this population to practice compassion meditation: “[…] people with recurrent depression usually have profoundly negative self-esteem and think very critically of themselves and within a classroom format within only eight weeks to expect them to do a compassion practice is actually asking an awful lot”. Secondly, both informants described how there may be a barrier between individuals who have experienced repeated depressive episodes and the ability to feel compassion for the self:

“Cos I think if you think about the experiences that people have come from, their particular traumatic background, they will have been taught not to treat themselves kindly or with compassion. They will have been taught to call themselves names and put themselves down and criticise themselves and not believe they’re worth anything. So it’s like a sort of barrier between themselves and the possibility of compassion”.

It was also suggested that addressing self-compassion through compassion meditation in MBCT, could backfire: “I can imagine some of my depressed patients going: ‘no way’, […] and when they can’t feel compassionate or kind to themselves or anybody else they then feel they’ve failed because the idea of failure is so close to the surface, this is just another reason for failure”. It was pointed out that because feeling like a failure is so present in a depressive way of thinking, being asked to be compassionate towards oneself, and not succeeding in this, could possibly just add to feelings of inadequacy. This could strengthen the idea of failure, rumination and discrepancy-based processing. In fact, it is as if the ‘road to self-compassion’ was seen as going through several steps, and that going straight for self-compassion is like a step that is too big to
take: “[…] one could think that self-compassion is so far away for them that targeting or talking about self-compassion would just be way too hard; you sort of have to walk every step and that would be a huge step and too difficult or too unrealistic to even imagine because that self-critical attitude.” In this quote, it is as if self-compassion should not be placed as the ultimate goal, but should be viewed as a side-effect of mindfulness meditation. Or rather, the intent may actually be to increase self-compassion, but by directing the attention on achieving this goal it may become even more difficult to attain. As one informant formulated it:

“[…] if you rushed in to kindness and compassion without seeing clearly the process that had got you there then there’s a danger that you are then short circuiting; you’re aware of a negative mood and you want to bring a positive mood to bear and there’s a danger you get into a sort of ‘let’s shove this negative mood aside by putting a positive mood in place’.”

“So that would be an argument for not actually using specific compassion meditations but to allow it to ‘come in through the back door’, through the way attentional training is taught, through the compassion of that particular moment at which you notice your mind has wandered and to notice if you’re rushing back to the breath for example’.”

This notion of letting self-compassion to develop gradually and ‘come in through the back door’, may be linked back to Halifax’s (2012) conception of compassion as a contingent process that can only be primed indirectly through the development of specific underlying factors. Elements of mindfulness meditation may facilitate such underlying factors (e.g., focused attention).

Both informants related the difficulty of being self-compassionate for individuals with a history of recurrent depression to Gilbert and colleagues' (2012) notion of compassion-aversion or fear of compassion. According to them, some individuals, particularly those high in self-criticism, see self-compassion and/or receiving compassion from others as extremely difficult, and are even fearful of compassion. One study explored the relationship between fear of; compassion for others; compassion from others; and compassion for self in a sample of students (n=222) and therapists (n=53) (Gilbert et al., 2011). Included were also measures of self-reported self-compassion (SCS), compassion for others, self-criticism, attachment style, as well as depression, anxiety, and stress. Results showed that fear of self-compassion was significantly associated with self-criticism, insecure attachment, and depression, anxiety, and stress. Yet, self-criticism was the only significant predictor of depression. Similarly, another study found that fear of compassion mediated the relationship between self-criticism and depression (Joeng & Turner, 2015), suggesting that fear of compassion may be an important factor in depression.

An EEG study that compared compassion meditation and breathing meditation in
previously depressed individuals lends further support to this argument (Barnhofer, Chittka, Nightingale, Visser, & Crane, 2010). Researchers found that participants with high rumination scores differed in how they responded to the two types of meditation compared to low scoring participants. In high ruminators there was a change in frontal EEG asymmetry during breathing meditation, but not during compassion meditation. The reverse pattern was found for the low-ruminator group. This suggests that people high in rumination – who are also likely to be high in self-criticism and fearful of compassion - may have difficulties with compassion meditation. Another study highlighting this issue is a qualitative study of ten individuals with either a depressive or anxiety disorder. Participants were interviewed on the topic of self-compassion. Responses suggested that even though self-compassion was rendered meaningful and relevant, being self-compassionate was viewed as difficult to enact, and that experiences with depression/anxiety negatively affected their ability to be self-compassionate (Pauley & McPherson, 2010).

Indeed, this evidence is in keeping with the tenet put forth by the developers of MBCT; that the programme was designed for individuals who, due to their history of recurrent depression, would be expected to have high levels of self-criticism and discrepancy-based processing (Segal et al., 2013). Thus, compassion and kindness should be facilitated indirectly (through the teacher). The MBCT developers saw a risk of triggering participants’ vulnerability to depression should participants struggle to be compassionate towards themselves. The authors stress that if the aim of the practice is to develop loving feelings, rather than loving intentions, this could reinforce the individuals’ belief of not being able to love or be loved. Thus, even though self-compassion is seen as crucial, it is not explicitly targeted in the MBCT (Segal et al., 2013).

However, even though developers of MBCT have tried to take this vulnerability to feelings of failure into account, the qualitative study by Allen and colleagues (2009) found that many participants reported feelings of personal failure when asked about the limitations of MBCT. The authors suggest that participants attempted to acquire acceptance-based mindfulness-techniques with a particular aim in mind (i.e., averting depression), and the continued presence of depressive symptoms were attributed to a failure of not 'doing it properly' - making it even more difficult to accept these symptoms. The authors stress that balancing acceptance of symptoms with a wish to be free from them is challenging, and teachers need to be attuned to tendencies in participants towards striving and self-devaluation. This study illustrates that even if the programme attempts to promote an accepting and non-striving attitude, including not striving towards self-compassion, this can be very challenging for individuals suffering from recurrent depression.
In contrast, it has also been argued that given the likely importance of self-compassion for mental health in general, and as a therapeutic ingredient in MBCT specifically, the effectiveness of the programme would benefit from adding elements of self-compassion training (Germer & Neff, 2013; Neff & Dahm, 2015). Mindful Self-Compassion (MSC; Neff & Germer, 2013) builds of the structure on MBCT, and was developed for the general public. MSC includes exercises explicitly focusing on cultivating self-compassion (e.g., loving-kindness meditation, affectionate breathing, soothing touch, self-compassionate letter writing). The authors point to a paradox inherent within self-compassion training as well: The present moment experience is mindfully accepted, but the motivation to be free from suffering is also present. This explains why mindfulness is an important element in the SCS because it insures that compassion doesn’t become “a slick new form of resistance (I’ll be kind to myself to make the pain go away)” (p. 21). It is argued that MBCT might be more effective in improving wellbeing for those who have low pre-existing levels of mindfulness, while MSC may be more effective for those with low levels of self-compassion, because “people suffering from severe shame or self-criticism, they might need to first cultivate self-compassion in order to have the sense of emotional safety needed to fully turn toward their pain with mindfulness” (p. 28).

No existing studies have directly compared treatment programmes such as MBCT and MSC. Still, Neff and Germer (2013) found a 43% increase in participants’ self-compassion levels (SCS) after participating the MSC programme that were maintained one year later. In comparison, studies that have found an increase in self-compassion (SCS) after MBCT ranges between 7% and 12% in various populations (Kuyken et al., 2010; Lee & Bang, 2010; Rimes & Wingrove, 2011). Neff and Dahm (2015) propose that MSC raises mindfulness levels to a lesser extent than MBCT, given that teaching mindfulness is only a secondary emphasis of MSC. They suggest that the programmes are complementary, but that an explicit focus on self-compassion is more beneficial for increasing self-compassion. However, the problem with comparing these studies is that populations vary to a large degree (i.e., from the general public to clinical groups), and as there may be important differences between such groups possible divergent effects of compassion meditation may arise. An important area for future research would be to determine whether individual differences in compassion aversion, rumination, and self-criticism play a role in the relative impact of each type of programme, and if adding compassion meditation to MBCT is beneficial for participants. In fact, one study has investigated the beneficial effects of adding self-compassion training following MBCT (Schuling et al., 2016). This RCT study investigated
the effects of participating in an eight week compassion training course for adults with recurrent depression who already participated in an MBCT course and found a significant reduction in depressive symptoms and increased levels of mindfulness (FFMQ) and self-compassion (SCS). However, data analysis on risk of depressive relapse is yet to be completed.

To summarise, both informants argued that people who are prone to self-criticism, feelings of failure and are vulnerable to depression would not benefit from compassion meditation, because this would evoke the very thing one tries to treat. This leads to a paradoxical stance: Self-compassion is an important mechanism underlying the therapeutic effect of MBCT, nevertheless self-compassion should not be addressed explicitly in treatment of recurrent depression. However, Neff and Dahm (2015) argue that individuals suffering from recurrent depression would benefit from compassion meditation, and propose that compassion meditation may be an effective supplement to MBCT - particularly for those who are highly self-critical. That is, compassion training could be seen as especially important for people high in self-criticism, whereas the very same point could be used to reason that these people would profit less from compassion meditation. Research is required which compare the relative impact of adding compassion meditation to MBCT for recurrent depression, with MBCT without compassion meditation, in order to delineate potentially unique benefits of an explicit focus on self-compassion on risk of depressive relapse. Longer follow-ups could inform whether the effect of MBCT on self-compassion and risk of relapse is sustained beyond a one year follow-up window.

On the basis of existing evidence, it is difficult to draw firm conclusions as to whether MBCT’s preventive effect is boosted by an explicit or implicit focus on self-compassion. Whilst there are various theoretical accounts in support of implicit or explicit focus respectively, the current empirical evidence is based on the former. Another unexplored point in the literature is the degree to which the distinction between implicit and explicit self-compassion has merit. The distinction between an explicit versus implicit focus on self-compassion in MBCT might be less clear-cut than is ostensibly the case, given that the programme, as both informants highlight, is permeated with a focus on self-compassion. There might be some populations benefitting from explicit compassion meditation, however I will argue, based on theoretical and empirical grounds, that this is unlikely for individuals suffering from recurrent depression. Caution is essential if explicitly targeting self-compassion, as this may retrigger discrepancy-based processing and feelings of failure. Thus, juxtaposing and discerning possible differences between MBCT with and without compassion training should be a key priority in future endeavours to increase our
understanding of the role self-compassion plays in MBCT.

5. Concluding Remarks

MBCT (Segal et al., 2013) is predicated on the Differential Activation Hypothesis (the DAH; Teasdale, 1988), stating that individual differences in the ease with which maladaptive cognitions and patterns of processing is reactivated by temporary dysphoric mood, increases the risk of depressive relapse. Thus, since this hypothesis emphasises habitual reactions to low mood, so well-rehearsed that they are perceived as involuntary, the relationship to depressive symptoms is put to the fore in the account of why people become recurrently depressed. The clinical implications of this programme is that individuals vulnerable to depressive relapse need to learn how to disengage from these maladaptive processes. In MBCT, it is hypothesised that increasing the capacity to switch from a ‘doing’ mode of mind, to a ‘being’ mode - an intentional, experiential and compassionate mode of mind, is prophylactic. There is now robust evidence to suggest that MBCT prevents risk of depressive relapse for individuals suffering from recurrent depression when compared to TAU, and comparable or in a few studies superior compared to active control treatments for those especially vulnerable to depressive relapse (Kuyken et al., 2016). As I have shown in this dissertation, current research endeavours to delineate the mechanisms through which MBCT is exerting its preventive effect in recurrent depression. There is both a theoretical body of work and emerging empirical evidence that a lack of self-compassion can be considered an important feature of recurrent depression. Current evidence suggests that self-compassion is cultivated during MBCT, and acts as a mechanism underlying MBCTs protective effects on relapse (van der Velden et al., 2015)

However, I have argued that there are several challenges within the existing body of research. First, there is a lack of consensus as to how self-compassion should be conceptualized. Critically, there is a lack of consensus as to how this construct relates to mindfulness (Strauss et al., 2016). That is, it is not clear whether compassion should be considered primarily a trait or a contingent dynamic process; a feeling, a motivational state, an attitude, a behavioural response or moral insight - or some combinations of these features. Second, the use of the Self Compassion Scale (SCS; Neff, 2003a), which is the most frequently used measure of self-compassion in MBCT research, is problematic given that it was originally developed for a non-clinical population, but is now frequently used to measure self-compassion in recurrently depressed individuals. There is evidence suggesting that the factor structure of the SCS does not fit this
population (Williams et al., 2014b). Thus, it is possible that the scale does not capture the extent of lack in self-compassion or presence of compassion aversion in recurrently depressed individuals, leading to understate this measure (i.e., a floor effect). Moreover, the SCS may largely measure other known constructs related to psychopathology and wellbeing, including mindfulness (Muris et al., 2016; Muris & Petrocchi, 2016). Nevertheless, this dissertation has argued, based on theoretical distinctions, differential findings from neurological correlates, and predictive utility, that it is reasonably to propose, with caution, a distinction between self-compassion and mindfulness. Still, investigating current scales of self-compassion and/or developing alternative measurements that are reliable and valid is an important prerequisite for future research on the cultivation of self-compassion in the context of mindfulness-based interventions.

Moreover, verifying statistically that self-compassion is a mediator in MBCT is not equal to verifying self-compassion as an underlying mechanism in recurrent depression, or explains how self-compassion short-circuits risk processes associated with relapsing. Therefore, interpretation of possible mechanisms in a theoretical context in addition to replication studies with larger sample sizes, are required. The qualitative data outlined above suggests that self-compassion in MBCT may be facilitated by; (1) non-specific factors (e.g., the group setting); (2) the instructor/teacher of the course modelling and/or embodying self-compassion; and (3) the mindfulness meditation practice involving two hypotheses. One suggestion is that self-compassion may mediate and/or interact with decentering: Observing oneself through decentering may activate the care-system in the brain, making compassion and care available to the self, and thereby prevent depressive relapse. However, this argument rests on the assumption that self-compassion and other compassion indeed are part of the same neurological system, and evidence is mixed and indirect regarding this association. Moreover, the association between self-compassion and decentering is likely complex, and possibly reciprocal. A second suggestion is that practicing to let thoughts, emotions, sensations, desires, expectations, and so-called “micro goals” pass by during the meditation practice, may be an initial start out point for developing acceptance, kindness, and self-compassion. The practice of letting go of goals or expectations may have a reinforcing or cascading/spiralling effect leading to changes in self-discrepancies through mechanisms of evaluative conditioning and/or emotional change. This may prevent depressive relapse by structurally changing the underlying depressive network.

If self-compassion is critical in short-circuiting relapse processes, this raises the question as
to whether self-compassion should be put explicitly to the fore in the various meditation practices in the programme. On one hand, one can argue that individuals suffering from recurrent depression (i.e. who are highly self-criticism) are precisely in need of an explicit focus on self-compassion (Neff & Dahm, 2015). On the other hand, as both informants suggested, one can also argue that individuals with a history of depression would not benefit from an explicit focus on self-compassion, because this may lead to discrepancy-based processing and feelings of failure – thereby possibly even triggering depressive relapse. This leads to a paradoxical conclusion: Self-compassion is an important mechanism underlying the preventive effect of MBCT; however, self-compassion should not be addressed explicitly in treatment of recurrent depression, but develop gradually through mindfulness meditation. However, MBCT might work differently for different groups, and through different mechanisms interacting in complex ways.

Davidson (2016) has recently pointed out an agenda for future investigations regarding MBCT research. Of these, I find the following questions especially relevant for the field of self-compassion in MBCT, which future research is required to focus on: (1) What psychological or biological characteristics do patients that respond best to MBCT share? E.g., individuals particularly lacking self-compassion may especially benefit from MBCT. (2) What are the mechanisms underlying the effects of MBCT for recurrent depression? Trials may adopt research designs that further unpack and disentangle self-compassion and other possible components of MBCT while examining each mediator separately in larger samples with longer follow-up periods (e.g., experimental manipulations or randomized controlled trials with dismantling designs). (3) How can self-compassion be measured as a potential mediator of the effect of MBCT? Future investigation need to evaluate the different subscales of mindfulness and self-compassion scales. Behavioural and neuroscience measures may also be used to better assess self-compassion, and distinguish it from mindfulness. Investigation may also include weekly measurements of these constructs in order to nuance development, and whether one ability precedes the other. (4) Might combining MBCT with other treatments provide additional benefits compared with MBCT? For instance, can compassion meditation training following MBCT be additionally helpful for some patients? These questions await further scrutiny.


