The role of self-compassion in psychotherapy

All psychotherapists should be aware of self-compassion as a powerful resource for enhancing well-being. When we give ourselves compassion, this allows us to cope with the pain of life without becoming derailed by it. Here we offer a panoramic view of the benefits of self-compassion and consider how psychotherapists can integrate it into treatment.

We can define self-compassion as being comprised of three core components: kindness, common humanity and mindfulness[1].

Most people try to be compassionate toward their friends and loved ones when they make a mistake, feel inadequate, or suffer misfortune. We tend to be much harsher with ourselves, however, saying cruel things that would never be said to a friend. Self-compassion turns this around, allowing us to acknowledge shortcomings while accepting ourselves as flawed, imperfect human beings. The kindness that characterizes self-compassion means that we are emotionally moved by our own pain, stopping to say: "This is really hard right now. How can I care for myself in this moment?". When we respond to ourselves with goodwill, we generate positive emotions that help us cope.

The sense of common humanity inherent to self-compassion helps us to feel connected to rather than separate from others. When we fail or feel inadequate in some way, we tend to irrationally feel like everyone else is just fine and it is only *me* who is struggling. This feeling of isolation creates a sense of disconnection that greatly exacerbates our suffering. Self-compassion recognizes that struggle is part of being human, an experience we all share. Unlike self-pity, compassion is, by definition, relational. It implies a basic mutuality in the experience of suffering, and springs from the acknowledgement that the shared human experience is imperfect.

In order to have compassion for ourselves, we need to be mindful of our pain. We cannot show ourselves compassion if we do not acknowledge that we are suffering. At the same time, if we fight and resist the fact that we are suffering, our attention becomes completely absorbed by our pain and we cannot step outside ourselves and adopt the perspective needed to give ourselves compassion. Mindfulness allows us to recognize that our thoughts and feelings are just that – thoughts and feelings – so that we can have compassion for our struggles.

There is a growing body of research demonstrating the potential of self-compassion in psychotherapy to relieve suffering across a range of clinical disorders, including depression, social anxiety disorder, eating disorders, dementia, and personality disorders[2]. In correlational studies, the trait of self-compassion is consistently associated with decreased psychopathology[3]. A meta-analysis of research on interventions such as compassion-focused therapy[4] found that treatment significantly relieved psychological distress among clients with a variety of diagnoses, even compared to active control groups[5]. A meta-analysis of self-compassion interventions in non-clinical populations found strong effect sizes in terms of reducing maladaptive eating behavior and rumination, and moderate effect sizes for reducing stress, anxiety, depression and self-criticism[6].

Bringing self-compassion into the therapy room can help clinicians be more effective. Psychotherapy is a challenging profession because therapists listen to the painful experiences of others all day long. Since human beings are hardwired to feel the emotions of others as their own, therapists inevitably experience empathic distress, which can lead to stress and burnout. Research indicates that self-compassion reduces burnout among therapists[7]. If therapists are compassionate toward their own empathic pain, not only will they be less distressed, but their compassion will be felt by clients through emotional attunement[8]. Over time, exposure to a therapist with a self-compassionate presence is likely to change how clients think and feel about themselves. Therefore, if therapists want their clients to become more self-compassionate, the first step is for them to cultivate self-compassion.

Psychotherapists can also directly teach clients how to respond to their difficulties in a more compassionate manner. For example, after a client reveals that he was sad after fighting with his son, the therapist might follow up by asking "Right now, what do you think you need?" or "If you had a friend in the same situation as you, what might you say to your friend, heart-to-heart?". These questions direct the client to explore how he could respond compassionately to his emotional pain, thereby building the resource of self-compassion.

The conversation also opens the door to practicing at home what was discovered in session. Fortunately, there are several practices available to clinicians that can be customized for individual clients to practice self-compassion. For example, the Mindful Self-Compassion training program contains seven formal meditations and twenty informal practices that can be used in daily life, and is available in workbook format[9]. Compassion-focused therapy[4] also provides a range of techniques that help clients both give and receive compassion.

Psychotherapists should be aware, however, that some clients may have negative reactions to self-compassion at first. The distress that arises when people give compassion to themselves or receive compassion from others is known as "backdraft"[1]. Backdraft can take the form of *thoughts*, such as "I'm unlovable"; *emotions,* such as grief or shame; *body* aches and pains; and *behaviors,* such as withdrawal or aggression.

Backdraft is an intrinsic part of the transformation process of self-compassion. Compassion activates old memories and makes them available for reprocessing – it provides an opportunity to receive the kindness and understanding that was lacking when the painful experiences originally occurred. This is a delicate process, and therapists need to go slowly and make sure that their clients are not overwhelmed, especially when backdraft consists of traumatic memories. As the resource of self-compassion develops, however, clients can develop the sense of safety needed to explore their inner and outer world.

In summary, self-compassion is a highly effective tool to help

alleviate suffering in psychotherapy, changing the lives of both patients and therapists for the better.

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In support of supportive psychotherapy

People get carried away by bells and whistles, but sometimes it is the basics that matter. Psychotherapists, like their patients, face discomfort with and may shy away in the face of strong emotions[1]. Yet focusing on strong emotions lies at the heart of psychotherapy. That is what good therapy, and particularly good supportive psychotherapy, should do.

At least before cognitive behavioral therapy took the world by storm, supportive psychotherapy was cited as the most widely practiced form of psychotherapy[2]. But what is supportive psychotherapy? It has meant too many things. The term initially denoted the lesser alternative to psychoanalysis in the last century, the treatment offered to patients who could not tolerate the interpretations or lack of structure of free association on the couch. In other words, anything other than psychoanalysis was supportive psychotherapy. Supportive psychotherapy has been variously described as an attempt to shore up rather than alter psychic defences and as gentle hand-holding. It has probably encompassed various forms of muddled eclectic psychotherapy[2].

Thirty years ago, we developed a time-limited, manualized form of affect-focused supportive psychotherapy in response to the long-standing research conundrum of what constitutes a psychotherapy control condition. Over the years we and others have tested this brief supportive psychotherapy (BSP) in nine randomized controlled trials to treat mood and to a lesser degree anxiety disorders, with a tenth study currently underway. In all of these instances, BSP has been the underdog comparison condition.

We recently amassed the results of those trials and found that BSP worked as well as the favored treatments in seven of the nine trials, and finished a credible, near-miss second in the other two[3]. This is actually big news: BSP performed very well, considering that researcher allegiance often affects trial outcomes[4]. On balance, the data indicate that BSP may have failed to resolve the dilemma of the less-active psychotherapy control condition. Whereas waiting lists and "treatment as usual" (at least in the fractured US health care system) are often unfairly weak comparisons, BSP may be too potent an intervention to serve as a less-active control[3]. On the contrary, it deserves listing in depression treatment practice guidelines. Other studies have used unmanualized, generic treatment titled "supportive therapy" (not BSP) with less positive results.

What is BSP? It is an elemental treatment: it distills psychotherapy to its emotional essence. Based on the work of psychotherapy giants such as C. Rogers[5] and J. Frank[6], BSP comprises the "common factors" building blocks that are part of all effective treatments and that account for the majority of all psychotherapies' outcomes[7] – the common factors, and not much more. Those common factors are: affective arousal, feeling understood by the therapist and developing a therapeutic alliance, providing a framework for understanding and a therapeutic ritual, evincing optimism for improvement, and encouraging success experiences[6]. Above all, BSP focuses on the patient's emotions and on emotional tolerance. Emotional tolerance may indeed constitute many patients' principal success experience in treatment. If psychotherapies are broadly divisible into exposure-focused and affect-based therapies, BSP surely falls in the latter camp: the only exposure here is to one's own emotional state.

BSP therapists are active listeners, often silent but encouraging, letting patients lead sessions, intervening only to steer patients towards recognition and tolerance of affect. The stance incorporates curiosity, sympathy, a search for mutual understanding of the patient's emotional state. Maintaining eye contact, the therapist mirrors the patient with nonverbal synchrony. Recognizing that patients are beset not only by outside stressors but by the stress of uncomfortable internal emotions, therapists help patients recognize and name their feelings ("What kind of upset? Which emotion is that?"). The therapist does not avoid powerful affects but seeks and tolerates them, demonstrating by example the mantra of treatment that *emotions are powerful but not dangerous*. Affect regulation, with the appreciation that one's uncomfortable feelings are meaningful reactions to life circumstances, is clinically helpful. This therapy is simple in its approach, yet not simple to deliver well.

While the patient is doing most of the talking, the therapist mentally sketches an emotional portrait of the individual. Who is this person? How does he/she react to particular situations, and with which emotions? Depressed and anxious patients frequently avoid interpersonal confrontations, having trouble asserting their wishes and struggling to say no. Helping to elicit emotionally-laden desires and particularly negative affects such as anger and sadness, the therapist normalizes them: "Is it reasonable to feel