1

A Model of Self-Compassion-Based Therapy

Christopher Germer

Compassion is a resource that has alleviated human suffering since time immemorial. The word is derived from its Latin roots: *com* (with) and *passion* (suffering). Our ability to *be* with a person's suffering, without denying, amplifying, or avoiding it, is fundamentally healing. Just recall the last time that you were struggling and someone took the time to listen deeply and speak compassionately with you. Chances are that you felt better, even though the circumstances of your life had not changed.

Compassion has been defined as "the feeling that arises when witnessing another's suffering and that motivates a subsequent desire to help" (Goetz et al., 2010, p. 351). From the Buddhist perspective, compassion can be directed outward toward others or inward toward oneself. Self-compassion is inner compassion. Research shows that people are generally more compassionate toward others than themselves (López et al., 2018). An informal definition of self-compassion is treating ourselves with the same kindness and understanding as we would treat a good friend. It's a compassionate U-turn.

In 2003, Kristin Neff (2003b) operationally defined self-compassion and created the Self-Compassion Scale (SCS; Neff, 2003a), which has been used in most self-compassion research. There are currently over 7,000 articles on self-compassion in the academic literature. The research clearly shows that self-compassion is good for mental health and well-being. Self-compassion is closely associated with happiness and life satisfaction, emotional resilience and coping, healthy habits such as diet and exercise, and more satisfying personal relationships (Neff, 2023). Self-compassion also appears to alleviate a wide range of psychological disorders, including anxiety, depression, eating disorders, addiction, personality disorders,

and psychosis (Germer, 2023). In light of the empirical evidence, more and more clinicians are becoming interested in helping their clients cultivate the resource of self-compassion.

This makes sense. Imagine that you have a client who suffers from anxiety or depression. Over the course of therapy, your client learns to recognize and validate how they feel rather than getting caught in useless rumination (mindfulness). Your client begins to feel less alone and more connected to others in the midst of their struggles (common humanity). Your client's inner dialogue is reassuring and supportive rather than dismissive or self-critical (self-kindness). Taken together, your client has become more self-compassionate and might even be able to manage life more on their own.

The purpose of this chapter is to outline a model of therapy called *self-compassion-based therapy*. First, I review the definition of self-compassion and the history of self-compassion in therapy. Then I explore the research on self-compassion as a transtheoretical and transdiagnostic process in therapy, identify three levels that self-compassion can be integrated into therapy, and consider putative mechanisms by which self-compassion creates positive change in therapy. Two practices are included in this chapter to give readers a direct experience of self-compassion.

What's in a Model?

The value of a therapy model lies in its ability to guide treatment. A model of therapy contains four main elements: (1) how symptoms are caused and maintained, (2) treatment techniques, (3) putative mechanisms of change, and (4) empirical support (Boswell et al., 2010). At present, the theory, research, and practice of self-compassion-based therapy appears robust enough to consider it a distinct model of therapy.

Therapy models are constructed out of converging theoretical, empirical, and clinical trends. The lens of the investigator inevitably influences how a model is described. The self-compassion-based therapy model described in this chapter is primarily informed by the mindful self-compassion (MSC) program (Germer & Neff, 2019; Neff & Germer, 2018), as I, along with Kristin Neff, developed the MSC program. Furthermore, most of the research on self-compassion uses Neff's SCS (Neff, 2003a), which has had a significant impact on how self-compassion is conceptualized and studied (Cha et al., 2023). MSC was originally designed as a training for the general public, not a therapy, but as you can see in this book, many clinicians are integrating the concepts and practices of MSC into their therapeutic work.

Another major influence on the current model is compassion-focused therapy (CFT; Gilbert, 2009, 2010), developed by Paul Gilbert and

colleagues to help clients cultivate compassion for themselves and others. Most research on self-compassion-based therapy has investigated CFT. Other empirically supported, self-compassion-based therapies that influenced the current model are acceptance and commitment therapy (Hayes et al., 2011), internal family systems (IFS; Schwartz & Sweezy, 2019), and emotion-focused therapy (EFT; Greenberg, 2006). The founders and practitioners of each self-compassion-based therapy would probably articulate the self-compassion-based therapy model in their own terms, but hopefully, the current effort is spacious enough to inspire therapists of all stripes to integrate self-compassion more deliberately into how they are doing therapy already.

What's Self-Compassion?

Let's start by reviewing what we mean by self-compassion. According to Neff's (2003b) model, self-compassion has three components: (1) mindfulness versus overidentification, (2) common humanity versus isolation, and (3) self-kindness versus self-criticism. These components are overlapping yet conceptually distinct.

Mindfulness refers to spacious, balanced, friendly awareness of moment-to-moment experience. The opposite quality, overidentification, means that we get entangled in our thoughts and feelings and lose perspective. A depressed client who spends hours ruminating about being a "bad person" is overly identified with that particular narrative of their life. Mindfulness allows the same person to see their thoughts and feelings as just that—temporary and incomplete constructions of reality. This perspective opens new possibilities, including the possibility of a compassionate response.

Self-compassion includes a sense of *common humanity*. When we struggle with emotional pain, we tend to blame ourselves for it and feel isolated and alone. Feeling alone only amplifies our suffering. However, when we're mindful and stop resisting our pain, or we connect with another person (like a therapist) amidst our pain, we're more likely to understand that suffering is part of life and our pain becomes more tolerable.

The third component is *self-kindness*. When things go wrong, we tend to be patient, understanding, and supportive of others and relatively harsh and critical of ourselves. Self-kindness refers to actively caring for ourselves when we suffer, fail, or feel inadequate. It's a benevolent attitude, despite our mistakes and imperfections, which allows us to learn and grow.

Many therapists equate self-compassion with self-kindness alone. However, without the components of common humanity and mindfulness, self-kindness can devolve into self-pity or sugarcoating reality, respectively.

On the other hand, some mindfulness-based therapists assume that self-compassion is nothing new—that it's part and parcel of mindfulness. We often see in clinical practice, however, that it is difficult to be mindful when we're in the grip of intense and disturbing emotions like shame, grief, rage, or despair unless we first hold *ourselves* in a warm and kind embrace. That's self-compassion. Finally, the component of common humanity helps us respond wisely to our challenges by making it possible to look beyond ourselves at the many causes and conditions that contribute to our suffering and to find a path forward. The three components of self-compassion work synergistically to help our clients heal and thrive.

Clinicians also tend to equate compassion and self-compassion with tender qualities like nurturing—qualities that are especially important when a client needs to be comforted, soothed, reassured, or validated. However, sometimes our clients need to protect themselves by creating safe boundaries, or by providing for their deepest needs, or encouraging themselves to overcome difficult challenges. That's when self-compassion needs to take a tough, even fierce turn (Neff, 2021). Both tender and fierce self-compassion can be taught and learned in psychotherapy.

To have a direct experience of the three components of self-compassion, try Practice A, "Self-Compassion Break," in the Appendix.

History of Self-Compassion in Psychotherapy

Although self-compassion is a relatively recent empirical construct, it has been embedded in psychotherapy for over a century under the umbrella of "self-acceptance." William James, Sigmund Freud, and B. F. Skinner all considered acceptance (self and others) to be a beneficial quality (Williams & Lynn, 2010). Carl Rogers (1951) specifically emphasized *self*-acceptance as a core change process in therapy. In the 1990s, with the introduction of mindfulness- and acceptance-based therapies (Hayes et al., 2011; Linehan, 1993; Segal et al., 2018), the focus of acceptance shifted away from the *person* to the person's *experience*. Mindfulness is loving awareness of moment-to-moment *experience* and compassion is loving awareness of the *experiencer*. Currently, the pendulum is swinging back to acceptance of the person with therapies such as CFT, and IFS, and secular compassion training programs like MSC and compassion cultivation training (CCT; Goldin & Jazaieri, 2017). CFT was the first empirically supported, explicitly compassion-based therapy. Paul Gilbert had the revolutionary insight, back in 2000, that the *tone* of a client's inner dialogue was more important than the *content* of thinking to alleviate depression. The main agenda of CFT is to "warm up the conversation" (P. Gilbert, personal communication, July 28, 2014).

Historically, the term *compassion* has been relatively absent from psychotherapy, perhaps because of its association with religion. However, compassion has not been absent from therapy itself—it has been embraced as therapeutic empathy. Empathy is experiencing the world of another as one's own. When we resonate with a client's experience, we are empathic. Nowadays, compassion is defined as empathy *plus* the wish and effort to alleviate suffering (Jinpa, 2010, in Jazaieri et al., 2014; Singer & Klimecki, 2014). Since the sole purpose of therapy is to alleviate suffering, therapeutic empathy has always been about compassion. From a research perspective, empathy is a strong predictor of therapy outcomes (Elliott et al., 2018).

At the present time, self-compassion is nestled comfortably in the emerging school of *mindfulness-*, *acceptance-*, and *compassion-based psychotherapy* (Germer & Siegel, 2012; Germer et al., 2016). The unifying principle of this school is helping clients to cultivate an accepting, nonadversarial relationship with their experience or with themselves. Mindfulness-based therapies regulate emotions by regulating attention and awareness—*what* we pay attention to and *how* we pay attention (Segal et al., 2018). Acceptance-based therapies focus more on nonavoidance and acceptance of moment-to-moment experiences (Hayes et al., 2011). Compassion-based therapies regulate emotion by activating qualities of warmth, care, and connection (Gilbert, 2009). Self-compassion-based therapy is a model *within* the model of mindfulness-, acceptance-, and compassion-based therapy because it contains elements of the other therapies but focuses primarily on changing our relationship to suffering through the cultivation of self-compassion.

Transdiagnostic and Transtheoretical Change Process

Although the research base still has some important gaps, empirical studies indicate that self-compassion is an underlying change process in therapy.

Transdiagnostic Process

Self-compassion-based therapy has been shown to alleviate a broad range of clinical conditions, suggesting that self-compassion is a *transdiagnostic* change process (Cuppage et al., 2018). For example, clinical diagnoses that improved with compassion-based treatment include anxiety, depression, trauma, eating disorders, addictions, personality disorders, and psychosis (see Germer, 2023). A meta-analysis of compassion-based interventions for different diagnoses found that treatment significantly relieved psychological distress and increased self-compassion even when the studies used active control groups (Kirby et al., 2017). Meta-analyses specifically

on *self*-compassion-based interventions found strong effect sizes for eating behavior and rumination (Ferrari et al., 2019), and small to medium effects for stress, anxiety, depression, and posttraumatic stress (Han & Kim, 2023).

Most of the outcome research showing positive change across diagnoses has been conducted using CFT (Millard et al., 2023). Although CFT cultivates compassion for self *and* others, it may be considered a self-compassion-based therapy because it primarily helps clients to be less harsh and more compassionate with themselves (see Chapters 2 and 13 for more about CFT). More randomized controlled trials are needed because the existing research contains many pilot or feasibility studies (Craig et al., 2020).

Self-compassion training for the general public has also demonstrated improvements in mental health. For example, MSC reduced anxiety and depression among adults in the community (Neff & Germer, 2013), as well as depressive symptoms among patients with diabetes (Friis et al., 2016). CCT has two self-compassion modules, decreased worry and emotional suppression (Jazaieri et al., 2014). Stand-alone compassion imagery training also produced psychological improvement in nonclinical populations (Maner et al., 2023).

There is a wealth of correlational data showing that self-compassion is associated with reduced psychopathology in adults (MacBeth & Gumley, 2012) and adolescents (Marsh et al., 2018), as well as adaptive coping (Ewert et al., 2021). Self-compassion correlates with fewer eating disorders (Braun et al., 2016) and decreased symptoms of obsessive–compulsive disorder (Wetterneck et al., 2013) and schizophrenia (Eicher et al., 2013). Self-compassion is consistently associated with less severe posttraumatic stress disorder (Winders et al., 2020). On the other hand, *low* self-compassion levels are found among people with bipolar disorder (Døssing et al., 2015), depression (Krieger et al., 2013), generalized anxiety disorder (Hoge et al., 2013), and substance use disorder (Phelps et al., 2018). Taken together, intervention and correlational studies clearly indicate that self-compassion is good for mental health.

Transtheoretical Process

Self-compassion has also been linked to successful outcomes in different kinds of therapies, suggesting that self-compassion is a *transtheoretical* change process. For example, both psychodynamic and cognitive therapy for Cluster C personality disorders (avoidant, dependent, obsessive–compulsive) increased self-compassion, and those increases predicted decreases in psychiatric symptoms, interpersonal problems, and personality pathology (Schanche et al., 2011). Neff and colleagues (2007) conducted

a study with the two-chair technique from EFT, a form of humanistic therapy, and found that it increased self-compassion and decreased self-criticism along with fewer experiences of depression, rumination, thought suppression, and anxiety. Recently, clinicians have begun integrating self-compassion training into cognitive and behavior therapies (Baumgardner & Benoit, 2024; Javidi et al., 2023).

Mindfulness- and acceptance-based treatments also increase self-compassion. Wadsworth and colleagues (2018) treated patients with dialectical behavior therapy and cognitive-behavioral therapy and found that improvements in anxiety and depression were related to increases in self-compassion. Participation in mindfulness-based cognitive therapy (MBCT) increased self-compassion even though self-compassion is not usually taught implicitly in MBCT (Birnie et al., 2010) and mediation analysis showed that self-compassion is responsible for many of the positive effects of MBCT (Kuyken et al., 2010). A meta-analysis of mindfulness programs with nonclinical populations showed a significant medium effect of pre–post changes in self-compassion (Golden et al., 2021).

In summary, the current research evidence on self-compassion as a transdiagnostic and transtheoretical change process is encouraging and growing rapidly.

Integrating Self-Compassion into Therapy

Self-compassion can be integrated into psychotherapy at three levels: (1) *compassionate presence*—how therapists relate to their own experience in therapy, (2) *compassionate alliance*—how therapists engage with their clients, and (3) *compassionate interventions*—how clients relate to themselves, especially during home practice. If a therapist brings all three levels into their clinical work, they are practicing self-compassion-based therapy. (See Chapter 11 for a case vignette of self-compassion-based treatment of shame.)

Level 1: Compassionate Presence

Compassionate presence refers to the clinician being with their own moment-to-moment experience in a compassionate way during therapy. Clinicians can be present while listening quietly or speaking with a client. According to Shari Geller (2017), therapeutic (or compassionate) presence entails being open to the client's moment-to-moment experience, attuning inwardly to how the clinician is resonating with the client while staying in contact with the relationship between them (see Chapter 6 for more on presence).

Although compassionate presence is not easily observable, it can have a meaningful impact on our clients. How does this work? We have specialized neurons in our brains—mirror neurons—that allow us to directly experience in our own bodies what other people are experiencing (Kilner & Lemon, 2013). Furthermore, people synchronize with one another on many levels—neural, perceptual, affective, physiological, verbal, and behavioral—which is a critical survival skill for human beings (Hu et al., 2022; Koole & Tschacher, 2016) and enhances the experience of compassion (Valdesolo & DeSteno, 2011). Interpersonal synchronization also allows us to regulate the emotional experience of others, such as when a therapist remains unruffled while a client relates a traumatic experience that has the effect of calming the client.

Compassionate presence can be practiced and learned. Bourgault and Dionne (2019) found that self-compassion practice is linked to therapeutic presence. Clinical psychology trainees who took the MSC training raised their self-compassion levels, but only when they were committed to the training (Yela et al., 2020). Personal practice, such as loving-kindness and compassion meditation, can help a clinician become more self-compassionate (Lv et al., 2023; Reilly & Stuyvenberg, 2023).

Level 2: Compassionate Alliance

The *compassionate alliance*, variously called the therapeutic alliance, therapeutic relationship, working relationship, or therapeutic bond, is considered a common factor in effective therapy. In a meta-analysis, Elliot and colleagues (2011) found that empathy is a relatively strong predictor of therapy outcome across different theoretical orientations. In another meta-analysis, Lambert and Ogles (2004) found that successful therapists tended to be warmer, more empathic, understanding, and supportive of their clients, and were less likely to blame, ignore, neglect, or reject their clients.

It appears that personal practice can also enhance the therapeutic alliance. Bibeau and colleagues (2016) found that loving-kindness and compassion meditation can have a positive impact on numerous therapeutic variables related to empathy, such as altruism, positive regard, prosocial behavior, affective empathy, and empathic accuracy.

There is a rule of thumb in the MSC program: "The best way to *teach* self-compassion is to *be* compassionate." In the therapeutic relationship, that means sustaining compassion for oneself and for the client while doing therapy. This can be difficult when clinicians feel the distress of their clients as their own (empathic distress). Self-compassion can help therapists disentangle and make room for compassionate responding. A practice that can be applied in the midst of challenging moments of therapy is giving and

receiving compassion (see Practice B, "Giving and Receiving Compassion," in the Appendix).

Key Elements in a Compassionate Therapeutic Relationship

What does a compassionate therapeutic relationship look like? It has three key elements (three *R*'s): radical acceptance, resonance, and resource building. *Radical acceptance* is the overall attitude of the treatment process, *resonance* is the primary mode of engagement, and *resource building* is the desired outcome of the therapy relationship. The three *R*'s are based on the "inquiry" method used by teachers of the MSC training to help their participants cultivate self-compassion (Germer & Neff, 2019).

Radical acceptance was first defined by Marsha Linehan as "the fully open experience of what is, entering into reality just as it is, at this moment . . . acceptance without the haze of what one wants and does not want it to be" (Robins et al., 2004, pp. 39–40). From a self-compassion point of view, radical acceptance means accepting *ourselves* just as we are. The invitation is to temporarily suspend the change agenda and allow kindness to flow naturally in response to suffering. As Carl Rogers (1961/1995) wrote, "the curious paradox is that when I accept myself as I am . . . change seems to come about almost unnoticed" (p. 17).

Resonance refers to affective attunement between the therapist and client—a sense of "feeling felt" (Siegel, 2010, p. 136). Interpersonal synchrony is a way of measuring resonance. Synchronous body movements between the therapist and client predicted the quality of the alliance as rated by the client at the end of therapy (Ramseyer & Tschacher, 2011). Neural synchrony, using dual electroencephalography, also correlated with the strength of the alliance (Lecchi et al., 2019). Skin conductance synchrony between therapist and client even predicted therapy *success*—namely, reduced symptom severity (Gernert et al., 2023).

Resource building is the third aspect of a compassionate alliance. How can a therapist help a client cultivate self-compassion through conversation? In the MSC training, the "inquiry" method serves this purpose. Inquiry is a self-to-other dialogue that mirrors the self-to-self relationship that teachers wish to cultivate in their students (see Chapter 10 for more on inquiry). In therapy, the first step is for the clinician to remain connected and aware of their own moment-to-moment experience—*listening with the heart*. Then, when it is the therapist's turn to speak, the therapist can share what touched or moved them while the client was talking (rather than their *thoughts* about what touched them)—*speaking from the heart*. For example, if the therapist was moved by a strength they saw in the client—such as courage, curiosity, mindfulness, or self-compassion—that can be named as an invitation to further discussion. If the therapist was touched

by a client's suffering—such as grief, sadness, or confusion—such moments of resonance can also be shared with clients, followed by self-compassion questions like "What do you need right now?," "What do you need to hear in a moment like this?," or "How would you treat a friend in the same situation as you?"

Level 3: Compassionate Interventions

Most clinicians think of interventions, especially home practices like meditation, when they think of self-compassion in therapy. However, interventions need to be grounded on the first two levels of integration: a compassionate presence and a compassionate relationship. Clients are more likely to do home practices if they feel connected with their therapists and the home practices arise out of relevant issues that were discussed in therapy. Not all clients are willing to do home practices, and if they don't, they can still learn self-compassion from the other two levels of treatment. Home practices are important because 1 hour of therapy per week is not much time to learn new habits of thinking and behaving. Studies on neuroplasticity show that mental practices like meditation can lead to changes in the structure and function of the brain (Lazar et al., 2005; Valk et al., 2017).

There is a wealth of self-compassion practices that clinicians can adapt for individual clients, especially from the MSC training and CFT (Irons & Beaumont, 2017; Neff & Germer, 2018). Clinicians can also modify traditional cognitive-behavioral exercises to cultivate self-compassion, such as adding compassionate self-talk to exposure therapy or behavioral activation. The self-compassion questions "What do you need right now?" and "How would you treat a friend?" also lead naturally to customizable home practices.

Mechanisms of Change

How does self-compassion work in therapy? An empirical argument has yet to be made that increases in mindfulness, common humanity, and self-kindness, and reductions in rumination, isolation, and self-criticism, are what lead to improvement in self-compassion-based therapy. Different self-compassion interventions are also likely to activate different components of self-compassion to varying degrees (Dreisoerner, Junker, & Van Dick, 2021).

Emotion regulation is a mechanism of change that is closely associated with self-compassion and therapy in general (Inwood & Ferrari, 2018; Paucsik et al., 2023). Neurophysiologically, self-compassion seems to improve emotion regulation by decreasing fear, especially by reducing activity in

the sympathetic nervous system (Breines et al., 2015; Dreisoerner, Junker, Schlotz, et al., 2021). Self-compassion also increases a sense of safety by enhancing vagally mediated heart rate variability (Petrocchi et al., 2017). Activity in the prefrontal cortex of the brain, an area commonly associated with emotion regulation, seems to be involved in self-compassionate responding as well (Guan et al., 2021; Parrish et al., 2018).

There are also a number of psychological mechanisms that may explain how self-compassion works. *Secure attachment* is associated with self-compassion (Joeng et al., 2017) and self-compassion mediates the relationship between insecure attachment and emotional distress (Mackintosh et al., 2018). *Reduced shame* is another putative mechanism. Shame is a predisposing factor in a wide variety of clinical conditions and many studies show that when self-compassion increases in therapy, shame tends to decrease (Kelly et al., 2014; Proeve et al., 2018). *Nonavoidance* may also explain how self-compassion works in therapy. For example, posttraumatic stress disorder is maintained by avoiding traumatic memories (Marx & Sloan, 2005) and self-compassion helps people acknowledge and accept their traumatic memories (Thompson & Waltz, 2008). At the simplest level, self-compassion may work by *classical counterconditioning.* When we pair a distress state with a compassion state (such as writing a compassionate letter to oneself), the distress state becomes more tolerable (Shaw & Kelly, 2024). Overall, the research on mechanisms of change suggests that when a client feels safe and supported, positive change can occur. This view overlaps with the research on the importance of empathy and positive regard in successful therapy.

Conclusion

In conclusion, current research demonstrates that self-compassion is good for mental health and self-compassion can be learned in therapy. The self-compassion-based psychotherapy model is embedded in the mindfulness-, acceptance-, and compassion-based model of therapy, but it is uniquely focused on helping clients cultivate a kind and supportive relationship with *themselves* in the midst of psychological suffering. Clients can learn self-compassion from the therapist's compassionate presence, the therapy relationship, and home practices, depending on the client's needs and the orientation of the therapist. An important foundation for doing this type of clinical work is a personal self-compassion practice. Self-compassion appears to work by enhancing emotion regulation through a variety of psychological and neurophysiological processes. Important areas for future research include (1) well-controlled studies of therapies specifically designed to enhance self-compassion in clients, (2) outcome research on

individual self-compassion practices, and (3) mechanisms of change in specific psychological conditions and populations. Although there is still much to be learned, therapists should feel emboldened by our current level of understanding to explore innovative ways of integrating self-compassion into therapy.

REFERENCES

Baumgardner, M., & Benoit, A. (2024). Integrating cognitive-behavioral therapy with compassion-focused therapy for the treatment of social anxiety disorder: An evidence-based case study. *Clinical Case Studies, 23*(2), 127–145.

Bibeau, M., Dionne, F., & Leblanc, J. (2016). Can compassion meditation contribute to the development of psychotherapists' empathy? A review. *Mindfulness, 7*(1), 255–263.

Birnie, K., Speca, M., & Carlson, L. E. (2010). Exploring self-compassion and empathy in the context of mindfulness-based stress reduction (MBSR). *Stress and Health, 26*(5), 359–371.

Boswell, J. F., Sharpless, B. A., Greenberg, L. S., Heatherington, L., Huppert, J. D., Barber, J. P., et al. (2010). Schools of psychotherapy and the beginnings of a scientific approach. In D. H. Barlow (Ed.), *The Oxford handbook of clinical psychology* (pp. 98–127). Oxford Academic.

Bourgault, M., & Dionne, F. (2019). Therapeutic presence and mindfulness: Mediating role of self-compassion and psychological distress among psychologists. *Mindfulness, 10*(4), 650–656.

Braun, T. D., Park, C. L., & Gorin, A. (2016). Self-compassion, body image, and disordered eating: A review of the literature. *Body Image, 17*, 117–131.

Breines, J. G., McInnis, C. M., Kuras, Y. I., Thoma, M. V., Gianferante, D., Hanlin, L., et al. (2015). Self-compassionate young adults show lower salivary alpha-amylase responses to repeated psychosocial stress. *Self and Identity, 14*(4), 390–402.

Cha, J. E., Serlachius, A. S., Kirby, J. N., & Consedine, N. S. (2023). What do (and don't) we know about self-compassion? Trends and issues in theory, mechanisms, and outcomes. *Mindfulness, 14*(11), 2657–2669.

Craig, C., Hiskey, S., & Spector, A. (2020). Compassion focused therapy: A systematic review of its effectiveness and acceptability in clinical populations. *Expert Review of Neurotherapeutics, 20*(4), 385–400.

Cuppage, J., Baird, K., Gibson, J., Booth, R., & Hevey, D. (2018). Compassion focused therapy: Exploring the effectiveness with a transdiagnostic group and potential processes of change. *British Journal of Clinical Psychology, 57*(2), 240–254.

Døssing, M., Nilsson, K. K., Svejstrup, S. R., Sørensen, V. V., Straarup, K. N., & Hansen, T. B. (2015). Low self-compassion in patients with bipolar disorder. *Comprehensive Psychiatry, 60*, 53–58.

Dreisoerner, A., Junker, N. M., Schlotz, W., Heimrich, J., Bloemeke, S., Ditzen, B., & van Dick, R. (2021). Self-soothing touch and being hugged reduce cortisol

responses to stress: A randomized controlled trial on stress, physical touch, and social identity. *Comprehensive Psychoneuroendocrinology, 8*, 100091.

Dreisoerner, A., Junker, N. M., & van Dick, R. (2021). The relationship among the components of self-compassion: A pilot study using a compassionate writing intervention to enhance self-kindness, common humanity, and mindfulness. *Journal of Happiness Studies, 22*, 21–47.

Eicher, A. C., Davis, L. W., & Lysaker, P. H. (2013). Self-compassion: A novel link with symptoms in schizophrenia? *Journal of Nervous and Mental Disease, 201*(5), 389–393.

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*(1), 43–49.

Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy, 55*(4), 399–410.

Ewert, C., Vater, A., & Schröder-Abé, M. (2021). Self-compassion and coping: A meta-analysis. *Mindfulness, 12*, 1063–1077.

Ferrari, M., Hunt, C., Harrysunker, A., Abbott, M. J., Beath, A. P., & Einstein, D. A. (2019). Self-compassion interventions and psychosocial outcomes: A meta-analysis of RCTs. *Mindfulness, 10*(8), 1455–1473.

Friis, A. M., Johnson, M. H., Cutfield, R. G., & Consedine, N. S. (2016). Kindness matters: A randomized controlled trial of a mindful self-compassion intervention improves depression, distress, and HbA1c among patients with diabetes. *Diabetes Care, 39*(11), 1963–1971.

Geller, S. M. (2017). *A practical guide to cultivating therapeutic presence*. American Psychological Association.

Germer, C. (2023). Self-compassion in psychotherapy: Clinical integration, evidence base, and mechanisms of change. In A. Finlay-Jones, K. Bluth, & K. Neff (Eds.), *Handbook of self-compassion* (pp. 379–415). Springer International.

Germer, C., & Neff, K. (2019). *Teaching the mindful self-compassion program: A guide for professionals*. Guilford Press.

Germer, C., Siegel, R. D., & Fulton, P. R. (Eds.). (2016). *Mindfulness and psychotherapy*. Guilford Press.

Germer, C. K., & Siegel, R. D. (Eds.). (2012). *Wisdom and compassion in psychotherapy: Deepening mindfulness in clinical practice*. Guilford Press.

Gernert, C. C., Nelson, A., Falkai, P., & Falter-Wagner, C. M. (2023). Synchrony in psychotherapy: High physiological positive concordance predicts symptom reduction and negative concordance predicts symptom aggravation. *International Journal of Methods in Psychiatric Research, 33*(1), e1978.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Routledge.

Goetz, J. L., Keltner, D., & Simon-Thomas, E. (2010). Compassion: An evolutionary analysis and empirical review. *Psychological Bulletin, 136*(3), 351–374.

Golden, H. L., Vosper, J., Kingston, J., & Ellett, L. (2021). The impact of mindfulness-based programmes on self-compassion in nonclinical populations: A systematic review and meta-analysis. *Mindfulness, 12*, 29–52.

Goldin, P. R., & Jazaieri, H. (2017). The compassion cultivation training (CCT) program. In E. M. Seppala, S. Simon-Thomas, S. L. Brown, M. C. Worline, C. D. Cameron, & J. R. Doty (Eds.), *The Oxford handbook of compassion science* (pp. 237–246). Oxford University Press.

Greenberg, L. (2006). Emotion-focused therapy: A synopsis. *Journal of Contemporary Psychotherapy, 36*(2), 87–93.

Guan, F., Liu, G., Pedersen, W. S., Chen, O., Zhao, S., Sui, J., & Peng, K. (2021). Neurostructural correlates of dispositional self-compassion. *Neuropsychologia, 160*, 107978.

Han, A., & Kim, T. H. (2023). Effects of self-compassion interventions on reducing depressive symptoms, anxiety, and stress: A meta-analysis. *Mindfulness, 5*, 1–29.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change*. Guilford Press.

Hoge, E. A., Hölzel, B. K., Marques, L., Metcalf, C. A., Brach, N., Lazar, S. W., & Simon, N. M. (2013). Mindfulness and self-compassion in generalized anxiety disorder: Examining predictors of disability. *Evidence-Based Complementary and Alternative Medicine, 576258*.

Hu, Y., Cheng, X., Pan, Y., & Hu, Y. (2022). The intrapersonal and interpersonal consequences of interpersonal synchrony. *Acta Psychologica, 224*, 103513.

Inwood, E., & Ferrari, M. (2018). Mechanisms of change in the relationship between self-compassion, emotion regulation, and mental health: A systematic review. *Applied Psychology: Health and Well-Being, 10*(2), 215–235.

Irons, C., & Beaumont, E. (2017). *The compassionate mind workbook: A step-by-step guide to developing your compassionate self*. Robinson.

Javidi, Z., Prior, K. N., Sloan, T. L., & Bond, M. J. (2023). A randomized controlled trial of self-compassion versus cognitive therapy for complex psychopathologies. *Current Psychology, 42*(2), 946–954.

Jazaieri, H., McGonigal, K., Jinpa, T., Doty, J. R., Gross, J. J., & Goldin, P. R. (2014). A randomized controlled trial of compassion cultivation training: Effects on mindfulness, affect, and emotion regulation. *Motivation and Emotion, 38*(1), 23–35.

Joeng, J. R., Turner, S. L., Kim, E. Y., Choi, S. A., Lee, Y. J., & Kim, J. K. (2017). Insecure attachment and emotional distress: Fear of self-compassion and self-compassion as mediators. *Personality and Individual Differences, 112*, 6–11.

Kelly, A. C., Carter, J. C., & Borairi, S. (2014). Are improvements in shame and self-compassion early in eating disorders treatment associated with better patient outcomes? *International Journal of Eating Disorders, 47*(1), 54–64.

Kilner, J. M., & Lemon, R. N. (2013). What we know currently about mirror neurons. *Current Biology, 23*(23), R1057–R1062.

Kirby, J. N., Tellegen, C. L., & Steindl, S. R. (2017). A meta-analysis of compassion-based interventions: Current state of knowledge and future directions. *Behavior Therapy, 48*(6), 778–792.

Koole, S. L., & Tschacher, W. (2016). Synchrony in psychotherapy: A review and an integrative framework for the therapeutic alliance. *Frontiers in Psychology, 7*, 862.

Krieger, T., Altenstein, D., Baettig, I., Doerig, N., & Holtforth, M. G. (2013). Self-compassion in depression: Associations with depressive symptoms, rumination, and avoidance in depressed outpatients. *Behavior Therapy, 44*(3), 501–513.

Kuyken, W., Watkins, E., Holden, E., White, K., Taylor, R. S., Byford, S., et al. (2010). How does mindfulness-based cognitive therapy work? *Behaviour Research and Therapy, 48*(11), 1105–1112.

Lambert, M., & Ogles, B. (2004). The efficacy and effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 139–193). Wiley.

Lazar, S. W., Kerr, C. E., Wasserman, R. H., Gray, J. R., Greve, D. N., Treadway, M. T., et al. (2005). Meditation experience is associated with increased cortical thickness. *Neuroreport, 16*(17), 1893–1897.

Lecchi, T., da Silva, K., Giommi, F., & Leong, V. (2019). Using dual-EEG to explore therapist–client interpersonal neural synchrony. *Frontiers in Psychiatry,* 1–15.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder.* Guilford Press.

López, A., Sanderman, R., Ranchor, A. V., & Schroevers, M. J. (2018). Compassion for others and self-compassion: Levels, correlates, and relationship with psychological well-being. *Mindfulness, 9*, 325–331.

Lv, J., Jiang, Y., Li, R., Chen, Y., Gu, X., Zhou, J., et al. (2023). Effects of loving-kindness and compassion meditations on self-compassion: A systematic review and meta-analysis. *Clinical Psychology: Science and Practice, 31*(1), 19–35.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*(6), 545–552.

Mackintosh, K., Power, K., Schwannauer, M., & Chan, S. W. (2018). The relationships between self-compassion, attachment, and interpersonal problems in clinical patients with mixed anxiety and depression, and emotional distress. *Mindfulness, 9*(3), 961–971.

Maner, S., Morris, P. G., & Flewitt, B. I. (2023). A systematic review of the effectiveness of compassion focused imagery in improving psychological outcomes in clinical and non-clinical adult populations. *Clinical Psychology and Psychotherapy, 30*(2), 250–269.

Marsh, I. C., Chan, S. W., & MacBeth, A. (2018). Self-compassion and psychological distress in adolescents—a meta-analysis. *Mindfulness, 9*, 1011–1027.

Marx, B. P., & Sloan, D. M. (2005). Peritraumatic dissociation and experiential avoidance as predictors of posttraumatic stress symptomatology. *Behaviour Research and Therapy, 43*(5), 569–583.

Millard, L. A., Wan, M. W., Smith, D. M., & Wittkowski, A. (2023). The effectiveness of compassion focused therapy with clinical populations: A systematic review and meta-analysis. *Journal of Affective Disorders, 326*, 168–192.

Neff, K. D. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*(3), 223–250.

Neff, K. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*(2), 85–101.

Neff, K. D. (2023). Self-compassion: Theory, method, research, and intervention. *Annual Review of Psychology, 74*, 193–218.

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*(1), 28–44.

Neff, K., & Germer, C. (2018). *The mindful self-compassion workbook: A proven way to accept yourself, build inner strength, and thrive*. Guilford Press.

Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality, 41*(1), 139–154.

Parrish, M. H., Inagaki, T. K., Muscatell, K. A., Haltom, K. E., Leary, M. R., & Eisenberger, N. I. (2018). Self-compassion and responses to negative social feedback: The role of fronto-amygdala circuit connectivity. *Self and Identity, 17*(6), 723–738.

Paucsik, M., Nardelli, C., Bortolon, C., Shankland, R., Leys, C., & Baeyens, C. (2023). Self-compassion and emotion regulation: Testing a mediation model. *Cognition and Emotion, 37*(1), 49–61.

Petrocchi, N., Ottaviani, C., & Couyoumdjian, A. (2017). Compassion at the mirror: Exposure to a mirror increases the efficacy of a self-compassion manipulation in enhancing soothing positive affect and heart rate variability. *Journal of Positive Psychology, 12*(6), 525–536.

Phelps, C. L., Paniagua, S. M., Willcockson, I. U., & Potter, J. S. (2018). The relationship between self-compassion and the risk for substance use disorder. *Drug and Alcohol Dependence, 183*, 78–81.

Proeve, M., Anton, R., & Kenny, M. (2018). Effects of mindfulness-based cognitive therapy on shame, self-compassion and psychological distress in anxious and depressed patients: A pilot study. *Psychology and Psychotherapy: Theory, Research and Practice, 91*(4), 434–449.

Ramseyer, F., & Tschacher, W. (2011). Nonverbal synchrony in psychotherapy: Coordinated body movement reflects relationship quality and outcome. *Journal of Consulting and Clinical Psychology, 79*(3), 284–295.

Reilly, E. B., & Stuyvenberg, C. L. (2023). A meta-analysis of loving-kindness meditations on self-compassion. *Mindfulness, 14*(10), 2299–2310.

Robins, C. J., Schmidt, H., III, & Linehan, M. M. (2004). Dialectical behavior therapy: Synthesizing radical acceptance with skillful means. In S. Hayes, V. Follette, & M. Linehan (Eds.), *Mindfulness and acceptance* (pp. 30–44). Guilford Press.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and theory, with chapters*. Houghton Mifflin.

Rogers, C. (1995). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin. (Original work published 1961)

Schanche, E., Stiles, T. C., McCullough, L., Svartberg, M., & Nielsen, G. H. (2011). The relationship between activating affects, inhibitory affects, and self-compassion in patients with Cluster C personality disorders. *Psychotherapy, 48*(3), 293–303.

Schwartz, R. C., & Sweezy, M. (2019). *Internal family systems therapy* (2nd ed.). Guilford Press.

Segal, Z., Williams, M., & Teasdale, J. (2018). *Mindfulness-based cognitive therapy for depression*. Guilford Press.

Shaw, J., & Kelly, A. (2024). How exposure to personal distress with and without self-compassion affects distress tolerance: Results from a two-sample randomized trial. *Mindfulness, 15*, 570–585.

Siegel, D. J. (2010). *Mindsight: The new science of personal transformation*. Bantam.

Singer, T., & Klimecki, O. M. (2014). Empathy and compassion. *Current Biology, 24*(18), R875–R878.

Thompson, B. L., & Waltz, J. (2008). Self-compassion and PTSD symptom severity. *Journal of Traumatic Stress, 21*(6), 556–558.

Valdesolo, P., & DeSteno, D. (2011). Synchrony and the social tuning of compassion. *Emotion, 11*(2), 262–266.

Valk, S. L., Bernhardt, B. C., Trautwein, F.-M., Böckler, A., Kanske, P., Guizard, N., et al. (2017). Structural plasticity of the social brain: Differential change after socio-affective and cognitive mental training. *Science Advances, 3*(10), e1700489.

Wadsworth, L. P., Forgeard, M., Hsu, K. J., Kertz, S., Treadway, M., & Björgvinsson, T. (2018). Examining the role of repetitive negative thinking in relations between positive and negative aspects of self-compassion and symptom improvement during intensive treatment. *Cognitive Therapy and Research, 42*(3), 236–249.

Wetterneck, C. T., Lee, E. B., Smith, A. H., & Hart, J. M. (2013). Courage, self-compassion, and values in obsessive–compulsive disorder. *Journal of Contextual Behavioral Science, 2*(3–4), 68–73.

Williams, J. C., & Lynn, S. J. (2010). Acceptance: An historical and conceptual review. *Imagination, Cognition and Personality, 30*(1), 5–56.

Winders, S. J., Murphy, O., Looney, K., & O'Reilly, G. (2020). Self-compassion, trauma, and posttraumatic stress disorder: A systematic review. *Clinical Psychology and Psychotherapy, 27*(3), 300–329.

Yela, J. R., Gómez-Martínez, M. Á., Crego, A., & Jiménez, L. (2020). Effects of the mindful self-compassion programme on clinical and health psychology trainees' well-being: A pilot study. *Clinical Psychologist, 24*(1), 41–54.