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Enhancement of self compassion in psychotherapy: The role of therapists' interventions

LIOR GALILI-WEINSTOCK ⦿, ROEI CHEN, DANA ATZIL-SLONIM,
ESHKOL RAFAELI, & TUVIA PERI

Department of Psychology, Bar-Ilan University, Ramat Gan, Israel

Abstract

Aim: Self Compassion (SC) has been consistently linked to decreased emotional distress and is offered as a mechanism of change in several therapeutic approaches. The current study aimed to identify therapists' interventions that enhance clients' SC within individual psychodynamic psychotherapy. We examined a diverse set of interventions as predictors of clients' SC, on treatment and session levels. We hypothesized that improvement in SC will be associated with greater use of *directive* or *common factor* interventions. *Method*: Client/therapist ($N = 89$) dyads from a university-based community clinic participated in the study. Therapists' interventions and changes in clients' SC level were monitored at each psychotherapy session. *Results:* Clients' SC in a given session was not predicted by therapist use of interventions from any of the three clusters in the previous session. However, positive change in SC across treatment was predicted by greater use of directive interventions. Furthermore, among clients with low pretreatment SC, a positive change in SC across treatment was predicted by lesser use of common factor interventions. *Discussion:* The results highlight the importance of understanding clients' pretreatment characteristics when selecting therapeutic interventions and suggest that the integration of directive interventions into the psychodynamic therapeutic practice may be beneficial in enhancing clients' SC.

Keywords: psychoanalytic/psychodynamic therapy; integrative treatment models

Clinical or methodological significance of this article: The current study takes an important step towards integrating the study of SC into the field of psychotherapy research, in an effort to understand what therapist interventions may enhance clients' SC. In terms of the clinical implications, our results may imply that SC develop gradually over the course of therapy, unfolding over time rather than changing rapidly as a function of any particular session. Furthermore, our results suggest that the integration of directive interventions into the more traditional psychodynamic therapeutic framework may be useful in enhancing clients' SC. Finally, our results highlight the importance of understanding clients' pre-treatment characteristics—namely, their SC (or conversely, self-criticism and shame) levels—when devising a therapeutic strategy.

The concept of self-compassion (SC), originally rooted in Buddhist philosophy, has gradually made its way into the mainstream of Western psychology. Over the last two decades, numerous studies have revealed the psychological benefits of being self-compassionate, and have linked SC to increased levels of wellbeing and decreased levels of distress and psychopathology (for meta-anlyses, see MacBeth & Gumley, 2012; Zessin, Dickhäuser, & Garbade, 2015). The literature has described SC as a trait, a psychological process, or a skill (Barnard & Curry, 2011), and growing evidence suggests that SC may be learned through deliberate practice and developed over time (Germer & Neff, 2013; Gilbert & Procter, 2006; Neff & Germer, 2013a). Within psychotherapy research, several pilot studies have demonstrated increases in clients' SC levels following SC-enhancement group interventions (Gilbert & Procter, 2006; Neff & Germer, 2013). However, the question of how SC may be cultivated within treatments that are not explicitly focused on this construct is yet to receive research attention. Thus, the aim of the current study is to explore the ways in which clients' SC

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*Correspondence concerning this article should be addressed to Lior Galili-Weinstock, Department of Psychology, Bar-Ilan University, Ramat Gan, Israel. Email: galili.lior@gmail.com

may be enhanced within the process of individual psychotherapy.

Most SC studies have been inspired by the work of Neff (e.g., 2003a) and Gilbert (e.g., 2010). According to Neff (2003a), SC is comprised of three elements: (1) self-kindness (vs. self-judgement), which involves the ability to treat oneself with understanding and avoid maladaptive self-criticism; (2) common humanity (vs. isolation), which involves the recognition that imperfections, failures, and inadequacies are experiences shared by all human beings; and (3) mindfulness (vs. over identification and rumination), which involves the acceptance and awareness of present-moment mental states without over-involvement with the experience. Gilbert (2009, 2010), discussing SC from an evolutionary perspective, described it as a motivational system designed to self-regulate negative emotions. He defined SC as the sensitivity to one own suffering, which leads to committed action aimed to prevent and alleviate it.

Research on SC has mostly focused on its psychological and behavioral correlates in nonclinical populations (cf., Zessin et al., 2015). SC has been found to be positively associated with happiness, increased life satisfaction, personal initiative, and social connectedness (Neff, 2003b; Neff, Kirkpatrick, & Rude, 2007; Neff, Pisitsungkagarn, & Hsieh, 2008). Individuals with higher SC have been shown to manage negative emotions better (Vettese, Dyer, Li, & Wekerle, 2011), and to experience decreased levels of stress, rumination, depression, and procrastination (MacBeth & Gumley, 2012; Raes, 2010; Samaie & Farahani, 2011; Sirois, 2014).

Recently, a growing number of studies have begun examining SC in clinical populations. As a general rule, SC has been found to be lower in clinical (vs. non-clinical) samples (e.g., Costa, Marôco, Pinto-Gouveia, Ferreira, & Castilho, 2016; Roemer et al., 2009; Vettese et al., 2011), and to be negatively associated with symptomatic distress (Ferreira, Matos, Duarte, & Pinto-Gouveia, 2014; Galili-Weinstock et al., 2018; Harwood & Kocovski, 2017; Hayes, Lockard, Janis, & Locke, 2016; Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013).

In light of these findings, psychotherapy researchers have started to search for specific interventions that promote SC. Several short-term programs have emerged which focus explicitly on reducing self-criticism and enhancing SC with its component skills (e.g., Gilbert, 2009; Neff & Germer, 2013). These programs utilize a diverse set of interventions including psychoeducation, guided imagery (Gilbert, 2009, 2010), mindfulness and loving-kindness meditation, writing tasks, and informal practices such as repeating a set of memorized self-compassionate phrases

(Germer & Neff, 2013). More recently, some of these interventions have been adjusted to create an online self-guided SC cultivation program (Finlay-Jones, Kane, & Rees, 2017). Preliminary evidence suggests that, following these interventions, participants show an increase in SC levels (Finlay-Jones et al., 2017; Neff & Germer, 2013a), reduced levels of self-criticism and shame, and increased ability for self-soothing and self-reassurance (Gilbert & Procter, 2006; Lucre & Corten, 2013).

The construct of SC as a whole as well as its components accord with various therapeutic approaches that are not explicitly focused on this construct. Specifically, the phenomena of self-criticism and perfectionism, which have been conceptualized as antonymous to the self-kindness component of SC (Neff, 2003a), have been identified as transdiagnostic targets for treatment in several different therapeutic models (for a recent review see Werner, Tibubos, Rohrmann, & Reiss, 2019). Within the experiential tradition, emotion focused therapy, and schema therapy are two contemporary therapies which emphasize the importance of working with patients' self-criticism (Greenberg & Watson, 2006; Young, Klosko, & Weishaar, 2003). Both therapies conceptualize self-criticism as a split between distinct aspects of the self, where one part harshly criticizes, evaluates, and blocks the experiences and healthy needs of another, more vulnerable part. In both therapies, two-chair techniques are used to express emotions and needs associated with each part of the self. Two studies found that a short intervention based on the two-chair task was associated with significant increases in SC and self-reassurance, and with a significant reductions in self-criticism, depressive, and anxiety symptoms (Neff et al., 2007; Shahar et al., 2012)

Within the psychodynamic tradition, several authors have recognized the therapeutic value of reducing the harshness of patients' super ego (for a review see Goldblatt, Herbstman, & Maltsberger, 2014). Within this theoretical framework, self-criticism (and in extreme cases, self-hatred) is often conceptualized in the context of an internalized parent–child relationship or traumatic childhood experiences (e.g., Aronfreed, 1964; Scharff & Tsigounis, 2003). Blatt (1974, 1995) described self-criticism as a dimension of psychological vulnerability, characterized by a sense of failure to fulfill one's (internalized) standards and by feelings of inferiority and guilt. He suggested that one of the primary tasks in treating self-critical individual is to help them relinquish the identification with judgmental parental figures and to establish new identifications and self-definitions (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982). Shahar (2001, 2013) developed an integrative

model for treating self-critical individuals in which he implements interventions such as the analysis of multiple-selves (or inner voices) and behavioral activation. Importantly, in all of these psychodynamic models, the therapeutic relationship has been offered to drive therapeutic change by allowing the client to internalize the non-critical values of the therapist (e.g., Blatt, 1995; Hoffman, 1994; Shahar, 2013).

To date, two studies have examined SC in the context of psychodynamic therapies (Galili-Weinstock et al., 2018; Schanche, Stiles, Mccullough, Svartberg, & Nielsen, 2011) and found that improvements in clients' SC levels during psychotherapy were tied to positive therapeutic outcomes such as reduced symptomatology and improved functioning. These results support the possibility that SC is a mechanism of change in psychodynamic therapy and highlight its importance to therapy outcomes. However, empirical examination of therapeutic interventions that are effective in enhancing clients' SC is scarce.

A few authors have published case studies in which they described their work with self-critical individuals and attempted to identify interventions useful in enhancing these individuals' SC (Layne, Porcerelli, & Shahar, 2006; Schanche, 2013). The interventions described were drawn from different therapeutic approaches (such as cognitive behavioral and affect phobia therapies) and were generally directive. Specific interventions included ones proactively addressing clients' self-hatred or consistently challenging self-critical beliefs (Layne et al., 2006), as well as gradually exposing clients to their avoided affect or establishing a compassionate inner dialogue using imagery of a compassionate other (Schanche, 2013).

Alongside these directive interventions, the case studies also suggested that the development of a strong therapeutic alliance may engender greater SC. Specifically, therapists' supportive attitudes toward their clients, as well as their focus on clients' efforts and strengths, were conceptualized to be models for a warm and supportive stance which could be internalized by the client (Layne et al., 2006).

In our view, the extant literature suggests that SC is a robust predictor of psychological health, and that it may be responsive to therapeutic interventions. Given its importance, we see a need to better understand what therapist interventions enhance client SC. Previous studies addressing this question have mostly focused on the circumscribed context of SC-enhancement group protocols or were limited to single-case case studies. In contrast, the current study aimed to identify therapists' interventions that enhance clients' SC within individual psychodynamic psychotherapy. Going beyond a single-case methodology, it examined a diverse set of interventions as

predictors of SC within a large sample of clients and therapists. Additionally, in line with current understanding regarding the importance of personalized therapy (e.g., Zilcha-Mano, 2019), we examined the role of clients' pretreatment characteristics, namely, their pretreatment SC levels, as a moderator of these interventions' effects.

To explore these questions, we monitored therapists' interventions, as well as changes in clients' SC level, at each psychotherapy session over the course of time-limited psychodynamic therapy. We used a measure that assesses various types of interventions from different therapeutic approaches (rather than one assessing only psychodynamic interventions) because of the growing evidence that therapists typically use a broad range of interventions, even within a single session (McCarthy & Barber, 2009; Thoma & Cecero, 2009). Furthermore, in line with the "smuggling hypothesis" (Ablon & Jones, 1998), previous studies have demonstrated that psychodynamic therapists tend to borrow and apply prototypical cognitive–behavioral interventions and techniques; this borrowing phenomenon has been found among both experienced and trainee psychodynamic clinicians (Ablon, Levy, & Katzenstein, 2006; Samstag & Norlander, 2019). We followed previous studies (McAleavey & Castonguay, 2014; Solomonov, Kuprian, Zilcha-Mano, Gorman, & Barber, 2016) and aggregated therapists' self-reported use of interventions to create three broad clusters of techniques: Directive, Exploratory, and Common Factors (CF) interventions. The Directive cluster included interventions drawn from cognitive, behavioral, and dialectic-behavioral therapy (e.g., "I set an agenda or established specific goals for the therapy session"). The Exploratory cluster included interventions drawn from psychodynamic and process-experiential therapy (e.g., "I encouraged the client to talk about feelings he/she had previously avoided or never expressed"). Finally, the CF cluster included interventions common across different approaches, mainly ones focused on the client-therapist relationship (e.g., "I was warm, sympathetic, and accepting").

Based on previous studies, which have identified a diverse set of interventions that promote clients' SC, and found those drawn from the Directive and the CF clusters to be most relevant, (e.g., Layne et al., 2006; Shahar, 2013), we generated the following hypotheses: (1) Greater use of Directive or CF interventions in a given session will be associated with improved client SC in the following session (*the session level hypothesis*); (2) Greater use of Directive or CF interventions throughout treatment will be associated with greater improvement in client SC from pre- to post-treatment (*the treatment level hypothesis*). We expected these associations to be stronger

among clients with low levels of pretreatment SC, for whom there is more room for improvement. Importantly, change in clients' SC was hypothesized to emerge above and beyond the impact of two session-level factors: the client's ratings of therapeutic alliance and of functioning. The former is a well-established and robust predictor of treatment outcomes (for a meta-analytic review see Flückiger, Del Re, Wampold, & Horvath, 2018). The latter is considered to be a session-level outcome, and has a strong association with SC level (Galili-Weinstock et al., 2018).

Method

Participants and Treatment

Clients. The participants ($N = 89$) were adults who received psychotherapy at a major university outpatient clinic. All clients were at least 18 years old ($M = 39.7$ years, $SD = 13.9$, age range 19–70 years), and the majority were female (59.6%). Most (63%) were single, divorced, or widowed, whereas 37% were married or in a permanent relationship. In addition, 56.2% had at least a bachelor's degree, and 82% were employed full or part time.

Clients' diagnoses were established based on the Mini International Neuropsychiatric Diagnostic Interview for Axis I DSM-IV diagnoses (MINI 5.0; Sheehan et al., 1998). The MINI 5.0 was administered in the intake meeting, which was conducted by trained psychologists who received weekly group supervision by a senior clinician (TP). All intake sessions were audiotaped, and a random 25% of the interviews were sampled and rated again by an independent clinician (LGW). The mean kappa values of the Axis I diagnoses was excellent ($k = 0.97$). Moderate inter-rater agreement was found for major depressive disorder ($k = 0.76$) and generalized anxiety disorder ($k = 0.77$), whereas excellent agreement was found for all other disorders.

Of our total sample, 43.8% of the clients had a single diagnosis, 10.2% had two diagnoses, and 11.2% had three or more diagnoses. The most common diagnoses were anxiety (25.8%) and affective disorders (15.7%), followed by comorbid anxiety and affective disorders (9%), comorbid anxiety disorders (3.4%) other comorbid disorders (including addiction, eating disorder etc.; 9%) and obsessive-compulsive disorder (2%).[1] A sizable group of clients (34.8%) reported experiencing relationship concerns, academic/occupational stress, or other problems, but did not meet criteria for Axis I diagnosis.

Of the 115 clients who began the study, 15 (13%) dropped out of therapy for various reasons (such as change in residence, or difficulties with taking time off work), and 6 (5.2%) did not complete the session-by-session questionnaires. Five additional clients (3.4%) were not included in the analysis since their therapist did not consent. Thus, our session-by-session analyses used data from 89 client/therapist pairs.

Therapists. The participating clients were assigned to therapists in an ecologically valid manner based on real-world issues such as therapist availability and caseload. The clients were treated by 58 therapists in different stages of clinical training, ranging from year 2 to year 5 within a clinical training program. Most ($N = 32$) therapists treated one client each, 19 treated two clients each, and 5 treated 3–4 clients each. The therapists were unaware of the study hypotheses. Each therapist received one hour of individual supervision and four hours of group supervision on a weekly basis. All therapy sessions were audiotaped for use in supervision with senior clinicians.

Individual psychotherapy consisted of once- or twice-weekly sessions of (primarily psychodynamic) psychotherapy, organized, aided, and informed (but not prescribed) by a short-term psychodynamic psychotherapy treatment model (Blagys & Hilsenroth, 2000; Shedler, 2010). The key features of this model include (1) a focus on affect and the experience and expression of emotions, (2) exploration of attempts to avoid distressing thoughts and feelings, (3) identification of recurring themes and patterns, (4) emphasis on past experiences, (5) focus on interpersonal experiences, (6) emphasis on the therapeutic relationship and (7) exploration of wishes, dreams, or fantasies. Moreover, as part of the clinic training program, therapists were introduced to additional therapeutic models (including cognitive behavioral therapy and schema therapy; Beck, 1976; Young, Klosko, & Wieshhar, 2003).

Treatment was open ended; however, given the constraints of the university-based outpatient community clinic, which operates on an academic schedule, treatment length was often limited to 9–12 months. The mean treatment length was 23.8 sessions ($SD = 9.6$, range = 6–70). A total of 2024 sessions were available for analysis.

Measures

Pretreatment Characteristics
Self-compassion scale (SCS; Neff, 2003b). This 26-item scale assesses six different aspects of SC. Three of these aspects are positive: (a) self-kindness (e.g., "I try to be understanding and patient towards those aspects of my personality I don't like"), (b) common humanity (e.g., "When I'm

down and out, I remind myself that there are lots of other people in the world feeling like I am"), and (c) mindfulness (e.g., "When something painful happens I try to take a balanced view of the situation"). The other three aspects are negative: (d) self-judgment (e.g., "I'm disapproving and judgmental about my own flaws and inadequacies"), (e) isolation (e.g., "When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world"), and (f) over-identification (e.g., "When I'm feeling down I tend to obsess and fixate on everything that's wrong"). These negative aspects are reverse coded. Responses to all items are given on a 5-point scale ranging from "Almost never" to "Almost always."

The SCS has demonstrated predictive, convergent, and discriminant validity (Neff, 2003b). An appropriate factor structure was found in a nonclinical English speakers sample, with a single overarching factor of "self-compassion" accounting for inter-correlations among the six subscales (Neff, 2003b). However, the generalizability of this factor structure across various populations and languages has been called into question (e.g., Hayes et al., 2016). While the majority of studies have replicated the six-factor structure of the scale (e.g, Arimitsu, 2014; Azizi, Mohammadkhani, Foroughi, Lotfi, & Bahramkhani, 2013; Castilho, Pinto-Gouveia, & Duarte, 2015; Garcia-Campayo et al., 2014), inconsistent findings were found regarding the higher order factor. While such an over-arching factor was found with a Chinese student sample and with Portuguese clinical and community samples (Castilho et al., 2015; Chen, Yan, & Zhou, 2011) it was not found with German and Italian student and community samples (Hupfeld & Ruffieux, 2011; Petrocchi, Ottaviani, & Couyoumdjian, 2014) nor in a second Portuguese clinical sample (Costa, Marôco, Pinto-Gouveia, Ferreira, & Castilho, 2016). In the present sample, the internal consistency of the full scale was high (α = .91).

Session-Level Measures

Session-level self-compassion index. To monitor changes in patients' SC levels from session to session, we used the SC- index (Galili-Weinstock et al., 2018) a short form based on the SCS (Neff, 2003b), with three items, each representing a different positive subscale of SC: (a) self-kindness ("When I had a hard time, I gave myself the caring and tenderness I needed"), (b) common humanity ("I tried to see my failings as part of the human condition"), and (c) mindfulness ("When something upset me I tried to keep my emotions in balance"). Clients were asked to rate each statement on a 5-point scale ranging from "Almost never" to "Almost always" with regards to the previous week. The between- and within-person reliabilities for the scale were computed using procedures outlined by Shrout and Lane (2012; See also Cranford et al., 2006), and these values were 0.79 and 0.77, respectively.

Outcome rating scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003). The ORS is a four-item visual analog scale developed as a brief alternative to the OQ-45 (Outcome Questionnaire 45; Lambert et al., 1996). Three of its items assess changes in areas of client functioning that are widely considered valid indicators of progress in treatment: individual (or symptomatic) functioning, interpersonal relationships, and social role performance (work adjustment and quality of life). An additional item assesses overall functioning. The visual analog scale is anchored at one end by the word *Low* and at the other end by the word *High*, which are converted into scores from 0 to 10 and then summed to a total score ranging from 0 to 40, with higher scores indicating better functioning. The ORS has demonstrated good reliability within a wide range of clinical settings and treatment modalities (e.g., Campbell & Hemsley, 2009; Duncan et al., 2003; Quirk, Miller, Duncan, & Owen, 2013; Reese, Norsworthy, & Rowlands, 2009; Schuman, Slone, Reese, & Duncan, 2015). Significant correlations (.50 to .83) were found between the ORS and other measures of psychological well-being/distress, such as the OQ-45, SCL-90, BDI, and CORE (Bringhurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Duncan et al., 2003; Janse, De Jong, Van Dijk, Hutschemaekers, & Verbraak, 2017; Reese et al., 2009). The reliability levels in the current study were high (within = 0.90, between = 0.96).

Working alliance inventory (WAI-SR; Hatcher & Gillaspy, 2006). The 12-item short form of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is based on Bordin's (1979) tripartite conceptualization of the client–therapist relationship, which includes agreement between the client and therapist on goals, the degree of concordance on tasks, and the strength of the therapeutic bond. Clients were asked to use a 7-point Likert scale to rate how accurately each item describes their current therapy experience. The WAI-SR has good reliability, with alpha coefficients for overall internal reliability ranging from .85 to .95. The reliability estimates of the subscales have also demonstrated fairly high internal consistencies, with

alphas of .82 to .88 on the Task subscale, .82 to .87 on the Goal subscale, and .85 on the Bond subscale. The between- and within-person reliabilities found in our sample were high (within = .91, between = 1.00).

The multitheoretical list of interventions—30 items. (MULTI-30; Solomonov, McCarthy, Gorman, & Barber, 2018), ***Therapists' version.*** The MULTI-30 is a short form of the MULTI (McCarthy & Barber, 2009) which was developed to assess the use of interventions across therapeutic orientations. Therapists rated items on a 5-point Likert scale of 1 (*not typical of the session*) to 5 (*very typical of the session*) based on the intensity and frequency of the use of interventions at the end of each session.

The eight subscales of the MULTI-30 have been found to be reliable and internally consistent (Solomonov et al., 2018). However, due to a need to decrease completion time and participant burden within the session-by-session data collection, we retained only six of the subscales: psychodynamic (e.g., "I made connections between the client's current situation and his/her past"), process-experiential (e.g., "I encouraged the client to focus on his/her moment-to-moment experience."), interpersonal (e.g., " I pointed out recurring themes or problems in the client's relationships"), cognitive–behavioral (e.g., "I set an agenda or established specific goals for the therapy session"), dialectical-behavioral (e.g., "I accepted the client for who he is and encouraged him to change") and common factor (CF; e.g., "I was warm, sympathetic and accepting").

As noted above, we followed previous studies (McAleavey & Castonguay, 2014; Solomonov et al., 2016) and aggregated the administered MULTI-30 items to create three broad clusters of techniques: Directive, Exploratory, and CF interventions. In our data the scores for each cluster ranged from 1–5. Therapists reported using CF-related interventions most ($M = 3.91$, $SD = 0.69$), followed by exploratory interventions ($M = 2.82$ $SD = 0.79$) and lastly, directive ones ($M = 2.6$, $SD = 0.61$). The internal consistency alpha was 0.87 for the directive cluster, 0.90 for the exploratory cluster and 0.82 for the CF cluster.

Procedure

The study was conducted in a university-based outpatient clinic between August 2015 and August 2016. The study procedures were part of the routine monitoring battery in the clinic. Clients and therapists were asked to provide written consent to participate in the voluntary study and were told that they could choose to terminate their participation in the study at any time without jeopardizing their treatment. The study was conducted in compliance with ethical standards and was approved by the university ethical review board.

The SCS questionnaire was administered to clients as part of the intake procedure (i.e., at pretreatment). The session-level questionnaires were completed electronically using computers located in the clinic rooms. Prior to each session, clients completed the session-level SC index and the ORS. Following each session, clients completed the WAI and therapists completed the MULTI.

Statistical Analyses

We used SAS PROC MIXED to estimate a 2-level multilevel model (MLM) for our predictions, as our data had a hierarchical structure. We opted for a 2-level model (sessions nested within clients) rather than a 3-level (session nested within client, nested within therapists) for several reasons.[2]

To test our session-level hypothesis, we examined level-1 (session level) effects of therapist interventions in a specific session (session *s*-1) on clients' SC ratings in the following session (session *s*), and also tested whether this association was moderated by clients' pre-treatment SC scores. To control for the effect of the therapeutic alliance and of clients' level of functioning, we included the previous session's WAI score (from session *s*-1) and the' ORS score (from session *s*) as covariates. Finally, the level-1 equation included the time effect (i.e., session number).

We used the *log* of the time effect to control for the clients' SC development across treatment. We opted for this log-linear (rather the linear) effect of time given previous findings which have suggested that the most rapid response occurs early in therapy (e.g., Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). Additionally, in the current study, the *log* time effect showed a better model fit (-2 *Log* = 2494) than the linear one (-2 *Log* = 2527). All of the level-1 effects were centered on each client's mean to disentangle the level-1 (within clients) from level-2 (client level) effects.

To test our treatment level hypothesis, we examined level-2 (client level) effects of therapist interventions (i.e., average level of interventions across treatment) on clients' SC ratings across treatment and tested whether this association was moderated by clients' pre-treatment SC scores. The inclusion of time effect (at level-1) allowed us to treat level-2 effects as a growth model as we investigated whether these previous effects interacted with time (i.e., rate of change). Moreover, the Level-2 equation

included time as a random effect, as appropriate in growth modeling. Finally, first-order autoregressive structure was imposed on the covariance matrix for the within-person residuals.

Specifically, we estimated the following model:[3]

Level 1: $SC_{sc} = \beta_{0c} + \beta_1 * log\ time + \beta_2 * client\ WAI_{s-1} + \beta_3 * client\ ORS_s + \beta_4 * Exploratory_{s-1} + \beta_5 * Directive_{s-1} + \beta_6 * CF_{s-1} + e_{sc}$.

Level 2: $\beta_{0c} = \gamma_{00} + \gamma_{01} * Pre\text{-}treatment\ SC + \gamma_{02} * Exploratory + \gamma_{03} * Directive + \gamma_{04} * CF + \gamma_{05} * Pre\text{-}treatment\ SC * Exploratory + \gamma_{06} * Pre\text{-}treatment\ SC * Directive + \gamma_{07} * Pre\text{-}treatment\ SC * CF + u_{0c}$;

$\beta_1 = \gamma_{10} + \gamma_{11} * Pre\text{-}treatment\ SC + \gamma_{12} * Exploratory + \gamma_{13} * Directive + \gamma_{14} * CF + \gamma_{15} * Pre\text{-}treatment\ SC * Exploratory + \gamma_{16} * Pre\text{-}treatment\ SC * Directive + \gamma_{17} * Pre\text{-}treatment\ SC * CF + u_{1c}$;

$\beta_2 = \gamma_{20}$;
$\beta_3 = \gamma_{30}$;
$\beta_4 = \gamma_{40} + \gamma_{41} * Pre\text{-}treatment\ SC_{gmc}$;
$\beta_5 = \gamma_{50} + \gamma_{51} * Pre\text{-}treatment\ SC_{gmc}$;
$\beta_6 = \gamma_{60} + \gamma_{61} * Pre\text{-}treatment\ SC_{gmc}$;

Results

Descriptive statistics and zero-order correlations among key study variables are presented in Table I. The results of our session, as well as treatment levels analyses are presented in Table II.[4]

Prior to our main analyses, we calculated the initial SC-index score for each client based on the average SC score of the first three sessions. We than calculated the final SC-index score for each client based on the average SC score of the three final sessions. A paired-samples t-test to assess whether a significant change occurred in the samples' SC-Index scores. The result indicate a significant improvement in clients' SC-index scores from the initial ($M = 3.24$, $SD = 0.71$) to the final ($M = 3.49$, $SD = 0.77$) stage of treatment ($t(87) = 3.36$, $p < 0.01$).

Session Level Effects

The session-level results of the MLM analysis showed a significant positive effect for time (*log* transformed; $\beta_1 = 0.12$, $SE = 0.04$, $p < 0.01$), indicating that overall, clients' session level SC ratings increased over time. In addition, we found a significant positive association between clients' session-level SC and ORS ratings ($\beta_3 = 0.03$, $SE = 0.002$, $p < 0.001$). None of the other level-1 effects were significant; thus, the results failed to support our first hypothesis, which was that directive or CF interventions would lead to next-session increases in SC.

Treatment Level Effects

At level-2 (the treatment-level), we found a positive main effect for pretreatment SC scores ($\gamma_{01} = 0.01$, $SE = 0.004$, $p < 0.001$), suggesting that higher pretreatment SC scores were associated with greater session-level SC ratings (averaged across treatment). Moreover, we found a significant interaction between clients' pretreatment SC scores and time (i.e., cross-level interaction; $\gamma_{11} = -0.006$, $SE = 0.002$, $p < 0.01$). To further explore this interaction, we estimated the simple slopes of *log* time (i.e., rate of change) for clients with high (+SD) vs. low (-SD) pretreatment SC scores. Clients with low pretreatment SC improved their SC levels across treatment ($\gamma_{11\ (low\ SC)} = 0.26$, $SE = 0.06$, $p < 0.001$). In contrast, no such improvement was found among clients with high pretreatment SC scores ($\gamma_{11\ (high\ SC)} = -0.00$, $SE = 0.06$, *n.s.*).

Table I. Means, standard deviations and intercorrelations of study variables.

Variable	1	2	3	4	5	6	7	8	9
1. SCS									
2. SC–Index	.39								
3. Initial SC–Index	.56	.64							
4. Final SC–Index	.32	.74	.55						
5. Directive	−.05	−.03	−.09	−.00					
6. Explorative	.02	−.05	−0.02	−.06	.81				
7. CF	−.18	−.12	−0.06	−.18	.56	.49			
8. WAI	.02	.07	0.01	−.00	.00	−.00	−.16		
9. ORS	.00	.26	0.00	.00	.00	.00	.00	.12	
Mean	74.85	3.42	3.24	3.49	2.60	2.82	3.91	26.61	25.62
SD	18.48	.80	0.71	0.77	.71	.79	.69	4.73	7.66

Note. SCS = Self-compassion Scale; SC-Index = Mean session-level self-Compassion Index; Initial SC-Index = First three sessions' mean Self-Compassion Index score; Final SC-Index = Final three sessions' mean Self-Compassion Index score; Directive = Mean session-level therapists' directive Interventions; Explorative = Mean session-level therapists' explorative interventions; CF = Mean session-level therapists' common factor Interventions; WAI = Mean session-level Working Alliance Inventory; ORS = Mean session-level Outcome Rating Scale.

Table II. Multilevel model predicting clients' SC session-level SC scores.

Effect	Estimate (SE)	Effect size
Fixed effects		
Intercept	3.46 (.08)***	
Session- level effects		
Log time	.12 (.04)**	.13
Lagged clients' WAI	.00 (.00)	
Clients' ORS	.03 (.00)***	.15
Lagged therapists explore interventions	−.00 (.03)	
Lagged therapists' CF interventions	−.03(.03)	
Lagged therapists' directive interventions	.03 (.03)	
Lagged therapists explore intervention * clients' pretreatment SC	−.00 (.00)	
Lagged therapists' CF interventions* Clients' pretreatment SC	−0.00(.00)	
Lagged therapists' directive interventions* Clients' pretreatment SC	−.00 (.00)	
Treatment-level effects		
Clients' pretreatment SC	.02 (.00)***	.18
Therapists' treatment-level explorative interventions	−.20 (.2)	
Therapists' treatment-level CF interventions	−.23(.17)	
Therapists' treatment-level directive interventions	.35 (.23)	
Log time * Clients' pretreatment SC	−.01 (.00)*	.11
Log time* therapists' treatment- level explorative interventions	−.17(.11)	
Log time * Therapists' treatment level CF interventions	−.16(.09)	
Log time * Therapists' treatment level directive interventions	.27 (.13)*	.07
Clients' pretreatment SC * therapists' treatment-level explorative interventions	−.00(.01)	
Clients' pretreatment SC* Therapists' treatment level CF interventions	−.00(.00)	
Clients' pretreatment SC* Therapists' treatment level directive interventions	.016(.016)	
Log time * Clients' pretreatment SC * Therapists' treatment-level explorative interventions	.01 (.01)	
Log time * Clients' pretreatment SC* Therapists' treatment level CF interventions	.01(.01)*	.1
Log time * clients' pretreatment SC * Therapists' treatment level directive interventions	−.01(.01)	
Random effects		
Intercept	.38 (.07)***	
Covariate between intercept and slope	.05(.03)*	
Slope of time	.08(.02)***	
AR(1)	.01(.04)	
Residual	.13(.01)***	
Model summary		
−2 Log L	1505.5	
# Estimated parameters	29	

*$p < .05$. **$p < .01$. ***$p < .001$.
Note. Effect sizes were calculated as semi-partial R^2 (Edwards, Muller, Wolfinger, Qaqish & Schabenberger, 2008)

Directive interventions as predictors of SC change. The significant interaction between directive intervention levels and *log* time in predicting SC change ($\gamma_{13} = 0.27$, $SE = 0.12$, $p < 0.05$) is presented in Figure 1. It suggests that clients who received different degrees of directive interventions showed distinct patterns of change in SC across treatment (i.e., rates of change). To probe this interaction, we estimated the simple slopes of *log* time for clients who received high (+SD) vs. low (-SD) levels of directive interventions. As predicted, clients who received more directive interventions showed significant improvement ($\gamma_{13(high\ directive)} = 0.27$, $SE = 0.12$, $p < 0.05$). This improvement was not found for clients who received fewer directive interventions ($\gamma_{13(low\ directive)} = -0.03$, $SE = 0.07$, *n.s.*).

Common factors interventions as predictors of SC change. The interaction between CF intervention levels and *log* time did not predict SC change ($\gamma_{14} = -.16$, $SE = .098$, *n.s.*). However, a significant 3-way interaction was found between CF intervention levels, *log* time, and pretreatment SC scores ($\gamma_{17} = 0.27$, $SE = 0.12$, $p < 0.05$; see Figure 2). Examination of the SC slopes for clients who received high (+SD) and low (-SD) levels of CF interventions revealed that among clients with low levels of pretreatment SC scores, fewer CF interventions were associated with improvement in SC ratings across treatment ($\gamma_{17\ (low\ SC,\ low\ CF)} = 0.52$, $SE = 0.13$, $p < 0.001$). No such improvement was found among clients with low pretreatment SC who received more CF interventions ($\gamma_{17(low\ SC,\ high\ CF)}$
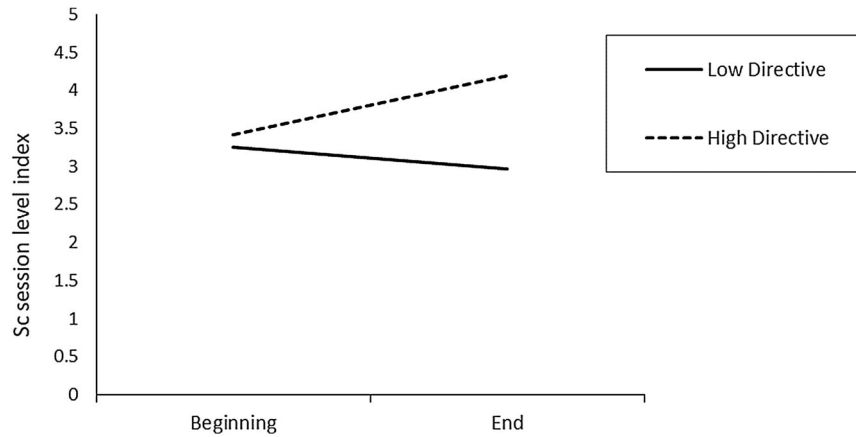
Figure 1. Clients' session-level SC as a function of time and therapists' use of directive interventions.

= −0.02, *SE* = 0.09, *n.s*) nor among clients with high pretreatment SC regardless of the levels of CF interventions received ($\gamma_{17 \text{ (high SC, high CF)}}$ = 0.06, *SE* = 0.08, *n.s*; $\gamma_{17(\text{high SC, low CF})}$ = −0.05, *SE* = 0.11, *n.s*).

Exploratory interventions as predictors of SC change. The interaction between exploratory intervention levels and *log* time did not predict SC change (γ_{12} = −0.166, *SE* = 0.109, *n.s.*), or was there a 3-way interaction involving pretreatment SC (γ_{15} = 0.006, *SE* = 0.007, *n.s.*).

To estimate the total explained variance of our model, we calculated the correlation between the predicted and observed outcome values (i.e., observed SC-index), which resulted in 25% (Peugh, 2010; Singer & Willett, 2003). Additionally, level-2 predictors explained a considerable amount of level-2 (between clients') variance in slopes (i.e., 16%), reducing it from .09 in the basic model (which included just the time effect on SC-index) to .07 in the full model described above.

Discussion

Self-Compassion (SC) has been consistently linked to improved wellbeing and decreased emotional distress (cf., Zessin et al., 2015) and has been proposed as a change mechanism in different psychotherapeutic approaches (e.g., Galili-Weinstock et al., 2018; Kuyken et al., 2010; Schanche et al., 2011). The aim of the current study was to examine therapists' interventions that may enhance clients' SC in individual psychotherapy, using session-by-session monitoring of both clients' SC levels as well as therapists' interventions. We hypothesized that clients' increases in SC will be associated with greater use by their therapists of directive or CF interventions at both the session level (i.e., from one session to the next) as well as the treatment level (i.e., from pre- to
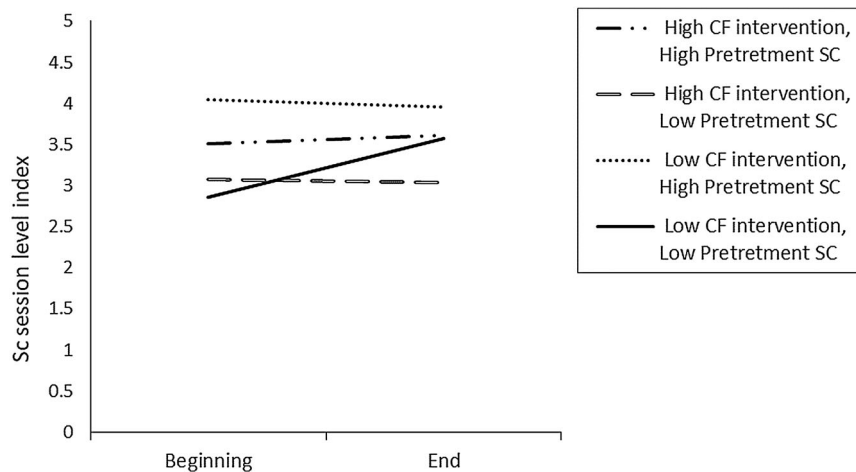

Figure 2. Clients' session-level SC as a function of time, clients' pretreatment SC levels and therapists' use of directive interventions.

post-treatment). We expected these effects to be stronger among clients who began therapy with lower levels of SC.

While no session-level effects were found, our *treatment level hypotheses* were partially supported by the data. Pre- to post-treatment increased improvement (i.e., higher rate of change) in clients' SC were predicted by greater therapist use of directive interventions. However, contrary to our prediction, among clients with low levels of pretreatment SC, pre- to post-treatment improvement in SC was predicted by lower therapist use of CF interventions. These treatment-level effects were significant above and beyond the effects of clients' ratings of the therapeutic alliance as well as their functioning level.

Our results suggest that directive interventions are useful in enhancing clients' SC. This finding accords with the work of several authors (e.g., Gilbert, 2009; Shahar, 2013) who highlight the importance of directive interventions in their work with clients who suffer from high levels of self-criticism and shame. It is important to note that therapists' directiveness is a broad term which may encompass numerous therapeutic techniques and practices. In the present study, directive interventions were defined as those typically characteristic of cognitive, behavioral, and dialectic- behavioral therapies (e.g., setting an agenda for the session, teaching new skills, encouraging the client to change specific behaviors, assigning and reviewing homework exercises, etc.). Further research is needed in order to identify the specific interventions that promotes SC. However, a recent study demonstrated that among psychotherapy clients, SC was tied to negative emotion differentiation (Galili-Weinstock et al., 2019). This finding may imply that directive interventions aiming to enhance clients' ability to experience their negative emotions more granularly may be effective in promoting SC.

With the present sample, psychodynamic psychotherapy was the dominant therapeutic approach used. Consequently, our results highlight the possible benefit of integrating different directive ingredients into a psychodynamic practice. This finding accords with previous studies which have explored such integration and its effect on therapy outcomes. For example, the utilization of cognitive–behavioral techniques alongside general adherence to a psychodynamic model of treatment for depression has been found beneficial to treatment outcome (Katz et al., 2019). Similarly, cognitive–behavioral interventions (applied within the framework of open-ended psychodynamic therapy) have been found to be more strongly associated with improved alliance and outcomes than the psychodynamic interventions themselves (Samstag & Norlander, 2019).

Psychodynamic therapists who employ cognitive–behavioral interventions (rather than strictly adhering to a psychodynamic theory or protocol) may do so because they are more flexible or responsive to the clients. In turn, flexibility and responsiveness have been linked to treatment outcome (Hardy, Stiles, Barkham, & Startup, 1998; Owen & Hilsenroth, 2014; Stiles & Horvath, 2017). Additionally, therapists who use cognitive–behavioral interventions may be perceived by their clients as more active, a perception which may facilitate positive outcomes regardless of the specific interventions delivered (Owen, Hilsenroth, & Rodolfa, 2013). Finally, with regards to SC-related outcomes, therapists would employ technical integration may explicitly and actively address the clients' self-to-self relating rather than taking a more passive stance. Such an active attitude and technique may play an important role in changing clients' maladaptive cognitive and emotional patterns and promoting change in their negative inner-dialogue.

To our surprise, among clients with low pretreatment SC scores, positive change in SC was tied to lesser use of CF interventions. In other words, among clients who began therapy with high levels of self-criticism and shame, therapists' excessive expressions of empathy, support, and encouragement did not enhance clients' SC. This effect surprised us. We had reasoned that CF interventions, which are aimed at strengthening the therapeutic bond, would be tied to improvement in SC, given the robust evidence for the importance of a strong therapeutic alliance to treatment outcomes (for a meta-analytic review, see Flückiger et al., 2018). Yet little is known regarding the actual effect of CF interventions on alliance, especially among clients with low levels of SC. Our results may suggest that, when used excessively, these interventions may have an iatrogenic effect for low SC individuals. One possibility is that the one widely-used CF intervention—namely, validation—could unintentionally confirm the self-punitive or self-critical voice of the client.

Previous studies have yet to explore the therapeutic relationship vis-a-vis clients' high or low SC. However, some insight can be drawn from studies which examined therapy with clients exhibiting perfectionism or self-criticism. These two constructs have been conceptualized as antonymous to the self-kindness component of SC, and have been found empirically to be negatively associated with SC (Neff, 2003a). To date, several authors have addressed the unique challenges posed by attempting to form a therapeutic bond with clients who suffer from maladaptive perfectionism or intense self-criticism (e.g., Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998; Shahar, 2001, 2013). These clients, who are

dominated by negative inner representations of both self and others, often expect the therapist to be critical and punitive in a way that often hampers their ability to benefit from the therapeutic relationship or to internalize the therapist's warm and supportive stance. Blatt et al. (1998) examined the therapeutic alliance formed by clients with high (vs. low) perfectionism and its effect on the outcome of short-term therapy for depression. Whereas clients' perfectionism levels were not tied to their alliance ratings, perfectionism and alliance did interact in predicting therapy outcomes; in particular, among clients with high levels of perfectionism, alliance ratings had no association with treatment outcome. As Blatt (1995) suggested, highly perfectionistic patients may be capable of perceiving their therapists in a positive light, but are less able to benefit from the alliance during this brief treatment. Instead, longer therapy may be advisable for such individuals, as this maladaptive tendency may change gradually over the course of long-term treatment (Blatt, 1995; Shahar, 2001). In our sample, the mean treatment length was 24 sessions. Thus, it is possible that if therapy would have continued, CF interventions may have had a different effect on the clients. Future studies should explore the effect of therapists' interventions on clients' SC level as it changes during different periods of longer-term therapeutic processes.

Our session level hypothesis—i.e., that directive or CF interventions would predict next-session SC—was not supported. This may suggest that SC changes result from longer therapeutic processes rather than from any single session or from the interventions used therein. This interpretation is in line with previous studies examining specific SC-enhancement interventions, which have found SC improvement only following therapeutic processes lasting 5–8 weeks (e.g., Gilbert & Irons, 2004; Neff & Germer, 2013b; Shahar et al., 2012) while failing to detect such an improvement following a single intervention (Kirkpatrick, 2005).

There are several limitations to consider when reviewing the current results. First, this naturalistic field study took place in a university community clinic, where the therapists are trainees. Although all therapists received intensive supervision, their relative inexperience may limit the ability to generalize our results to more experienced clinicians. Second, the sample size available to us may have posed a limitation on the study's power to detect effects. Future (and more robustly powered) replication of this work could take a further step and explore the effects of therapists interventions on distinct changes in the three sub-components of SC. Third, though our use of therapist-report measures to assess therapist interventions may have some benefits

(e.g., offering access to the therapists' intentions; McAleavey & Castonguay, 2014), they may also introduce serious biases. For example, therapists who identify themselves as cognitive–behavioral may selectively recall their use of techniques which are drawn from their theoretical perspective. Moreover, using only the therapists' ratings does not allow us to investigate the dynamics between therapists' use of techniques and clients' experience and perception. We encourage future studies to utilize additional perspectives, such as the clients or objective raters. Future studies may also benefit of examining the therapist's explicit narrative about their chosen techniques to allow for a better examination of conscious use of techniques. Forth, due primarily to statistical concerns, our intervention measures were created by aggregating multiple subscales into three broad clusters. Future studies could explore the effect of more narrowly-defined interventions on the development of clients' SC. Finally, the statistical analyses conducted in this study are correlational; consequently, causality cannot be explicitly assumed as some unmeasured variable(s) could have influenced our measured variables.

These limitations notwithstanding, the current study takes an important step towards integrating the study of SC into the field of psychotherapy research, in an effort to understand what therapist interventions may enhance clients' SC. Our results suggest that SC is responsive even to interventions that are not explicitly targeted at facilitating change in this construct.

One clinical implication of this study is the importance of understanding clients' pre-treatment characteristics—namely, their SC (or conversely, self-criticism and shame) levels—when selecting interventions. When working with clients who suffers from low levels of SC or from high levels of self-criticism and shame, specific challenges should be taken into consideration. Clinician should be aware of the possibility that excessive CF interventions (such as validation and empathic listening) may actually affirm their clients' negative inner dialogue and self-perceptions.

Another implication stems from the realization that SC develops gradually over the course of therapy, unfolding over time rather than changing rapidly as a function of any particular session. Consequently, clinicians should gird themselves with considerable patience when working with their clients on this important goal. Furthermore, for clients who begins therapy with lower levels of SC, longer therapy may be advisable.

Finally, our results suggest that the integration of directive interventions into a more traditional psychodynamic therapeutic practice may promotes clients' SC. While more research is needed to identify specific

directive interventions, our results point to interventions drawn from cognitive, behavioral, and dialectic-behavioral therapy as beneficial in helping clients develop the positive qualities of SC and thereby improving their emotional health and wellbeing.

Notes

[1] The following DSM-IV diagnoses were assumed in the affective disorders cluster: major depressive disorder, dysthymia and bipolar disorder. The following DSM-IV diagnoses were assumed in the anxiety disorders cluster: panic disorder, agoraphobia, generalized anxiety disorder and social anxiety disorder.

[2] (a) Recent findings have shown that small numbers of clients per therapist (up to 10 clients per therapist) might lead to inflation of the third level effects (Schiefele, et al., 2017). (b) In the current study, the level-3 variance of the clients' SC ratings was not significant ($Z = 0.89$, n.s.) and (c) it accounted for less than 1% of the variance.

[3] All of the level-1 effects were centered on each client's mean and all of the level-2 effects were centered on the sample mean.

[4] The main results of the study are presented in Table II. A Full table of effects is available online at https://osf.io/egvfr/

ORCID

Lior Galili-Weinstock 🆔 http://orcid.org/0000-0003-3581-4066

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