LETTER TO THE EDITOR

Does Self-Compassion Entail Reduced Self-Judgment, Isolation, and Over-Identification? A Response to Muris, Otgaar, and Petrocchi (2016)

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I read with interest the critique of the Self-Compassion Scale (SCS) published in *Mindfulness* titled "Protection as the Mirror Image of Psychopathology: Further Critical Notes on the Self-Compassion Scale" (Muris et al. 2016). The critique is based in large part on a recent article I published in Mindfulness (Neff 2016) titled "The Self-Compassion Scale is a Valid and Theoretically Coherent Measure of Self-Compassion" and readers interested in the topic should probably read this article in addition to the critique to make sense of the issues involved. Although I do not agree with most of the authors' criticisms, it is my hope that an objective discussion can be had of the merits and drawbacks of using the SCS as it is currently designed. I will therefore consider each substantive issue in turn, briefly outlining the issues and providing my response, so that readers can decide for themselves.

In my article, I responded to an earlier critique by Muris (2015) which had argued that inclusion of subscales measuring self-judgment, isolation, and over-identification in the SCS was a "mismeasure" of self-compassion, by pointing out that the SCS measures self-compassion exactly as I define it. In their new critique the authors write "this is just totally incorrect. In fact, even in her more recent papers, she still advocates that the construct basically contains three positive components that are dimensional in nature. The negative components in the SCS are merely described as the opposites of the three positive components." The issue appears to be whether describing the negative components as opposite to

the positive components means they are not part of the definition of self-compassion, and more importantly, whether the negative components should be included in the definition of self-compassion in the first place.

In the introduction to the SCS scale development paper, I wrote "Self-compassion…entails three basic components: 1) extending kindness and understanding to oneself rather than harsh self-criticism and judgment; 2) seeing one's experiences as part of the larger human experience rather than as separating and isolating; and 3) holding one's painful thoughts and feelings in balanced awareness rather than over-identifying with them. These aspects of self-compassion are experienced differently and are conceptually distinct, but they also tend to engender one another. For instance, the accepting, detached stance of mindfulness lessens self-judgment. Conversely, if one stops judging and berating oneself long enough to experience a degree of self-kindness, the impact of negative emotional experiences will be lessened, making it easier to maintain balanced awareness of one's thoughts and emotions. Similarly, realizing that suffering and personal failures are shared with others lessens the degree of blame and harsh judgment placed on oneself, just as a lessening of self-judgment can soften feelings of uniqueness and isolation" (Neff 2003a, p. 224–225). In other words, I defined self-compassion as a state of mind involving increased self-kindness and reduced self-judgment, increased common humanity and reduced isolation, increased mindfulness and reduced over-identification, and proposed that these elements mutually influence each other.

It should be noted that each pair of opposing components focus on a different dimension of self-to-self relating—how individuals emotionally respond, cognitively understand, or pay attention to their suffering. In every moment of failure or distress, individuals have a choice to be caring and understanding toward themselves (self-kindness) or cold and critical

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(self-judgment), of framing their imperfect experience in light of the shared human experience (common humanity) or falling into the egocentric fallacy that "it's just me" (isolation), and paying clear, balanced attention to one's experience of suffering (mindfulness), or running away with a dramatic storyline of what is happening (over-identification). Muris et al. (2016) are correct in pointing out that I discuss self-compassion in terms of three components, when in fact each is comprised of two opposing sub-components, and that three times two yields a total of six. The reason I tend to write about self-compassion as having three main components is because I believe it is more heuristic to discuss it in these terms.

One of my main goals as a researcher has been to describe the construct of self-compassion in a way that is easy to understand and remember for the general public as well as academics, and ultimately, to help people learn to be more self-compassionate. To this end, I find it easier for people to think about self-compassion in terms of the three compassionate dimensions of self-kindness, common humanity and mindfulness, and to embed discussion of the fact that self-compassion also entails lessened self-judgment, isolation, and over-identification in my description of these dimensions. Moreover, because teaching people to be more self-compassionate involves helping them to replace the three uncompassionate responses to suffering with the three compassionate ones, describing self-compassion in this way seems to make intuitive sense to people.

I have been explicitly clear since first defining the construct that an important feature of a self-compassionate frame of mind is not responding with self-judgment, isolation, and over-identification. In fact, I argued that one of the main ways self-compassion is different from self-pity is because it does not include excessive self-focus or the exaggeration of personal suffering (i.e., isolation and over-identification; Neff 2003b). Theoretically, one could argue that a state of mind should be defined only in terms of what is present, and not what is absent. However, I am not the only scholar who includes negative components when defining self-compassion. Paul Gilbert (2010) also includes the lack of self-judgment as a key attribute in his definition of self-compassion, but refers to this lack as "non-judgment." Of course, the absence of judgment and the presence of non-judgment are exactly the same. Non-judgment is also part of the common definition of mindfulness, in terms of the absence of resistance to and judgment of one's present moment experience (Kabat-Zinn 1994). From my point of view, knowing the degree to which individuals are being self-judgmental, feeling isolated, or are over-identifying with their negative emotions is central to the process of assessing how self-compassionate they are.

In order to develop a measure of self-compassion that captured my theoretical conception of the construct, I first pilot tested a pool of 71 potential items (Neff 2003a), with roughly the same number of items designed to represent the three positive and three negative dimensions of self-compassion. Muris et al. (2016) assert that "the key reason" I included items that measured uncompassionate behavior was because I wanted to include items that negated the positive ones, presumably to avoid response bias (Muris and Petrocchi 2016). If this had been my primary concern, however, I would have just written a few items such as "I am unkind to myself" or "I don't tend to see my failures as part of the human experience" and reverse-coded responses. The reason I included equal numbers of items describing behaviors of self-judgment, isolation and over-identification was because the lack of this type of uncompassionate responding was a key part of my definition of self-compassion.

In study 1 of my scale development paper, I conducted a series of CFAs to test the hypothesized factor structure of the SCS. Before conducting study 1, I had expected that items assessing each pair of opposites (e.g., items assessing self-kindness and self-judgment) would be so strongly correlated that they would form a single dimension. Instead, I found that model fit was better when the positive versus negative components of each dimension were modeled separately. In the discussion of study 1, I wrote "it makes sense theoretically that the positive and negative aspects of the three components of self-compassion should form six separate but correlated factors given that these components did not vary in a lockstep manner, so that having low levels of one behavior necessarily means having high levels of the other" (Neff 2003a, p. 234). In other words, I clearly acknowledged that the negative factors were dimensions in their own right, and should be measured as such. Study 2 of the paper confirmed the six-factor structure of the SCS, and also confirmed that a single higher-order model could be used to justify use of a total scale score in addition to examining the six subscales separately.

Muris et al. (2016) write "researchers using the SCS frequently neglect this important issue and only compute a total SCS score by summing the ratings across all items" implying that researchers do not understand the factor structure of the SCS. Given that the scale development paper clearly specifies that the SCS can be used to examine the six subscales separately or else to calculate an overall self-compassion score, presumably researchers make the decision to examine a total score out of choice, not out of neglect.

Since publishing the SCS and becoming more familiar with the work of Paul Gilbert, it makes more sense to me than ever that the positive and negative components of self-compassion should be assessed as separate factors. Gilbert's Social Mentality Theory (Gilbert 2005) posits that compassionate ways of responding to suffering tap into parasympathetic nervous system activity, and uncompassionate ways of responding tap into the sympathetic nervous system, suggesting that they should not be measured as a single factor. As I pointed out in Neff (2016), however, "While the sympathetic and parasympathetic nervous systems can be understood as

distinct, this does not mean they are completely isolated and unrelated to one another, and in fact, research suggests the two systems continuously interact and co-vary (Porges 2001). There is no reason, therefore, why a single summary score cannot be used to assess the relative balance between the two (e.g., the extent to which one system is activated while the other is deactivated), especially given that aspects of each are measured as separate factors before being combined into an overall self-compassion score." I hold to this view, and believe that conceptualizing self-compassion as a dynamic system, and using a total SCS score to assess the relative balance of system components makes sense.

In Neff (2016) I also presented a summary of new evidence justifying the use of an overall scale score in addition to six separate subscale scores (Neff et al., submitted for publication), given that original findings using a higher-order model to justify use of a total scale score have not been consistently replicated (e.g., Williams et al. 2014). I summarized a set of analyses conducted on the factor structure of the SCS in a student, community, meditator and clinical sample using a bifactor model, which is more theoretically consistent with my conceptualization of the SCS than the higher-order model that was originally used. (Note that I originally discussed examining five samples, with the community sample being split into healthy versus dysphoric subsamples, but based on feedback from reviewers it was decided to examine the community sample as a whole since it is more representative.) The bifactor approach was not widely known when I first constructed the SCS, but it is increasingly popular among psychometricians because it is specifically designed to account for the simultaneous unitary and multidimensional structure of self-report scales, which many consider to provide a more realistic representation of complex psychological constructs (e.g., Chen et al. 2012; Reise 2012; Thomas 2012). One advantage of the bifactor model is that it does not completely rely on model fit as an indicator of scale structure the way that other models do—and over-reliance on model fit has been heavily criticized in psychometric circles (Marsh et al. 2005; Marsh et al. 2004; Saris et al. 2009; West et al. 2012). The model can also generate an OmegaH index, which estimates the amount of variance attributable to a general factor even in the presence of multidimensionality, and can calculate the amount of error in a model, providing a more tangible basis for researchers to decide if a scale is measuring what it purports to measure.

Our analyses examined a six-factor-correlated model, a higher-order model, and a bifactor model in all samples. We found that the six-factor-correlated model had the best fit, and that the higher-order model generally had a poor fit. The bifactor model, however—which models the existence of six subscale factors and single general factor simultaneously—had adequate model fit in the student, community and meditator samples, though fit was suboptimal in the clinical sample. In all samples the model did not evidence more than 6 %

error, however. Moreover, the OmegaH indexes indicated that at least 90 % of the error-free variance in responses could be accounted for by a total SCS score across samples. All the items of the SCS were also found to evidence significant factor loadings in the moderate to large range both on their respective subscale factors as well as an overall self-compassion factor across samples. For this reason, we interpreted findings to support the idea that the SCS could be used as originally proposed—to measure either a total self-compassion score or else six separate subscales scores.

In response to these findings, after pointing out that the correlated-six-factor model "unequivocally" demonstrated the best fit, Muris et al. (2016) write "Oddly enough, based on the observation that the bifactor model demonstrated 'acceptable fit' in three (non-clinical) of the five samples and the finding of a satisfactory omega test statistic (which is known to be inflated in lengthy scales containing multiple factors, like the SCS; see Reise et al. 2010), Neff concluded that there is sufficient proof to justify the use of the SCS total score. Such a selective decision by Neff is of course unwarranted. Actually, her results should give rise to a cautionary note rather than an encouragement regarding the employment of the SCS total score." I would argue the contrary, that ignoring evidence that 90 % of the variance in item responses is attributable to a general self-compassion factor would be the more selective and unwarranted decision. It is important to note that the six-factor model does not test for a general factor, so the fact that it had a better fit than the higher-order or bifactor models says nothing about whether or not use of a total score is justified. Given the controversy around model fit, moreover, it seems most appropriate to include other indicators such as the Omega H index, error level, and factor loadings to determine if an SCS total score can be used in addition subscale scores.

It is not clear why the authors reference Reise et al. (2010) to claim that the OmegaH index is inflated in lengthy scales containing multiple factors like the SCS. The cited article presents no such argument. Perhaps the authors meant to reference Reise et al. (2013), who do discuss the fact that measures with a larger number of subscale factors can lead to structural coefficient bias. Even so, they clearly state that at high values of omegaH (>0.80) inflation is not a problem. As soon as this data is published, of course, readers can decide for themselves.

The authors conclude their critique by writing "There is one other important reason why we plead against the use of the SCS total score, and this has to do with the inclusion of the three negative components, which goes completely against the idea of measuring a protective mechanism. Specifically, in our opinion, the negative components are problematic because they assess characteristics that are known to be associated with psychopathology." In fact, this argument contains a number of threads. One is that the SCS should not measure the lack of

uncompassionate behavior because self-compassion is a protective mechanism, whereas the three negative components represent vulnerabilities to distress. The second is that self-judgment, isolation and over-identification have already been examined as predictors of psychopathology, making studies conducted with the SCS redundant with prior research and presumably uninteresting. The third (made in more detail elsewhere; Muris and Petrocchi 2016) is that because research with the SCS finds that the negative factors tend to be more powerful predictors of psychopathology than the positive factors, the SCS inflates the link between self-compassion and well-being.

Firstly, it is unclear why such a rigid distinction is made between protective factors and vulnerabilities. In many ways the lack of vulnerabilities can be seen as a protective factor, just as the lack of protective factors can be seen as a vulnerability. In fact, one of the reasons I do not generally frame my work as part of the positive psychology movement is because I believe this distinction is often over-simplified. To my mind, the fact that a self-compassionate mind-state offers protection against the vulnerabilities associated with self-judgment, isolation, and over-identification is one of its greatest strengths. The finding that the negative subscales are more powerful predictors of psychopathology than the positive ones is not surprising to me, and in fact fits with my own data examining the link between the SCS subscales and various aspects of wellbeing (Neff et al. in preparation). It is quite likely that the main mechanism by which a self-compassionate state of mind leads to lower levels of psychopathology is because it reduces self-judgment, isolation and over-identification. I actually alluded to this in my original paper defining self-compassion (Neff 2003b, p. 93) writing "Individuals who are self-compassionate should evidence greater psychological health than those with low levels of self-compassion, because the inevitable pain and sense of failure that is experienced by all individuals is not amplified and perpetuated through harsh self-condemnation (Blatt et al. 1982), feelings of isolation (Wood et al. 1990) and over-identification with thoughts and emotions (Nolen-Hoeksema 1991)." Although research on self-judgment (which overlaps with self-criticism), isolation (which overlaps with egocentric perspective-taking), and over-identification (which overlaps with rumination) is not new, from my point of view the identification of a trainable state of mind in which maladaptive tendencies toward self-judgment, isolation, and over-identification are reduced is indeed important and noteworthy.

If it were the case—as Muris et al. (2016) appear to be arguing—that a self-compassionate state of mind does not entail reduced levels of self-judgment, isolation and over-identification, and only involves increased levels of self-kindness, common humanity, and mindfulness, then the fact that the SCS measures the three negative components would indeed be problematic, and would suggest that findings of the

negative link between self-compassion and psychopathology using the SCS were inflated. It would also suggest that justification for efforts to teach people how to be more self-compassionate through interventions such as Mindful Self-Compassion (MSC; Germer and Neff 2013) or Compassion Focused Therapy (CFT; Gilbert 2009) would be ill-founded. Fortunately, research suggests that this is not the case.

There is increasing evidence to suggest that training in self-compassion reduces levels of self-judgment, isolation, and over-identification. In Neff (2016) I reanalyzed the data from our randomized controlled trial of the 8-week MSC program (Neff and Germer 2013) and found participation in the program decreased scores on the three negative subscales of the SCS (32 to 35 %) to approximately the same degree as it increased scores on the three positive subscales (21 to 36 %). In an intervention which asked women with body image dissatisfaction to listen to the guided self-compassion meditations on my website for three weeks (Albertson et al. 2014), results indicated that scores in self-judgment (26 %), isolation (21 %), and over-identification (23 %) decreased even more than scores in self-kindness (15 %), common humanity (15 %), and mindfulness (17 %) increased. Other intervention studies report data for constructs that overlap with the negative components of self-compassion, even though changes in self-compassion subscale scores were not reported. For instance, Falconer et al. (2014) conducted a virtual reality study involving giving oneself compassion with an avatar, and found self-criticism levels were reduced, and studies of self-compassion interventions for athletes (Mosewich et al. 2013) and female college students (Smeets et al. 2014) have been found to reduce self-criticism and rumination. This data suggests that adopting a compassionate frame of mind involves a reduction in the negative components of self-compassion alongside an increase in the positive ones.

Research on the impact of self-compassion interventions on psychopathology also replicates results found with an SCS total score, suggesting that the SCS does not misrepresent the relationship between the two. For instance, Shapira and Mongrain (2010) found that writing a self-compassionate letter to oneself once a day for 7 days decreased depression for 3 months. Albertson et al. (2014) found listening to self-compassion meditations for 3 weeks reduced body dissatisfaction and shame. Kelly and Carter (2015) found that 3 weeks of self-compassion training reduced eating disorder pathology among individuals with binge eating disorder. Arch et al. (2014) found that brief self-compassion training reduced anxiety and maladaptive physiological response to social threat. Neff and Germer (2013) found that participation in MSC reduced depression, anxiety and stress for at least a year. A randomized controlled trial of an adaptation of MSC for adolescents (Bluth et al. 2015) found it reduced depression. And of course, the ever-expanding literature on CFT suggests that teaching people to be more self-compassionate reduces psychopathology

for individuals suffering from a variety of disorders (see Leaviss and Uttley 2015, for a systematic review).

In addition, a growing body of research using experimental mood inductions of self-compassion (typically by having people write about an experience of suffering in a kind and compassionate way) also suggests that self-compassion reduces psychopathology. For instance, experimental research has found that engendering a self-compassionate mind-state reduces negative emotions among undergraduates (Arimitsu and Hofmann 2015; Leary et al. 2007; Odou and Brinker 2014), decreases depressed mood among people with major depressive disorder (Diedrich et al. 2014), reduces depressive symptoms in shame-prone individuals (Johnson and O'Brien 2013), reduces overeating in dieters (Adams and Leary 2007), and reduces disordered eating behavior and body shame in female undergraduates (Breines et al. 2014).

Muris et al. (2016) write that "Our critical remarks are not meant to cast doubts on the relevance of self-compassion as a protective mechanism within the context of mental health problems" but that by "partially operationalizing self-compassion as a mirror image of psychopathology, the link with mental health problems becomes clearly inflated." They conclude by writing "for those who intend to use the scale in future studies, our urgent advice would be to analyze the six subscales separately. Especially within the context of psychopathology, we consider this as the only way to examine the contribution of true self-compassion components beyond the tautological influence of the negative components." First, I would like to point out that the authors' description of the operational definition of self-compassion as a "mirror image" of psychopathology and claims that it is "tautological" would only make sense if, in fact, the negative components of self-compassion were forms of psychopathology themselves. While self-judgment, isolation and over-identification are negative ways of relating to oneself that can *lead* to psychopathological outcomes such as depression or anxiety, they are not *the same* as psychopathological outcomes. Thus, claims of tautology are not relevant here. Nonetheless, the assertion that use of a total SCS score inflates the link between self-compassion and psychopathology is a serious one. This is in fact an empirical question. Future research might test this proposition by comparing effect sizes when the link between self-compassion and psychopathology is examined using an SCS total score versus an intervention or mood induction. Neff and Germer (2013) found that participation in MSC had a moderate to large effect on anxiety and depression (Cohen's $d = 0.76$ and 0.86, respectively) in keeping with meta-analyses of studies using an SCS total score (MacBeth and Gumley 2012; Zessin et al. 2015). Still, direct examination of this issue in future research is needed to settle the issue.

For now, it is worth considering what the impact might be of researchers adhering to Muris et al.'s (2016) advice to analyze the six subscales of the SCS separately rather than

calculating a total self-compassion score, and adopting their view that self-compassion has little to do with the levels of self-judgment, isolation, and over-identification that people display. Let us say there was a researcher who was interested in body dissatisfaction and eating disorders among women, and was curious about whether self-compassion might help. Before embarking on the expensive and time consuming task of developing a self-compassion focused intervention for this population, she decides to conduct preliminary research examining the link between self-reported self-compassion, body dissatisfaction, and disordered eating behavior. For the sake of argument, let us say that the negative link between self-compassion and disordered eating was largely explained by the reduced self-judgment, isolation, and over-identification entailed by a self-compassionate mind-state, and the positive components of self-compassion were not particularly strong predictors. If the researcher were to examine the six subscales separately and focus only on data obtained with the positive subscales, or were to actually follow the advice given by the authors elsewhere (Muris and Petrocchi 2016) to "discard the negative items from the questionnaire" altogether—she might conclude that teaching these women to be more self-compassionate would be a waste of time. If she adopted the point of view, however, that a reduction in self-judgment, feelings of isolation and over-identification are intrinsic to a self-compassionate frame of mind, her conclusion might be that teaching self-compassion to people with body dissatisfaction and eating disorders would indeed be a worthwhile endeavor (a conclusion supported by the research mentioned above).

Perhaps a lesson learned from Muris et al.'s (2016) critique of the SCS is that I should always describe self-compassion as being comprised of six components, rather than as three components each containing two opposing pairs. As I said, however, I find the three-component description of self-compassion is easier to understand and remember for the general public. Regardless, I believe that self-compassion is best defined and measured as entailing less self-judgment, isolation, and over-identification as well as more self-kindness, common humanity and mindfulness, and that we need a measurement tool that can facilitate research on the six components of self-compassion as well the overall construct simultaneously. If it turns out that the factor structure of the SCS is not consistently replicated—especially in translation across a variety of cultural contexts—I would suggest that before jumping to the conclusion that the theory needs to be revised, attempts should be made to rewrite the SCS scale items so that they more adequately represent the theory. Given that teaching people to be more self-compassionate clearly involves changes in all six components, this suggests that all six are part of a self-compassionate frame of mind and should be measured as such.

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