Self-Compassion, Stress, and Coping

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Abstract

People who are high in self-compassion treat themselves with kindness and concern when they experience negative events. The present article examines the construct of self-compassion from the standpoint of research on coping in an effort to understand the ways in which people who are high in self-compassion cope with stressful events. Self-compassionate people tend to rely heavily on positive cognitive restructuring and less so on avoidance and escape but do not appear to differ from less self-compassionate people in the degree to which they cope through problem-solving or distraction. Existing evidence does not show clear differences in the degree to which people who are low versus high in self-compassion seek support as a coping strategy, but more research is needed.

The degree to which people cope effectively with stressful life events is a primary determinant of their subjective well-being. Not surprisingly, researchers have devoted a great deal of effort toward understanding which coping strategies and processes are most effective under various circumstances and identifying individual differences in the ways in which people cope with negative events. The goal of this article is to explore the role of self-compassion in coping and well-being.

The Conceptualization and Measurement of Self-compassion

Although self-compassion has been discussed in Eastern philosophy—Buddhism in particular—for centuries, it appeared in the psychological literature only recently with Neff's (2003a,b) publication of two articles that described the construct of self-compassion and provided a self-report inventory for the measurement of individual differences in the tendency to be self-compassionate. In essence, self-compassion involves directing the same kind of care, kindness, and compassion toward oneself that one conveys toward loved ones who are suffering. According to Neff (2003a), self-compassion involves 'being open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, non-judgmental attitude toward one's inadequacies and failures, and recognizing that one's experience is part of the common human experience' (p. 224).

Neff conceptualized self-compassion in terms of three primary features – self-kindness, common humanity, and mindfulness. The central aspect of self-compassion involves treating oneself kindly when things go wrong. For instance, when they fail or make a critical error, self-compassionate people tend to treat themselves with greater kindness, care, and compassion and with less self-directed criticism and anger than people who are low in self-compassion. Self-compassion also involves being reassuring rather than critical toward oneself when things go wrong (Gilbert, Clarke, Kemple, Miles, & Isons, 2004). Treating oneself kindly can manifest itself in overt actions such as taking time off to give oneself a break emotionally or in mental acts of kindness such as engaging in self-talk that is positive, encouraging, and forgiving.

The second feature of self-compassion, common humanity, involves recognizing that one's experiences, no matter how painful, are part of the common human experience. When people fail, experience loss or rejection, are humiliated, or confront other negative events, they often feel that their experience is personal and unique when, in reality, everyone experiences problems and suffering. Realizing that one is not alone in the experience reduces people's feelings of isolation and promotes adaptive coping (Neff, 2003a).

The third feature of self-compassion, according to Neff (2003b), involves taking a balanced perspective of one's situation so that one is not carried away with emotion. When faced with trials and tribulations, people who are low in self-compassion tend to dwell on the negativity of the situation and wallow in their emotions. In contrast, those who are able to maintain perspective in the face of stress and approach the situation with mindfulness (Brown & Ryan, 2003) cope more successfully. Neff (2003b) identified mindfulness as a core component of self-compassion and suggested that being mindful of one's feelings is essential to showing oneself compassion.

Self-compassion is typically measured with the Self-Compassion Scale (SCS; Neff, 2003a), a 26-item self-report scale that assesses six factors that reflect the positive and negative poles of the three components of self-compassion just described – self-kindness/self-judgment, common humanity/perceived isolation, and mindfulness/over-identification. Confirmatory factor analyses support the notion that these six subscales reflect three higher-order factors that comprise a single latent variable of self-compassion. The SCS has high internal reliability ($\alpha = 0.90$) and test–retest consistency (0.93, Neff, 2003a). The scale has also been shown to have convergent validity as it correlates highly with ratings of self-compassion by therapists and romantic partners (Neff, 2006; Neff, Kirkpatrick, & Rude, 2007b; Neff, Rude, & Kirkpatrick, 2007a) and predicts the degree to which people's thoughts are self-compassionate (Leary, Tate, Adams, Batts Allen, & Hancock, 2007). Additionally, Buddhist monks, who typically undergo training to promote their self-compassion, scored higher in self-compassion than the general population (Neff, 2003a).

Although most researchers have studied self-compassion as an individual difference variable, some have also examined the effects of inducing a self-compassionate mindset. For example, researchers have examined the effects of a brief self-compassion induction on self-relevant thoughts and emotion, as well as on maladaptive behaviors that may result from a lack of self-compassion (Adams & Leary, 2007; Leary et al., 2007). Furthermore, clinical psychologists are beginning to design interventions that rely heavily upon self-compassion (Gilbert & Irons, 2004; Gilbert & Procter, 2006).

Whether measured as a trait or induced as a state, self-compassion relates positively to indices of psychological well-being. People who score high in self-compassion tend to score lower on measures of neuroticism and depression, and higher on measures of life satisfaction, social connectedness, and subjective well-being (Leary et al., 2007; Neely, Schallert, Mohammed, Roberts, & Chen, 2009; Neff, 2003b; Neff et al., 2007a,b; Neff et al., 2007b). Furthermore, people who are self-compassionate are buffered against feelings of anxiety after experiencing a stressor, even after partialling out self-esteem (Neff et al., 2007b). These findings suggest that self-compassion can be conceptualized as a coping strategy that promotes well-being and positive psychological functioning. Thus, considering self-compassion in terms of theory and research on coping may illuminate the role that self-compassion plays in well-being and offer new directions for research.

Consensus does not exist regarding the best system for categorizing the many coping strategies that have been identified in research on stress and coping. In a synthesis of research on various coping strategies, Skinner, Edge, Altman, and Sherwood (2003)

identified 400 types of coping, showing little agreement among theorists in the best ways to conceptualize categories of coping strategies.

The most popular taxonomy of coping involves the distinction between problem-focused and emotion-focused coping. Lazarus and Folkman (1984) defined problem-focused coping as 'coping that is aimed at managing or altering the problem causing the distress' and emotion-focused coping as 'coping that is directed at regulating emotional responses to the problem' (Lazarus & Folkman, 1984, p. 150). However, studies have shown that most people use both problem-focused and emotion-focused coping when dealing with stressful events and that a particular action can often reflect either strategy (Lazarus, 1996). Not only is disentangling the nature and outcomes of each strategy difficult, but some actions are used both to solve the problem and regulate emotion, and some actions, such as seeking social support, do not clearly reflect either type of strategy. Similar problems arise with the distinction between approach versus avoidance coping. For example, help-seeking behaviors both orient the person away from the stressor (avoidant) and toward outside support (approach). Because help-seeking is positive to some extent, it could be classified as an approach behavior, yet the action itself avoids the stressor.

After reviewing and critiquing the literature, Skinner et al. (2003) identified five core categories of coping: positive cognitive restructuring, problem solving, seeking support, distraction, and escape/avoidance. This taxonomy is useful for considering the nature of self-compassion as a coping strategy.

Positive Cognitive Restructuring

Positive cognitive restructuring involves changing one's view of a stressful situation in order to see it in a more positive light. Cognitive restructuring includes lower-order actions such as being optimistic, engaging in positive thinking, and playing down negative consequences. In some taxonomies, it has often been couched within accommodative or secondary control strategies (to be discussed later).

Self-compassion involves a certain degree of positive restructuring as people who are high in self-compassion construe negative events in less dire terms than people low in self-compassion. After receiving a dissatisfying midterm grade, more self-compassionate students reported using the coping strategies of acceptance and positive reinterpretation to cope with the failure. Self-compassion was also negatively related to focusing on negative emotions (Neff, Hsieh, & Dejitterat, 2005).

In a study by Leary et al. (2007), participants reported about a negative event that they had experienced over the previous four days on four different occasions. Each time, participants described a recent negative event, rated how bad it was, and reported their thoughts and feelings about the event. Participants who were higher in self-compassion as measured by the SCS were less likely to have negative thoughts such as 'Why do these things always happen to me?' and 'I'm such a loser'. Furthermore, participants who were high in self-compassion were less likely to generalize the negative event to opinions about themselves than those who were low in self-compassion. For example, they were less likely to think that their lives were more 'screwed up' than other people's lives were.

Given the link between self-compassion and well-being, efforts have been made to lead research participants to use a self-compassionate mindset in thinking about their problems. Although only a handful of studies have looked at self-compassion inductions and therapeutic interventions, all have focused on helping people cognitively restructure their thoughts in a self-compassionate direction.

In one laboratory experiment, Leary et al. (2007) asked participants to recall a negative event that they had experienced and to answer three questions that led them to think about it in a self–compassionate way (coinciding with the three components of self–compassion identified by Neff, 2003a). In essence, this experimental manipulation focused on a cognitive reframing of the situation. The self–compassion induction led participants to take greater responsibility for the event yet to experience less negative affect and to report stronger feelings of similarity with other people.

In another laboratory experiment, Adams and Leary (2007) studied the effects of a very brief self–compassion induction on eating among women who scored high in eating guilt. After female participants were directed to eat a doughnut (a food that women high in eating guilt regard as taboo), the researcher led some participants to think about overeating in a self–compassionate manner. Highly restrictive eaters who were given the self–compassion induction were less distressed and subsequently ate less in a follow–up taste test compared with restrictive eaters who did not receive the self–compassion induction.

In a short–term intervention technique, Neff et al. (2007b) used a Gestalt two–chair technique that lowers feelings of self–criticism and helps people show themselves more compassion (Greenberg, 1983; Safran, 1998). The technique begins with the participant thinking about a time in which he or she was particularly self–critical. Then the therapist helps the participant identify both the self–critical 'voice' and the second 'voice' that responds to the criticism. The therapist coaches the two 'voices' until reaching a resolution. In this study, participants reported for the 'therapy' several times over a 1–month period during which their self–compassion was measured. As levels of self–compassion increased throughout the month, the participants criticized themselves less and experienced less depression, rumination, thought suppression, and anxiety.

Gilbert and Procter (2006) developed a group–based therapy intervention called compassionate mind training (CMT) that relies on cognitive restructuring to teach self–critical clients to develop the skills to be more self–compassionate. CMT involves twelve 2–hour sessions in which participants are taught about the qualities of self–compassion, encouraged to explore their fears about being too self–compassionate, and asked to reflect on their tendencies to be self–critical in a non–judgmental way. Results showed that CMT resulted in a significant decrease in depression, feelings of inferiority, submissive behavior, shame, and self–attacking tendencies. This research showed the most long–lasting effects of teaching people to be more self–compassionate.

Each of these intervention techniques focused primarily on positive cognitive restructuring to help participants view their situation with greater self–directed compassion. As the studies show, there are clear benefits to applying cognitive restructuring within a self–compassion induction. Merely telling people what it means to be self–compassionate may help them show more self–compassion in the future, but creating a self–compassionate mindset that is automatic will likely require a stronger and more involved self–compassion intervention. Further research is needed to assess the degree to which these effects continue after treatment has ended. Additionally, studies have yet to identify the specific length of treatment needed in order to have long–lasting effects.

Problem–Solving

The coping category of problem–solving, which resembles Lazarus and Folkman's (1984) problem–focused coping strategy, encompasses actions such as planning, strategizing, and applying effort that aim to correct the situation rather than passively allowing the stressor to continue (Skinner et al., 2003). Thus, problem–focused coping involves fixing the

problem at hand. Research suggests that problem–solving or problem–focused coping is extremely beneficial when people are able to take steps to correct the problem (Lazarus, DeLongis, Folkman, & Gruen, 1985). However, when the negative event cannot be fixed or changed, adopting a problem–solving strategy can be maladaptive because the person may continually try to correct something that cannot be fixed. For example, older adults encounter a host of unchangeable problems as they age, for which problem–focused coping may not be effective.

Research connecting self–compassion to problem–solving coping strategies is mixed. Self-compassion is positively associated with variables that predict action–oriented coping such as optimism, curiosity, exploration, and personal initiative (Neff et al., 2007a). These findings suggest that self-compassionate people may be more likely to actively engage with the environment rather than to be passive observers. The association with personal initiative supports the suggestion that self–compassion is related to taking responsibility for oneself and for attaining one's goals.

In educational psychology, researchers have distinguished between mastery–based and performance–based learning goals (Dweck, 1986). Mastery–based goals are related to intrinsic motivation for a genuine understanding of the material, whereas performance–based goals focus on evaluations of success and failure and are motivated by a desire to enhance one's self–worth or public image. Consistent with the notion that self–compassionate people are motivated to do things that help themselves, self–compassion is positively correlated with mastery–based goals and negatively associated with performance–based goals (Neff et al., 2005). To the extent that people high in self–compassion are more intrinsically motivated, they should be more motivated to continue to learn after receiving negative feedback than people who are low in self–compassion. A study by Neff et al. (2005) found that the relationship between self–compassion and mastery–based goals was mediated by lower fear of failure and greater perceived competence among self–compassionate individuals. Taken together, these findings provide support for self–compassion as a problem–solving strategy, but other results suggest otherwise.

For example, a second study by Neff et al. (2005) specifically tested the relationship between self–compassion and various coping strategies identified by the COPE scale (Carver, Scheier, & Weintraub, 1989). Self-compassion did not correlate significantly with the tendency to use any of the problem–focused strategies including active coping, planning, suppression of competing activities, restraint coping, and seeking instrumental support. Furthermore, in the study mentioned earlier in which participants reported on a negative event that had occurred during the past 4 days, self–compassion was not related to ratings on the problem–solving item, 'I took steps to fix the problem or made plans to do so' (Leary et al., 2007).

Thus, research on the relationship between self–compassion and problem–solving coping has yielded mixed results. Self-compassion is related to variables that reflect active and assertive approaches to problems, yet when tested directly, self–compassion has shown no significant relationship with problem–solving coping techniques. Perhaps, the relationship between self–compassion and problem–solving coping depends on whether people perceive that they have control in the situation. Self-compassionate people may be likely to engage in problem–solving techniques only when they perceive that the problem can be fixed by taking action.

Seeking Support

The third coping category encompasses a broad array of tactics that involve seeking help, advice, comfort, and support from parents, friends, professionals, spiritual figures, and

others. Although some taxonomies of coping suggest that seeking support should be considered a higher-order factor in its own right, other theorists have included it as a lower-order factor that can serve a variety of higher-order functions (Connor-Smith, Compas, Wadsworth, Thomsen, & Saltzman, 2000; Walker, Smith, Garber, & Van Slyke, 1997). For example, someone could seek support as either a problem-focused or emotion-focused strategy.

Although one might expect that people who desire to treat themselves caringly might turn to other people for support at times, available evidence suggests that self-compassion is not related to seeking instrumental support (a problem-solving tactic discussed earlier) or emotional support from other people (Neff et al., 2005). Additionally, following a negative event, self-compassionate individuals were no more likely to seek the company of other people (Leary et al., 2007). Although these findings suggest that self-compassion is not related to seeking support from other people, the data are admittedly thin on this question. Furthermore, evidence showing that securely attached people—who also tend to be higher in self-compassion—use others for social support (Gillath, Shaver, & Mikulincer, 2005) suggests that self-compassion and support-seeking may be related in some contexts.

Whether they seek support more than those who are low in self-compassion, people who are high in self-compassion may benefit from the indirect, implied support provided by the realization that other people share whatever problems they may have. As noted, a primary component of self-compassion involves recognition of one's common humanity. To the extent that people recognize and relate to the negative experiences of other individuals, they should realize that their own problems are not unique and also feel a greater sense of connection and empathy vis-à-vis other people. In a study asking participants to write an essay about their greatest weakness, self-compassionate individuals were more likely to use language that connoted social connections, such as 'we', that refers to relationships with family, friends, and people in general (Neff et al., 2007b). Thus, self-compassion may allow people to derive indirect social support from the knowledge that they are in the same boat as other people. Although self-compassion involves a heightened recognition of one's connection to other people, self-compassionate individuals are not necessarily more likely to seek support from others in times of need, and further research is needed to understand how self-compassion relates to people's perceptions of their connections with other people and the broader social world.

Distraction

Distraction involves using behaviors such as watching television, exercising, reading, or engaging in other pleasurable activities to distract oneself from the stressful event. Distraction is a passive coping strategy in that the person copes without directly confronting the situation or trying to solve the problem. Distraction is sometimes conceptualized as an accommodative or secondary control coping tactic (Connor-Smith et al., 2000; Skinner & Wellborn, 1994; Walker et al., 1997), which involve changing one's goals in order to accept failure, unpleasant circumstances, or other problems (Brandstadter, Rothermund, & Schmitz, 1997). For children attempting to cope with pain, for example, accommodative coping strategies help the child not to think about the pain rather than reducing the pain itself. In this situation, using a distraction technique is an accommodative strategy (Walker et al., 1997). Similarly, secondary control involves changing oneself and one's reactions in relation to the environment, whereas primary control involves controlling the environment itself (Bailis & Chipperfield, 2002; Heckhausen & Schulz, 1995). When

confronted with a situation in which a stressor is unavoidable, people may distract themselves from the situation, a secondary control strategy.

Whether distraction is adaptive and effective depends on the situation. To the extent that the situation cannot be changed, distraction may be helpful. For example, accommodative coping strategies appear to be more beneficial for people after the age of 70, possibly because fewer stressors are under people's control after that age (Brandstadter et al., 1997), and thus, people find it helpful to change their goals to match their situation. One of the ways in which people may take their mind off of pain, worries, or other difficult circumstances that are associated with aging is by using distraction techniques.

With the exception of one study that found that people high in self-compassion were no more likely to try to do things to take their mind off of negative events (Leary et al., 2007), research has not provided insight into how self-compassion might be related to the use of distraction as a means of coping with difficult and distressing events. One question to be addressed is whether distraction is more adaptive in the face of unchangeable stressors. Perhaps self-compassionate people are more likely to use distraction primarily when conditions cannot be changed.

Escape and Avoidance

The final coping category identified by Skinner et al. (2003) is escape–avoidance. This strategy involves disengaging cognitively or behaviorally from the stressful experience. Traditionally, researchers have viewed avoidant coping strategies as a variety of emotion-focused strategy in which people avoid the stressor to manage their emotions (Lazarus, 1993). However, research has distinguished two types of emotion-focused strategies—one involving disengagement, and the other involving efforts to explore and understand one's emotions (Zeidner, 1995). The latter category has been shown to be adaptive and positively related to psychological functioning (Stanton, Danoff–Burg, Cameron, & Ellis, 1994; Stanton, Kirk, Cameron, & Danoff–Burg, 2000). Avoidant coping strategies are often viewed as maladaptive because they are related negatively to psychological well-being (Carver et al., 1989), but these results suggest that avoidant coping may be linked only with the disengagement type of emotion–focused coping.

Research supports a negative relationship between self-compassion and avoidance-oriented coping strategies. In a study by Neff et al. (2005), participants were evaluated after receiving an unsatisfactory midterm grade. They were told to focus on their reactions to their poor test performance and complete the COPE scale (Carver et al., 1989). Self-compassion was negatively related to two of the three avoidance-oriented coping strategies, specifically denial and mental disengagement. Furthermore, in examining the link between Post-traumatic Stress Disorder (PTSD) and self-compassion, Thompson and Waltz (2008) found that self-compassion was negatively related to experiential avoidance, a symptom of PTSD.

The mindfulness component of self-compassion involves taking a balanced perspective in which one acknowledges and tries to understand one's emotions without either repressing them or becoming overwhelmed. Thus, as a coping strategy, self-compassion explicitly involves not running away from one's negative emotions but rather striving to understand one's reactions with equanimity (Neff, 2003b).

Viewed in one light, the reactions of highly self-compassionate people could also be interpreted as indifference, a refusal of accept responsibility (an avoidant or escape-oriented response), or as passivity (which could also be viewed as avoidance). However, self-criticism is probably more likely than self-compassion to lead people to avoid dealing

with problems and to repress painful feelings (Horney, 1950; Reich, 1949). Research clearly shows that people who are self-compassionate are more likely to accept responsibility for their mistakes and failures than those who are less self-compassionate (Leary et al., 2007). Treating themselves kindly despite their problems and failures allows people who are high in self-compassion to accept responsibility and to move on rather than engaging in defensiveness or denial.

Given that self-compassionate people are less judgmental and more likely to forgive their faults and inadequacies, they have less of a need to deny their failures and shortcomings. In fact, people who are high in self-compassion take greater responsibility for their failures and make needed changes while maintaining a loving, caring, and patient approach toward themselves. Being compassionate toward oneself instills a protective environment where it is safe to acknowledge one's inadequacies and seek ways to improve. Self-compassion implies wanting the best for oneself, and this desire naturally leads to positive self-changes.

Other Coping Strategies

In addition to the five coping categories that Skinner et al. (2003) found appeared most frequently in the literature, seven other categories were identified, two of which, rumination and self-pity, are directly relevant to self-compassion. As a coping strategy, rumination involves repetitively focusing on a stressor in a pessimistic and negative manner and has been shown to be associated with dysphoria and other psychological difficulties (Nolen-Hoeksema, 1991). One study found that self-compassion was negatively related to rumination (Neff et al., 2007b).

Likewise, self-compassion is probably negatively correlated with self-pity, which should be lowered by recognition of one's common humanity. Self-compassion should encourage people to accept negative life events as part of the common human experience rather than feel sorry for themselves. In addition, the mindfulness aspect of self-compassion should help prevent people from becoming overwhelmed with self-directed negativity.

Proactive Coping

Coping is typically viewed as a response to existing stressors or negative events. However, people sometimes begin to cope in preparation for anticipated negative events. Proactive coping, also termed preventative coping and anticipatory coping, involves making an effort to prepare for stressful events that could occur in the future (Aspinwall, 2005; Aspinwall & Taylor, 1997; Greenglass, 2002). Although relatively unexplored, proactive coping holds promise for understanding psychological variables that lead people to take care of themselves before problems arise. To the extent that self-compassion involves a desire to do what's best for oneself and to minimize one's future suffering, self-compassion may be related to proactive coping. When faced with the threat of future negative events, self-compassionate people may be more likely to deal with them proactively.

One promising area of proactive coping research involves how people prepare for and cope with aging. The many changes, losses, and declines that accompany aging can be considered a multitude of potential future stressors. Kahana and Kahana (2003) proposed a proactivity-based model of successful aging in which they suggested that people's internal resources can foster proactive adaptations, including traditional preventative adaptations (such as exercise), corrective adaptations (such as marshalling social support), and emergent adaptations (such as self-improvement). Proactive coping may help older people

avoid certain mental and physical problems that accompany aging (Greenglass, Fiksen-baum, & Eaton, 2006). If people who are high in self-compassion are more likely to cope proactively, they may fare better as they age.

Among other things, a proactive approach to life involves taking care of one's health through exercise and diet. However, such behaviors are not unequivocally healthy when they are motivated by judgment and criticism or by a desire to be accepted by other people. A few studies have looked at the connection between self-compassion and behaving in healthy ways. For example, women who were high in self-compassion were more intrinsically than extrinsically motivated to exercise, and their reasons for exercising were not related to ego concerns (Magnus, 2007). Another study looked at how self-compassion was related to how women coped after eating personally forbidden food (Adams & Leary, 2007). Typically highly restrictive eaters overeat after they break their diet, but in this study, highly restrictive eaters who were led to be self-compassionate did not exhibit dysregulated eating.

Although little research has evaluated the relationship between self-compassion and proactive coping, self-compassion could play an important role in this process. People who cope proactively begin to prepare themselves in advance for possible distressing situations in the future. Therefore, one would presume that when stressors arise, self-compassionate people are more prepared to deal with their effects. The act of pro-actively coping could also delay the stressor for a longer period of time, such as when exercise prevents physical decline. If self-compassion is related to proactive coping, teaching people to be more self-compassionate should be beneficial no matter people's current life situation.

Conclusion

Self-compassion may be a valuable coping resource when people experience negative life events. People who are self-compassionate are less likely to catastrophize negative situations, experience anxiety following a stressor, and avoid challenging tasks for fear of failure. Research suggests that self-compassion can play an important role in the coping process.

Among the five coping categories discussed here – positive cognitive restructuring, problem solving, seeking support, distraction, and escape/avoidance – self-compassion relates most strongly to positive cognitive restructuring. Most existing research on the relationship between self-compassion and coping suggests that self-compassion involves thinking about stressful situations in ways that enhance coping. In contrast, self-compassion did not relate strongly to problem-solving techniques, suggesting that people who are self-compassionate are not necessarily more likely to try to change their situation than people who are low in self-compassion. (However, the finding that self-compassion is associated with mastery-based goals qualifies this conclusion.) Although the existing evidence does not show differences in the degree to which people who are low versus high in self-compassion seek support, more research on this question is needed.

Little research has examined the connection between self-compassion and the use of distraction as a coping technique. On one hand, self-compassion may be negatively related to distraction because self-compassion involves being mindfully aware of one's situation and cognitively accepting it. On the other hand, both distraction and positive cognitive restructuring are accommodative and secondary control strategies. Perhaps treating oneself kindly sometimes requires people to distract themselves from the situation at hand.

The final coping strategy, escape-avoidance, shows a negative relationship with self-compassion. People who are more self-compassionate are more willing to accept responsibility for negative events, and they are less likely to use avoidant coping strategies. Escape-avoidance is perhaps the most maladaptive of the five primary coping techniques. Thus, its negative relationship with self-compassion reinforces the claim that self-compassion can be viewed as a more adaptive mindset.

Although some people are naturally more self-compassionate than others, people can be led to be more self-compassionate. Researchers have induced self-compassion by helping people cognitively reframe negative events, leading to a more positive and open acceptance of the event. Further work in this area should address the possible long-term benefits of self-compassion interventions. Another promising area of research involves proactive coping. The relationship between self-compassion and personal initiative suggests that self-compassionate people take a more proactive approach to life, and this relationship may have implications for how people prepare for and deal with negative events.

In conclusion, self-compassion appears to reflect a way of coping with negative events that is characterized primarily by positive cognitive reframing, although other coping tactics may also be more common among self-compassionate people. Future research should strive to identify the thought patterns that differentiate low and high self-compassionate people with an eye toward developing self-compassion interventions that improve coping.

Short Biographies

Ashley Batts Allen's research revolves around self-processes, specifically how people's feelings and beliefs about themselves influence their responses to the social world. She recently received funding from the National Institute of Health to support her research on self-compassion and well-being in older adults. She received her B. A. in psychology from Wake Forest University, her M. A. in social psychology from Duke University, and is now pursuing her doctoral degree in social psychology at Duke University.

Mark Leary is Professor of Psychology and Neuroscience and Director of the Duke Interdisciplinary Initiative in Social Psychology at Duke University. He received his Ph.D. in social psychology at the University of Florida and has taught at Denison University, the University of Texas, and Wake Forest University. His research focuses on social motivation and emotion, particularly the processes by which people think about and evaluate themselves, the effects of self-reflection on emotion and psychological well-being, and how behavior and emotion are influenced by people's concerns with how they are perceived and evaluated by others. He is a Fellow of the American Psychological Association, the Association for Psychological Science, and the Society for Personality and Social Psychology. He was the founding editor of the journal, Self and Identity, and is currently editor of Personality and Social Psychology Review.

Endnote

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References

Adams, C. E., & Leary, M. R. (2007). Promoting self-compassionate attitudes toward eating among restrictive and guilty eaters. *Journal of Social and Clinical Psychology*, **26**, 1120–1144.

Aspinwall, L. G. (2005). The psychology of future-oriented thinking: From achievement to proactive coping, adaptation, and aging. *Motivation and Emotion*, **29**, 203–235.

Aspinwall, L. G., & Taylor, S. E. (1997). A stitch in time: Self-regulation and proactive coping. *Psychological Bulletin*, **121**, 417–436.

Bailis, D. S., & Chipperfield, J. G. (2002). Compensating for losses in perceived personal control over health: A role for collective self-esteem in healthy aging. *Journals of Gerontology: Series B: Psychological Sciences and Social Sciences*, **57**, 531–539.

Brandstadter, J., Rothermund, K., & Schmitz, U. (1997). Coping resources in later life. *European Review of Applied Psychology*, **47**, 107–114.

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*, **84**, 822–848.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, **56**, 267–283.

Connor-Smith, J. K., Compas, B. E., Wadsworth, M. E., Thomsen, A. H., & Saltzman, H. (2000). Responses to stress in adolescence: Measurement of coping and involuntary stress responses. *Journal of Counseling and Clinical Psychology*, **68**, 976–992.

Dweck, C. S. (1986). Motivational processes affecting learning. *American Psychologist*, **41**, 1040–1048.

Gilbert, P., Clarke, M., Kemple, S., Miles, J. N. V., & Isons, C. (2004). Criticizingand reassuring oneself: An exploration of forms, style, and reasons in female students. *British Journal of Clinical Psychology*, **43**, 31–50.

Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory*, **12**, 507–516.

Gilbert, P., & Procter, S. (2006). Compassionate Mind Training for People with High Shame and Self-Criticism: Overview and Pilot Study of a Group Therapy Approach. *Clinical Psychology & Psychotherapy*, **13**, 353–379.

Gillath, O., Shaver, P. R., & Mikulincer, M. (2005). An attachment-theoretical approach to compassion and altruism. In P. Gilbert (Ed.), *Compassion: Conceptualisations, Research, and Use in Psychotherapy* (pp. 121–147). London: Routledge.

Greenberg, L. S. (1983). Toward a task analysis of conflict resolution in Gestalt Therapy. *Psychotherapy: Theory, Research, and Practice*, **20**, 190–201.

Greenglass, E. (2002). Proactive coping and quality of life management. In E. Frydenberg (Ed.) *Beyond Coping: Meeting Goals, Visions, and Challenges* (pp. 37–62). New York: Oxford University Press.

Greenglass, E., Fiksenbaum, L., & Eaton, J. (2006). The relationship between coping, social support, functional disability and depression in the elderly. *Anxiety, Stress & Coping: An International Journal*, **19**, 15–31.

Heckhausen, J., & Schulz, R. (1995). A lifespan theory of control. *Psychological Review*, **102**, 284–304.

Horney, K. (1950). *Neurosis and Human Growth The Struggle Toward Self-Realization*. New York: Norton.

Kahana, E., & Kahana, B. (2003). Patient proactivity enhancing doctor-patient-family communication in cancer prevention and care among the aged. *Patient Education and Counseling*, **50**, 67–73.

Lazarus, R. S. (1993). From psychological stress to the emotions: A history of a changing outlook. *Annual Review of Psychology*, **44**, 1–21.

Lazarus, R. S. (1996). The role of coping in the emotions and how coping changes over the life course. In C. Maletesta-Magni & S. H. McFadden (Eds.), *Handbook of Emotion, Adult Development, and Aging* (pp. 289–306). New York: Academic Press.

Lazarus, R. S., DeLongis, A., Folkman, S., & Gruen, R. (1985). Stress and adaptational outcomes: The problem of confounded measures. *American Psychologist*, **40**, 770–779.

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer.

Leary, M. R., Tate, E. B., Adams, C. E., Batts Allen, A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology*, **92**, 887–904.

Magnus, C. M. (2007). *Does Self-Compassion Matter Beyond Self-Esteem for Women's Self-Determined Motives to Exercise and Exercise Outcomes?* Unpublished Master's Thesis, University of Saskatchewan, Saskatoon, Canada.

Neely, M. E., Schallert, D. L., Mohammed, S. S., Roberts, R. M., & Chen, Y. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students' well-being. *Motivation and Emotion*, **33**, 88–97.

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

Neff, K. D. (2003b). Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself. *Self and Identity*, **2**, 85–101.

Neff, K. D. (2006, August). *The Role of Self-Compassion in Healthy Relationship Interactions*. Paper presented at the annual meeting of the American Psychological Association, New Orleans, LA.

Neff, K. D., Hsieh, Y.-P., & Dejitterat, K. (2005). Self-compassion, Achievement Goals, and Coping with Academic Failure. *Self and Identity*, **4**, 263–287.

Neff, K. D., Rude, S. S., & Kirkpatrick, K. L. (2007a). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of Research in Personality*, **41**, 908–916.

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

Nolen-Hoeksema, S. (1991). Ruminative coping with depression. In J. Heckhausen, C. S. Dweck (Eds.) *Motivation and self-regulation across the lifespan* (pp. 237–256). Cambridge, England: Cambridge University Press.

Reich, W. (1949). *Character and Analysis*. New York: Orgone Institute Press.

Safran, J. D. (1998). *Widening the Scope of Cognitive Therapy: The Therapeutic Relationship, Emotion, and the Process of Change*. Northvale, NJ: Jason Aronson.

Skinner, E. A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: A review and critique of category systems for classifying ways of coping. *Psychological Bulletin*, **129**, 216–269.

Skinner, E. A., & Wellborn, J. G. (1994). Coping during childhood and adolescence: A motivational perspective. In D. Featherman, R. Lerner & M. Perlmutter (Eds.) *Life-Span Development and Behavior* (Vol. 12, pp. 91–133). Hillsdale, NJ: Erlbaum.

Stanton, A. L., Danoff-Burg, S., Cameron, C. L., & Ellis, A. P. (1994). Coping through emotional approach: Conceptualization and confounding. *Journal of Personality and Social Psychology*, **66**, 350–362.

Stanton, A. L., Kirk, S. B., Cameron, C. L., & Danoff-Burg, S. (2000). Coping through emotional approach: Scale construction and validation. *Journal of Personality and Social Psychology*, **78**, 1150–1169.

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

Walker, L. S., Smith, C. A., Garber, J., & Van Slyke, D. A. (1997). Development and validation of the pain response inventory for children. *Psychological Assessment*, **9**, 392–405.

Zeidner, M. (1995). Adaptive coping with test situations: A review of the literature. *Educational Psychologist*, **30**, 123–133.