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**UNIVERSITY OF SOUTHAMPTON**  
**FACULTY OF MEDICINE, HEALTH, AND LIFE SCIENCES**  
Department of Clinical Psychology

What do recent developments in the area of self-compassion have to offer the treatment of social anxiety?

Sara Thomas

This thesis is submitted in partial fulfilment of the requirement for the degree

Doctorate in Clinical Psychology

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**ABSTRACT**

FACULTY OF MEDICINE, HEALTH, AND LIFE SCIENCES

**Doctorate in Clinical Psychology**

**WHAT DO RECENT DEVELOPMENTS IN SELF-COMPASSION HAVE TO OFFER THE TREATMENT OF SOCIAL PHOBIA?**

By Sara Thomas

A variety of recent literature has considered the impact of self-compassion on mental health. Further research is needed, but the evidence to date suggests that self-compassion is associated with psychological well-being (Neff, 2003a; Neff, Kirkpatrick, Rude, 2007; Neff, Rude, Kirkpatrick, 2007), and that enhancing self-compassion can buffer against social-evaluative concerns (Leary, Tate, Allen, & Adams, 2007, Neff, 2003a). Additionally, when enhancing self-compassion has been used as part of a treatment for mental health problems, symptoms have reduced (Gilbert & Procter, 2006; Linehan, Heard, & Armstrong; 1999; Lee, 2005; Mayhew & Gilbert, 2008; Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000). In the following papers, the role of self-compassion in the development and maintenance of social phobia is investigated. In the first paper, current aetiological and maintenance models are reviewed, and hypotheses made about how self-compassion may impact on these processes. Evidence from both clinical and nonclinical studies is used to support these hypotheses, and further research is suggested.

In the second paper some of these hypotheses are tested. In this study, evaluations of performance, post-event processing, and anxiety were measured in a socially anxious analogue group, following a stressful social situation. These scores were then compared to those of other socially anxious participants who did not undergo a self-compassion induction. Results showed no differences in levels of post-event processing or anxiety between the groups. However, participants in the self-compassion group rated their performance more closely to the rating of an independent observer than participants in the other groups. This suggests that increasing self-compassion facilitated greater objectivity when evaluating participants' own performances of a socially stressful task. Implications for the treatment of social phobia are discussed, and suggestions are made for further research.

Literature review

What do recent developments in the area of self-compassion have to offer the treatment of social anxiety?

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I the undersigned confirm that the work I have presented as my thesis is entirely my own work. Reference to, quotation from, and discussion of the work of any other person has been accurately acknowledged within the work in accordance with University guidelines for production of theses.

Signed:

Sara Thomas

Date: 25 May 2010

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## Abstract

A variety of recent literature has considered the impact of self-compassion on mental health. Further research is needed, but the evidence to date suggests that self-compassion is associated with psychological well-being (Neff, 2003a; Neff, Kirkpatrick, Rude, 2007; Neff, Rude, Kirkpatrick, 2007), and that enhancing self-compassion can buffer against social-evaluative concerns (Leary, Tate, Allen, & Adams, 2007, Neff, 2003a). Additionally, when enhancing self-compassion has been used as part of a treatment for mental health problems, symptoms have reduced (Gilbert & Procter, 2006; Linehan, Heard, & Armstrong; 1999; Lee, 2005; Mayhew & Gilbert, 2008; Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000). The following paper explores the role that self-compassion may have in the aetiology and maintenance of social phobia. In order to do this, current aetiological and maintenance models are reviewed, and hypotheses made about how self-compassion may impact on these processes. Evidence from both clinical and nonclinical studies is used to support these hypotheses, and further research is suggested.

Key words: social anxiety disorder, social phobia, self-compassion, post-event processing

Social phobia is characterised by harsh self-criticism and preoccupation with anxiety-related thoughts and sensations. A self-compassionate perspective represents the opposite stance to these kinds of cognitions and to this cognitive style. Self-compassion involves treating oneself kindly, and being aware of, but not over-identifying with one's difficult or painful emotions (Neff, 2003a), and therefore may be useful for understanding and treating social phobia. Research on self-compassion is in the early stages, but there is evidence which demonstrates that self-compassion is linked to psychological well-being and resilience (Leary, Tate, Allen, & Adams, 2007; Neff, 2003b; Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). With the exception of one study (Price 2008), the research has not looked directly at self-compassion in relation to social phobia, but it has proved to be useful for other highly self-critical groups. In the following paper it will be argued that research on self-compassion is highly relevant to social phobia because of the propensity for socially phobic individuals to be harshly self-critical. Future research which examines how self-compassion relates to social phobia is proposed. In order to do this, a brief definition of self-compassion will be presented, along with a description of the only current measure of self-compassion, the Self-Compassion Scale (Neff, 2003a). After a brief definition of social phobia, aetiological models of the disorder will be considered in relation to self-compassion. This will be followed by an exploration of how self-compassion may relate to maintenance models of social phobia. The potential benefits of self-compassion for individuals with social phobia will be considered in relation to factors within these models, with support from the literature. Suggestions for research will be made throughout.

## 2. Literature search

A literature search was carried out using Ovid Medline (R) database (1996 – present). Search terms included were social anxiety disorder, social phobia, post-event processing and self-compassion.

The current interest in self-compassion comes from Buddhist philosophy, where compassion towards the self (and others) is seen as central to managing destructive emotions, such as fear, anger, envy, and vengeance (Goleman, 2003), and releasing oneself from suffering (Gilbert, 2005a). Neff (2003a) proposes that self-compassion consists of 3 components: self-kindness, mindfulness, and common humanity. Self-kindness involves treating oneself with kindness in times of pain or failure. This is in contrast to a harsh, self-critical attitude towards oneself. Mindfulness refers to a cognitive style which involves maintaining awareness of ones' painful emotions, rather than disconnecting from them. However, it does not involve over-identifying with these emotions, or getting 'caught up' in them. A mindful approach is also objective and non-judgemental. Common humanity refers to a view that ones' failures, shortcomings, and pain are universal, human experiences, rather than experiences which engender isolation or a sense of being different from others.

Self-compassion has been applied to treatments for a range of clinical problems, including depression (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; Gilbert & Procter, 2006), voice hearing (Mayhew & Gilbert, 2008), borderline personality disorder (Linehan, Heard, & Armstrong; 1999), and trauma-related disturbance (Lee, 2005). All of the above authors have found that enhancing self-compassion has a beneficial effect for these problems, which are all associated with high levels of self-criticism. Self-compassion enhancement has not yet been incorporated into treatments for social phobia, but I will argue that a range of evidence from other areas suggests that self-compassion may aid understanding of the development and treatment of the disorder.

In order to study self-compassion, it is important to be able to measure it. The only published self-compassion measure to date is the Self-Compassion Scale (SCS; Neff 2003b). The SCS is a 26-item questionnaire designed to measure Neff's three proposed components of self-compassion and their opposites: self-kindness vs. self-judgment, mindfulness vs. over-identification, and common humanity vs. isolation. Items either endorse a self-compassionate perspective (e.g. I'm kind to myself when experiencing suffering), or a non-

compassionate perspective (e.g. When I see aspects of myself I don't like, I tend to get down on myself). In a series of validation studies of the measure (Neff, 2003b), the SCS had high test-retest reliability (.93). Neff (2003b) also found that SCS scores were negatively correlated with self-criticism (-.65), and positively correlated with a sense of social connection (.41), showing divergent and convergent validity, respectively. Construct validity for the SCS was shown in a study in which scores on the SCS differentiated between a sample of Buddhists (who were expected to have higher levels of self-compassion) and a sample of undergraduate students (who were expected to have lower levels of self-compassion) (Neff, 2003b). Additionally, scores on the SCS predicted the number of years of Buddhist practice (within the Buddhist sample), indicating that the measure was sensitive to the higher levels of self-compassion expected from the longer practicing Buddhists (Neff, 2003b). Factor analyses of the measure confirm the factor structure of the SCS (Neff, 2003b). Given these results, the SCS appears to be psychometrically sound. A limitation of the SCS is that it measures only trait self-compassion, so it may not be useful for assessing changes in self-compassion over short periods of time.

In the next section, social phobia will be briefly defined and an overview of current aetiological models will be given. Current aetiological models of social phobia will then be summarised and the potential impact of self-compassion on the development of social phobia will be considered.

#### 4. Defining social phobia

Social anxiety disorder is characterised by the fear of negative evaluation by others in social situations. It is a common and debilitating problem, which appears to have high levels of comorbidity, including anxiety, mood, and substance misuse disorders (de Ruiter et al., 1989; Hunt & Andrews, 1995; Last, Strauss, & Francis, 1987; Sanderson, Di Nardo, Rapee, & Barlow, 1990).

Diagnosis of social anxiety disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders (4<sup>th</sup> ed.) (American Psychiatric Association, 2004), requires "a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny by others. The individual feels he or she will act in a way (or show

anxiety symptoms) that will be humiliating or embarrassing", (p. 416). Social anxiety related to only one social situation (e.g. public speaking) falls into the 'specific' subtype. An individual is deemed to have the 'general' subtype when the anxiety is related to a range of social situations.

Two other important criteria for a diagnosis of social anxiety disorder relate to the impact that the anxiety has on the individual. It must cause considerable distress, and impair functioning in at least some parts of daily life. These criteria indicate a problem of differentiating between pathological levels of social anxiety and the lower levels found to be common within the wider population (Mattick & Clark, 1998). Many believe that social anxiety disorder should not be viewed as a qualitatively distinct category, but as the high end of a continuum, which includes no social anxiety at one end and, at its most extreme, avoidant personality disorder (Rapee & Spence, 2004; Leary & Kowalski, 1995). For clarity, the term 'social phobia' will refer to the diagnosis of social anxiety disorder, while 'social anxiety' will refer to subclinical levels along the continuum. Estimates of the lifetime prevalence of social phobia range from 7%-13% in Western societies (Furmark, 2002). Studies consistently show greater prevalence among women than men (Furmark, 2002). Age of onset is typically in early to mid-teens (Rapee, 1995). The causes of social phobia are not straight-forward. Current aetiological models of social phobia are discussed below.

### 5. Aetiological models of social phobia and self-compassion

The causes of social phobia are not as well understood as the factors that maintain the disorder (Rapee & Spence, 2004). Evolutionary models of social anxiety have been proposed as a basis for explaining the development of social anxiety. Gilbert (2005b) proposes that self-compassion and associated systems play a role. Evidence for this model is examined. Another prominent aetiological model of social phobia is presented (Rapee & Spence, 2004), and considered in relation to self compassion. It will be argued that self-compassion fits well with aetiological models of social phobia, and this warrants further research.

## 5.1 Evolutionary models

Evolutionary models of social anxiety (Baumeister and Tice, 1990; Gilbert & Trower, 2001) propose that social anxiety has evolved as a mechanism for preserving needed social bonds. Because as humans we are social beings who do not often survive in isolation, we are motivated to be valued by others (Gilbert, 2001). Making a good impression is important, and anxiety arises when one feels incapable of doing this (Schlenker & Leary, 1982). According to Gilbert and Trower (2001), social anxiety is a normal reaction to the perceived threat of loss of status or resources, when one is already in a position of relatively low status. In order to avoid aggression or conflict, one behaves submissively (e.g. avoids eye contact, talks briefly, and criticises oneself). While these behaviours may help to avoid conflict, they can also result in loss of status and heightened vulnerability. This state increases social anxiety.

Gilbert proposes that in these situations, a certain set of emotions, information processing strategies, and neural pathways are triggered, which constitute his *social rank mentality*. It involves “striving to be valued by others for social inclusion (or to exert control over others), seeking status in the eyes of others to be chosen in the competitions for social place, being highly sensitive to social comparisons with fears of ‘not being good enough or inferior’, and heightened shame sensitivity”, (Gilbert, 2005b, p.17). If this mentality is activated often, it can result in feeling rejected, shamed, depressed and socially anxious. Gilbert suggests that compassion occurs in response to the activation of a *care-giving mentality*, which involves care, co-operation, and concern for others. According to Gilbert, the care-giving mentality arises from positive experiences of care by early attachment figures. Those experiences of safeness and soothing are internalised, so that the person is able to soothe themselves in times of pain. Therefore self-compassion is thought to be a learned skill which can be strengthened through practice. Gilbert views the social rank and care giving mentalities as mutually exclusive, so that only one can be experienced at a time.

An implication of this model for social phobia is that individuals with social phobia may have underdeveloped self-soothing systems, and may be less self-compassionate. When in stressful social situations, their social rank mentality may become activated, and they may not be able to activate self-soothing when

needed or when appropriate. Based on the model, it would be possible to increase self-compassion through repeated stimulation of the care-giving mentality. Therefore increasing self-compassion may take time and practice. Once strengthened, self-compassion may decrease anxiety and social evaluative concerns (associated with the social rank mentality), if activated in stressful social situations.

Research which supports aspects of this model comes from a study carried out on Buddhist monks by Davidson and colleagues (Lutz, Brefczynski-Lewis, Johnstone, Davidson; 2008). This research group compared the neurological activity of Buddhist monks who had well established compassion meditation practices with participants who were trained in the basics of compassion meditation two weeks prior to the study. In the study, functional magnetic resonance imaging (fMRI) scans were taken of participants while they either meditated or refrained from meditating. In each state, participants were played auditory vocalizations, designed to elicit empathic responses, or neutral vocalizations, such as the sounds of a distressed woman, a baby laughing, or background noise at a restaurant. The brain scans showed that activity in parts of the brain associated with emotions and empathy (the insula and the temporal parietal juncture, the latter particularly in the right hemisphere) were most pronounced in the expert meditators when they were exposed to the emotional vocalizations. This suggests that the expert meditators may have experienced higher levels of empathy or compassion. These findings support Gilbert's notion that compassion has specific neural correlates. It also suggests that these neural pathways can be strengthened through practice, in this case through compassion meditation. A weakness of this study is that it is difficult to isolate the impact of the compassion meditation practice from other potential confounding factors, such as previous trait compassion. Highly compassionate individuals may be more drawn to becoming monks and developing a meditation practice.

It would be interesting to examine the neural activity of other groups who are high or low in self-compassion to see whether differences exist. Additionally, this study looked at compassion towards others, which is often associated with self-compassion in the literature, but may be somewhat different to self-compassion.

Further research may look at the neural impact of being exposed to one's own emotional stimuli during meditation. Finally, this study involved non-clinical samples, who may have a different experience of meditation from individuals with social phobia or other mental health problems. For example, it may be very difficult for these individuals to establish a meditation practice. If as Gilbert describes, self-compassion is associated with neural pathways established through positive early attachment experiences, perhaps self-compassion is not possible in people who lack these early experiences. In a study by Gilbert and colleagues (Gilbert, Clark, Hempel, Miles, & Irons 2004) individuals high in self criticism found it more difficult to bring into mind an image of themselves that was soothing, accepting and compassionate than low self-critics. To assess the possibility of developing self-compassion in clinical groups, we will now look at research carried out by Gilbert and colleagues in which clinical samples were given training in self-compassion.

Compassionate mind training (CMT) was developed by Gilbert and colleagues (Gilbert & Irons, 2005) to strengthen the underdeveloped care-giving mentality hypothesized in his theory in people with mental health problems. The training involves learning to respond to problematic behaviours and emotions compassionately. For example, recognising the fear which drives the use of safety behaviours in OCD, and responding compassionately. Imagery is used to develop feelings of compassion, as is common practice in Buddhist compassion meditation (Rinpoche, & Mullen, 2005). Patients are asked to generate an image of a self-compassionate part of themselves, while bringing to mind memories of when others have been compassionate towards them, or they have felt compassion towards others, and they experienced a feeling of warmth. Once patients experience this image and associated feelings of warmth and self-acceptance, they are asked to re-evaluate their self-critical thoughts. Patients are encouraged to consider CMT a physiological therapy for the brain, which requires repetition.

Pilot studies of CMT have been carried out with participants who hear malevolent voices (Mayhew & Gilbert, 2008), or have other chronic mental health problems (Gilbert & Proctor, 2006). Both of these studies found that compassionate mind training was followed by reductions in depression and

anxiety. Mayhew and Gilbert (2008) also found reductions in psychoticism, paranoia, obsessive compulsive disorder and interpersonal sensitivity. Gilbert and Proctor (2006) found reductions in self-criticism, shame, inferiority, and submissive behaviour. These studies involved small participant numbers, so further research is needed in order to generalise the results to wider populations, but this innovative approach does show promise as a therapeutic tool for a variety of problems. As CMT was developed broadly for individuals who are self-critical rather than for a specific diagnosis, and it is used as an adjunct to therapy rather than a stand alone therapy, it may be justifiably offered to individuals with social phobia in addition to CBT. A future study could offer CBT or CBT plus CMT to a sample of people with social phobia. The amount of input should be balanced between the groups, so that participants in CBT+CMT group do not receive more hours of input, which would confound the results.

Further research is needed to examine Gilbert's model. Initially, it is important to investigate whether individuals with social phobia are less self-compassionate than others, and whether they have more difficulties self-soothing. This may be achieved with a correlational study using either samples of people who are high and low in social anxiety, or a clinical sample of people diagnosed with social phobia and a nonclinical sample. Scores for the two groups on the SCS, social anxiety, and perhaps measures of self-soothing could be compared. To test the notion that strengthening self-compassion would decrease social anxiety, a self-compassion induction would be needed. This may need to be repeated over time, as the model suggests, in order to achieve a substantial increase. Then anxiety and cognitions could be measured during/after a stressful social situation. These scores could then be compared to those of a socially anxious control group, who have not received self-compassion training. If Gilbert's model is supported, increasing self-compassion may be an antidote for social anxiety, as it should stop concerns about social rank.

Gilbert's model is the only model of social anxiety that emphasises the role of self-compassion in the development of social anxiety, as self-compassion is a relatively new concept within western psychology. It is important to consider another prominent aetiological model (Rapee & Spence, 2004) of social phobia

to assess whether self-compassion might fit into a broader, and perhaps more empirically supported model of social phobia.

### 5.2 Rapee and Spence's model of social phobia (2004)

Several factors have been identified which put individuals at risk of developing social phobia, such as temperament, parenting style, and aversive social experiences. Many of these factors are incorporated into Rapee and Spence's (2004) model of the aetiology of social phobia. They suggest that genetic factors such as temperament and sociability determine a 'set point' for an individual along the social anxiety continuum. The continuum ranges from no social anxiety to extreme social anxiety, with a diagnosable level of social phobia falling toward the upper end. Then environmental factors, such as parental influence, aversive social experiences and negative life events can shift the individual's social anxiety level up or down the continuum, at times creating a new set-point. The model accounts for the fact that no one factor appears to be essential for the development of social phobia (Rapee & Spence, 2004).

Additionally, these factors do not just put individuals at risk of developing social phobia. They are risk factors for anxiety disorders generally, depression, and alcohol abuse (Andrews, 1996; Nelson, et al., 2000).

What role might self-compassion play in the development of social anxiety considering the Rapee and Spence model? High levels of self-compassion may provide a buffer against difficult experiences, which could otherwise lead to the onset of social phobia. Research has not been carried out on children, but the evidence with adults to date shows that self-compassion is associated with lower levels of negative affect following difficult experiences (Leary et al., 2007) and less depression and anxiety (Neff, 2003b; Neff Kirkpatrick & Rude, 2007). Self-compassion may provide a reframing of difficult life events as normal experiences which happen to others too. An attitude of self-kindness may provide the comfort or self-soothing, turning negative affect into positive affect. It may decrease the psychic need to disconnect from painful feelings, and decrease the fear of difficult situations. Additionally, being able to face difficult situations and cope with the emotions they evoke may engender a sense of self-esteem as well as self-compassion, which is also associated with positive mental health (Harter, 1999).

Two studies have shown that self-esteem is moderately correlated with self-compassion (Neff, 2003b; Leary et al. 2007). In a third study, Price (2008) measured self-compassion and self-esteem in a socially anxious sample. Participants who received a self-compassion induction showed a higher correlation between implicit and explicit self-esteem, (in comparison to socially anxious participants who did not experience a self-compassionate induction). Low correlations between implicit and explicit self-esteem have been associated with poorer outcomes (Kernis, Cornell, Sun, Berry, & Harlow, 2003). Price (2008)<sup>1</sup> hypothesised that this stronger positive correlation suggests a smaller discrepancy between implicit and explicit self-esteem for the socially anxious participants who received the self-compassion induction. This may be associated with more stable self-esteem which could have positive implications for resilience in the face of set-backs or failures. Further research is needed in this area.

Self-compassion as a buffer against social phobia would help to account for the fact that some individuals do not develop social phobia while others do, when exposed to the same risk factors. However, self-compassion is unlikely to be the only protective factor. It is also possible that genetically influenced factors, such as temperament, affect one's ability to be self-compassionate. Following Gilbert's theory that self-compassion is learned from experiences of being soothed by early attachment figures, it is possible that children who are easily agitated and difficult to soothe may have fewer positive experiences of being successfully soothed as infants. This interactive influence between parent and child is believed by some (Hudson & Rapee, 2004) to play a role in the development of social anxiety.

Research on self-compassion, genetic factors, and parenting style would be valuable, but very difficult to carry out, given the complex, multi-factorial nature of interactions between genetics and environment. To assess whether high levels of self-compassion prevent the development of social phobia, a longitudinal study could be carried out, though this would be very costly, and again difficult to isolate the impact of self-compassion. The lower level of empirical support for aetiological theories reflect these difficulties. Research on

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<sup>1</sup> This study was carried out in conjunction with the study described in the following empirical paper.

how self-compassion impacts on maintenance models social phobia may be more easily achieved. Before considering how self-compassion may impact on factors maintaining social phobia, one of the most prominent models of social phobia (Clark & Wells, 1995) is described.

## 6. Maintenance models of social phobia

Cognitive models of social phobia (Hofman, 2007; Clark & Wells, 1995; Rapee & Heimberg, 1997) emphasise the role of cognitive distortions and information processing biases in the development and maintenance of the disorder, as well as the behaviours which prevent the correction of these distortions. The model which has most driven research on social phobia is the Clark and Wells model (1995) which is summarised below.

Clark and Wells propose four main processes which are thought to maintain social phobia: self-schemata, self-focused attention, safety behaviours, and rumination on negative aspects of a social situation before and after they occur, also known as anticipatory and post-event processing. According to the model, social situations activate a range of beliefs relevant to the self (e.g. "I'm odd", "I must always sound intelligent", "If I blush, I'll be humiliated"). These assumptions lead the individual with social phobia to view the social situation as dangerous. The perceived danger leads to self-focused attention, safety behaviours, and somatic and cognitive symptoms. Self-focused attention involves tuning in to internal experiences such as thoughts and sensations, which are often used to form mental images of the self as the individual believes he or she is being viewed by others. For example, the sensation of warmth to the face may trigger a mental image of self with bright red cheeks, and a belief that this is how the person appears to others at the time. Focusing on internal sensations (which are likely to include symptoms of anxiety) tends to heighten the experience of anxiety, and decreases the opportunity for individuals to notice positive feedback from others. Safety behaviours are used to prevent or minimise the feared consequences of poor social performance. This may include memorising things to say, or holding onto something to reduce hand tremors. The use of safety behaviours prevents individuals from re-evaluating their inaccurate assumptions about the dangerousness of a situation. Instead they attribute the absence of a

catastrophe to their use of the safety behaviours (Salkovskis, 1991; Clark & Wells, 1995). Sweating, shaking, and blushing are examples of somatic symptoms associated with anxiety, which are often feared and experienced as more intense because the individual focuses on them. Cognitive symptoms include a bias towards noticing negative feedback from others, and interpreting ambiguous feedback as negative. Finally, anticipatory and post-event processing involves going over details of social situations, which tend to focus on negative aspects of those events, with the effect that the events are recalled as being more negative than they were, and future situations are expected to be negative. These processes may strengthen negative self-schemata.

How might self-compassion impact factors which maintain social anxiety? To address this question the potential benefits of self-compassion will be considered in relation to individual maintaining factors taken from the Clark and Wells model.

### 6.1 Negative perceptions of self and performance, and self-compassion

People with social anxiety disorder are believed to hold beliefs about themselves and how they should perform in social situations which lead them to be harshly critical of themselves (Clark & Wells, 1995; Hofman, 2007). These beliefs include unconditional negative beliefs about themselves, such as "I'm odd" or "I'm stupid". They also include excessively high standards for their behaviour in social situations and beliefs about the consequences of not achieving these standards, which are exaggerated. These negative beliefs about self are thought to colour their evaluations of their performance in social situations, so that individuals with social phobia are overly negative in judgements of their performance. In both patient and analogue studies, participants high in social anxiety tend to rate themselves more negatively than participants low in social anxiety (Stopa & Clark, 1993; Rapee & Lim, 1992; Alden & Wallace, 1995). In most of the studies there was no significant difference in performance (as rated by observers) between low and high socially anxious groups. In the one study which reported lower objective performance scores for the socially phobic group (Stopa & Clark, 1993), participants still underestimated their performance in comparison to the anxious and nonanxious controls, when the actual difference was taken into account. These highly critical evaluations of self and performance

are thought to increase perceived danger and anxiety (Clark & Wells, 1995).

This is supported by research that shows that when these distortions are corrected via video-feedback, social anxiety is reduced (Rapee & Hayman, 1996). Negative evaluations of performance reinforce beliefs that the individual will not be able to achieve the expected standard, which increases social anxiety (Leary & Kowalski, 1995).

Through cognitive behavioural treatment (CBT) of social phobia, the most commonly used talking therapy for social phobia (Hofman, 2007), these cognitions are targeted directly in order to change them. This may be done in a number of ways, including assessing evidence for and against the belief or video-feedback, where the individual watches him or herself carrying out a social task, and then re-evaluates how they came across. For a significant number of individuals with social phobia, CBT is effective (Heimberg et al. 1998; Clark et al., 2003; Davidson et al., 2004). However, each of these studies shows that CBT does not work for a significant minority. As there is no direct evidence of how self-compassion impacts self-criticism in social anxiety, literature on the relationship between self-compassion and self-criticism in other clinical and non-clinical populations will be considered.

While working with other self-critical client groups, some authors have found that developing self-compassion can be more effective for clients whose problems are resistant to change using CBT (Lee, 2005), or clients who relapse following successful treatment with CBT (Segal, Williams, & Teasdale, 2002). With some clients CBT does not appear to affect change on an implicit or emotional level (Lee, 2005). Some clients report that when challenging their negative thoughts, they can “know it ‘in their head’... but not feel it ‘in their heart’” (Lee, 2005, p. 327). This heart-head lag has been observed particularly in people who are highly self-critical and lack the ability to be empathic towards themselves (Lee, 2005). Thus, Lee argues that teaching self-compassion may be a more effective route to change than thought challenging for highly self critical people. Although this has not yet been applied clinically to people with social phobia, it may be useful for countering the harshly negative views of self described by individuals with social phobia.

Further evidence for a link between self-compassion and social phobia comes from research which shows that people low in self-compassion also tend to under-evaluate their performance. Leary and colleagues (Leary et al., 2007) asked participants to make up a children's story while being video-recorded. Their performance was then rated by themselves and two other participants – one high and one low in self-compassion. Participants low in self-compassion tended to rate their performance lower than observers did, while participants high in self-compassion did not rate themselves significantly differently to the observers. These findings are consistent with the idea that self-compassion allows more accurate appraisal of ones own performance in a socially stressful situation. However, this study only shows a correlation between self-compassion and self-evaluations. It cannot prove a causal relationship.

Another study has examined further the relationship between self-compassion and self-criticism by manipulating self-compassion (Neff, Kirkpatrick, & Rude, 2007). The authors induced self-compassion by carrying out the Gestalt two-chair technique with 40 undergraduates. Each participant engaged in one experimental one-to-one session, which lasted from 15 to 60 minutes. In the session, participants remembered a time when they were self-critical, and had a dialogue between their self-critical voice and the part of self that felt attacked. The authors measured self-compassion and other outcome factors one week prior to and three weeks after the experimental manipulation, under the guise of another study. They found that increases in self-compassion were associated with decreases in self-criticism as well as depression, rumination, thought suppression, and anxiety. It is difficult to isolate the specific impact of targeting self-compassion in this exercise, as there was no control condition. It is possible that the equivalent time spent with a therapist engaged in a non self-compassion oriented task would have had similar effects on outcome. Additionally, events outside of the experimental session may have caused changes in the outcome scores.

A strength of the study is that the therapists who conducted the experimental sessions rated the participants self-compassion at the end of the session, based on the content elicited by the two-chair technique. These ratings correlated with participant self-report ratings of self-compassion three weeks later. This lends

support to the accuracy of the self-ratings, and perhaps the impact of the induction on self-compassion. The effects of trait self-compassion were controlled by simply looking at increases in self-compassion scores over time rather than the scores themselves. This study supports the notion that self-compassion decreases self-criticism, but further research is needed.

Further research is needed to support the idea that self-compassion reduces self-criticism, but these early results are promising. If self-criticism is reduced by self-compassion, increasing self-compassion may be useful for countering the excessively negative self-beliefs thought to maintain social phobia. Although self-compassion is thought to reduce self-criticism, it usually does not do this by challenging thoughts directly, as is the case in cognitive therapy. However, there is one exception to this.

A specific negative view that is often reported by individuals with social anxiety, viewing oneself as 'odd' or 'different', may be directly countered with a self-compassionate perspective. The common humanity component involves seeing one's flaws and pain as part of the human condition, not as something which separates one from others. Inducing self-compassion has been shown to increase participant reports of believing themselves to be like others (Leary et al., 2007). Adopting this view would enable a less threatening reframing of social blunders and anxious feelings as normal experiences, which are shared by others, rather than one's inferiority to others. This decrease in threat may reduce anxiety and stop the maintenance cycle of social phobia. Further research is needed to examine the relationship between self-compassion and self-schemata and evaluations of performance in social phobia. It would be interesting to see the effect of a self-compassion induction on self-appraisals and evaluations of performance of a socially anxious sample following a socially stressful situation.

The impact of self-compassion on Clark and Wells' remaining maintenance factors for social phobia – self-focused attention, safety behaviours, and post-event processing will be discussed below, followed by examination of the impact of self-compassion on anxiety more broadly.

## 6.2 Self-focused attention and self-compassion

Individuals with social phobia tend to show a bias toward processing of internal information (rather than external) when in socially stressful situations (see Clark & McManus, 2002 for a more in-depth review of the evidence). The self-focused attention described by individuals with social phobia involves a preoccupation with internal events, i.e. thoughts and sensations. As these thoughts tend to be negatively biased, and the sensations are often symptoms of anxiety, feelings of anxiety are enhanced. This internal information is then used to make judgments of how one is viewed by others (Mansell & Clark, 1999; McEwan & Devins, 1983; Mellings & Alden, 2000). Reducing self-focused attention through attention training has been shown to reduce symptoms of social anxiety (Wells & Papageorgiou, 1998).

Reducing self-focused attention by refocusing attention on external information appears to reduce social anxiety. The mindfulness element of self-compassion may provide a means of doing this. Mindfulness involves a particular way of paying attention, which is “on purpose, in the moment, and non-judgementally” (Kabat-Zinn, 1990, p.4). Being mindful involves noticing and labelling thoughts and emotions (or any kind of stimuli), but not ruminating on them or overvaluing them. When thinking about self-focussed attention, this may be helpful in a two ways. Firstly, if trained in mindfulness, an individual with social anxiety could intentionally focus attention on external information, such as focusing on what another person is saying. When attention inevitably switches to internal signs of anxiety, such as feeling sweaty, a mindful approach would be to notice the thought (e.g. “I’m sweating”), and return attention to the external. In this way mindfulness can be used as a way of reducing self-focused attention.

Additionally, the importance given to these internal sources of information may be decreased. Mindfulness involves stepping back and watching thoughts and emotions in such a way that allows objectivity, rather than quickly jumping to conclusions and getting caught up in assumptions about meaning or what will happen. This distance from one’s thoughts and emotions may stop the rash interpretations common in social phobia. When they do occur, a mindful approach would be to again notice the thought and refocus attention on the external, so that no thought is either banned or overvalued.

To test the hypothesis that mindfulness may decrease self-focussed attention, mindfulness training could be carried out with socially phobic or highly socially anxious individuals. Self-focussed attention could be measured before and after mindfulness training, perhaps by asking participants to recall details of a recent social interaction, a task which has been used to measure self-focused attention in the past (Kimble & Zehr, 1982; Daly, Vangelisti, & Lawrence, 1989).

### 6.3 Safety behaviours and self-compassion

Safety behaviours are used to reduce or hide one's anxiety, but ultimately they serve to maintain it by preventing distorted thoughts from being corrected (Well & Clark, 1995; Hofman, 2007). The safety behaviours can be credited with preventing catastrophes when they do not occur, rather than recognising the inherent lack of danger in a situation. Studies have shown that refraining from safety behaviours decreases social anxiety (Wells et al., 1995). Additionally, when patients are asked to stop using safety behaviours in therapy, outcomes for CBT for social phobia improve (Morgan & Raffle, 1999).

A self-compassionate approach may decrease the use of safety behaviours in a number of ways. Firstly, self-compassion may decrease the perceived need for safety behaviours by stopping the maintenance cycle of social phobia at an earlier stage (by softening harshly negative self-schemata or reducing self-focused attention). If these factors have been diffused, the individual's anxiety may not be great and the person may not feel the need to engage in safety behaviours. Assuming self-schemata and self-focused attention are activated, and result in feelings of anxiety, a self-compassionate approach may help by evoking empathy for oneself and a view that this kind of difficult situation happens to others as well. Thus difficult feelings would be "transformed into a more positive feeling state" (Neff, 2003a), from anxiety and self-attacking to kindness and self-soothing. Again, if this occurred, the urge to use safety behaviours may be diminished. The mindfulness component of self-compassion may also be helpful for managing anxiety during social situations, instead of using safety behaviours.

Mindfulness involves observing thoughts and emotions without overvaluing them. This includes behavioural urges. With a mindful stance, feeling compelled to do something (e.g. I must avoid eye contact with others in order to hide anxiety) does not necessarily lead to this action. An aim of mindfulness is for the individual to see that if they can watch their thoughts and emotions, they must be separate from them. This can provide the distance to make better choices about whether they act on those thoughts and emotions. Mindfulness has been used as a tool for tolerating distress and avoiding engaging in problematic behaviours in therapies for other mental health problems.

Mindfulness is used in this way in Dialectical Behaviour Therapy (DBT; Linehan, 1993), a treatment developed to reduce self-harm in people with borderline personality disorder. Like safety behaviours in social phobia, self-harm is thought to provide a means of reducing difficult emotions (Linehan, 1993).

Mindfulness is one strategy promoted as a way to tolerate distress and avoid engaging in self-harm. It is thought to create a distance between the individual and their self-critical thoughts, painful emotions, and urges to self-harm. This is thought to stop the escalation of painful emotions and/or promote the decision to manage emotions by means other than self-harm. Several studies have shown that successful completion of DBT decreases self-harm (e.g. Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). It is difficult to gauge the impact of mindfulness in these studies, as it is only part of the treatment. However, mindfulness has been incorporated into other treatments which have also been found to be effective, such as Mindfulness-based Cognitive Therapy for Depression (MBCT; Segal, Teasdale & Williams, 2002) and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2004) for a range of problems. Each of these therapies has gained empirical support (Teasdale et al., 2000; Bach & Hayes, 2002).

The literature suggests that mindfulness is helpful for changing patterns of thought and reducing problematic coping behaviours in a range of disorders. Considering the high rate of comorbidity in social anxiety, and similarities in the function of problematic behaviours, it is reasonable to assume that mindfulness may have a benefit for treating social phobia as well. Mindfulness may be particularly helpful for reducing safety behaviours, as it may distance individuals

from difficult thoughts and feelings, and impulses to engage in safety behaviours. Research is needed to assess the impact that self-compassion has on safety behaviours. This may be done by inducing self-compassion in a socially anxious sample and then asking participants to engage in a socially stressful activity, such as giving a speech or answering a question as if they were in a job interview. Then participants and observers could rate how often safety behaviours were used by the participant during the activity. Self-compassion will now be considered in relation to Clark and Wells' final maintenance factor, post-event processing.

#### 6.4 Post-event processing and self-compassion

In the literature on social phobia, post-event processing refers to ruminating on aspects of a social situation after it occurs. Research has shown that people high in social anxiety experience more prolonged and negatively biased post-event processing (Rachman et al., 2000; Mellings & Alden, 2000; Dannahy & Stopa, 2007). This is believed to strengthen negative self-schemata, and expectations of poor performance in the future. It is often experienced as intrusive (Rachman et al., 2000).

In CBT for social phobia, patients are encouraged to stop post-event processing (Clark & Wells, 1995), but this is not always possible. Another approach thinking more broadly about the CBT model may be to challenge some of the negative content of ruminations, (e.g. consider alternative explanations for aspects of the event which the patient has interpreted negatively). This approach may be helpful, but as stated above these methods do not always work. Mindfulness may be another helpful technique for reducing post-event processing, or at least the impact that it has on social phobia. Two areas of evidence which support this hypothesis include a nonclinical study on self-compassion and rumination, and literature on the use of mindfulness with other clinical populations.

Neff, Kirkpatrick and Rude (2007) found that increasing self-compassion decreased rumination in a nonclinical sample. After inducing participants to be more self-compassionate via the two-chair technique, participants who showed increases in self-compassion over a 4 week period also showed lower levels of rumination and depression.

Rumination has been formulated as a maintaining factor for other mental health problems, including other anxiety disorders (Wells, 1997) and depression (Teasdale, 1999). High levels of comorbidity exist between social anxiety and depression and other anxiety disorders, which suggests that all of these disorders may have common generating or maintaining factors, such as rumination. Therefore therapies which are effective for treating rumination in these disorders may provide suggestions for treating rumination in social phobia. Teasdale (1999) proposes that relapse in depression occurs when dips in mood elicit dormant patterns of negative thinking, which have developed during previous episodes of depression, and are strengthened with each episode. These patterns of negative thinking involve rumination on “deficiencies of self, self-blame, a perceived dependence of self-worth on approval of others, and hopelessness” (Allen and Knight, 2005, p. 248). MBCT (Segal, Teasdale & Williams, 2002) uses mindfulness to identify the re-emergence of these patterns, as a way of preventing relapse in people with a history of depressive episodes. Once these patterns are noticed, the individual can take steps early on to avert relapse, including disengaging from the thoughts and not over-identifying with them. After 8-week interventions including guiding patients to establish a mindfulness meditation practice, relapse was reduced in patients with a history of three or more episode of depression (Teasdale et al, 2000; Ma & Teasdale, 2004). A limitation of this study is that MBCT involves both mindfulness and other components of cognitive therapy, so it is difficult to assess the impact of each on outcome. This is particularly the case as standard cognitive therapy for depression is used when individuals are in a depressive episode and MBCT is used after recovery from depression. However, these results are promising.

If mindfulness can help people with depression to stop negative rumination, it may be useful for reducing the negative self-evaluative ruminations found in social phobia. As it is applied to the treatment for depression, mindfulness may help individuals with social phobia notice when they are engaging in post-event processing. It may promote the notion that thoughts are not facts, and that they are not necessarily worth engaging. It may also aid one's ability and motivation to disengage from post-event processing when it occurs.

Further research is needed to test the hypothesis that mindfulness training would decrease post-event processing. A group of socially anxious people could be asked to carry out a socially stressful task. Then a third of participants could be given a mindfulness induction, a third no intervention, and a third a placebo intervention (to control for non-specific effects of the self-compassion induction). Post-event processing could then be assessed in the days following the event.

The potential for self-compassion to prevent or reduce social anxiety has been examined by considering how it may impact on aspects of aetiological models and maintenance of models of social anxiety. Additional evidence which is relevant to social anxiety is a body of research on the impact of self-compassion in the face of social-evaluative threats. This evidence is discussed below, implications for treatment of social phobia are drawn, and further research is proposed.

## 7. Self-compassion and anxiety

Anxiety is also a major aspect of social anxiety, as it is the primary emotion experienced when social anxiety is activated. If self-compassion plays a role in the maintaining factors of social anxiety, as discussed above, it would be expected to decrease anxiety for individuals with social phobia in social-evaluative situations. One study has examined this hypothesis directly (Price, 2008). In this study a brief written exercise was used to induce self-compassion in a group of individuals who scored highly on a measure of social anxiety, Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1997), following a speech task. The results did not support a link between self-compassion and a reduction in anxiety, relative to the control conditions. However, it was concluded that the self-compassion induction may have been too brief to achieve a meaningful increase in self-compassion. This is understandable when considering Gilbert's conceptualisation of self-compassion as something which develops over time with repetition. Additionally, Gilbert proposes that individuals who are highly self-critical, as people with social phobia appear to be, may have an underdeveloped ability to be self-compassionate. It is suggested by Gilbert that for these individuals, developing self-compassion may take more practice. For others, increasing self-compassion may be easier. This study was important

as it is the only study to date to investigate the effects of self-compassion on social anxiety. Additionally, the results suggested that self-compassion may have a positive impact of self-compassion on patterns of self-esteem. Other studies which did not use highly socially anxious participant samples when investigating the link between self-compassion and anxiety provide support for the link between the two.

Neff and colleagues have found that trait anxiety and self-compassion are negatively associated (Neff, 2003b; Neff, Rude, & Kirkpatrick, 2007).

Participants higher in self-compassion reported lower levels of trait anxiety. These studies were correlational and cannot show whether self-compassion decreases anxiety, anxiety causes decreased self-compassion, or a third factor controls both anxiety and self-compassion. Other research has explored this link further by inducing self-compassion, and measuring anxiety afterwards (Neff, Kirkpatrick & Rude, 2007; Leary, et al., 2007). The results of these studies are particularly relevant to social anxiety because they involve socially stressful situations.

This effect was also found in a study where self-compassion was experimentally enhanced (Leary, et al., 2007). Leary and colleagues asked 115 undergraduate participants to write about a negative event from their past which involved failure, humiliation, or rejection. Participants were then randomly assigned to one of four groups: self-compassion, self-esteem, writing control, or true control. The true control simply filled out outcome measures. The other three groups responded to prompts which were designed to enhance either self-compassion or self-esteem, or to encourage a more generic processing of the emotional content elicited by the event. The third condition was created in light of evidence that simply writing about one's thoughts and feelings can have a therapeutic effect (Pennebaker, Colder, & Sharp, 1990). The results for this study showed that participants in the self-compassion group reported less negative affect, including anger, sadness, and anxiety, and more happiness. This indicates that a brief self-compassion induction may decrease anxiety. It suggests that self-compassion may be powerful, even in small doses. When considering the implications of this study for clinical treatment of social phobia it is limited by the mildness of the nature of the task (thinking about a distressing event from the

Developments in self-compassion 31 past), and the fact that the sample was nonclinical and was not particularly high in social anxiety. However, this study may form a useful template for future research on self-compassion and social anxiety. If self-compassion does reduce anxiety in individuals high in social anxiety, a written exercise designed to induce self-compassion following a socially stressful situation may reduce subsequent anxiety. The key concern is to achieve the correct 'dose' of self-compassion that can override the entrenched patterns associated with social anxiety.

## 8. Conclusions

Self-compassion provides new ways of understanding the aetiology of social anxiety, and may contribute to therapies for social phobia in the future. Being kind to oneself, mindful rather than over-identifying with one's emotions, and viewing one's flaws as part of being human seem particularly helpful for social phobia, which is characterised by self-criticism, feeling odd or different from others, focusing on one's anxiety, managing one's anxiety via the use of safety behaviours, and ruminating on past events. Research to date shows that self-compassion is associated with positive psychological well-being. Evidence also suggests that self-compassion can be successfully increased, although it may take more practice with people who are highly self-critical, including individuals high in social anxiety. Lastly these increases in self-compassion appear to be associated with positive outcomes, such as decreased anxiety in clinical and nonclinical samples. This suggests that enhancing self-compassion may be useful for treating social phobia, but much more research is needed to assess this.

More research is needed to examine Gilbert's model of social anxiety. This includes assessing whether self-compassion and social anxiety are negatively correlated, as predicted by Gilbert's theory. Research on brain activity in other high and low self-compassionate groups, including perhaps individuals with social phobia would be interesting, as well as focusing on eliciting self-compassionate responses rather than compassionate responses to others. Further research is needed to examine whether Compassionate Mind Training is effective at increasing self-compassion and if it is useful for individuals with

social phobia. In relation to the Rapee and Spence model, it would be interesting to investigate the potential role of self-compassion as a buffer against early experiences which might otherwise lead to the development of social phobia. An ambitious study might involve measuring levels self-compassion in children and subsequent incidence of social phobia in participants in early adulthood. Additionally, it would be useful to study the effects of enhancing self-compassion on each of Clark and Wells proposed maintenance factors: self-schemata, self-focused attention, post-event processing, and safety behaviours. This might involve a self-compassion induction and measurement of these factors during or after a socially stressful task, such as giving a speech or answering questions as in a mock interview.

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Empirical Paper

The impact of an experimentally induced self-compassionate perspective on evaluations of performance and post event processing in a socially anxious analogue group.

Sara Thomas

Harshly negative appraisals of performance and post-event processing are two factors widely believed to maintain social phobia. This study aimed to examine the impact of a self-compassion induction on evaluations of performance and post-event processing in a socially anxious analogue group following a stressful social situation.

Sixty-three socially anxious participants completed an impromptu two-minute, video-recorded speech and then were randomly assigned to one of three conditions designed to influence the way in which they processed the speech. After completing a written task, in response to one of three sets of instructions, participants completed various measures, including the Self-Compassion Scale, the Performance Rating Form, and the Thoughts Questionnaire. For the following three days participants also completed the Daily Thoughts Questionnaire. Later, independent raters viewed the recorded speeches and completed the observer version of the Performance Rating Form for each speech.

The results showed that the self-compassion group's self-ratings of their performance were significantly closer to the independent observers' ratings than those of the other groups. No significant differences were found in relation to post-event processing or anxiety. This suggests that increasing self-compassion may be useful in the treatment of social phobia, by decreasing harshly negative appraisals of performance which are thought to be key in maintaining the disorder. Further implications of the study and suggestions for research are discussed.

Key words: social anxiety, social phobia, self-compassion, post-event processing.

Social anxiety disorder is a common and often debilitating mental health problem characterised by fear of rejection in social situations. Current cognitive models of social anxiety emphasise the self-evaluation that takes place during the social situation and afterwards, in the form of post-event processing. The focus of this paper is the impact of self-compassion on self-evaluation in social anxiety.

Self-compassion, as defined by Neff (2000a) involves “experiencing feelings of caring and kindness towards oneself, taking an understanding, non-judgemental attitude towards one’s inadequacies and failings, and recognizing that one’s experience is part of the common human experience” (p. 224). This attitude of self-kindness during incidents of failure may be particularly helpful in the treatment of social anxiety, which is often characterised by harsh self-criticism. Self-compassion and its component parts have been used successfully in the treatment of other mental health problems (e.g. depression, borderline personality disorder, and psychosis; Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; Linehan, Heard & Armstrong, 1993; Bach & Hays, 2002). In this study we begin to investigate the value of self-compassion in relation to social anxiety.

Information processing models of social anxiety have been the focus of much research over the past two decades (Clark & Wells, 1995; Rapee & Heimberg, 1997). Hofman’s model (2007) incorporates important features of previous models, and identifies some additional cognitive factors that are thought to maintain the disorder. According to Hofman, social anxiety is associated with unrealistic social standards and difficulties selecting attainable social goals. In challenging social situations, individuals with social anxiety focus their attention on their anxiety, view themselves negatively, overestimate the negative consequences of a social encounter, believe that they have little control over their emotional response, and underestimate their social performance. To prevent these social failings, individuals with social anxiety avoid social situations, use safety behaviours, and ruminate on these events after they happen. This rumination is often known as post-event processing. The current

study is focused on two of these factors, namely the bias toward negative evaluation of one's performance, and post-event processing.

Individuals with social anxiety disorder tend to evaluate their performance more negatively than non-anxious individuals, even when actual differences in performance are accounted for (Stopa & Clark, 1993; Rapee & Lim, 1992; Alden & Wallace, 1995). In these studies socially anxious individuals and non-anxious controls were asked to complete either a speech or a conversation with a confederate. They were then asked to rate their performance. In each study the socially anxious groups rated their performance more negatively than the non-anxious control groups. These negatively biased perceptions of their performance were what they expected other people see as well. In just one of the studies the socially anxious group was objectively less skilled than controls (Stopa & Clark, 1993). Given this difference, the socially anxious group still underestimated their performance. In each of the studies there was a greater discrepancy between self and observer ratings for the socially anxious groups than for control groups.

In a related study (Newman, Hofman, Trabert, Roth, & Taylor, 1994), socially anxious individuals were assessed after successful treatment. Compared to a waitlist control group, those participants who had been treated for social anxiety disorder rated their performance of a social task more highly. Observer ratings showed no difference between the groups. This underestimation of social abilities may contribute to the maintenance of social anxiety. Discounting one's social ability increases the discrepancy between the person's desired performance, or what the person believes is expected by others, and the performance that the person feels capable of delivering (Rapee & Heimberg, 1997; Hofman, 2007). As a result, the fear of social disapproval, which is central to social anxiety, is increased (Rapee & Lim, 1992).

A self-compassionate perspective involves viewing oneself and one's performance objectively, not over-identifying with one's emotions, and being kind to oneself rather than hypercritical. This may reduce negatively-biased self-evaluations of performance in social anxiety. Leary and colleagues (Leary, Tate, Adams, Allen, & Hancock, 2007) looked at the associations between self-compassion and students' thoughts and feelings in relation to recent negative

events. Participants were asked to indicate how they reacted to the situation (e.g. "I tried to be kind to myself", and "I was really hard on myself") and to rate the degree to which they experienced certain thoughts (e.g. "I seem to have bigger problems than other people", and "I'm a loser") and feelings (e.g. sadness, anger, anxiety, and shame). Students high in self-compassion were more likely to keep the situation in perspective, experience lower negative emotions, and later feel they handled the situation better. They were also less likely to report feeling a "loser". The same authors found that participants high in self compassion were more likely to predict that they would react calmly to hypothetical social situations (e.g. forgetting one's line in a play), with less personalising and catastrophising (Leary et al., 2007).

A fourth study carried out by Leary and colleagues in this series is most directly relevant to the current study. In it, participants who were high or low in self-compassion were asked to make-up a children's story without preparation and say it out loud while being video-recorded. Each video-recording was then viewed by the participant in the recording and by two other participants (observers), one high and one low in self-compassion. The results showed that low and high self compassionate individuals were rated similarly by observers, i.e. there was no objective difference in the performance of the story task between low and high compassion individuals. There was no significant difference between self and observer ratings for the high self-compassion group. This suggests that participants high in self-compassion were able to see their performance objectively. The low self-compassion group rated their performance significantly lower than the observers, indicating an unduly harsh self-assessment. This study shows a pattern similar to many social anxiety studies. Participants low in self-compassion or high in social anxiety are less objective in assessing their own performance of stressful social situations and tend to be overly critical of their own performance. This tends to occur in the absence of objective deficiencies their performances and without impacting on their assessment of others' performances.

If self-evaluations are more accurate, the discrepancy between one's desired performance, or the performance one believes is expected by others, and the performance one is able to achieve is narrowed, which should reduce anxiety. In

a study involving a mock interview task, self-compassion protected against self-evaluative anxiety (Neff, Kirkpatrick, & Rude, 2007). A decrease in anxiety experienced in social situations may lead to a decrease in the use of safety behaviours and in less avoidance of social situations, both of which are thought to prevent socially anxious individuals from disproving inaccurate beliefs about themselves and their performance (Hofman, 2007). This may also reduce post-event processing, another factor thought to maintain social anxiety.

Post-event processing is described as a detailed mental re-examination of a social situation following the event. It is a kind of rumination, which may be more likely to happen, for people with social anxiety, after a negative or ambiguous social situation. Typically the person focuses on anxious feelings and negative self-perceptions, and recalls the interaction as being more negative than it was (Clark & Wells, 1995). It is believed that memories of other situations of perceived social failings are also recalled, supporting the person's negative view of self. Repeatedly ruminating on these thoughts may serve to stamp them into mind more firmly (Rachman, Grüter-Andrew, & Shafran, 2000), where they are later more likely to be recalled in anticipation of a new social situation. The negative recollections then increase anxiety and expectation of failure in the new social situation.

Several studies have found a link between post-event processing of negative social situations and social anxiety in student populations (Dannahy & Stopa, 2007; Abbott & Rapee, 2004; Lundh & Sperling, 2002; Mellings & Alden, 2000; Rachman, et al., 2000). In each of these studies, participants performed a social task, such as a conversation with an unknown individual or an impromptu speech. Participants high in social anxiety reported more negative post-event processing immediately afterwards, and up to a week following the task. Abbott and Rapee (2004) found that participants high in social anxiety maintained negative evaluations of their performance after a week, while participants low in social anxiety reported more positive self-evaluations of performance after a week.

Post-event processing is characterised by a focus on anxious feelings and self-critical thoughts and memories. A self-compassionate perspective might change

several aspects of this process. It might stop the person from getting 'caught up' in feelings of anxiety or shame. The ruminative or repetitive quality of the memories may be reduced. The memories of the situation might be more objective, which should decrease the bias towards recalling negative aspects of the event. Perceived failings might be viewed as normal or human, rather than producing the sense of being different, or odd. Individuals could have feelings of compassion and kindness towards themselves for their feelings of anxiety, embarrassment and shame, which might serve to lessen these feelings rather than enhance them. Neff's (2003b) finding that self-compassion was negatively associated with rumination provides support for the notion that it may impact on post-event processing, which is a kind of rumination.

Enhancing self-compassion in order to reduce symptoms of social phobia would provide an alternative to a cognitive behavioural therapy (CBT) approach, which is the most popular and best-researched therapy for social phobia (Hofman, 2007). Within a CBT approach, the accuracy of overly critical self-evaluations is challenged. This is helpful in many cases, but there is a significant minority of people who remain symptomatic following treatment (e.g. Clark et al., 2003). Rather than focusing on the accuracy of evaluations, promoting self-compassion would encourage socially anxious individuals to be kind to themselves when they feel they have performed badly in a social situation. It would also encourage them to stand back from their emotions rather than getting caught up in them. In these ways, self-compassion may be seen to work differently to a CBT approach, which involves changing beliefs in order to reduce distressing emotions. Self-compassion may be seen to address emotional distress directly, which perhaps then leads to less biased beliefs. As a relatively new area of study in western psychology, it is not clear how self-compassion works. Further research is needed to better understand this.

Leary et al. (2007) have shown that it is possible to experimentally induce a self-compassionate perspective. Non-clinical student participants were asked to think of a past failure, rejection or loss that made them feel badly about themselves and to answer questions about it. The study divided participants into four groups – self-compassion, self-esteem, disclosure, and control. Participants in the self-compassion group were asked to respond to prompts that tapped into

the three components of self-compassion identified by Neff (2003a; self-kindness, common humanity, and mindful acceptance). In the self-esteem group, participants answered questions designed to make them feel good about themselves. The disclosure group was included to partial out the impact that simply writing openly about one's feelings and thoughts can have (Pennebaker, Colder and Sharp, 1990). In this group, participants were told to "really let go and explore their deepest emotions about the event", (Leary et al., 2007; p.39). Participants in the control group were given no written instructions in order to capture their normal way of processing the memory. All participants were then asked to rate how they felt after completing the task (e.g. happy, down, angry, anxious, etc.) They also rated how much they felt they were like other people. The authors found that the self-compassion group rated themselves lower on the negative emotion items. In other words they felt less bad following the exercise than participants in the other groups. The self-compassion group also reported seeing themselves as more similar to other people. This suggests that self-compassion was induced, reducing negative emotions and making participants view their difficult life event as a normal human experience.

Leary et al. (2007) highlight the potential benefits that a self-compassionate perspective may have in clinical settings where clients are excessively self-critical. Gilbert and colleagues (Gilbert & Irons, 2005; Gilbert & Proctor, 2006) have begun to explore the benefits of self-compassion in a clinical setting. Research on the relevance of self-compassion for social anxiety has not been carried out, but self-compassion does appear to protect against social evaluative concerns in non-socially anxious populations (Neff et al., 2007; Leary et al., 2007).

The current study investigates the impact of inducing a self-compassionate perspective on a socially anxious non-clinical population. The study's design is based on that of Leary and colleagues (2007). As in the previous study, the current study employed an emotional control group, control group, and self-compassion group. The task used to elicit difficult emotions and thoughts was an impromptu speech, as it was thought to elicit the specific thoughts and emotions experienced in social anxiety. This was in contrast to the task used in Leary and colleagues' study, which was to think of past event.

The focus of the current study was to assess the impact of self-compassion on perceptions of performance of a speech, and post-event processing. The impact of self-compassion on anxiety is also investigated.

Four hypotheses were tested in the current study, based upon Hofman's (2007) model and previous research on self compassion:

1. The self-compassion induction would improve participants' perceptions of their performance of the speech.
2. The self-compassion induction would bring participants' perceptions of their performance closer to those of an independent observer.
3. A self-compassionate perspective would reduce post-event processing.
4. The self-compassion induction would reduce anxiety.

## 2. Method

This study was run as part of a larger study (Price, 2008). Participants were asked to complete additional measures that are not relevant to the present study, but are indicated in a full protocol of the wider study in Appendix A.

The University of Southampton School of Psychology Ethics Committee granted approval for this study (see Appendix B for the approval letter).

A pilot study was carried out on 15 participants before finalizing the procedure. Following feedback from pilot study participants, the instructions for the written task were modified to make them clearer. The self-compassion and emotional control instructions remained very similar to those developed by Leary et al. (2007) as they were effective manipulations with a non-socially anxious sample.

### 2.1 Design

This study used a mixed design with one between-subjects factor (group) and one within-subjects factor (time).

## 2.2 Participants

Initially, 456 students and employees of the University of Southampton were screened using the Social Interaction Anxiety Scale (Mattick & Clarke, 1997). Those individuals scoring at least 1 SD above the mean (29 or above) were invited to participate in the study (mean SIAS score = 37.4,  $SD = 8.1$ ).

The 63 individuals who completed the study were divided between three experimental groups, each consisting of 21 individuals. The self-compassion group (mean SIAS = 36.2;  $SD = 6.26$ ) consisted of 7 males and 14 females (mean age = 23.9;  $SD = 10.3$ ). The emotional processing group (mean SIAS = 38.24;  $SD = 10.13$ ) consisted of 7 males and 14 females (mean age = 22.23;  $SD = 7.23$ ). The control group (mean SIAS = 37.76;  $SD = 7.62$ ) consisted of 9 males and 12 females (mean age = 21.66;  $SD = 3.98$ ). There were no significant differences between the groups in terms of age ( $F(2,62) = 0.483, p = 0.619$ ) or gender ratio ( $\chi^2(2) = 0.648, p < 0.76$ ).

Participants took part in the study in exchange for course credit or a small payment (£7.50). The study took 45-60 minutes for each participant to complete.

## 2.3 Measures

### 2.3.1 Standardised measures

#### 2.3.1.1 Social Interaction Anxiety Scale (SIAS, Mattick & Clarke, 1997)

The SIAS is a 20-item self-report measure of social anxiety used in this study to screen potential participants. Examples of items include, "I get nervous if I speak with someone in authority", and "I have difficulty making eye contact with others". Each item on the SIAS has four responses ranging from *not at all* to *extremely*. Total scores range from 0 to 60, with higher scores indicating more social anxiety. The SIAS has good internal consistency ( $\alpha = 0.93$ ; Mattick & Clarke, 1997) and good test-retest reliability ( $r = 0.92$ ; Mattick & Clarke, 1997). Cronbach's  $\alpha$  for the current sample was 0.75. This measure was selected for pragmatic reasons. An existing database of SIAS scores was used initially to recruit participants for the study.

### 2.3.1.2 Beck Depression Inventory (BDI-II; Beck, Steer & Brown, 1996)

The BDI-II is a measure of depression, which was used in the present study to check whether group differences in the dependent measures were due to differing levels of depression. Depression is associated with anxiety (Nolen-Hoeksema, 2000) and may affect post-event processing (Abbott and Rapee, 2002).

Each of the 21 items has four responses which relate to levels of depression experienced in the past two weeks. Scores range from 0 to 63. The BDI-II has good reliability, validity, and internal consistency ( $\alpha = 0.93$  in college students; Beck, Steer, & Garbin, 1988). In this sample Cronbach's  $\alpha$  of 0.94 was found.

### 2.3.1.3 State-Trait Anxiety Inventory (STAI; Spielberger, Gorusch & Lushene, 1983)

The STAI is a self-report inventory of anxiety. Half of the 40 items measure state anxiety (anxiety experienced at the moment) and half measure trait anxiety (anxiety experienced generally). State and trait anxiety items are presented and scored separately so that they can be used independently, as they were in this study. The trait anxiety measure was administered at the beginning of the experiment to ensure that group differences found in the dependent measures were not due to group differences in trait anxiety. The state anxiety scale was given 3 times during the experiment to measure group differences in anxiety as well as within-group changes in anxiety over time.

Items on each half of the STAI (trait and state anxiety) have four possible responses, leading to totals of 0-80. The test-retest reliability for the trait scale was 0.73 – 0.86 (Spielberger, 1983). Concurrent validity with other anxiety scales was 0.73-0.85 (Spielberger, 1983). In this sample Cronbach's  $\alpha$  of 0.91 was found on the state measure. A Cronbach's  $\alpha$  of 0.93 was found for the Trait measure.

### 2.3.1.4 Self-Compassion Scale (SCS; Neff, 2003b)

The SCS is a 26 item questionnaire designed to measure self compassion. Items are rated on a 5 point scale ranging from "almost never" to "almost always". The global self-compassion score is derived from the mean of 5

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subscales, which are Self-kindness, Self-judgement, Common humanity, Isolation, Mindfulness, and Over-identified. The SCS has good internal consistency and good test-retest reliability (Neff, 2003b). In this study a Cronbach's  $\alpha$  of .81 was found for self-kindness, .69 for self-judgement, .77 for common humanity, .81 for isolation, and .78 for over-identification.

### 2.3.2 Performance measures

#### 2.3.2.1 Difficulty of the speech task

In order to check whether the groups differed in terms of how difficult they found the speech task, participants were asked to rate how difficult they found the task on a scale of 0-10 where 0 is not at all difficult and 10 is the most difficult (see Appendix D).

#### 2.3.2.2 Performance Rating Form

A measure of public speaking performance was adapted from Rapee and Lim (1992, see Appendix E). For this study 1 item was taken off the questionnaire because it was not relevant to this study. There was no audience present with whom to make eye contact when participants gave their speeches. This left 16-items describing aspects of giving a speech (e.g. "Content was understandable", "Stuttered", "Had long pauses"), which participants rate according to how much they believed this described their performance of the speech. The Scale consists of six positive and ten negative items, all rated on a 5-point scale of 0-4 (Not at all – Very much). There are two versions of the measure, one for the participants to complete based on their own performance and one for an observer who has watched the speech to complete. They each have the same content.

In the present study, participants completed the performance rating form immediately after the speech and after the written task in order to measure between-group differences and within-group differences over time. An independent observer rated participants' performances (of the speech) using the observer form while viewing the video-recordings of the speeches. This provided a check of how realistic the groups were in their estimations of their performances. Four items from the Performance Rating Form were discarded

from the analysis of the observer vs. participant ratings (but not from the participant only analysis), leaving 12, because the observer was unable to give a rating based on the video recording (e.g. the observer could not see whether the participant was sweating). A Cronbach's  $\alpha$  of .9 was found for this measure.

The reliability of the observer's ratings was assessed by correlating the scores of a second independent observer on half of the cases (32). A coefficient of  $r = .67$ ,  $p = .01$  was found, indicating an adequate level of agreement.

### 2.3.3 Measures of post-event processing

#### 2.3.3.1 Thoughts Questionnaire

The Thoughts Questionnaire, modified by Dannahy and Stopa (2007) from Edwards, Rapee, and Franklin (2003), was used to measure post-event processing of their performance on the speech task (see Appendix F). The scale consisted of 27 items (11 positive items, 14 negative items and 2 neutral items). Higher scores indicate more frequent post-event processing. Internal consistency for the measure is good (Edwards et al. 2003). In the present study the scale was modified to measure post-event processing in relation to a specific social task, not general levels of post-event processing. A Cronbach's  $\alpha$  of .87 was found for this sample.

#### 2.3.3.2 Daily Thoughts Questionnaire

The Daily Thoughts Questionnaire (DTQ) modified from Dannahy & Stopa (2007), is designed to measure the amount of ruminative thinking done in a day around a specific task (see Appendix G). It was given to participants to complete for the day of the experimental session and each of the 2 days following it. Participants rated items on a 5-point scale ranging from 0 (never) to 4 (very often). A negative item score was calculated by totalling the 3 negatively valenced items. Two positively valenced items were totalled for a positive score, and scores from all items made up the total score. Higher scores indicate higher levels of post-event processing. A Cronbach's  $\alpha$  of .80 was found for the DTQ in this sample.

### 2.3.4 Manipulation check – compliance with written instructions

The degree that participants thought they were able to comply with the instructions on the written task was measured (see Appendix H) in order to establish any differences between groups. Participants were asked to rate how much of the time they were able to stick to the instructions on a scale of 0-10, where 0 is none of the time and 10 is all of the time.

### 2.3.5 Anxiety before and after the experiment

Participants were asked to rate their current anxiety on a scale of 0-10 (no anxiety – most anxiety) at the beginning of the research session and at the end of the session (See Appendix I). Participants who rated their anxiety as higher at the end of the session than at the beginning were offered a 10 minute guided relaxation exercise. None of the participants required this exercise.

## 2.4 Experimental manipulation

After giving a speech, participants were given written instructions which asked them to think about their speech and write about their thoughts and feelings about it in specific ways, according to their assigned condition.

### 2.4.1 Self-compassion instructions

The self-compassion instructions were designed to induce self-compassion relating to participants' self-perceptions of their performance of the speech. These instructions were based on instructions written by Leary et al. (2007), as those instructions were shown to induce self-compassion in a non-socially anxious sample. The self compassion instructions were the following:

*We are interested in the way that people respond to giving a speech. What you write down will not be evaluated.*

*Imagine that you have just watched a friend giving a speech. Spend a few minutes thinking about how you would talk to your friend about his or her speech. Think about what feedback you would give to him or her. Consider how you would feel towards your friend and how you would show those feelings.*

*Imagine yourself giving this feedback to your friend. Notice your tone of voice and the words you would use. Picture your body language and your expression. Notice how you would feel giving the feedback to your friend.*

*Spend a few minutes thinking about this.*

*Write a paragraph below about the speech you just gave, showing the same understanding and concern towards yourself, as you would to a friend. Write it as if you were speaking to a friend (i.e. You...).*

*Now we would like you to consider how other people experience speeches. Think about the difficulties that they experience. Consider what thoughts and feelings they have giving a speech. Try to imagine what it's like for other people in these situations. See if you can get into their heads and imagine how they might feel. Take a few minutes imagining what other people feel when they give a speech.*

*Please write a paragraph about how other people experience giving speeches, focusing on how they feel.*

*Finally, step back from your experience of giving the speech. Reflect on your experience of giving the speech in an objective way. Consider how you performed and how you felt without getting 'caught up' in the emotion.*

*After thinking about this, write a paragraph describing your experience of giving the speech in an objective way.*

#### 2.4.2 Control instructions

In the control condition participants were invited to think about their performance of the speech as they would normally, and write down the content of those thoughts and feelings. The control instructions were the following:

*We are interested in the way people respond to giving a speech. We will be asking you to think about your performance in the way you normally would and then write down your thoughts. What you write will not be evaluated. Please*

*spend 5 minutes thinking about your performance when you gave the speech in the way you normally would. Then write everything you thought about below.*

#### 2.4.3 Emotional processing instructions

The emotional processing instructions aim to elicit deeper emotional and cognitive processing of the speech task in order to make a distinction between the effects of a self-compassionate versus a more general emotional processing of the socially stressful event, giving a speech. The emotional control instructions were the following:

We are interested in the way that people respond to giving a speech. We will be asking you to think about your speech and then to write about your thoughts and feelings. What you write will not be evaluated.

*Please spend some time reading through this.*

*I would like for you to write about your very deepest thoughts and feelings about the speech you have just given. In your writing I'd like you to really let go and explore your deepest emotions and thoughts.*

*Consider how you felt when you were giving the speech. Remember the thoughts that were going through your mind. Think about your performance and how you came across.*

*Go back in your mind to when you were giving the speech. Notice how you were feeling at the time. Tune in to any sensations you felt in your body. Notice the sound of your voice.*

*Pay attention to the thoughts that were going through your head and the emotions you experienced.*

*The most important thing is that you really let go and dig down to your deepest thoughts and feelings about your performance of the speech.*

*Take a few minutes to reflect on this and then write down your deepest thoughts and feelings about the speech. Please write in the space below and continue over the page.*

## 2.4 Procedure

Participants were asked to read an information sheet and sign a consent form. They then completed the BDI-II, the STAI State and Trait scales, and gave a rating (0-10) of how anxious they felt at that moment.

Next, participants were asked to give a two minute, video-recorded speech without preparation on one of the following topics: the pros and cons of the death penalty, the pros and cons of the war in Iraq, and the pros and cons of legalising cannabis. They were told that the recording of their speech would be viewed and rated by a expert in communications. Participants then signed a consent form regarding giving the speech and being video-recorded. This was not given at the beginning of the session as it may have influenced scores on the early measures. All of the participants signed the consent form and carried on with the study. Following the speech participants completed a second STAI State measure and Performance Rating Form, and rated how difficult they found giving the speech.

Participants were then given 1 of the 3 sets of the written instructions described above (according to their assigned condition), and asked to read and follow the instructions. After the written task, participants were then given another set of questionnaires (STAI state, Performance Rating Form and the Thoughts Questionnaire), the order of which was counter-balanced. Additionally participants rated their ability to comply with the instructions, and their level of anxiety at the end of the session.

The Daily Thoughts Questionnaires were sent home with participants to complete at the end of the day and each night for the subsequent two nights. They were asked to return the questionnaires by putting them into a secure box within the department, or where more convenient by posting them to the author. Three days after participants attended the research session, they were sent the

### 3. Results

Data were analysed using SPSS version 14.0. A minimum alpha level of  $p = .05$  was used for all tests. Except where specified, all analyses were run on the entire data set of 63.

#### 3.1 Data Screening

Kolmogorov-Smirnov tests were used to check the distribution of data. Variables that were not normally distributed were transformed using square root transformations. Data for the BDI and SIAS were normalised using these transformations, and the transformed scores were used in the analyses. Transformations did not normalise scores for the difficulty rating of the speech, the compliance with the written task measure, and the difference between self and observer ratings of performance. In these cases untransformed data were used in the analyses of variance. Although it is important to be aware of this in the interpretation of the analyses, Howell (2000) argues that ANOVA is extremely robust, particularly in relation to violations of the assumption of normality.

#### 3.2 Standardised measures

Table 1 shows mean scores for social anxiety, depression, self-compassion, and trait and state anxiety. There were no significant differences between the groups on any of the measures.

Table 1: Means and standard deviations of scores on standardised measures

|                       | Self-compassion |           | Emotional processing |           | Control  |           | F Statistic |
|-----------------------|-----------------|-----------|----------------------|-----------|----------|-----------|-------------|
| Variable              | <i>M</i>        | <i>SD</i> | <i>M</i>             | <i>SD</i> | <i>M</i> | <i>SD</i> |             |
| SIAS                  | 36.19           | 6.26      | 38.24                | 10.13     | 37.76    | 7.62      | .15         |
| BDI-II                | 13.67           | 12.92     | 16.52                | 11.94     | 12.35    | 8.05      | .68         |
| Self-Compassion Scale | 2.78            | .65       | 2.55                 | .69       | 2.55     | .54       | .98         |
| STAI Trait            | 46.95           | 10.99     | 50.38                | 12.26     | 45.9     | 8.33      | .99         |
| STAI State 1          | 37.05           | 8.62      | 43.52                | 11.2      | 38.57    | 6.47      | 2.99        |

Note: STAI state 1 was completed before the speech; STAI state 2 was completed after the speech. P values ranged from .06 for the STAI State 1 to .74 for the STAI Trait.

### 3.3 Manipulation check

Following the experimental manipulation, participants rated the degree to which they had followed the written instructions on a scale of 0-10. The mean ratings were 6.95 ( $SD = 1.34$ ) for the self-compassion group, 7.75 ( $SD = 1.45$ ) for the emotional processing group, and 6.9 ( $SD = 1.77$ ) for the control group, indicating a reasonable degree of compliance in each group. There were no significant differences between the three groups,  $F(2, 60) = .14, p = .87$ , which indicates that all of the groups followed the instructions equally well.

### 3.4 Performance

#### 3.4.1 Difficulty of Speech Task

Participants also rated how difficult they found the speech task. The mean ratings were 7.1 ( $SD = 2.05$ ) for the self-compassion group, 6.85 ( $SD = 1.81$ ) for the emotional processing group, and 6.81 ( $SD = 1.86$ ) for the control group. A one way ANOVA showed no significant differences between the groups,  $F(2, 61) = .14, p = .87$ .

#### 3.4.2 Participants' perceptions of performance on the speech task

Table 2 shows the means and standard deviations for participants' self-ratings of their speech performance. Participants made two sets of ratings, one after completing the speech and the second one following the written task. A two (time) by three (group) mixed design ANOVA was used to compare participants' ratings of their performance immediately after giving the speech and after the experimental manipulation. There was no main effect of group,  $F(2, 60) = .17, p = .85$ , but there was a main effect of time,  $F(1, 60) = 6.09, p = .016$ . Mean scores for all participants were 36.70 ( $SD = 11.00$ ) immediately after the speech and 35.38 ( $SD = 12.01$ ) after the written task. All participants rated their performances as better after the written task than they had immediately after giving the speech. There was a non-significant trend towards an interaction between time and group on the speech task,  $F(2, 60) = 2.68, p = .077$ .

Table 2: Means and standard deviations of participant ratings on the Performance Rating Form at time 1 and time 2

|                      | Self-compassion |           | Emotional processing |           | Control  |           |
|----------------------|-----------------|-----------|----------------------|-----------|----------|-----------|
| Variable             | <i>M</i>        | <i>SD</i> | <i>M</i>             | <i>SD</i> | <i>M</i> | <i>SD</i> |
| Performance Rating 1 | 36.43           | 13.57     | 36.43                | 10.31     | 37.24    | 9.19      |
| Performance Rating 2 | 33.38           | 14.45     | 36.19                | 10.94     | 36.57    | 10.60     |

### 3.4.3 Observer's perceptions of performance on speech task

As well as participants' self-ratings, we also asked independent observers to rate video-tapes of the speeches. We predicted that the self-compassion written task would reduce self-critical appraisals of performance on the speech task. Therefore, the discrepancy between self and observer ratings would be reduced in the self-compassion group. In order to assess this we calculated two difference scores. In the first set we subtracted participant ratings immediately after the speech from observer ratings. In the second set we subtracted participant ratings made following the written task from the observer ratings.

Table 3 shows the means and standard deviations of the two sets of difference scores, which were analysed in a two-way mixed mode ANOVA. There was no main effect of group,  $F(2, 59) = 1.41, p = .25$ , but there was a main effect of time,  $F(1, 59) = 5.82, p = .019$ . All participants' ratings were closer to the observer's performance ratings after the written task. This effect was moderated

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 by a time by group interaction,  $F(2, 59) = 5.22, p = .008$ , which is shown in Figure 1. Post hoc paired t-tests showed a significant difference between the first and second set of difference scores in the self-compassion group,  $t(20) = -4.26, p = .000$ . This suggests that participants in the self-compassion group rated their performance more objectively after the self-compassion induction than they had done before the induction. No significant difference was found between the first and second set of difference scores for the control or emotional processing groups,  $t(19) = .46, p = .65$  and  $t(20) = -.323, p = .75$ .

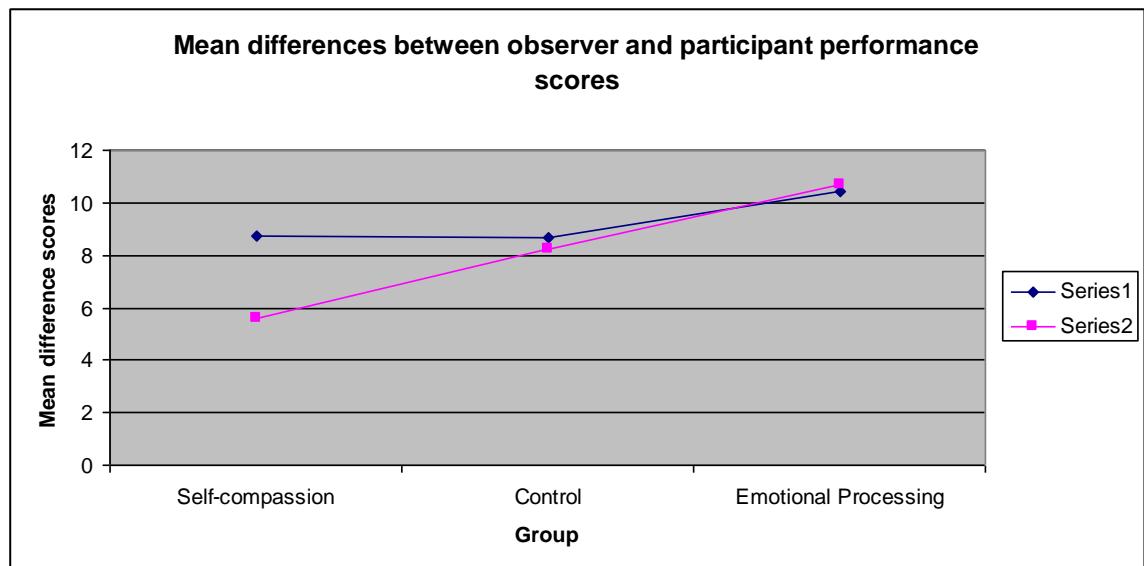
Table 3: Means and standard deviations of differences between observer performance ratings and participant performance ratings at time 1 and time 2<sup>2</sup>.

|  | Self-compassion |           | Control  |           | Emotional Processing |           |
|--|-----------------|-----------|----------|-----------|----------------------|-----------|
| Variable   | <i>M</i>        | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i>             | <i>SD</i> |
| Difference score 1<br>(Participant's 1st performance rating minus observer rating)             | 8.71            | 7.12      | 8.65     | 5.56      | 10.43                | 6.36      |
| Difference score 2<br>(Participant's 2 <sup>nd</sup> performance rating minus observer rating) | 5.62            | 7.28      | 8.25     | 6.68      | 10.67                | 7.60      |

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<sup>2</sup> Participant self-ratings of performance at time 1 and time 2 were subtracted in turn from the observer ratings in order to produce the difference scores above. Some items rated by the participants were not included as the observer was unable to rate them by watching a recording of the speech. For example, the observer could not assess whether the participant was sweating. This is why a significant interaction was found for the difference scores, while only a trend towards significance was found for the participant performance scores above.

Figure 1: Mean differences between observer and participant performance scores.



### 3.5 Post-event processing

#### 3.5.1 Thoughts Questionnaire

The Thoughts Questionnaire was administered to establish whether the self-compassion induction reduced post-event processing immediately after the written task. The mean scores were 65.67 ( $SD = 15.16$ ) for the self-compassion group, 73.33 ( $SD = 17.69$ ) for the control group, and 66.95 ( $SD = 13.58$ ) for the emotional control group. A one-way ANOVA showed no significant differences between the groups,  $F(2, 60) = 1.46, p = .24$ .

#### 3.5.2 Daily Thoughts Questionnaires

Table 4 shows group means and standard deviations for the DTQ. Scores were compared to assess whether the self-compassion group reported less post-event processing than the other groups over the rest of the day of the experiment and during the following two days. A three (time) by three (group) mixed design ANOVAs were used to analyse the following three sets of scores from the DTQs: total scores, negative scores, and positive scores. Total scores were calculated by adding the rating from each item on the DTQ. Negative scores represented the total of negatively-valenced items and positive scores were a total of positively-valenced items. For the total scores there was an effect

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 of time,  $F(2, 84) = 68.09, p = .000$ , but no effect of group,  $F(2, 42) = .87, p = .43$ , or interaction of time x group,  $F(4, 84) = .78, p = .53$ . Similarly, there was an effect of time,  $F(2, 84) = 63.13, p = .000$ , for the positive scores, but no effect of group or time by group interaction,  $F(2, 42) = .71, p = .50$  and  $F(4, 84) = .45, p = .72$ , respectively. An effect of time was found for the negative scores,  $F(2, 82) = 34.59, p = .000$ . No effect of group or time by group was found,  $F(2, 41) = .24, p = .79$ , and  $F(4, 82) = .35, p = .79$ , respectively.

Table 4: Means and standard deviations of scores for day 1, day 2, and day 3 on the DTQ \*.

|                | Self-compassion |           | control  |           | Emotional processing |           |
|----------------|-----------------|-----------|----------|-----------|----------------------|-----------|
| Variable       | <i>M</i>        | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i>             | <i>SD</i> |
| DTQ 1 total    | 1.47            | 1.07      | 1.11     | .57       | 1.30                 | .75       |
| DTQ 2 total    | .87             | 1.11      | .48      | .52       | .73                  | .74       |
| DTQ 3 total    | .38             | .61       | .22      | .35       | .50                  | .72       |
| DTQ 1 positive | .58             | .49       | .40      | .27       | .50                  | .49       |
| DTQ 2 positive | .27             | .52       | .10      | .17       | .20                  | .32       |
| DTQ 3 positive | .13             | .34       | .06      | .19       | .10                  | .22       |
| DTQ 1 negative | .95             | .82       | .85      | .65       | .92                  | .61       |
| DTQ 2 negative | .57             | .68       | .44      | .60       | .57                  | .67       |
| DTQ 3 negative | .27             | .36       | .21      | .47       | .43                  | .76       |

\* All scores were square root transformed to create a normal distribution

### 3.6 Anxiety

The STAI was administered to measure anxiety following the speech task and following the written task to establish whether the self-compassion instructions reduced anxiety more than the other sets of instructions. Table 5 shows means and standard deviations for these scores. A mixed design ANOVA was used to analyse differences between the groups. There was a main effect of time,  $F(2, 60) = 53.64, p = .000$  which shows that all participants' anxiety reduced over time. There was no effect of group,  $F(2, 60) = .166, p = .85$ , and there was no

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 interaction of time by group,  $F(2,60) = .301, p = .74$ . This suggests that the self-compassion instructions did not reduce participants' anxiety more than the control or emotional processing instructions.

Table 5: Means and standard deviations for ratings of anxiety on the STAI State measure after the speech task and following the written task.

|              | Self-compassion |       | Emotional processing |       | Control |       |
|--------------|-----------------|-------|----------------------|-------|---------|-------|
| Variable     | M               | SD    | M                    | SD    | M       | SD    |
| STAI State 2 | 48.52           | 12.89 | 51.14                | 11.19 | 50.62   | 10.15 |
| STAI State 3 | 42.29           | 12.67 | 43.33                | 11.18 | 42.67   | 8.94  |

#### 4. Discussion

The aim of the current study was to investigate the impact of an induced self-compassionate perspective on factors thought to maintain social anxiety. In the study, induced self-compassion helped socially anxious participants view their performance of a speech more objectively. Self-compassion did not reduce post event processing or the anxiety aroused by a stressful social situation. These results will now be discussed in relation to theory and recent research findings on social anxiety and self compassion.

The present study's finding that a self compassionate perspective increased the objectivity of participants' appraisals of their performance is consistent with the theory and research base for self-compassion. It is important to note that participants in the self-compassion group did not simply rate their performance more positively, which would have created a significant difference in time two performance scores between the groups. Instead it takes comparison to observer ratings to see a significant difference between groups, indicating that participants in the self-compassionate group had a more objective view of their performance rather than purely a more positive view.

The results of this study are consistent with those of Leary and colleagues (2007), who found in their series of studies that participants high in self-compassion were more accurate in appraising their own performance than

Developments in self-compassion 66 participants low in self-compassion. When self-compassion was induced, participants were less critical of themselves. The present study shows that a self-compassion induction can produce more accurate perceptions of performance in a socially anxious group.

Achieving a more objective perception of one's performance through self-compassion would be predicted by the literature on self-compassion. According to Neff (2003a), several aspects of self-compassion lead one to be less self-critical and more able to judge one's actions objectively. Self-compassion involves self-kindness, which is the antithesis of the harshly self-critical view associated with social anxiety. Mindful acceptance involves stepping back from one's emotions, which allows one to accurately assess one's performance. Accepting one's faults as part of being human, rather than feeling isolated by them may also make objective perceptions more possible.

If a more accurate appraisal of performance is made, the discrepancy between the person's desired performance, or what the person believes is expected by others, and what they feel capable of delivering would be decreased. This may decrease the fear of social disapproval, which is central to social anxiety (Rapee & Lim, 1992).

Harshly critical perceptions of performance are a hallmark of social anxiety, which are thought to contribute to the maintenance of the disorder (Hofman, 2007; Clark & Wells, 1995; Rapee & Heimberg, 1997; Stopa & Clark, 1993; Rapee & Lim, 1992; Alden & Wallace, 1995).

CBT for social anxiety, an evidence-based treatment for social anxiety, includes correcting these misperceptions as an important element of treatment (Hofman, 2007). Therefore, self-compassion may be useful in the treatment of social anxiety as this study shows that it appears to modify harsh perceptions of performance in socially anxious people. Using self-compassion to change perceptions of performance differs from a CBT approach in that it would not involve directly challenging perceptions. As CBT does not work for everyone, this may be a useful addition to treatment. It must be noted that this is the first effect found in the first study of self-compassion and social anxiety, so further research is required.

The present study did not find an effect of self-compassion on post-event processing. Participants in the self-compassion group experienced equivalent levels of positive, negative and total amounts of post-event processing, or rumination. The impact of self-compassion on rumination is a less well studied area within the literature. Neff (2003b) found that self-compassion is associated with lower levels of rumination. It is possible that post-event processing is more difficult to change than other factors maintaining social anxiety. A one-off, 10 minute self-compassion induction may not be enough to change what may be a long-standing pattern of thinking.

The self-compassion induction did not impact on participants' reported anxiety levels. This contrasts with Leary and colleagues finding that a self-compassion induction reduced negative emotions, including anxiety, in nonclinical student population. Perhaps the anxiety aroused by this socially stressful situation in a socially anxious population is so elevated or automatic that it would take more self-compassion training to notice a decrease in anxiety. Alternately, it may take more opportunities to practice self-compassion, or a less stressful situation in which to practice it, in order to reduce anxiety. It is possible that due to high levels of anxiety, participants struggled to develop a self-compassionate perspective.

Despite experiencing levels of anxiety equivalent to those of the other groups, the self-compassion group were able to become more objective in assessing their performance. This suggests that self-compassion participants were able to 'stand back' from their feelings of anxiety, reducing the impact of anxiety on their judgements of their performance. As focusing on feelings of anxiety is considered a maintaining factor for social anxiety (Hofman, 2007; Clark & Wells, 1995; Rapee & Heimberg; 1997), this skill may be very useful for the treatment of social anxiety.

A limitation of this study include was the brief nature of the self-compassion training. Self-compassion involves a complex set of skills and ways of thinking, which normally requires practice. Within Buddhist tradition compassion towards self and others is practiced repeatedly over much longer periods. The need for

practice and repetition is also emphasised where self-compassion and/or mindfulness is used in the treatment of other mental health problems (e.g. Gilbert, 2009; Linehan, 1999). Leary was able to show that a brief induction period could modify non-anxious individuals' self-criticisms. This study was a first attempt at inducing self-compassion in order to influence social anxiety, and as such did not request a great investment of time from participants. The positive result found in the present study supports further, more intensive self-compassion training, which may be expected to have a much greater impact on social anxiety.

The high level of anxiety experienced by participants due to giving an impromptu speech may have also interfered with their ability to develop a self-compassionate perspective. Leary's task of recalling a past event is likely to be much less anxiety provoking than giving an impromptu speech, which may explain why Leary and colleagues found reductions in negative emotions, including anxiety, while the present study did not. Future research may benefit from the use of a less anxiety-provoking task.

In retrospect, it is possible that the part of the self-compassion instructions designed to elicit self-kindness may have been more effective if they had been more explicit. This set of instructions involved considering how one would feel towards a friend who had just given a similar speech. It is assumed that participants will imagine that the friend has experienced the speech similarly to the participant (e.g. feeling anxious and critical of his or her performance), and feelings of empathy and a drive to comfort the friend will be elicited. However, it is possible that the friends imagined by participants may be perceived as more competent public speakers, who are not in need of a compassionate and reassuring response. Although the content of responses was not formally analysed, the author's impression was that participants did respond compassionately in the exercise. A risk of making the instructions more explicit is that it may lead participants to think more negatively about their own performance.

More broadly, it was difficult to judge the effectiveness of the experimental manipulation, inducing self-compassion, as self-compassion was not measured

before and after the manipulation. Had a state measure of self-compassion existed, this may have been used before and after the manipulation. However, there is a risk that completing the form before the experiment may have contaminated the results by cueing all of the groups into the purpose of the study or priming them to be more self-compassionate. The content of the written exercise could have been used to assess the impact of the self-compassion induction. This was not done because participants may have felt more pressure to perform during the written task, which may have interfered with their ability to comply with the instructions. Instead participants were told that their written work would not be evaluated in order to facilitate their compliance.

The decision to use the SIAS to select participants for the present study was based largely on the existence of a database of results, providing a large pool of potential participants. Subsequently, only a few of these participants were recruited, and only for the pilot study. This arrangement potentially could have compromised the study. Firstly, two to three months elapsed between the time participants completed the SIAS and the time the present study was run. As a result participant levels of social anxiety may have changed. In order to ensure that participants continued to meet the cut-off for social anxiety, the SIAS was administered a second time at the beginning of the experimental session. Secondly, it is possible that a measure selected for convenience may not have been the best measure for the study. The Fear of Negative Evaluation Scale (Watson & Friend, 1969) was also considered, but ruled out due to criticisms of the validity of some of its items (Rodebaugh et al., 2004). Other measures focus more on somatic or behavioural symptoms of social phobia (e.g. Social Phobia and Anxiety Inventory (Turner Beidel, & Dancu, 1996). In contrast, the SIAS focuses on key cognitions central to the present study, and was perhaps the most appropriate one to use in this case.

The present study shows that a brief self-compassion induction can impact on some factors which maintain social anxiety, namely harshly self-critical perceptions of performance and focusing overly on anxiety. As a part of the larger study, Price (2008) has looked at the impact of self-compassion on self-image within a socially anxious group, and associations between self-compassion and self-esteem. These studies have not looked at the impact of

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self-compassion on other factors which maintain social anxiety, e.g. avoidance and safety behaviours. This may be a subject for future research.

In conclusion, a self compassion induction appeared to modify harshly negative perceptions of performance in a socially anxious group. It did not reduce anxiety or post event processing. In order to further assess whether self-compassion training may benefit treatment for social anxiety, further research is needed. Research may include a longer course of self-compassion training; a better check of the effectiveness of the self-compassion training; assessment of self compassion on other factors thought to maintain social anxiety, such as avoidance and safety behaviours; and, perhaps, using a social task which is less stressful than the speech task used in the present study.

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Appendix A: Design protocol

Recruitment

Undergraduate psychology students will be screened using the Social Interaction Anxiety Scale (SIAS). Many participants were screened as part of the year 1 and year 2 pretest that took place at the beginning of the academic year.

Additional participants will be recruited via posters and adverts in Psychobook and Facebook. Psychology students who have not completed to year 1 and year 2 screening will be given 1 course credit. Nonpsychology students will be offered the chance of winning one of two £10 prizes.



75 undergraduates whose scores on the SIAS fall 1 standard deviation or more above the mean score will be recruited for the study. They will be offered 6 course credits for participating.



Testing session (Approximately one to one and a half hours)



The consent form (1<sup>st</sup> page only) will be given to participants to read and sign. All participants will complete the State Trait Anxiety Inventory (STAI; state and trait forms), and Beck Depression Inventory-II (BDI-II), and the anxiety rating scale (which will be used to monitor if they need to be offered the progressive relaxation exercise at the end of their experimental session).



Participants will then be asked to give a two minute speech. Written consent to do the speech and to be video-taped will be gained. Participants will be told that an independent rater will view the tape of their speech and evaluate their performance. Participants will complete a 2 minute speech which is video-taped with the investigator in the room but not watching.

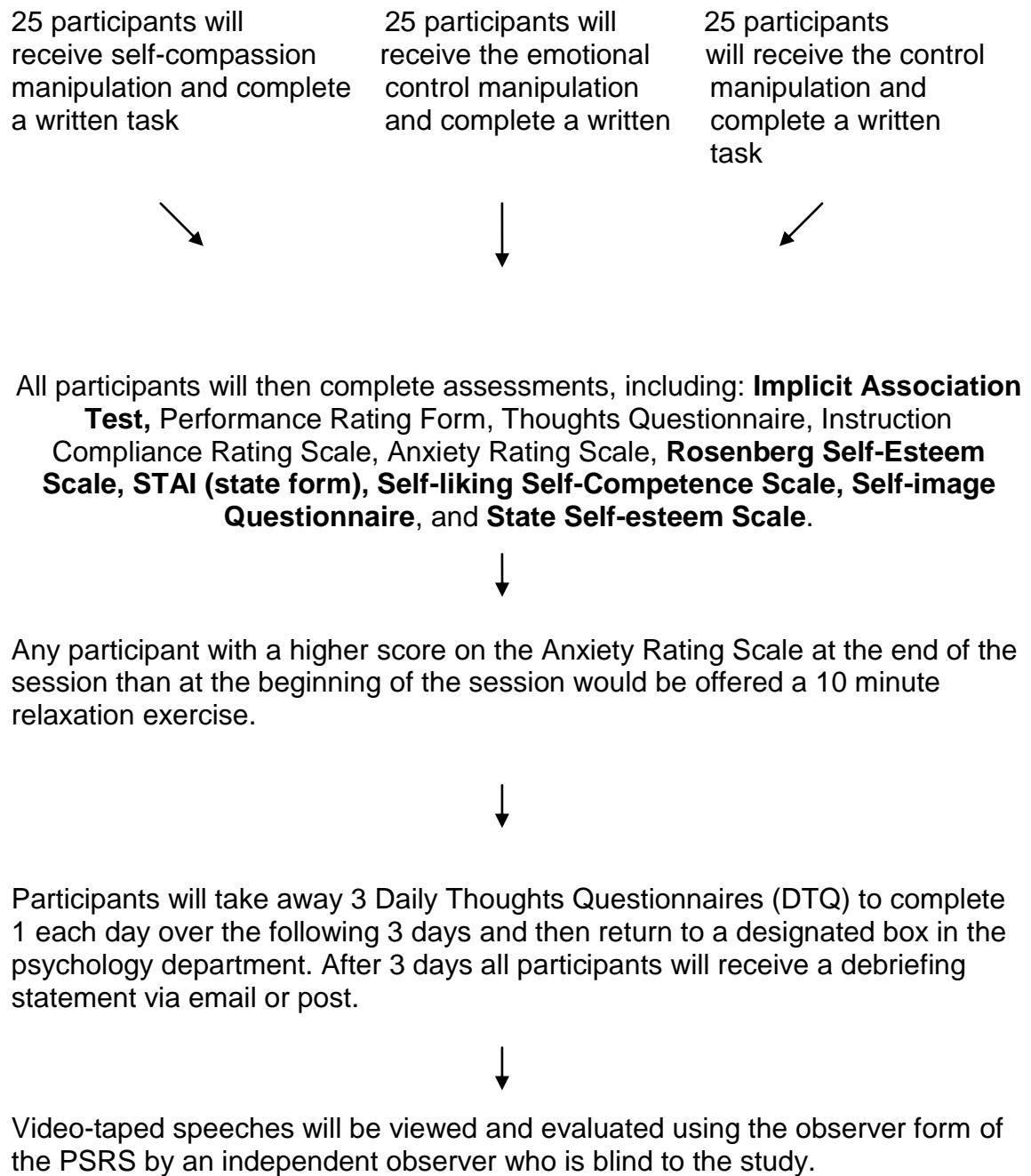


Next participants will complete the STAI (state form only), Performance Rating Form, **Self-image Questionnaire**, and the difficulty rating scale.

Conditions



<sup>3</sup> The measures in bold form part of the larger study (Price, 2008).





**Ethics Application**

Smith K.M.

**Sent:** 16 May 2007 14:44

**To:** thomas s.s. (sst105); price e.d. (edp105)

**Attachments:**  [Indemnity Insurance Form.doc \(57 KB\)](#) [\[Open as Web Page\]](#)

Dear Sara & Emma

**Re: Attitudes towards the self**

The above titled application was approved by the School of Psychology Ethics Committee on 16 May 2007.

You will now need to complete the attached insurance form - and return to the address provided.

Should you require any further information, please do not hesitate in contacting me. Please quote reference CLIN/04/56.

Best wishes,

Kathryn

Miss Kathryn Smith  
Secretary to the Ethics Committee  
School of Psychology  
University of Southampton  
Highfield  
Southampton SO17 1BJ  
Tel: 023 8059 3995 Fax: 023 8059 2606  
Email: [kms@soton.ac.uk](mailto:kms@soton.ac.uk)

Appendix C: Consent form

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## Attitudes towards the self

### Consent Form for Research Participants

#### Information sheet

We are Sara Thomas, and Emma Price, Trainee Clinical Psychologists working with Dr Lusia Stopa at the University of Southampton. We are requesting your participation in a study regarding attitudes towards the self. This will involve a number of tasks, both social and non-social and will take approximately 45 minutes to 1 hour to complete. Personal information will not be released to or viewed by anyone other than researchers involved in this project. Results of this study will not include your name or any other identifying characteristics.

Your continued participation in this research will be taken as evidence of your giving informed consent to participate in this study and for your data to be used for the purposes of research, and that you understand that published results of this research project will maintain your confidentiality. Your participation is voluntary and you may withdraw your participation at any time. If you choose not to participate there will be no consequences to your grade or to your treatment as a student in the psychology department. If you have any questions please ask us now or contact us, Sara Thomas on [sst105@soton.ac.uk](mailto:sst105@soton.ac.uk) or Emma Price on [edp105@soton.ac.uk](mailto:edp105@soton.ac.uk).

#### Statement of Consent

I \_\_\_\_\_ have read the above informed consent form.  
[participant's name]

I understand that I may withdraw my consent and discontinue participation at any time without penalty or loss of benefit to myself. I understand that data collected as part of this research project will be treated confidentially, and that published results of this research project will maintain my confidentiality. In signing this consent letter, I am not waiving my legal claims, rights, or remedies. A copy of this consent letter will be offered to me.

#### (Circle Yes or No)

I give consent to participate in the above study.

Yes      No

Signature

Date

Name

I give consent to be videotaped/audiotape.

Yes      No

I understand that these videotapes/audiotapes will be stored securely.

Yes      No

Signature

Date

Name

I understand that if I have questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I can contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 3995.

Appendix D: Measure of Difficulty of the speech task

### **Difficulty Rating Scale**

How difficult was it for you to give the speech? Rate the difficulty on a scale of 0-10 where 0 is not at all difficult and 10 is the most difficult a task could be.

Not at all  
difficult

## The most difficult

0

1

2

3

4

5

6

7

8

9

10

Appendix E: Performance Rating Form (self and other versions; adapted from Rapee & Lim, 1992)

## Performance Rating Form - SELF

We would like you to rate your performance of the speech on the features listed below. For each feature, please circle the appropriate number to indicate how you felt you performed the speech. Your evaluation will remain confidential.

|  | Not at all | slightly | moderately | much | very much |
|--|------------|----------|------------|------|-----------|
| 1. Content was understandable            | 0          | 1        | 2          | 3    | 4         |
| 2. Stuttered                             | 0          | 1        | 2          | 3    | 4         |
| 3. Had long pauses (more than 5 seconds) | 0          | 1        | 2          | 3    | 4         |
| 4. Fidgeted                              | 0          | 1        | 2          | 3    | 4         |
| 5. "Um"ed and "Ah"ed                     | 0          | 1        | 2          | 3    | 4         |
| 6. Had a clear voice                     | 0          | 1        | 2          | 3    | 4         |
| 7. Seemed to tremble or shake            | 0          | 1        | 2          | 3    | 4         |
| 8. Sweated                               | 0          | 1        | 2          | 3    | 4         |
| 9. Blushed                               | 0          | 1        | 2          | 3    | 4         |
| 10. Face Twitched                        | 0          | 1        | 2          | 3    | 4         |
| 11. Voice quivered                       | 0          | 1        | 2          | 3    | 4         |
| 12. Appeared confident                   | 0          | 1        | 2          | 3    | 4         |
| 13. Appeared nervous                     | 0          | 1        | 2          | 3    | 4         |
| 14. Kept audience interested             | 0          | 1        | 2          | 3    | 4         |
| 15. Generally spoke well                 | 0          | 1        | 2          | 3    | 4         |
| 16. Made a good impression               | 0          | 1        | 2          | 3    | 4         |

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Performance Rating Form - OTHER

We would like you to rate the person on the features listed below. For each feature, please circle the appropriate number to indicate how you felt they rated. Your evaluation will remain confidential.

|  | Not at all | slightly | moderately | much | Very much |
|--|------------|----------|------------|------|-----------|
| 1. Content was understandable            | 0          | 1        | 2          | 3    | 4         |
| 2. Stuttered                             | 0          | 1        | 2          | 3    | 4         |
| 3. Had long pauses (more than 5 seconds) | 0          | 1        | 2          | 3    | 4         |
| 4. Fidgeted                              | 0          | 1        | 2          | 3    | 4         |
| 5. "Um"ed and "Ah"ed                     | 0          | 1        | 2          | 3    | 4         |
| 6. Had a clear voice                     | 0          | 1        | 2          | 3    | 4         |
| 7. Seemed to tremble or shake            | 0          | 1        | 2          | 3    | 4         |
| 8. Sweated                               | 0          | 1        | 2          | 3    | 4         |
| 9. Blushed                               | 0          | 1        | 2          | 3    | 4         |
| 10. Face Twitched                        | 0          | 1        | 2          | 3    | 4         |
| 11. Voice quivered                       | 0          | 1        | 2          | 3    | 4         |
| 12. Appeared confident                   | 0          | 1        | 2          | 3    | 4         |
| 13. Appeared nervous                     | 0          | 1        | 2          | 3    | 4         |
| 14. Kept audience interested             | 0          | 1        | 2          | 3    | 4         |
| 15. Generally spoke well                 | 0          | 1        | 2          | 3    | 4         |
| 16. Made a good impression               | 0          | 1        | 2          | 3    | 4         |

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Appendix F: Thoughts Questionnaire (Adapted from Edwards, Rapee, and  
Franklin (2003) by Dannahy and Stopa (2007))

**THOUGHTS QUESTIONNAIRE**

This questionnaire examines how you may think about the various aspects of the speech which you have just given. Some people may have very few thoughts about the conversation, whereas others may have thoughts about some of the things mentioned below. Please rate each statement as to how much you have thought about each aspect **in the time since you gave your speech.**

**I thought about this since I gave my speech**

| 0<br>4<br>Never  | 1<br>Not Often | 2<br>Sometimes | 3<br>Often | 4<br>Very Often |
|--|----------------|----------------|------------|-----------------|
| 1. I could have done much better   | 0              | 1              | 2          | 3               |
| 2. How anxious I felt  | 0              | 1              | 2          | 3               |
| 3. The person who watches my video will be interested in what I had to say   | 0              | 1              | 2          | 3               |
| 4. I should have talked about something else                                 | 0              | 1              | 2          | 3               |
| 5. The person watching the video will like me                                | 0              | 1              | 2          | 3               |
| 6. The person watching the video will not be interested in what I had to say | 0              | 1              | 2          | 3               |
| 7. My blushing/sweating/dry mouth/shaking was obvious                        | 0              | 1              | 2          | 3               |
| 8. How well I handled the task   | 0              | 1              | 2          | 3               |
| 9. I made a fool of myself   | 0              | 1              | 2          | 3               |
| 10. My speech flowed well  | 0              | 1              | 2          | 3               |
| 11. How much I enjoy these situations  | 0              | 1              | 2          | 3               |
| 12. How I always do badly in this type of situation                          | 0              | 1              | 2          | 3               |
| 13. The speech was awkward   | 0              | 1              | 2          | 3               |
| 14. I must have looked stupid  | 0              | 1              | 2          | 3               |
| 15. How smoothly it all went   | 0              | 1              | 2          | 3               |
| 16. How self-conscious I felt  | 0              | 1              | 2          | 3               |
| 17. How incompetent I appeared   | 0              | 1              | 2          | 3               |
| 18. That I made good points  | 0              | 1              | 2          | 3               |
| 19. How many pauses I made   | 0              | 1              | 2          | 3               |
| 20. How confident I felt   | 0              | 1              | 2          | 3               |
| 21. I came across as self-assured  | 0              | 1              | 2          | 3               |

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|                                     | 0 | 1 | 2 | 3 | 4 |
|-------------------------------------|---|---|---|---|---|
| 22. How awkward I felt              | 0 | 1 | 2 | 3 | 4 |
| 23. That I was at my best           | 0 | 1 | 2 | 3 | 4 |
| 24. How nervous I was               | 0 | 1 | 2 | 3 | 4 |
| 25. I didn't make a good impression | 0 | 1 | 2 | 3 | 4 |
| 26. Other aspects of the situation  | 0 | 1 | 2 | 3 | 4 |
| 27. The situation overall           | 0 | 1 | 2 | 3 | 4 |

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Appendix G: Daily Thoughts Questionnaire (adapted from Dannahy and Stopa  
(2007))

## **DAILY THOUGHTS QUESTIONNAIRE**

This questionnaire examines how often you may have thought about the various aspects of the session in which you gave a speech. Some people may have had very few thoughts about the speech task, whereas others may have thought frequently about some of the things mentioned below. Please rate each statement as to how much you have thought about each aspect **today**.

### **I thought about this:**

|          |          |          |          |          |
|----------|----------|----------|----------|----------|
| <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|----------|----------|----------|----------|----------|

|       |           |           |       |            |
|-------|-----------|-----------|-------|------------|
| Never | Not Often | Sometimes | Often | Very Often |
|-------|-----------|-----------|-------|------------|

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. Thoughts about the speech task during the day   | 0 | 1 | 2 | 3 | 4 |
| 2. How anxious I felt                              | 0 | 1 | 2 | 3 | 4 |
| 3. How well I handled the task                     | 0 | 1 | 2 | 3 | 4 |
| 4. How badly I came across                         | 0 | 1 | 2 | 3 | 4 |
| 5. How smoothly it all went                        | 0 | 1 | 2 | 3 | 4 |
| 6. How I always do badly in this type of situation | 0 | 1 | 2 | 3 | 4 |
| 7. Other aspects of the situation                  | 0 | 1 | 2 | 3 | 4 |



**Instruction Compliance Rating Scale**

While reading the instructions and doing the writing task, how much of the time were you able to keep the instructions in mind? Rate how you did on a scale of 0-10 where 0 is none of the time and 10 is all of the time.

|                     |   |   |   |   |   |   |   |   |   |   |    |                    |
|---------------------|---|---|---|---|---|---|---|---|---|---|----|--------------------|
| None of<br>the time | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | All of<br>the time |
|---------------------|---|---|---|---|---|---|---|---|---|---|----|--------------------|

Appendix I: Measure of anxiety before and after the experiment

## **Anxiety Rating Scale**

How anxious are you right now? Rate your anxiety on a scale of 0-10 where 0 is not at all anxious and 10 is the most anxious you have ever felt.

A horizontal scale with numerical labels from 0 to 10. The label 'No anxiety' is positioned above the first tick mark, and the label 'Most anxiety' is positioned above the last tick mark. The scale is marked with vertical tick marks at each integer value from 0 to 10.

Appendix J: Debrief statement

## Attitudes towards the self

### Debriefing Statement

The aim of this research was to assess whether an induced self-compassionate perspective impacts self esteem, perceptions of performance, and post event processing in socially anxious people following a social task. Self-esteem was measured using the Implicit Association Test (IAT: Greenwald et al., 1998), the Rosenberg Self-Esteem Scale (RSE: Rosenberg, 1965), and the Self-Liking/Self-Competence Scale (SLCS: Tafarodi & Swann, 1995). Perceptions of performance were measured using the Public Speaking Rating Scale (PSRS; Rapee & Lim, 1992). Post event processing was measured using the Thoughts Questionnaire (Edwards, Rapee & Franklin, 2003) and the Daily Thoughts Questionnaire (Dannahy & Stopa, 2006).

You were one of 60 participants who indicated socially anxious tendencies on a previous questionnaire allocated to either the self compassion induction or the control instruction condition. In the self compassion condition participants were given instructions which aimed to induce a compassionate perspective towards themselves in relation to their performance on the speech task. The instructions in the control condition were written to encourage processing of performance on the speech task which more closely replicates 'normal' processing. We hypothesized that inducing self compassion would improve participants' perceptions of their performance, increase self esteem, and decrease post event processing.

Your data will help our understanding of how self compassion induction impacts symptoms of social anxiety. It may lead to improved treatments for social anxiety.

Once again results of this study will not include your name or any other identifying characteristics. The experiment did use deception. You were not told initially that you would be asked to give a 2 minute speech. This was withheld so that baseline measures were not tainted by the anxiety of anticipating the speech. You may have a copy of this summary if you wish, and I can provide you with a summary of the results when the study is complete.

If you have any further questions please contact us Sara Thomas at [sst105@soton.ac.uk](mailto:sst105@soton.ac.uk), Emma Price at [edp105@soton.ac.uk](mailto:edp105@soton.ac.uk), or Lusia Stopa at [L.Stopa@soton.ac.uk](mailto:L.Stopa@soton.ac.uk).

Thank you for your participation in this research.

If you are interested, additional information about social anxiety in general and relevant research papers follow the end of this letter

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.  
Phone: (023) 8059 3995.

Social anxiety is a normal experience. Some people have higher levels of social anxiety than others. If you feel that it is a significant problem for you (e.g., if you feel that your anxiety prevents you from doing things on a regular basis), then there are various forms of help that you can access:

- The university counselling service (<http://www.counsel.soton.ac.uk/index/>) or your GP.
- Butler, G. (1999). *Overcoming Social Anxiety: A Self-help Guide Using Cognitive Behavioural Techniques*. An excellent self-help guide!
- <http://www.social-anxiety.org.uk> A good starting point for people just finding out about social anxiety and related issues, to enable them to access further information through this site and through external links; and to act as a central hub for the community of those with social anxiety problems in the UK.
- <http://www.babcp.com> (British Association for Behavioural and Cognitive Psychotherapies).
- <http://www.metta.org.uk/home.asp> (Masses of therapies from 'the holistic web').
- <http://www.phobics-society.org.uk/> (the largest charity dealing with anxiety and phobias). Providing support and help if you've been diagnosed with, or suspect you may have an anxiety condition as listed on the right. They can also help you deal with specific phobias such as fear of spiders, blushing, vomiting, being alone, public speaking, heights - in fact, any fear that's stopped you from getting on with your life.